Submitter : **Ms. Marcia Daigle** **Date: 10/29/2007**

Organization : **Louisiana State University Hospitals**

Category : **Hospital**

Issue Areas/Comments

Medicaid Outpatient Hospital Service and Rural Health Care Services

Medicaid Outpatient Hospital Service and Rural Health Care Services

The safety net hospital and clinic system operated by the Louisiana State University is significantly negatively impacted by this proposed rule, which contrary to best practices principles in today s health care delivery is likely to decrease access to quality outpatient preventive, primary and secondary care.

The proposed rule will result in the immediate loss of at least $11.3M in Medicaid Physician UPL payments. Additionally, once CMS applies the proposed rule to state government providers, there likely will be a loss of an estimated $16.5M in Medicaid outpatient hospital UPL payments. Second, there will be a much greater loss (at least $80.6M) should CMS exclude all costs related to interns and residents. Eliminating Medicaid GME payments would significantly threaten the ability of teaching hospitals to continue providing round the clock care for the poor, limit the hospitals and medical schools ability to maintain high quality educational programs for all types of health care professionals, and hamper the viability of crucial clinical research programs. Also, the elimination of Medicaid GME will result in substantially increased professional services costs.

Finally, the proposed rule violates Congress' Legislative Moratorium on CMS' Cost Limit Rule published May 29, 2007. Congress issued said moratorium in U. S. Public Law 110-28, Section 7002(a), effectively keeping CMS from making changes in Medicaid regulations limiting government providers to cost or cutting GME payments.

Submitter : **Ms. Carolyn Scanlan** **Date: 10/29/2007**

Organization : **HAP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-44-Attach-1.PDF

#44

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

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 Pennsylvania's nearly 250 member hospitals and health systems, The Hospital & Healthsystem Association of Pennsylvania (HAP) appreciates 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.

CMS describes the Medicaid hospital outpatient proposed policy changes as clarifications to current rules. CMS further states that because 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. HAP respectfully disagrees on all points.

The proposed rule is making major policy changes to the Medicaid program and we would note that a 30-day comment period is an insufficient time period for public comment. In issuing these proposed regulations, 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. In conjunction with the American Hospital Association and other state hospital associations, HAP strongly opposes the changes proposed and urges CMS to withdraw this rule.

MORATORIUM

CMS violates the year-long moratorium secured by P.L. 110-28 because 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.]

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CMS' proposed rule violates the moratorium in two ways:

First, the agency 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" (pages 55158, 55165 to 55166).

Second, the rule violates the moratorium with regard to the treatment of GME costs. The proposed rule does not permit state Medicaid programs to count 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. 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 pediatric, obstetric and disabled population while Medicare serves an elderly population. Yet, despite these differences, CMS is proposing 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.

Given the already inadequate payment by Medicaid for Outpatient services, these changes would only further exacerbate the financial instability of the very institutions providing needed access to Outpatient care for Medicaid patients.

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. CMS has not identified a problem with current state Medicaid programs to justify this policy change. In fact, the agency states in the proposed rule's preamble that in examining 32 state plan amendments over the last four years, CMS found only one state that defines non-hospital services as part of the outpatient hospital Medicaid set of services (page 55161). In addition, while 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. Again, this proposed change fails to recognize the essential differences between Medicare and Medicaid and could result in jeopardizing access to needed health care.

Further, 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 their DSH reimbursement. Currently, CMS views only the costs for providing inpatient and outpatient hospital services as allowable for determining a hospital's uncompensated care costs. The agency's proposed narrow definition would exclude many costs now included in hospitals' Medicaid DSH calculations, potentially limiting DSH payments to already financially challenged hospitals.

UPL Calculations

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. Therefore, 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, 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 hospital-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

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. HAP believes that the agency has failed to perform the due diligence necessary to make these statements. Furthermore, HAP contends 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, and ultimately access to outpatient care for Medicaid patients.

HAP strongly 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 services for potentially millions of vulnerable patients served by the Medicaid program.

Thank you for considering these comments. If you have any questions, please feel free to contact Melissa Speck, HAP's director, policy development, at (717) 561-5356 or mspeck@haponline.org or Michael Lane, HAP's director, health care finance policy, at (717) 561-5317 or mlane@haponline.org.

Sincerely,

Carolyn F. Scanlan

CAROLYN F. SCANLAN
President and Chief Executive Officer

Submitter : **Ms. Jack Stolier** **Date: 10/29/2007**

Organization : **Louisiana Health Services Recovery Council**

Category : **Other Association**

Issue Areas/Comments

Clinic Upper Payment Limit

Clinic Upper Payment Limit

Re: CMS-2213-P--Outpatient clinic and hospital services facility services definition

The Louisiana Health Services Recovery Council opposes CMS proposed rule (CMS-2213-P) regarding the outpatient clinic and hospital services facility services definition published at 72 Fed. Reg. 55158 (Sept. 28, 2007). The Recovery Council was created by the Louisiana Legislature to coordinate hurricane recovery activities in the parishes of the state that were most severely affected by Hurricanes Katrina and Rita.

Several hospitals in the affected areas had hospital-based rural health clinics (RHCs) that will be adversely affected by CMS attempt to exclude the costs of those clinics from DSH eligibility. These hospital-based RHCs function as part of the hospital, and help the hospitals provide the same care previously provided by the emergency department, but in a more clinically appropriate and less costly setting. The proposed rule would cover more expensive uncompensated emergency room care, but uncompensated hospital-based RHC care would not be included in DSH-eligible costs.

CMS proposed rule is contrary to good public policy. Rather than reward use of cheaper and more appropriate RHC services, it does just the opposite. The proposed rule actually creates financial incentives to use scarce and expensive emergency department services, even though hospital-based RHC services can be provided at a fraction of the cost and do not tie up critical emergency care resources. CMS proposed rule creates exactly the wrong incentive, and will most adversely affect the very citizens and constituents most in need of equal access: the indigent and uninsured.

By establishing hospital-based RHCs, our hospitals have attempted to end the burden placed on emergency rooms that are used for primary care. Now, CMS is attempting to re-establish the use of the emergency department for routine medical care by those who are unable to afford other forms of care. This is not appropriate. Use of hospital-based RHC s should be encouraged, not discouraged, because RHC use will save taxpayer dollars.

The proposed change will have an especially severe impact on our constituents, still recovering from Hurricanes Katrina and Rita. Uncompensated care costs to rural hospital-based RHC s many of these hospitals are already running at a deficit-- will be in the millions of dollars. This will further limit these hospitals ability to provide the increased volume of uncompensated care that they have been asked to provide after the 2005 storms.

Additionally, the proposal will most adversely affect the very citizens and constituents that the Secretary profess to represent and champion equal access for, namely the indigent and uninsured. In fact this is diametrically opposed to the guiding principles that CMS has tried to etch in stone.

Please withdraw the proposed rule.

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

Organization : Director, Government Reimbursement

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-2213-P-46-Attach-1.DOC

#46

Parkland Health & Hospital System

October 29, 2007

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

Parkland Memorial Hospital

Ref: CMS-2213-P — Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

Community Oriented Primary Care

Dear Mr. Weems:

Parkland Health & Hospital System (Parkland) writes to convey serious concerns regarding the Centers for Medicare and Medicaid Services' (CMS) proposed clarification of outpatient clinic and hospital services definition and Upper Payment Limit (UPL). ***Parkland strongly requests that CMS withdraw the proposed rule..***

Parkland Community Health Plan, Inc.

Parkland fills a unique place in the Dallas / Fort Worth Metroplex and has since our inception in 1894. We are mandated to furnish medical aid and hospital care to indigent and needy persons residing in Dallas County. However, our services go far beyond the Dallas County lines as we are a regional referral center. We provide $409 million in uncompensated care annually. This is due to the fact that we were the first Level I trauma center in the state and are only one of two in Dallas County. Additionally, we operate a Level III Neonatal Intensive Care Unit and the second largest civilian burn center in the United States. On an annual basis, we will admit 42,682 patients and deliver 16,489 babies. Through our outpatient clinics and our system of community health centers, we will have 876,555 visits annually. In short, we are the provider of last resort. Dallas County has few other options should Parkland go away.

Parkland Foundation

As written, the Proposed Rule allows states to use costs as an acceptable UPL for private hospitals, and in so doing provides much more detail than previously on acceptable methodologies for determining costs, methodologies that would likely be used in applying any cost limit to governmental entities as well. Public, safety net hospitals, such as Parkland, have created models that heavily depend upon keeping unfunded individuals out of the inpatient environment. Physician services and pharmaceuticals contribute greatly to this end. These rules would ultimately increase the cost of caring for the uninsured, by shifting care from early detection and treatment, to emergency care, overburdening an already stressed system.

The Proposed Rule would have an indirect impact on disproportionate share hospital (DSH)

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reimbursement for private and governmental hospitals alike, although this aspect of the proposal is not acknowledged by CMS. To the extent that the new, narrow definition of outpatient hospital services excludes services a state is currently treating as outpatient services, the uncompensated care costs associated with those services would no longer be includable in a hospital's DSH cap. Excluded services would likely include routine vision services, professional services, take home medications and supplies, clinic services not provided by a provider-based hospital department and other services not covered in the Medicare outpatient hospital benefit.

Definition of Outpatient Hospital Services
Parkland appreciates the fact that CMS is proposing to clarify what is described as the current vague regulatory definition of the Medicaid benefit for "outpatient hospital services." This definition would apply to all hospital providers, regardless of governmental status. Section 1905(a)(2)(A) of the Social Security Act lists "outpatient hospital services" among the other services covered as part of the Medicaid benefit, but does not provide any further definition. Under the current definition, outpatient hospital services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services" that are furnished to outpatients by or under the direction of a physician or dentist in a hospital that meets the requirements for participation in Medicare.

However, the CMS proposal narrows the definition of outpatient services below what the SSA definitions currently include. The Proposed Rule would limit the scope of services included in the definition of outpatient hospital services by (1) excluding any services not treated as outpatient hospital services under Medicare; (2) excluding services provided by entities that are not provider-based departments of a hospital; and (3) excluding services covered elsewhere in the State Plan. While the narrowing of this definition would not prohibit a state from reimbursing providers for these services, it would exclude the costs from DSH and UPL computations, even though they are legitimate costs that meet the definition of outpatient services.

Aligning Medicaid services with Medicare.
The Proposed Rule would limit Medicaid outpatient hospital services to those paid by Medicare as an outpatient hospital service. According to the preamble, this definition would include prosthetic devices, prosthetics, supplies, orthotic devices, durable medical equipment and clinical diagnostic laboratory services. The new definition excludes professional services, take home medications and take home supplies, presumably even though the hospital may bill for the services. Parkland disagrees with the CMS assertion that this clarification is necessary "to prevent duplicative payments for professional services that are reimbursed under a separate payment methodology." These services meet the definition of outpatient services and this clarification is an unnecessary limitation of payment for actual costs incurred by the outpatient hospital facility.

Disproportionate Share Hospital Payments
The proposed rule does not discuss the implications of its new narrow definition of outpatient hospital services for DSH payments. However, CMS has very consistently taken the position in recent years that DSH payments can only be paid to the extent of a hospital's uncompensated costs of *inpatient and outpatient hospital* care. Any services not considered by CMS to be inpatient or outpatient hospital services cannot be included as uncompensated costs for purposes of DSH reimbursement. The proposed rule narrows the definition of outpatient hospital services and requires states to treat certain services as non-hospital services. This would cause those services presumably to be excluded from hospital DSH caps.

Private Outpatient Hospital and Clinic Upper Payment Limits
CMS further proposes to clarify the current definition of the private outpatient hospital and clinic upper payment limits (UPL), which limit payments to a "reasonable estimate of the amount that would be paid for services

furnished by the group of facilities under Medicare payment principles." This approach seems reasonable, but it is important that CMS use the appropriate fields in calculating amounts.

CMS proposes to limit states' calculation of the hospital outpatient UPL to one of two permissible methodologies:

- An estimate of Medicare allowable cost calculated based on ratios of costs-to charges, taken directly from designated sections of the Medicare cost report; or,
- An estimate of Medicare allowable payment calculated based on ratios of payments-to-charges derived from designated sections of the Medicare cost report.

Specifically, a cost-to-charge UPL would be calculated using ratios found on the Medicare cost report (CMS 2552-96) on Worksheet C, Column 9, lines 37-68 or Worksheet D, Part V, Column 1.01, lines 37-68. A payment-to-charge ratio would be calculated using outpatient hospital service payment references on Worksheet E, Part B and charge data from Worksheet D, Part V and Part VI. The proposed approach would limit GME costs for UPL and DSH. These are paid under Medicare payment principles, making the proposed rule in direct conflict with Medicare payment principles.

Regulatory Impact and Effective Date

In the preamble to the Proposed Rule, CMS explains that it believes the fiscal impact "would be minimal." According to CMS, the Proposed Rule is a clarification of an existing definition of outpatient hospital services, would not require states to eliminate coverage and applies only to private providers. Furthermore, CMS believes that few states currently cover non-hospital services as part of the hospital outpatient benefit. As a result of this minimal estimated impact,

CMS states that this proposal does not reach the threshold to be categorized as a "major rule." Practically, this means that, unlike the Cost Limit Rule, which is considered a major rule under the Congressional Review Act and thus cannot be implemented for 60 days after finalization, this rule can take effect whenever specified by the agency once it is properly finalized.

CMS' impact estimates notwithstanding, there would likely be a much more significant impact if this definition of outpatient services and associated standard for calculating outpatient costs is applied to governmental hospitals under the Cost Limit Rule. CMS justifies its estimate of minimal impact on private providers based on the fact that states are not currently paying private providers up to the UPL anyway; this is not the case with many governmental hospitals.

In addition, CMS does not explicitly say in the Proposed Rule or the preamble that these changes are only prospective. Retroactive rulemaking is generally disfavored, and prospective application is implied by the Proposed Rule. For example, CMS seems to admit that physician services may be permissibly included as outpatient hospital services under current regulations. Nevertheless, CMS indicates that it has already been implementing these proposed UPL requirements when states submit State Plan Amendments as part of its review of program financing.

Moratorium - Reissuing Regulations from the Cost Limit Rule.

The Moratorium signed into law as part of H.R. 2206 prohibits CMS from "tak[ing] any action (through promulgation of regulation . . .) to . . . finalize or otherwise implement provisions contained in the [Cost Limit Rule] . . ." In the Proposed Rule, CMS reissued regulatory language from the final Cost Limit Rule redefining the categories of providers (state, non-state governmental and private) subject to upper payment limits (UPLs). In

issuing the Proposed Rule, CMS is again attempting to remove facility ownership from consideration in applying the outpatient UPL, a change that is clearly within the scope of the prohibition adopted by Congress in the Moratorium.

Moratorium - Medicaid GME

Additionally, the Proposed Rule effectively prohibits states from including GME costs in the outpatient UPL. CMS' detailed new requirements for calculating cost for purposes of the outpatient hospital UPL reduces the ability of states to make payments for GME by excluding GME costs from those that may be included. This result is in clear conflict with the language of the moratorium prohibiting the promulgation of regulations restricting payments for Medicaid GME.

Parkland appreciates the opportunity to submit these comments and to reiterate our strong opposition to the proposed rule. If you have any questions, please contact either myself or Dr. Jennifer Cutrer and Steven Bristow with our legislative affairs department.

Respectfully,

Keri Disney
Director, Government Relations

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

Organization : **St. Louis Children's Hospital**

Category : **Health Care Provider/Association**

Issue Areas/Comments

Clinic Upper Payment Limit

Clinic Upper Payment Limit

See Attachment

GENERAL

GENERAL

See Attachment

Medicaid Outpatient Hospital Service and Rural Health Care Services

Medicaid Outpatient Hospital Service and Rural Health Care Services

See Attachment

Outpatient Hospital Service and Rural Health Clinic Services

Outpatient Hospital Service and Rural Health Clinic Services

See Attachment

Outpatient Hospital and Clinic Seravices: Application of Upper Payment Limits

Outpatient Hospital and Clinic Seravices: Application of Upper Payment Limits

See Attachment

Upper Payment Limits

Upper Payment Limits

See Attachment

CMS-2213-P-47-Attach-1.PDF

#47

Children's
HOSPITAL • ST. LOUIS

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Lee F. Fetter
President and Senior Executive Officer

October 29, 2007

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

Attn: CMS-2213-P
Medicaid Program: Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

Dear Sir/Madam:

On behalf of the children in the St. Louis area who receive their health care through Medicaid, St. Louis Children's Hospital (SLCH) appreciates being able to submit comments to the Centers for Medicare and Medicaid Services (CMS) on your proposed rule on Medicaid outpatient hospital services published in the September 28th *Federal Register*. SLCH is a major provider of outpatient services for children in both Missouri and Illinois insured by Medicaid. The proposed regulatory changes would have a negative impact on the children we serve and our hospital.

We strongly urge CMS not to implement the rule for two reasons. First, it is our understanding that Congress' moratorium on implementation of changes to state financing mechanisms and graduate medical education payments under Medicaid deny CMS the authority to implement the rule as currently drafted. Second, The National Association of Public Hospitals has done a detailed analysis of the proposed regulation on outpatient hospital services and found that the regulation 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 (UPLs) and 2) the proposed regulation would no longer allow graduate medical education costs in the calculation of the outpatient UPL.

We also urge CMS not to implement the rule for several additional reasons:

The Proposed Rule Overlooks Critical Outpatient Hospital Services for Children
We understand that CMS is trying to provide more clarity on what is and what is not a Medicaid outpatient hospital service, but the narrow Medicare definition included in the proposed regulation does not reflect the true nature of the Medicaid program and the significant role it plays for children. More than one-fourth of all children are insured by Medicaid and over fifty percent of Medicaid beneficiaries are children.

The Medicare definition for outpatient services is inappropriate for children because it was not developed to address their unique health care needs. Services not specified in the Medicare definition include, but are not limited to, dental and vision services, annual checkups, and immunizations. The different health care needs of children and adults should be examined and changes made before the Medicare definition is adopted for the Medicaid population. If this is not done, children could lose important outpatient health care services.

The Proposed Rule Threatens the Financial Viability of Children's Hospitals
Children's hospitals are major providers of outpatient hospital services for children; on average a children's hospital provides care in more than 300,000 outpatient visits per year. At St. Louis Children's Hospital, as most children's hospitals, children insured by Medicaid account for about fifty percent of all of our outpatient visits. Most children's hospitals provide a full range of outpatient services to children insured by Medicaid. At SLCH we offer extensive outpatient services in our clinics for children with cerebral palsy, cleft palates, and craniofacial problems to name a few.

The changes in the outpatient hospital services definition would have a negative impact on our hospital. We recognize that the regulation says that services taken out of the outpatient hospital services definition could still be provided under different benefit categories. However, by taking services out of the definition, CMS would be lowering reimbursement for these important services that our hospital provides to children insured by Medicaid. This reduction would exacerbate the inadequate Medicaid outpatient reimbursement our hospital receives, which already falls substantially below the cost of care we provide. In Missouri, Medicaid reimburses our hospital at 48 percent of charges for outpatient services.

The proposed regulation may also affect the calculation of our Medicaid Disproportionate Share Hospital (DSH) payments. If services are no longer classified as outpatient hospital services, then they would no longer be included in the calculation of our DSH cap. This could result in a smaller payment for our hospital. As a safety net hospital, DSH payments are vital to our ability to care for all children.

CMS Is Unable to Estimate Impact of the Proposed Rule
Due to lack of data, CMS states it is unable to estimate the impact of the proposed regulation. This is extremely troubling for our hospital. Before a regulation of this magnitude is implemented, the impact should be specified and addressed. CMS does not address the potential effect on children and children's providers of adopting a Medicare service definition. This change could impact the services hospitals are able to provide for children and therefore children's access to outpatient hospital services. CMS should explore the potential effects of

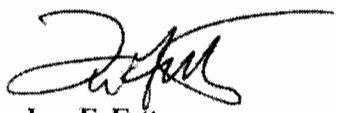
these changes and any revisions needed to continue to provide quality and accessible health care services for children.

Conclusion

As you can see from our comments, we are extremely concerned about this proposed regulation and the impact it would have on children enrolled in Medicaid and on children's hospitals. We encourage CMS to delay the implementation of the regulation to allow time for a thorough review of the proposed regulation's impact on children enrolled in Medicaid and the providers who serve them.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact Emmy McClelland at (314) 286-2144 or exm2008@bjc.org. Thank you for your consideration.

Sincerely,



Lee F. Fetter
President

Submitter : **Mr. Michael Hill** **Date: 10/29/2007**

Organization : **New Hampshire Hospital Association**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-48-Attach-1.PDF

#418

New Hampshire Hospital Association

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 New Hampshire's member hospitals, the New Hampshire Hospital Association (NHHA) appreciates 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.

Comment Period
Given the far-reaching and significant impact on hospitals and state Medicaid programs, the 30-day comment period for this proposed rule is an insufficient timeframe for public comment. CMS describes these policy changes as "clarifications" to current rules and further states that these changes will not result in significant financial impact. The proposed rule is, in fact, making major policy changes to the Medicaid program which will have a significant financial impact over and above that which is intended by the proposed rule.

Therefore, the New Hampshire Hospital Association urges CMS to withdraw this rule, and submits these comments with strong opposition to the changes proposed.

Moratorium
CMS is violating Congress' year-long moratorium (PL 110-28) barring the agency from regulating on matters pertaining to how states finance their Medicaid programs and fund graduate medical education (GME) payments. These proposed policy changes are based on provisions in the May 28 final rule that Congress explicitly instructed CMS 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)

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CMS violates the moratorium in two ways.

1. 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).

2. The rule violates the moratorium with regard to the treatment of GME costs. The proposed rule does not permit state Medicaid programs to count GME costs in determining the UPL. This violates the moratorium barring any regulatory activity on restricting GME or such payments made.

Access to Care

New Hampshire Medicaid physician payment fees are so terribly inadequate that most Medicaid recipients are unable to access primary care at non-hospital-based physician practices. In order to continue to offer Medicare and Medicaid beneficiaries the same opportunities to access quality health care, most primary care physician practices in the state converted to provider-based entities under CMS regulations. By doing so, hospital-based practices that meet CMS' provider-based criteria have achieved efficiencies and economies of scale that independent physician practices cannot, and are therefore better situated to treat a greater number of these patients.

Under the proposed rules, CMS is "restricting the Medicaid outpatient hospital definition to facility services only to prevent duplicative payments for professional services that are reimbursed under a separate payment methodology ..." CMS' concerns that payments are duplicative are unfounded. NH Medicaid's claims processing system already has the proper edits built in to screen for duplicate payments. In addition, NH Medicaid currently does not have the capability and resources to modify its MMIS system to pay claims according to the proposed method. If adopted, the proposed rules would place undue administrative burdens on states to modify their systems. NH Medicaid is in the process of transitioning to a new MMIS system. Therefore, unnecessary duplicative administrative expenses would be incurred by the State to comply with the proposed regulations.

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 to calculate the hospital outpatient UPL. CMS bases its 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, CMS is proposing 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 preventive, 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, CMS does not identify a problem with current state Medicaid programs to justify this policy change. In fact, CMS states in the preamble of the proposed rule that in examining 32 state plan amendments, CMS found only one state that defines non-hospital services as part of the outpatient hospital Medicaid set of services (72 Fed. Reg, 55161). In addition, while 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 whether access to such services within the community exist outside of the hospital outpatient department.

UPL Calculations. 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.

In proposing a new methodology to determine UPL calculations, 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.

Therefore, we find it nearly impossible to assess the change in UPL methodology because the universe is unknown.

This new formula for calculating UPL would have a major impact on NH hospitals because they are currently paid under a different formula that accounts for allowable outpatient costs associated with providing care in an outpatient department of the hospital. In addition, 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 CMS' new proposed methodology.

Conclusion
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 NHHA believes that the agency has failed to perform the due diligence necessary to make these statements. Furthermore, we contend that these policy changes not only will have a significant fiscal impact on New Hampshire's hospitals, but could potentially affect coverage for outpatient hospital services.

NHHA 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 the NH Medicaid programs, cuts in payments to hospitals, and reduced access to needed services for vulnerable people served by the Medicaid program.

Sincerely,

Mike Hill

Mike Hill
President

Submitter : **Ms. Martha Roherty** **Date: 10/29/2007**

Organization : **American Public Human Services**

Category : **Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-49-Attach-1.DOC

#49

October 29, 2007

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

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

Dear Mr. Weems:

The American Public Human Services Association and its affiliate, the National Association of State Medicaid Directors, respectfully submits this comment letter on the proposed rule for Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit published in the September 28, 2007, *Federal Register (72 FR 55158)* for the Centers for Medicare and Medicaid Services.

Please be assured that APHSA and NASMD share your strong commitment to protecting the fiscal integrity of the Medicaid program. We appreciate the opportunity to work with CMS to develop proposals and guidance that will provide consistency and stability to the Medicaid program while serving those in need. However, we submit that the agency's proposed rule creates some additional challenges for states to achieve this goal.

The proposed rule contains many provisions that are of concern to APHSA and NASMD. First, this rule runs counter to the legislative moratorium (Moratorium) on implementation of cost limits on payments to governmental providers and restrictions on Medicaid Graduate Medical Education (GME) payments. Second, this rule may have an unacknowledged impact on Disproportionate Share Hospitals (DSH) payments due to the limited definition of outpatient hospital services, which may end up costing states more. Finally, the rule would implement rigid restrictions for upper payment limit (UPL) methodologies for private outpatient hospitals and clinics. It is our position that this proposed rule would have a negative financial impact on the ability of states' Medicaid programs to care for uninsured patients.

CMS has violated the congressional Moratorium and, in any event, failed to clarify how this Proposed Rule interacts with the Moratorium.

Of initial note, the proposed rule is in breach of the legislative Moratorium, signed into law on May 25, 2007, prohibiting "any action" to implement a rule to impose a cost limit on Medicaid payments to governmental providers (CMS-2258-FC, the Cost Limit Rule) or similar provisions, or any rule restricting payments for Medicaid Graduate Medical Education.

Graduate Medical Education

The language of the Moratorium prohibits CMS from "tak[ing] any action (through promulgation of regulation, issuance of regulatory guidance, or other administrative action) to…promulgate or implement any rule or provision restricting payments for graduate medical education under the Medicaid program." (P.L. 110-28, Sec. 7002(a)) In this proposed rule, CMS' detailed new requirements for calculating costs for purposes of the outpatient hospital UPL excludes GME costs from the equation. This would essentially prohibit states from providing outpatient-related GME payments. CMS' proposal directly violates the Moratorium because states have never before been prohibited from providing outpatient GME support.

Cost Limit Rule

The Proposed Rule also violates the Moratorium with the reissuing of Cost Limit Rule language that redefines the provider categories that are subject to the UPLs, despite explicit Congressional mandate that it not take action to implement any provision of that rule. 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," The Cost Limit Rule removed from the definitions all references to ownership. Since the Moratorium prohibits CMS from "tak[ing] any action (through promulgation of regulation…) to…finalize or otherwise implement provisions contained in the Cost Limit Rule…", CMS is violating Congress' directive not to take any action to implement any provision of that rule by proposing to reissue the revised category language in this Proposed Rule.

Congressional Intent

Finally, this proposed rule disregards Congressional aim regarding the Medicaid Act. A majority of House and Senate members have vocally opposed a number of Medicaid policy proposals set forth in President Bush's FY 2007 and 2008 budget requests. Despite lack of Congressional support, CMS has moved forward with issuing cost limit and GME regulations. In response, Congress adopted the Moratorium in both areas. In an apparent rush to regulate, CMS issued the final cost limit rule on May 25, 2007, the day the President signed the Moratorium into law. Both the implementation of the final rule and this Proposed Rule are in direct violation of the Moratorium.

This Proposed Rule may have a potentially significant impact on DSH payments.

Currently, Disproportionate Share Hospital (DSH) payments are used in hospitals to offset some of the unreimbursed costs that are incurred by the treatment of uninsured patients. Narrowing the definition of a covered service under the DSH would have a significant financial impact on both public and private hospitals that are already being squeezed by the rising costs and

declining percentage that insurance covers. As a result, this Proposed Rule would restrict the access to care for Medicaid and uninsured patients.

The Proposed Rule ignores significant differences in the scope and purposes of the Medicaid and Medicare programs in requiring coterminous coverage of outpatient hospital services.

Given the separate statutory authority for the Medicare and Medicaid programs, it is unclear why "consistency" would provide a sufficient statutory basis for this regulation. APHSA and NASMD question the policy basis for insisting on rigid, coterminous definitions when the two programs are very different in scope, have very different purposes and cover different populations, with Medicaid's focus on providing services to low-income populations with differing needs. For example, Medicare completely excludes from coverage services that policymakers have determined are critical to the health of Medicaid populations such as dental care for children or vaccinations. Medicare also does not include outpatient hospital reimbursement for vision, psychiatric services that state Medicaid programs have seen the value of reimbursing at a hospital rate to meet specific needs of their patient populations.

CMS' definition of outpatient hospital services to exclude services otherwise covered by the State Plan is not required by the Medicaid statute.

A narrowing of the definition of outpatient hospital services is essentially a cut in hospital Medicaid reimbursement. The Proposed Rule narrows the definition of outpatient hospital services in multiple ways, many of which would have the effect of reducing reimbursement for the very ambulatory care services that states have sought to encourage hospitals to provide. The narrowing of the definition of outpatient hospital services would restrict the scope of services by: excluding any services not reimbursed as outpatient hospital services under Medicare, excluding services provided by entities that are not provider-based departments of a hospital, and excluding services covered elsewhere in the State Plan.

Additionally, the Proposed Rule would further exclude from the outpatient hospital services definition those services that are covered and paid "under the scope of another Medical Assistance service category under the State Plan," though states "may continue to cover any service that is authorized under section 1905(a) of the Act within the State Plan under a coverage benefit that is distinct from outpatient hospital services" (72 FR at 55161). However, nothing in the language or the history of the Medicaid statute requires categories of covered services to be discrete and mutually exclusive. Indeed, the U.S. Court of Appeals for the Fifth Circuit implicitly rejected mere reliance on a service being reference in a different enumerated category from outpatient hospital services under section 1905(a)(2) of the Act as sufficient reasoning for excluding the service from the regulatory definition of outpatient hospital services. (*Louisiana Dep't of Health and Hosps v CMS., 346 F. 3d 571(5th Cir., 2003)*).

Medicaid is the nation's safety net, and it is important for CMS to reexamine the effects that all of these proposed restrictions will have on states. This proposed rule would restrict the ability for Medicaid funds to be used to train the next generation of doctors, serve as the foundation of local emergency response systems, and provide coverage to the nation's uninsured and underinsured.

Thank you for the opportunity to comment on the proposed rule. If you have any additional questions, please contact Martha Roherty, NASMD Director at (202) 682-0100.

Sincerely,

Jerry W. Friedman
Executive Director

Submitter : Ms. Christine Bronson **Date:** 10/29/2007

Organization : Minnesota Department of Human Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-2213-P-50-Attach-1.PDF

#50

Minnesota Department of **Human Services**

October 29, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2213-P
PO Box 8017
7500 Security Boulevard
Baltimore, MD 21244-8016

Minnesota Department of Human Services Comments on:
Docket: CMS-2213-P, Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

Dear Mr. Weems:

Thank you for the opportunity to comment on the proposed rule. Minnesota shares the goal of promoting fiscal integrity in the Medicaid program. However, we have concerns about several of the policies the Centers for Medicare & Medicaid Services (CMS) is proposing and strongly recommend that you consider these concerns and revise the regulations accordingly.

We are concerned about CMS' decision to limit the Medicaid outpatient hospital benefit to those services that would be allowable under Medicare and that could not be covered under the scope of another Medicaid service category. CMS' notes two reasons for this limitation: 1) The 2003 Fifth Circuit decision in Louisiana v. HHS, regarding the use of uncompensated costs for clinic services in calculating the facility-specific DSH limits for hospitals; and 2) the potential for overlap between outpatient hospital and other mandatory and optional benefits, and a potential for inappropriately high payment rates for those services that may be provided under benefits.

It is well-established that Congress intended states to have flexibility in defining their Medicaid covered benefits, and the scope of those benefits, within certain standards. In this regulation, CMS is essentially removing any flexibility with regard to the outpatient hospital benefit. We suggest that there are measures that are more narrowly targeted to resolving the issues as CMS describes them, than requiring states to standardize to Medicare and excluding services that can be covered under other Medicaid categories. The issue regarding the facility-specific DSH limits can be resolved by revising the proposed regulation governing DSH payments and reporting. CMS has many tools already available to it to address inappropriately high Medicaid payment rates.

In addition to unnecessarily limiting state flexibility, the requirement that states standardize to the Medicare benefit and create mutually exclusive Medicaid categories of services can create a number of new problems. First, in a general sense, overlap between the various Medicaid mandatory and optional

benefits is inherent in the medical system, inherent in the structure of Title XIX, and necessary to ensure access to care. For example, routine non-surgical dental services can be provided in a clinic setting for the majority of Medicaid recipients. However, developmentally disabled individuals or those with severe physical disabilities (such as those using ventilators) often need to be anesthetized and carefully monitored whenever any dental work is performed. Given the complexities involved in providing care to these special needs populations, it would be medically irresponsible to perform even routine dental procedures in a non-hospital setting. Prohibiting Medicaid coverage for services that could be covered under state law as outpatient hospital services because of concerns about overpayment is unnecessarily restrictive. When medical necessity requires the resources of an outpatient hospital setting, payment commensurate with the use of those resources is appropriate even if the procedure is more commonly performed in a less intensive setting.

The concept that services can overlap service categories is long-standing in Medicaid policy. CMS, (then HCFA) summarized the concept best in response to comments on a nurse-midwife regulation:

> While we view each category of service as separate and distinct, the categories are not mutually exclusive. Some services...can be classified in more than one category. It is also possible that a service provided may meet the requirements under one category and not another even though, as a general rule, the service could be classified under either category. The specific circumstances under which a service is provided and how the provider bills for the service determines how the service is categorized and which regulatory requirements apply. *(60 FR 61483, Nov. 30, 1995)*

Medicare and Medicaid are distinctly different programs. The populations covered and the benefits covered are very different. Using Medicare as a model for standardizing Medicaid programs is going to have a negative effect on children, and people in need of services that are limited or not covered by Medicare (such as mental health services, chemical dependency, etc). This limitation may work to prevent states from developing and implementing new and innovative service delivery models targeted to special populations. Again, CMS already has a number of statutes and regulations at its disposal that can be used to limit inappropriate payment rates.

We do not believe that CMS has adequately demonstrated the need for the proposed changes to the regulations regarding the definition of outpatient hospital services or the calculation of upper payment limits (UPL) for outpatient hospital services. Given the significant administrative burden the proposed rule imposes on states and providers, the costs of the changes proposed regarding UPLs for privately-owned outpatient hospital services do not appear to be justified by any demonstrable benefit to the federal government.

Moreover, the rule represents a significant and restrictive change in the definition of the phrase "Medicare payment principles" as that phrase is used in the upper payment limit sections of 42 CFR 447. This rule proposes to limit the calculation of the "amount Medicare would pay" for the Medicaid services provided in outpatient hospital settings to hospitals' costs, or to an amount that is actually less than the Medicare payment rate. In addition, the rule would exclude allowable graduate medical education (GME) costs. Both of these options produce a "Medicare payment amount" that doesn't reflect the payment methodologies Medicare actually uses.

The proposed requirements regarding UPL calculations for outpatient hospital services impose a considerable administrative burden on states and providers. CMS proposes to limit the Medicare comparison amount for the outpatient hospital UPL to either the cost-to-charge or payment-to-charge ratios derived from hospitals' Medicare cost reports. Although the proposed regulatory text at §447.321(b)(i)(B) is not explicit, the preamble language implies that CMS expects the cost-to-charge and payment-to-charge ratios to be applied on a cost center specific basis instead of on an aggregate facility level. This would require states to actually run Medicaid charge data through the Medicare cost report of each hospital and ensure that the Medicaid charges are mapped to the correct cost centers. Minnesota does not currently require Medicaid charge data to be processed through hospitals' Medicare cost reports, nor do we require hospitals to submit their Medicare cost reports to us. The proposed UPL requirements in this rule will impose a new and significant administrative burden on both the state and the almost 200 privately-owned hospitals that participate in Medicaid. To the extent that Minnesota's Medicaid payments for most outpatient hospital services are already at or below the Medicare Ambulatory Payment Classification (APC) payment amounts, the increased costs of complying with the proposed UPL changes would not produce *any* savings at either the state or federal level.

The proposed rule does not take into account Medicare's payment methodologies for critical access hospitals. Medicare pays critical access hospitals 101 percent of allowable costs or more. By limiting the Medicare comparison payment amount for outpatient hospital services to no more than costs; this rule penalizes states that set payment rates for critical access hospitals using the actual Medicare payment methodology. Since above-cost payment is the routine Medicare payment methodology for critical access hospitals, a UPL regulatory limit of costs seems unduly restrictive.

As an alternative to using Medicare cost-to-charge ratios to define what Medicare would pay for the Medicaid services in the UPL calculation, the rule would allow states to use the payment-to-charge ratios from the Medicare cost reports. However, the payment-to-charge ratios CMS proposes would produce a "Medicare payment amount" that is at least 20 percent *below* the actual Medicare rates. This is because the cost report worksheets CMS would require states to use in the UPL calculation do not include beneficiary co-payment and co-insurance amounts which are factored into the total Medicare rate amounts. Generally, the cost-sharing requirements for most Part B services are 20 percent of the total rate amount but are can be higher than 20 percent for some outpatient hospital services. We recommend that CMS revise the payment-to-charge language in the UPL section of the regulation so that the payment amount references to the Medicare cost report include the co-payment amounts.

The proposed rule also appears to be in conflict with section 7002(1)(C) of P.L. 110-28 which prohibits CMS from placing new restrictions on Medicaid payments for graduate medical education (GME). The provisions of this rule would exclude direct medical education costs from the allowable costs used as the Medicare comparison amount in the UPL calculations for outpatient hospital services. These costs are included on hospital cost reports and Medicare pays them. Medicare payment principles clearly envision reimbursement for GME costs. Excluding the GME costs from the Medicare allowable cost determinations for UPL purposes appears to be a violation of the Congressional moratorium on restrictions of Medicaid payments for GME because it would limit total Medicaid payments for states

that pay GME in Medicaid to a Medicare comparison amount that specifically excludes allowable Medicare GME costs.

The rule proposes to require that payments for rural health clinic (RHC) services be included when calculating the upper payment limits for privately-owned clinics at §447.321. CMS would also restrict the methodology used to calculate the UPL for those clinics to a procedure-by-procedure comparison to the Medicare fee schedule amounts for non-facility settings. Neither Medicaid nor Medicare pays RHCs based on the fee schedule amounts. States are required to make Medicaid payments to RHCs that are at least as generous as the cost-based PPS payment system implemented in section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act. When the new cost-based PPS payment system for FQHCs and RHCs was implemented, CMS (then HCFA) advised states that the Medicare and Medicaid upper payment limits did not apply. In discussions concerning the cost limit rule published in the Federal Register on May 29, 2007, CMS acknowledged that UPLs did not apply to FQHCs. We recommend that the agency confirm that UPLs are also not applicable to payments for RHC services.

The UPL calculation methodology proposed in this rule will limit Medicaid payments for outpatient hospital services to costs. In the discussion of this provision, CMS makes the statement that a cost-to-charge ratio will produce the highest amount that Medicare would pay for outpatient hospital services. This statement is not accurate. While it is true that at the aggregate national level, Medicare Ambulatory Payment Classification (APC) rates are designed to pay at 85 percent of outpatient hospital costs, very efficient individual hospitals with lower costs can actually receive higher-than-cost reimbursement from the APC payment rates. In addition, as noted above, Medicare pays critical access hospitals 101 percent of allowable costs. Minnesota currently has 80 hospitals that are designated as critical access hospitals.

By limiting the UPL to costs, this rule penalizes states with large numbers of critical access providers. State Medicaid programs that follow Medicare payment methods for critical access hospitals and pay rates equal to 101 percent of costs would have to offset those above-cost amounts by reducing payments to non-critical access providers to amounts that are less than their costs.

The proposed rule would also prohibit professional services and clinical laboratory services from being included in the outpatient hospital UPL calculation. Medicare allows critical access hospitals to bill professional and clinical laboratory costs on the hospital claim form. Clinical laboratory costs billed by critical access hospitals are included on the cost report and reimbursed at 101 percent of costs. And while professional services delivered by critical access hospitals are not included on the cost report, they are reimbursed at 115% of Medicare physician fee schedule amounts.

The exclusion of professional services from the definition of outpatient hospital services also has implications for facility-specific disproportionate share hospital limits. This impact was not addressed in the regulatory impact section of the proposed rule. When hospitals employ salaried physicians, those costs are legitimate hospital costs and should remain eligible for DSH reimbursement.

The impact statement of the regulation highlights the fact that there is no real need for this proposed regulation. In the impact statement discussions, CMS notes that although more than 60 percent of states' outpatient hospital payment methodologies have been reviewed, only one state has been identified as including services that would not be covered under the Medicare outpatient hospital payment system under the Medicaid definition of outpatient hospital services. Even in that single case, CMS goes on to note that the Medicaid payments in that state would not exceed the proposed Medicaid payment limits. Given these results, the restrictions CMS would place on states' ability to define and pay for Medicaid outpatient hospital services would appear to be directed at limiting the potential for some future and as yet unrealized funding abuses. We recommend that CMS address those concerns in a more appropriate and direct manner and continue to allow states to define the Medicaid benefit structure to meet the needs of their Medicaid populations.

Sincerely,

Christine Bronson

Christine Bronson
Medicaid Director

Submitter : **Mrs. Kim Duggan** **Date: 10/29/2007**

Organization : **Missouri Hospital Association**

Category : **Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-51-Attach-1.PDF

#51

MISSOURI HOSPITAL ASSOCIATION

Marc D. Smith, Ph.D., President

October 29, 2007

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

Re: (CMS-2213-P) Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

Dear Mr. Weems:

On behalf of the Missouri Hospital Association and the 145 hospitals that comprise the membership, the following comments on the Centers for Medicare & Medicaid Services' proposed rule changing Medicaid policy for federal reimbursement of Medicaid hospital outpatient services are respectfully offered for your consideration.

CMS describes the Medicaid hospital outpatient proposed policy changes as clarifications to current rules. CMS further states that because 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. MHA disagrees on all points.

This rule (1) unnecessarily narrows the definition of outpatient hospital services, with a significant but unacknowledged impact on disproportionate share hospital payments; and (2) is overly prescriptive in dictating upper payment limit methodologies for private outpatient hospitals and clinics. Of more concern, however, the proposed rule violates a recent legislative moratorium on implementation of a cost limit on payments to governmental providers or restrictions on Medicaid graduate medical education payments. For these reasons, we urge CMS to withdraw the proposed rule immediately.

Moratorium

Because the proposed rule violates the moratorium, CMS is legally obligated to withdraw it, and we urge you to do so immediately. Congress enacted the moratorium specifically to prevent CMS from taking "any action" to develop new policies in areas in which this proposed rule purports to regulate. Moreover, the proposed rule is bad policy, and would have a significant negative financial impact on both governmental and private hospitals serving Medicaid and uninsured patients. In our opinion, the proposed rule violates the moratorium in two ways.

First, the agency 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 or -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 count 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. 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, CMS is proposing 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 of 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, CMS does not identify a problem with current state Medicaid programs to justify this policy change. In fact, the agency states in the proposed rule's preamble that in examining 32 state plan amendments over the last four years, 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 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, 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, CMS views only the costs for providing inpatient and outpatient hospital services as allowable for determining a hospital's uncompensated care costs. The agency's proposed narrow definition would exclude many costs now included in hospitals' Medicaid DSH calculations, potentially limiting DSH payments to already financial strapped hospitals.

UPL Calculations. CMS states that the proposed changes in the UPL methodology only will apply 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. Therefore, 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, 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.

The Impact on Outpatient Hospital Services for Children

The narrow Medicare definition included in the proposed regulation does not reflect the reality of the Medicaid program today and the significant role it plays for children. More than one-fourth of all children are insured by Medicaid and over 50 percent of Medicaid beneficiaries are children. The Medicare definition for outpatient services is inappropriate for children because it was not developed to address their unique health care needs. Services not specified in the Medicare definition include, but are no limited to, dental and vision services, annual checkups, and immunizations. The different health care needs of children and adults should be examined and changes made before the Medicare definition is adopted for the Medicaid population. If this is not done, important outpatient health care services for children could be threatened.

The changes in the outpatient hospital services would have a negative impact on children's hospitals. We recognize that the regulation says that services taken out of the outpatient hospital services definition could still be provided under different benefit categories. However, by taking services out of the definition, CMS would be lowering reimbursement for these important services that are provided to children insured by Medicaid. This reduction would exacerbate the

inadequate Medicaid outpatient reimbursement, which already falls substantially below the cost of care provided.

In addition, the proposed regulation would exclude services provided by entities that are not provider-based departments of a hospital. This new requirement could jeopardize the care provided in the outpatient clinics at children's hospitals. If the services provided in such clinics or other outpatient sites would no longer be reimbursed at the outpatient hospital services level, it would affect the ability of these organizations to provide such services in the community. Again, the adoption of a Medicare policy in the Medicaid program would be inappropriate given the different populations and purposes of the two programs.

Finally, the proposed regulation also may affect the calculation of Medicaid DSH payments. If services are no longer classified as outpatient hospital services, they no longer would be included in the calculation of the DSH cap. This could result in smaller payments to children's hospitals. As safety net hospitals, DSH payments are vital to the children's hospitals' ability to care for all children.

Conclusion

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. Furthermore, 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 services for potentially millions of vulnerable people served by the Medicaid program.

We appreciate the opportunity to share our comments and would be pleased to discuss them further. For additional information, please contact me at 573/893-3700, ext. 1345 or *kduggan@mail.mhanet.com*.

Sincerely,

Kim Duggan

Kim Duggan
Vice President of Medicaid and FRA

kd/kh

Submitter : Mr. Larry Naake **Date:** 10/29/2007

Organization : National Association of Counties

Category : Local Government

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2213-P-52-Attach-1.DOC

#52

NACo National Association of Counties
The Voice of America's Counties

October 29, 2007

Mr. Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, S.W.
Washington, DC 20201

Attention: CMS-2213- Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

Dear Mr. Weems:

On behalf of the National Association of Counties (NACo), I ask that the Centers for Medicare and Medicaid Services (CMS) withdraw the Proposed Rule (CMS-2213-P) published in the *Federal Register* on September 28, 2007. The Proposed Rule would severely restrict the ability of states and counties to provide essential services in the community to vulnerable populations.

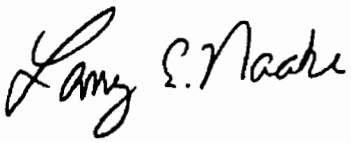
Because counties are both payers and providers of last resort in many states, we are alarmed by any proposal which will weaken the local health safety net. This proposed rule appears to narrow the definition of outpatient hospital services unnecessarily, particularly for disproportionate share hospital (DSH) payments and also seems overly prescriptive in dictating upper payment limit (UPL) methodologies for private outpatient hospitals and clinics. More importantly, however, the proposed rule violates the recent legislative moratorium (the Moratorium) on implementation of a cost limit on payments to governmental providers or restrictions on Medicaid graduate medical education (GME) payments. Accordingly, NACo urges you to withdraw the proposed rule immediately.

Because the proposed rule violates the Moratorium, CMS is legally obligated to withdraw it, and we urge you in the strongest terms to do so immediately. Congress enacted the Moratorium specifically to prevent CMS from taking "any action" to develop new policies in areas in which this Proposed Rule purports to regulate. Moreover, the Proposed rule is bad policy, and would have a significant negative financial impact on both governmental and private hospitals serving Medicaid and uninsured patients. Coming in the wake of several other regulations issued by CMS that would impose large cuts on these hospitals—including the rule imposing a governmental provider cost limit and restricting sources of non-federal share funding – CMS' latest administrative action would be devastating to public, teaching and other safety net hospitals. Cumulatively these rules would severely undermine the local health care safety net in communities across the country.

NACo urges CMS to step back and consider the cumulative effect of its ever more restrictive Medicaid policies on the nation's safety net and the patients who rely on it for care. In addition to covering care for eligible populations, Medicaid supports an institutional safety net of health care

providers that are critical to the well-being of their communities. If enacted, these rules would mean that such providers will no longer be able to serve our communities' poor, uninsured and underinsured. We urge you to withdraw this regulation.

Respectfully,



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