Submitter : **Mr. alan aviles** **Date: 10/29/2007**

Organization : **new york city health and hospitals corporation**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2213-P-33-Attach-1.PDF

#33

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
125 Worth Street, Room 514, New York, NY 10013 Tel: 212-788-3321 alan.aviles@nychhc.org
nyc.gov/hhc

Alan D. Aviles
President

October 29, 2007

Mr. Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Weems:

RE: Proposed Rule CMS 2213-P – Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

On behalf of the New York City Health and Hospitals Corporation (NYCHHC), the public hospital system of New York City, I urge the Centers for Medicare and Medicaid Services (CMS) to withdraw Proposed Rule CMS 2213-P (the Proposed Rule).

Changes contained in the Proposed Rule would reduce annual Medicaid funding to NYCHHC in excess of $100 million annually. Our primary concern is that the Proposed Rule would be a severe burden for "all-inclusive rate" providers (also known as "flat rate" providers) such as NYCHHC. Simply put, the proposed CMS methodology for calculating the Upper Payment Limit (UPL) for Medicaid hospital outpatient services does not take into account the charge structure of health systems which are all-inclusive rate providers. While we understand CMS' desire to better define the scope of outpatient services covered under Medicaid, it is important that any new reporting system include an alternative that takes into account varied charge structures existing throughout the country.

CMS' proposed methodology would mandate States to use either departmental-level "cost-to-charge ratios" or a global outpatient "payment-to-charge" ratio derived from a hospital's most recently filed Medicare cost report, which would then be multiplied by the hospital's Medicaid outpatient hospital charges to determine the hospital's Medicaid UPL for outpatient services. Although this methodology could be used to calculate the Medicaid UPL for hospitals with comprehensive departmental charges, it fails to take into account the unique circumstances pertaining to all-inclusive rate providers such as NYCHHC.

The principle of "cost apportionment," which is the basis for preparing Medicare hospital cost reports, is described in the Provider Reimbursement Manual (PRM) § 2200.1. In general, providers are required to apportion cost to Medicare beneficiaries based on the ratio of covered beneficiary charges to total patient charges on a departmental basis. This charge-based departmental apportionment of cost cannot be used, however, unless the provider has developed and used a detailed charge structure that enables it to record total and Medicare beneficiary charges by department.

Since its inception in 1970, NYCHHC has been recognized as an all-inclusive rate provider by both Medicare and Medicaid. NYCHHC's 11 acute care hospitals do not have detailed departmental charges; rather, these hospitals charge a global fee based on the number of days the patient spends in the hospital. NYCHHC hospitals do bill separate charges for a limited assortment of ancillary services such as laboratory and radiology, but not enough to enable them to meet the requirements for departmental cost apportionment.

CMS has recognized the unique situation of all-inclusive rate providers by making separate provisions where a provider does not maintain departmental charges for the apportionment of cost. These are referenced in PRM § 2208.1, Methods of Cost Apportionment for All-Inclusive Rate or No-Charge Structure Providers, which states as follows:

> "The approved methods for apportioning allowable cost between Medicare and non-Medicare patients under the program are not readily adaptable to those hospitals having an all-inclusive rate (one charge covering all services) or a no-charge structure. Therefore, alternative methods of apportionment have been developed for all-inclusive rate or no-charge structure hospitals. These methods are available only to those hospitals which do not have charge structures for individual services rendered."

As all-inclusive rate providers, NYCHHC hospitals do not report departmental cost-to-charge ratios on Worksheets C and D, and these worksheets cannot therefore be used in the calculation of the Medicaid hospital outpatient UPL as outlined by CMS in the Proposed Rule. The absence of fully-developed charges at the NYCHHC hospitals would also distort the alternative payment-to-charge ratio proposed by CMS using Worksheet E of the Medicare cost reports.

Pursuant to PRM § 2208.1, NYCHHC has been authorized by CMS to use utilization statistics rather than charges to prepare Medicare cost reports for all of its acute care hospitals. Under this alternative methodology approved by Medicare, each NYCHHC hospital prepares special "off-cost report" worksheets to split Medicare

allowable cost from Worksheet B, Part I, Column 27 for all ancillary and outpatient cost centers between the inpatient and outpatient areas based on the same statistics that are used to allocate costs on the New York State Medicaid Institutional Cost Report (ICR). Total allowable outpatient cost is then divided by total outpatient visits reported on the Medicaid ICR to develop a total outpatient cost per visit, which is then multiplied by Medicare outpatient visits from the Provider Statistical and Reimbursement Reports (PS&R) to calculate allowable Medicare outpatient cost.

If CMS is intent on using the Medicare cost reports as the basis for determining the UPL for Medicaid hospital outpatient services for all-inclusive rate providers such as NYCHHC, the same methodology that is currently being used by NYCHHC to prepare both the Medicare cost reports and the New York State Medicaid ICRs could also be used in lieu of the charge-based methodology from the Proposed Rule. Under this alternative, the total allowable outpatient cost per visit from the HHC Medicare cost reports could be multiplied by HHC Medicaid outpatient visits to calculate the Medicaid outpatient UPL for the NYCHHC hospitals. Such an alternative would be consistent with the NYCHHC Medicare and Medicaid cost reporting principles already approved by CMS and would avoid the inaccuracies inherent in using cost-to-charge or payment-to-charge ratios for all-inclusive rate providers such as NYCHHC.

In light of the shortcomings of CMS' proposed UPL calculation for hospitals without departmental charges, CMS should allow states to use an alternative methodology such as the one discussed above to calculate the Medicaid hospital outpatient UPL for all-inclusive rate providers.

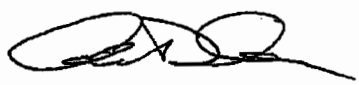
We are also concerned about the Proposed Rule's impact on disproportionate share hospital (DSH) payments and excluding some services that are currently reimbursed as Medicaid outpatient hospital services. By "aligning" Medicaid outpatient hospital services with Medicare, coverage for some services including, dental, vision and psychiatry would be eliminated. A by-product of such would be the reduction of a hospital's DSH cap for the uncompensated costs of such services furnished to Medicaid and indigent patients. In any event, given the different populations served by the two programs (Medicare is primarily for seniors while Medicaid covers millions of children as well as persons in other age categories), it does not appear to be good public policy to expect both programs to cover similar outpatient hospital services.

Finally, we believe that CMS' action in issuing the Proposed Rule violates a recent legislative moratorium (the Moratorium) (Public Law No. 110-28, Section 7002 (a)) which prohibits CMS from implementation a rule imposing a cost limit on Medicaid payments to governmental providers (CMS-2258-FC, the Cost Limit Rule), or any rule restricting payments for Medicaid graduate medical education (GME).

A major repercussion of the Proposed Rule is the exclusion of Graduate Medical Education (GME) costs from state calculations of the outpatient Medicaid UPL. However, the Moratorium prohibits CMS from taking actions that "implement any rule or provisions restricting payments for graduate medical education under the Medicaid program." States have never before been limited in providing outpatient GME support. Additionally, the Proposed Rule reissues regulatory language from the final cost limit rule redefining the categories of providers subject to UPL The outpatient UPL in effect at the time of the Moratorium applied to three categories of providers: State government owned or operated facilities; Non-State government-owned or operated facilities; and privately-owned and operated facilities (42 C.F.R. § 447.321(a). The Cost Limit Rule amended these categories to State government operated facilities; non-State government operated facilities; and privately operated facilities (42 C.F.R. § 447.321(a), as revised by 72 Fed. Reg. 29748, 29835 (May 29, 2007)), essentially removing all references to ownership. In including the reissue of the revised category language from the Cost Limit Rule in this Proposed Rule, CMS may be in violation of the Moratorium.

NYCHHC strongly urges CMS to withdraw this Proposed Rule. We hope that stakeholders, Congress, CMS, and the nation's hospitals could work together in order to better service the nation's Medicaid patients.

Sincerely,



Alan D. Aviles

Submitter : Mr. Santiago Mu?oz **Date:** 10/29/2007

Organization : University of California

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-34-Attach-1.PDF

CMS-2213-P-34-Attach-2.PDF

#34

UNIVERSITY OF CALIFORNIA

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October 29, 2007

Mr. Kerry Weems, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2213-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

SUBJECT: Comments on Proposed Rule CMS-2213-P
Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Proposed Rule CMS-2213-P related to Medicaid hospital outpatient services. Specifically, this rule limits the definition of outpatient hospital services, and will negatively impact disproportionate share hospital ("DSH") payments as well as the upper payment limit for Medicaid payments to teaching hospitals. These comments are submitted on behalf of the University of California (UC) Health System and its academic medical centers (AMCs) located at Davis, Los Angeles, Irvine, San Diego, and San Francisco. We are extremely concerned with impact of this proposed rule, which apparently is designed to further restrict federal financial participation ("FFP") for Medicaid payments to safety net providers, and respectfully urge its withdrawal.

The UC clinical enterprise is the fifth largest healthcare delivery system in California and provides patient care services valued at over $4 billion. In alignment with their patient care work, the UC AMCs play a critical role in a number of broad public-policy goals, including the education of health professionals and the advancement of medical science through cutting-edge research.

Specifically, the UC AMCs offer services that are essential to the health and well being of Medicaid beneficiaries and all Californians including a broad array of highly specialized services, such as trauma, neo-natal intensive care, cancer centers, geriatric

and orthopedic centers of excellence, organ transplant programs, world class primary and preventive care, and extensive sub-specialties often available only in an academic setting. Moreover, UC AMCs sponsor more than 300 residency training programs in all recognized specialties and subspecialties of medicine and surgery — nearly 4,000 residents participate annually in these programs.

Medicaid and uninsured patients represent nearly 30% of the patient population at the UC AMCs. We rely heavily on Medicaid payments to help ensure access to this patient population and also provide a learning venue for the nation's future physicians. This is especially important considering that we attract the highest resource intensive patients requiring specialty, tertiary and quaternary care. Quite simply, a significant number of our Medicaid patients have medical conditions that can only be managed in tertiary referral hospitals such as an academic medical center. The complexity of our patient population is reflected in the specialty and regional nature of the care we provide. Notwithstanding the provision of these essential services, we believe the UC AMCs, and similarly situated hospitals would be negatively impacted by the proposed rule.

The proposed rule should be withdrawn for a number of reasons. First, the current Congressional moratorium, which specifically prevents CMS from implementing restrictive cost-limit and GME rules, would preclude CMS from implementing Proposed Rule CMS-2213-P.

Second, by re-defining hospital outpatient services, CMS would effectively limit the hospital services recognized as uncompensated care costs for DSH payment purposes, including the OBRA 1993 limit, depriving hospitals of substantial costs for which DSH funds could be available. Among the major categories of uncompensated hospital services that no longer would be recognized are physician services, home health services, physical, speech and occupational therapy services, services provided by hospital-based federally qualified health centers, and services provided by outpatient and clinic components of the hospital that are recognized as hospital-based under state law, but not for Medicare payment purposes. We are concerned that changes of this magnitude may result in the reduction of critical health care services that public hospitals throughout California are uniquely qualified to provide, thereby limiting services and health care access to vulnerable populations.

Lastly, the proposed rule also changes the methodology by which the upper payment limit ("UPL") is calculated for private hospitals. The UPL currently in place bases Medicaid payments on a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles. The rule would base the UPL calculation on costs and payments for outpatient services from the Medicare cost report. More specifically, the methodology established in the proposed rule for computing the UPL would exclude the costs and payments for interns and residents and would result in an inaccurate calculation of the estimated amount that

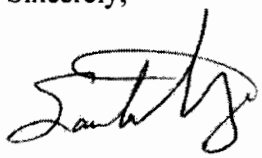
Medicare would pay for the services. Under the Medicare cost reporting rules, the costs of interns and residents are excluded from the cost-to-charge ratios on Worksheet C and Worksheet D, Part V of the Medicare cost report. Similarly, the Medicare payments for interns and residents are excluded from the Medicare hospital outpatient payments on Worksheet E, Part B. This exclusion makes sense under the Medicare program, as the costs of interns and residents are paid separately under the GME and Indirect Medical Education ("IME") payments. Medicare pays for GME and IME as part of the inpatient hospital payments, but these payments also cover services provided in outpatient areas. The exclusion of the costs of and payments for interns and residents will result in an incorrect calculation of the total Medicare cost-to-charge and payment-to-charge ratios. Furthermore, as noted above, the proposed methodology, which would exclude GME and IME costs, constitutes an implementation of the GME rule that is the subject of the congressional moratorium.

We are concerned that CMS may attempt to apply this flawed methodology to publicly operated hospitals, such as the UC AMCs, while the congressional moratorium is in place. Additionally, we are very concerned with the impact on hundreds of providers nationwide committed by mission to training the next generation of American medical professionals. The long term impact on teaching programs may well lead to physician shortages and access issues.

Finally, there are a number of other legal and technical issues raised in the comment letter submitted by the coalition of California's public hospitals, which we support and incorporate by reference.

Thank you for the opportunity to comment on this proposal. If there are questions or if I can provide any additional information or input, please contact me at 510-987-9062 or santiago.munoz@ucop.edu.

Sincerely,



Santiago Muñoz
Associate Vice President
Clinical Services Development

c: Medical Center CFOs

Submitter : **Mr. Greg Gombar** **Date: 10/29/2007**

Organization : **Carolinas Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Dear Mr. Weems:
Attn: CMS-2213-P Medicaid Program; Clarification of
Carolinas Medical Center (CMC) appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on its proposed rule on Medicaid outpatient hospital services published in the September 28th Federal Register. As a major provider of outpatient services in our region, the proposed regulatory changes would have a substantial and negative effect on our hospital and the patients we serve and we urge CMS to withdraw the proposed rule and suspend any further regulatory action attempting to change how states finance their Medicaid programs until Congress has completed its action in this area of Medicaid regulation.

We urge CMS not to implement the rule for the following reasons. Primarily, the proposed rule violates a Congressional moratorium prohibiting CMS from implementing changes to state financing mechanisms and graduate medical education payments under Medicaid. On May 25, 2007 President Bush signed H.R. 2206 U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 into law. Within this law is language clearly prohibiting CMS from implementing rules or provisions similar to those published in this proposed rule. The proposed rule on outpatient hospital services violates the moratorium in two ways: 1) the proposed regulation includes language from the state financing mechanism regulation that redefines categories of providers for the purposes of the upper payment limits (UPL) and 2) the proposed regulation would no longer allow graduate medical education (GME) costs in the calculation of the outpatient UPL.

The Centers for Medicare and Medicaid Services attempt to standardize the methodology for calculating UPL is problematic for teaching hospitals. As a public hospital with a medical education program with over 200 residents, CMC is pleased with the moratorium language included in H.R. 2206 prohibiting CMS from promulgating or implementing any rule or provisions restricting payments for graduate medical education under the Medicaid program. The proposed rule, if implemented, will have a significant financial impact to CMC, costing approximately $7 million annually in GME payments alone. The rule, as proposed, prohibits states from including graduate medical education costs in the outpatient upper payment limit
Mr. Kerry N. Weems
October 28, 2007
Page Two

(UPL). CMS requirements under the proposed rule for calculating cost for the outpatient hospital UPL reduces the ability of the states to make payment for GME by excluding those costs from those that may be included. This portion of the rule is clearly in violation of the language signed into law under H.R. 2206 which prohibits the secretary of Health and Human Services from promulgating or implementing any rule or provisions restricting payments for graduate medical education under the Medicaid program.

We are extremely concerned about this proposed regulation and CMS willingness to violate a Congressional mandate specifically preventing CMS from taking any action to develop new policies in the very areas this proposed rule purports to regulate. This proposed rule has significant and negative impact on our ability to continue to provide access to our patients in clinically appropriate and cost-effective environments. We urge CMS to withdraw this rule and suspend any further regulatory activity that affects the issues contemplated under the moratorium signed into law under H.R. 2206. We appreciate the opportunity to present our comments and would be pleased to discuss the impact of this proposed rule on our operations and our patients.

Thank you for your consideration.

Greg A. Gombar
Executive Vice President

Submitter : **Mr. Anthony Santangelo** **Date: 10/29/2007**

Organization : **Partners HealthCare System**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-36-Attach-1.DOC

#36

PARTNERS™
HEALTHCARE SYSTEM

By Electronic Mail

October 29, 2007

Kerry Weems.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW., Room 445-G
Washington, DC 20201

Attention: CMS-2213-P ---Medicaid Program: Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit; Proposed Rule (Vol. 72, No. 188), September 28, 2007

Dear Mr. Weems:

Partners HealthCare System, Inc. (Partners) is pleased to comment on the Proposed Rule for the Medicaid Program: Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit; Proposed Rule (Vol. 72, No. 188), as published in the September 28, 2007 Federal Register, on behalf of its member acute care hospitals:

Institution	**Medicare Provider Number**
Brigham & Women's Hospital	220110
Faulkner Hospital	220119
Massachusetts General Hospital	220071
Martha's Vineyard Hospital	221300
Nantucket Cottage Hospital	221301
Newton-Wellesley Hospital	220101
North Shore Medical Center	220035

Kerry Weems, Acting Administrator, CMS
Comments to CMS-2213-P ---Medicaid Program: Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit; Proposed Rule

I. Insufficient Comment Period

At the outset, we object to the short (30-day) comment period allowed for this proposed rule. This rule is, we strongly believe, considerably more than a "clarification" – it makes significant policy changes to the Medicaid program. Further, it may well have a financial impact far greater than CMS believes – for example, the definition of a governmental hospital remains unresolved under the congressional moratorium. It is our understanding that the full spectrum of providers affected by this proposed rule cannot be determined until this definition is resolved.

II. Key Policy Concerns

We join our colleagues at the American Hospital Association (AHA), Massachusetts Hospital Association (MHA) and National Association of Public Hospitals and Health Systems (NAPH) in urging CMS to withdraw this proposed rule for the following reasons:

1. **Violates Medicaid GME provision of Moratorium:** By effectively prohibiting states from including GME costs in the outpatient UPL, this proposed rule directly violates the Moratorium prohibiting any action to implement a rule restricting payments for Medicaid graduate medical education. We believe CMS proposed action is directly counter to Congressional intent.
2. **Potential impact on DSH Payments:** The proposed rule may have an adverse ripple effect on states' ability to support the provision of uncompensated care by hospitals. Specifically, the exclusion of services that are currently treated as outpatient hospital services may result in the subsequent denial of uncompensated care costs associated with those services from a hospital's DSH cap. DSH funding plays a critical role in supporting hospital care provided to uninsured patients. We oppose actions that adversely affect this important funding mechanism.

III. Other Issues

We note that a number of policy, legal and technical issues have been raised by AHA and NAPHS. We ask CMS to give full consideration to these issues. In particular, we reiterate the view expressed by others that there are key differences between the Medicare and Medicaid programs in scope of services and their target populations. States must have the flexibility to address these key differences through the use of alternative UPL calculation methodologies that more accurately capture these differences, adhere to standards of reasonableness and fulfill the policy intent of the Upper Payment Limit.

We thank you for this opportunity to comment and, in closing, again urge CMS to withdraw this rule. Please contact me at asantangelo@partners.org or 617-726-5449 should you have any questions.

Sincerely,

Anthony J. Santangelo, Jr.
Director, Government Revenue

Submitter : Mr. Peter Schonfeld **Date:** 10/29/2007

Organization : Michigan Health & Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-37-Attach-1.DOC

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

October 29, 2007

Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: (CMS-2213-P) Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit (Vol. 72, No. 188), September 28, 2007

Dear Mr. Weems:

On behalf of its 145 members, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to comment to the Centers for Medicare & Medicaid Services' (CMS) regarding the proposed rule revising Medicaid policy for federal reimbursement of Medicaid hospital outpatient services.

The CMS describes the Medicaid hospital outpatient proposed policy changes as clarifications to current rules. In addition, the CMS indicated that because the agency believes these changes will not result in a significant financial impact, the proposed rule is not considered a major rule and, therefore, a 30-day comment period is sufficient. The MHA disagrees on all points and believes the proposed rule is making major policy changes to the Medicaid program. As a result, a 30-day comment period is insufficient time for public comment. We also believe that the CMS is violating Congress' moratorium barring the agency from regulating on matters pertaining to how states finance their Medicaid programs and fund graduate medical education (GME) payments. **As a result, the MHA submits these comments with strong opposition to the changes proposed and urge the CMS to withdraw this rule.**

MORATORIUM

The CMS violates the year-long moratorium secured by P.L. 110-28 since the policy changes proposed are based on provisions within the May 28 final rule that Congress explicitly instructed the agency not to implement. ((CMS-2258) *Final Rule - Medicaid Program; Cost Limit for Providers Operated by Units of Government* (Vol. 72, No. 102), May 29, 2007) The CMS' proposed rule violates the moratorium in two ways.

First, the CMS proposes changes to the hospital outpatient upper payment limit (UPL) methodology. The proposed changes are based on a new definition of the categories of providers (state, non-state governmental and private) found in the final rule subject to the moratorium. The definition of these categories is important because each category has a different aggregate UPL calculation. Current

regulations define the three categories as: state government-owned or -operated facilities; non-state government-owned or -operated facilities; and private-owned and -operated facilities. (42 C.F.R. Section 447.321 (a)) The May 28 final rule redefines the categories by removing ownership status and the proposed rule relies on this new definition and restates it as, "State government-operated facilities ...Non-state government-operated facilities ...privately operated facilities" (pp 55158, 55165-66).

Second, the rule violates the moratorium with regard to the treatment of Graduate Medical Education (GME) costs. The proposed rule does not permit state Medicaid programs to include GME costs in determining the UPL – a clear violation of the moratorium barring any regulatory activity on restricting GME or such payments made.

SCOPE OF HOSPITAL OUTPATIENT SERVICES AND UPL CALCULATIONS

The proposed rule substantially departs from long-standing Medicaid policy regarding the definition of Medicaid outpatient hospital services and how costs for such services are treated for the purposes of calculating the hospital outpatient UPL. The CMS bases its dramatic shift in policy on the need to align Medicaid outpatient policies with Medicare outpatient polices, although these programs serve very different populations. Medicaid serves a largely pediatric population while Medicare serves an elderly population. Yet despite these differences, the CMS proposes to narrowly define Medicaid hospital outpatient services to align it with Medicare. The only justification for aligning the hospital outpatient policies for these two programs would be to limit Medicaid federal spending for hospital outpatient programs and state Medicaid programs overall.

Scope of Services. Current Medicaid regulations broadly define allowable hospital outpatient services to include preventative, diagnostic, therapeutic, rehabilitative or palliative services provided under the direction of a physician or dentist in a hospital. Under the proposed rule, the types of services that are at risk for not being reimbursed through hospital outpatient programs include Medicaid's early and periodic screening and diagnostic treatment dental services for children; physician emergency department services; physical, occupational and speech therapy; outpatient clinical diagnostic laboratory services; ambulance services; durable medical equipment; and outpatient audiology services. However, to justify this policy change, the CMS has not identified a problem with current state Medicaid programs. In fact, the agency states in the proposed rule's preamble that in examining 32 state plan amendments over the last four years, the CMS found only one state that defines non-hospital services as part of the outpatient hospital Medicaid set of services. (72 Fed. Reg. at 55161) In addition, while the CMS states that the services no longer reimbursed through hospital outpatient departments will be paid for through other parts of the Medicaid program, the agency fails to demonstrate that there is access to such services within the community outside of the hospital outpatient department.

Further, the CMS' attempt to narrow the definition of allowable hospital outpatient services poses serious implications for Medicaid disproportionate share hospital (DSH) payments. A hospital's uncompensated care costs help determine a hospital's DSH reimbursement. Currently, the CMS views only the costs for providing inpatient and outpatient hospital services as allowable for determining a hospital's uncompensated care costs. The CMS's proposed narrow definition would exclude many costs currently included in hospitals' Medicaid DSH calculations, potentially limiting DSH payments to hospitals that serve a high proportion of Medicaid patients and which are already struggling financially.

UPL Calculations. The CMS states that the proposed changes in the UPL methodology will apply only to private outpatient hospital UPLs. While this may appear straightforward, it is not. The definition of a governmental hospital remains unresolved because it falls within the scope of the final rule that is subject to the congressional moratorium. As a result, we find it nearly impossible to assess the change in UPL methodology because the universe is unknown.

In proposing a new methodology to determine UPL calculations, the CMS violates its own description of the proposed rule as one of "clarifications." States currently have some measure of flexibility in calculating the UPL. However, the proposed rule would limit states to two permissible methods of calculating the new UPL: Medicare cost-to-charge ratio based on Medicare allowable costs; and Medicare payments-to-charge ratio based on allowable costs. The cost information is to be derived from hospitals' filed Medicare cost reports. The selected ratios would be multiplied by Medicaid outpatient charges based on Medicaid paid claims.

This new formula for calculating UPL would have a major impact on hospitals. For example, children's hospitals would not have their costs appropriately accounted for in the new UPL methodology, particularly the Medicare payment-to-charges ratio, because they have little to no Medicare volume. GME costs also would not be accounted for in the new UPL methodology using the Medicare cost-to-charge ratio. In addition, state Medicaid programs would face a new administrative burden in attempting to adapt their current UPL calculations to this new proposed methodology.

CONCLUSION

The CMS states in the preamble that the fiscal impact of this rule would be minimal because the rule is a clarification of existing policy and would not result in the elimination of coverage. The MHA believes that the agency has failed to perform the due diligence necessary to make these statements. As a result, we would contend that these policy changes not only will have a significant fiscal impact on many state Medicaid programs, but could potentially affect coverage for outpatient hospital services.

The MHA urges CMS to withdraw this rule and suspend any further regulatory activity that affects the issues encompassed under the moratorium secured by P.L. 110-28. These proposed policy changes will result in cuts to state Medicaid programs, cuts in payments to hospitals, and reduced access to needed medical services for Michigan's most vulnerable residents who are served by the Medicaid program.

If you have any questions, please Marilyn Litka-Klein, Senior Director, Health Finance Policy and Data Services, at (517) 703-8603 or mklein@mha.org.

Sincerely,

Peter Schonfeld
Senior Vice President
Policy and Data Services

Submitter : Mr. Phillip Saperia **Date:** 10/29/2007

Organization : The Coalition of Behavioral Health Agencies, Inc.

Category : Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-38-Attach-1.PDF

#38

THE COALITION OF BEHAVIORAL HEALTH AGENCIES, INC.

October 29, 2007

Center for Medicare and & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

Re: CMS-2213-P; Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit (Federal Register, Vol. 72, No. 188, September 28, 2007)

The Coalition of Behavioral Health Agencies is submitting its comments on behalf of the more than 100 community based agency members who provide mental health and chemical dependence services to more than 350, 000 adults and children in a very diverse New York City and environs.

CMS is proposing the above changes as an emergency regulation, requiring merely 30 days of comment. The Coalition disagrees that this proposed change is minor and that 30 days is sufficient for adequate analysis and comment on its likely impact to the already fragile health and behavioral health service system.

Furthermore, this rule promulgation in a 30 day period is a direct violation of the Congressional moratorium barring CMS from regulating on matters relating to how states finance their Medicaid programs. Contrary to the statement on regulatory impact, the changes are, in fact, a major change in current practice with significant economic effects.

Many Medicaid financed programs, serving needy and vulnerable consumers, are fragile and at fiscal risk. Changes in finance methodologies require enough time to consider and make certain that any changes are reasonable and that such changes would be fully understood and calculated in their effect. Also such changes require time enough to involve input from all stakeholders. The 30 day period is grossly inadequate. While our agencies would not be directly affected by Graduate Medical Education payments, changes in the GME provision are also subject to the congressional moratorium and therefore not a fit subject for emergency rule making. Violation of congressional moratoria is bad precedent and should not be permitted.

The Coalition seeks the withdrawal of this rule by CMS. We are opposed to the changes proposed.

Proposal is Arbitrary

The proposed regulatory changes seem arbitrary, not developed with care and not fulfilling CMS's own purposes. CMS posits its purpose as to improve functionality of the Upper Payment Limit (UPL), provide more transparency in determining coverage and clarify the scope of services for which federal participation is available. To the contrary, the impact of the regulation would be to remove from the current scope of services some previously reimbursable services and fail to identify services that are and are not allowable under the new methodology. Consequently, such a rule is neither transparent nor clarifying. Moreover an entire new system for determining the Upper Payment Limit (UPL) is to be implemented.

Impact is Uncalculated

Within the text of the proposed regulatory changes, CMS admits that "(d)ue to a lack of available data, we cannot determine the fiscal impact of this proposed rule." The changes, therefore, could impact negatively on providers of clinic services, and in turn on the consumers who rely on these clinics for psychiatric treatment. The risk of disruption of clinical treatment is much too high given how little is known about the fiscal impact of this proposal.

Major vs. Minor Change and Related Costs

Assertions in the Regulatory Impact Statement about the limited nature of the change (an assertion contested by The Coalition), would allow HHS to implement these changes in a short time. If these changes are finalized, it would lead to a fundamental overhaul of current New York State billing practices. This will require computer system changes, retraining of staff and changes in forms and submissions to billing intermediaries. All of these changes would take significant time and entail significant costs to providers. Consequently, providers would be at risk for disallowances for charges made in good faith under current rules if they are found to exceed the UPL or other requirements of this new regulation.

Exclusion of Previously Authorized Costs and Valuable Services

The proposed regulations will allow Medicaid billing only for services authorized for reimbursement under Medicare. This will disallow a number of valuable services, such as day treatment, continuing day treatment and intensive psychiatric rehabilitation which are not covered by Medicare. States would then be left with the difficult choice of paying in full for the cost of these programs, or eliminating these services altogether, leaving thousands of New Yorkers with profound psychiatric disabilities without care.

Furthermore, the proposed rule would terminate the federal share of funding for the federally-mandated Early and Periodic Screening and Diagnosis Treatment (EPSDT) services for children.

Reductions in Quality of Care

By limiting the locations where services may be provided and requiring separation of professional and other charges, the proposed regulation will result in the reduction of the quality of care provided to consumers. The introduction on page 55159 of the Federal Register acknowledges the requirement that Medicaid reimburse quality care. Many aspects of care for

behavioral health clients require services in settings outside the walls of the clinic and require professional and non-professional efforts which address aspects of behavioral health problems that are not directly treatment of the client. These services and out-side clinic service locations are time honored ways of providing continuous, comprehensive and high quality care and positively affect treatment.

Creation of Liability for Every Provider

The Federal Register filing (p. 55160) reports that the current regulations limit outpatient hospital and rural health clinic payments in privately operated facilities to a "reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles." This requirement has been met in the past by comparing the overall costs for all providers to the estimated cost for such services under Medicate. In the explanation of the newly prescribed methodologies for determining the UPL, the regulation is described as being applied "for each provider as reported by MMIS." This provision seems to be designed to require cost comparisons on a provider by provider basis. All differences in location, populations served or of other differentiating parameters would be removed from consideration and the leveling benefits of considering the system as a whole would be lost. This provision would put individual providers at potential risk, despite their real world differences, if their charges differ from those calculated to be allowable under Medicare.

In summary, the proposed regulations violate the moratorium secured by P.L. 110-28 wherein Congress explicitly instructed CMS not to implement the May 28 final rule. The proposed changes are sufficiently complex and problematic that they can hardly be considered "non-major." They are likely to negatively affect many providers, and by extension many consumers of service, and should not be allowed to take effect without major scrutiny and widespread opportunity for analysis, stakeholder comment and possible modification. **In the strongest possible terms, we urge CMS to withdraw this rule.**

Sincerely,

Phillip A. Saperia
Executive Director

Submitter : **Date: 10/29/2007**

Organization :

Category : **Local Government**

Issue Areas/Comments

Upper Payment Limits

Upper Payment Limits

The proposed methodologies (cost-to-charge and payment-to-charge) ratios do not take into account alternative charge structures that have been allowed by Medicare. For example, hospitals that use an all-inclusive charge system have been permitted to complete their Medicare cost reports by using relative value units (RVUs) instead of charges. CMS should permit an alternative for the upper payment limit calculation that is set forth in this rule.

Submitter : **Ms. Heidi Conrad** **Date: 10/29/2007**

Organization : **Regions Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Upper Payment Limits

Upper Payment Limits

Outpatient Hospital and Clinic Services: Application of Upper Payment Limits (Proposed ? 447.321)
The proposal for defining the Outpatient UPL appears to be inconsistent with the current approach for Inpatient UPL calculation. The Payment to Charge ratio should be based on gross reimbursement not net after deductibles and coinsurance. Inpatient hospital UPL calculation is based on all of the Medicare components and compared to all but the disproportionate share part of the Medicaid payment. There is no deductible or coinsurance offset. The Outpatient UPL equivalent for Medicaid is Medicare Gross APC and fee schedule payment rates. In addition, the proposed Outpatient UPL calculation begins at a level that is, in essence, about 85% of cost at the top end "Gross Reimbursement" for APCs and fee schedule reimbursement. Therefore, we are already limited to much less than actual cost.

CMS-2213-P-40-Attach-1.RTF

#40

October 24, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: **CMS–2213-P**

Dear CMS:

Thank you for this opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule entitled *"Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit"* (September 28, 2007). As an entity that would be adversely affected by the proposed rule, we have significant concerns about the proposed changes to the Upper Payment Limits.

Regions Hospital is a leading, full-service hospital providing outstanding medical care, with special programs in heart, women's services, cancer, surgery, digestive care, seniors' services, behavioral health, burn, emergency and trauma. The health professionals at Regions Hospital are involved in teaching and research focused on improving health and medical care. As a safety net provider (we are a former county hospital) and second highest provider of charity care in Minnesota, stewardship and service are key components of our mission. In 2006, Regions provided over $41 million in uncompensated care to members of our community.

Outpatient Hospital and Clinic Services: Application of Upper Payment Limits (Proposed § 447.321)

The proposal for defining the Outpatient UPL appears to be inconsistent with the current approach for Inpatient UPL calculation. The Payment to Charge ratio should be based on gross reimbursement not net after deductibles and coinsurance. Inpatient hospital UPL calculation is based on all of the Medicare components and compared to all but the disproportionate share part of the Medicaid payment. There is no deductible or coinsurance offset. The Outpatient UPL equivalent for Medicaid is Medicare Gross APC and fee schedule payment rates. In addition, the proposed Outpatient UPL calculation begins at a level that is, in essence, about 85% of cost at the top end "Gross Reimbursement" for APCs and fee schedule reimbursement. Therefore, we are already limited to much less than actual cost.

We encourage CMS to reconsider this proposed calculation of upper payment limits in the outpatient setting and to adjust it to better reflect the costs of providing care to Medicaid patients.

Sincerely,

Heidi Conrad
Chief Financial Officer, Regions Hospital

Submitter : **Ms. Anne McLeod** **Date: 10/29/2007**

Organization : **California Hospital Association**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-41-Attach-1.DOC

#41

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

October 29, 2007

Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2213-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: (CMS-2213-P) Medicaid Program; clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit (Vol. 72, No. 188), September 28, 2007

Dear Mr. Weems:

On behalf of the California Hospital Association (CHA), thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule changing Medicaid policy for federal reimbursement of Medicaid hospital outpatient services. CHA represents more than 400 hospital and health system members, including general acute-care hospitals, children's hospitals, rural hospitals, psychiatric hospitals, academic medical centers, county hospitals, investor-owned hospitals and multi-hospital health systems. These hospitals furnish vital health care services to millions of our state's citizens. CHA also represents more than 100 Executive, Associate, and Personal members. CHA provides its members with state and federal representation in the legislative, judicial and regulatory arenas, in an effort to improve health care quality, access and coverage; promote health care reform and integration; achieve adequate health care funding; improve and update laws and regulations; and maintain public trust in health care.

Although CMS describes the Medicaid hospital outpatient proposed policy changes as clarifications to current rules that will not result in significant financial changes, CHA disagrees with these points and believes that the proposal is a major rule and requires more than a 30-day comment period. The proposed changes are without justification and appear to only limit federal Medicaid hospital payments and state Medicaid program funding. Moreover, CHA believes that CMS is violating Congress' May 2007 moratorium prohibiting CMS from implementing regulations on how states finance Medicaid programs and fund graduate medical education (GME) payments. CHA urges CMS to withdraw the proposed rule. The CHA comments on the proposed changes reflect our opposition.

The Proposed Rule Violates the Moratorium

The proposed changes in this rule violate the moratorium implemented by P.L. 110-28 in two ways. First, the proposal attempts to redefine categories of providers for the purpose of calculating the upper payment limit (UPL) using language from the state financing mechanism regulation. The moratorium redefines the categories by removing ownership status and the proposed rule relies on this new definition using "State government-operating facilities" and "Non-state government-operated facilities" and "privately

operated facilities." Second, the proposal restricts the ability for GME costs to be used in the calculation of the outpatient UPL; which is a clear violation of the moratorium barring any regulatory activity restricting GME or such payments made. Congress explicitly instructed CMS not to implement policy changes related to these provisions within the May 28 final rule (CMS-2258 Final Rule – Medicaid Program; Cost Limit for Providers Operated by Units of Government (Vol. 72, No. 102), May 29, 2007).

Narrow Definition of Medicaid Outpatient Services and UPL Calculation Changes

The proposed rule calls for a significant narrowing of the definition of outpatient services recognized under the Medicaid program for no reason other than to limit federal hospital payments and program funding. The Medicaid program serves a predominant pediatric population while the Medicare program serves mostly elderly beneficiaries. Aligning the outpatient services for the two programs shows no practical application considering the two disparate populations served by the two programs. California's Medicaid program is comprised of 52 percent children. The types of programs at risk for not being reimbursed through hospital outpatient programs under the proposed rule include dental, vision, annual screenings and immunizations.

Further reduction in payments to hospitals for these services would place greater burden on California's hospitals that are already severely uncompensated for the cost of providing care to its Medicaid beneficiaries. Moreover, CMS has failed to demonstrate that access to services would not be affected by moving these reimbursable services out of the hospital outpatient setting. Spending per Medicaid enrollee is already 40 percent below the national amount, and further cuts to reimbursement would provide an even greater barrier to access to these important and necessary services.

CMS states that the proposed changes in the UPL calculation methodology would only apply to private outpatient hospital UPLs. This is impossible to assess since the definition of a governmental hospital remains unresolved because it falls within the scope of the final rule that is subject to the congressional moratorium. In addition, the proposed rule would limit states to only two allowable methods of calculating the UPL. The Medicare cost-to-charge ratio based on Medicare allowable costs would prohibit hospitals that care for California's children from not having their costs appropriately accounted for because they have little-to-no Medicare volume.

GME costs also would not be accounted for in the new UPL methodology using the Medicare cost-to-charge ratio. This would have a significant impact on teaching hospitals that serve low-income Californians that train tomorrow's physicians. In addition, the proposed change could also adversely impact the calculation of Medicaid Disproportionate Share Hospital (DSH) payments. Any services not considered by CMS to be inpatient or outpatient hospital services cannot be included as uncompensated costs for purposes of DSH reimbursement. Thus, to the extent that this proposed rule narrows the definition of outpatient hospital services and requires California to treat certain services as non-hospital services, those services would also presumably be excluded from hospital DSH caps.

Conclusion

CHA does not believe that the changes in the proposed rule are merely clarifications, but that they are significant and could result in significant financial impact to California hospitals. The major policy changes proposed in this rule warrant that CMS perform comprehensive due diligence to review the potential impact on Medicaid beneficiaries and the hospitals who serve them. The 30-day comment

period is insufficient to fully analyze the effect of the proposed changes. CMS is in direct violation of Congress' moratorium restricting the agency from regulating on matters pertaining to how California will finance its Medicaid program and fund GME payments. For all of these reasons, CHA urges CMS to withdraw this rule and adhere to the moratorium secured by P.L. 110-28.

Thank you for the opportunity to provide our comments. If you have any questions or need more information, please call me at (916) 552-7536, or contact me at amcleod@calhospital.org.

Sincerely,

Anne M. McLeod
Vice President, Reimbursement and Economic Analysis

Submitter : **John R. Guhl** **Date: 10/29/2007**

Organization : **New Jersey DMAHS**

Category : **State Government**

Issue Areas/Comments

Outpatient Hospital and Clinic Seravices: Application of Upper Payment Limits

Outpatient Hospital and Clinic Seravices: Application of Upper Payment Limits

New Jersey Division of Medical Assistance and Health Services
Comment on CMS-2213-P

The New Jersey Medicaid program reimbursement for hospital outpatient services is cost-based. Physician costs are included in the reimbursement if the hospital incurs costs and the physicians do not have separate physician billing. Similarly, the physician reimbursement regulations instruct doctors not to seek reimbursement for services rendered in hospitals if they are reimbursed by the hospital. The State is concerned about CMS intention to remove physician costs from outpatient reimbursement. We anticipate a negative impact on our clients and the hospitals that serve them.

Outpatient clinics serving women and children in New Jersey will be jeopardized if the proposed rule is adopted. At the very least, hospitals and physicians may need to re-evaluate their contracts and may decide to reduce or eliminate services. These are essential services for our country s most vulnerable citizens.

State Medicaid programs serve different populations than Medicare. Moreover, the States vary in their ranges of services and how those services are provided. Under the proposed rule, States will not have the flexibility intended by Title XIX if states are essentially compelled to use Medicare definitions of hospital-based services, hospital outpatient facility payments not to exceed Medicare, and separate provider payments for physicians and other professionals. The proposed rule indicates that CMS is seeking to align two fundamentally different programs, ignoring the Congressional intent that State Medicaid programs are diverse and must have flexibility in reimbursement methodologies.

The proposed rule s upper payment limit provision appears to violate the recent Congressional moratorium on any action by CMS on Medicaid reimbursement for Graduate Medical Education (GME), as well as the moratorium on cost limits for governmental hospitals.

The proposed regulation is ambiguous. It is unclear whether New Jersey will be permitted to continue its current approved payment methodology, including physician costs, and adjust the upper payment limit. The State has an approved State plan for outpatient reimbursement that includes physician costs in a cost-based system.

The New Jersey Division of Medical Assistance and Health Services therefore requests that CMS withdraw the proposed rule.

Upper Payment Limits

Upper Payment Limits

New Jersey Division of Medical Assistance and Health Services
Comment on CMS-2213-P --

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