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

Organization : PEACH, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2213-P-65-Attach-1.DOC

#65

October 29, 2007

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

Attention: CMS-2213-P

To Whom it May Concern:

I am writing on behalf of Private Essential Access Community Hospitals, the association of private disproportionate share (DSH) hospitals in California, to convey our concerns about aspects of the proposed rule "Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit," which was published in the *Federal Register* on September 28, 2007.

Introduction to PEACH

Private Essential Access Community Hospitals (PEACH) is a network of the core, private, safety-net hospitals in California that care for a disproportionate share of low-income, medically vulnerable patients. Despite an increased need for services, declining revenues, and a host of other challenges, PEACH hospitals remain dedicated to their mission of providing choice and access to high-quality, culturally appropriate and cost-effective care to all patients, regardless of their ability to pay. PEACH is committed to preserving these private safety-net hospitals through the active development and aggressive advocacy of public policy at the state, local, and federal levels. PEACH member hospitals are located in key regions of the state where large numbers of uninsured and low-income populations reside, including the San Francisco Bay area, Central Valley, Inland Empire, and the southern California counties of Los Angeles, Orange, and San Diego. Some of these PEACH hospitals have served their diverse communities for more than 100 years. Our members' health care professionals communicate in nearly 30 languages and are culturally sensitive to serving patients of all ethnic backgrounds. Our member hospitals rely primarily on Medi-Cal and Medicare as the primary source of payment for patient services provided; many PEACH members have a patient mix of Medi-Cal, Medicare and charity care that exceeds 80% of total care provided.

Summary of Views

PEACH believes the proposed approach would pose problems for Medi-Cal (California's Medicaid program), providers of outpatient care to Medicaid patients, and to Medicaid patients themselves, possibly jeopardizing the latter's access to care. In particular, we object to aspects of how the UPL would be calculated under the new regulation and oppose what we understand will be the creation of separate outpatient UPLs for private hospital-based outpatient providers and for private non-hospital outpatient providers. We fear these new approaches are overly restrictive and will unduly limit California's ability to legitimately draw down the federal financial participation it needs to adequately

reimburse the state's participating providers. We also are concerned about the impact the proposed regulation could have on the hospital-specific Medicaid DSH upper payment limits of many PEACH hospitals that are essential providers of outpatient care to Medicaid patients. Finally, we are very concerned that the Centers for Medicare & Medicaid Services (CMS) seeks to implement this regulation without a meaningful analysis of its potential impact on providers that receive outpatient Medicaid payments. Combined, we fear that these problems could cause financial harm to many such providers and eventually affect access to care for some Medicaid recipients. They also would pose a significant obstacle to California's current effort to reform its Medicaid program.

We address these concerns separately below.

Concern About the Proposed UPL Calculation Methodology

Medicare and Medicaid, in PEACH's view, are not similar in many important ways that seem to be assumed, to a degree, in this proposed regulation. The result, we believe, is that Medi-Cal could be deprived of the flexibility it needs to expend its limited resources in the most productive manner possible.

PEACH is concerned, for example, about the proposal that states only be permitted to use Medicare cost-to-charge ratios (or payment-to-charge ratios – the same arguments basically apply to both ratios) to calculate what Medicare would pay for state-approved Medicaid services. We believe this is an overly restrictive approach. It assumes, for example, that such ratios are uniform within hospital-based outpatient provider organizations; this is not necessarily true. CMS has acknowledged this concept in the past when proposing a new methodology for calculating relative values for the Medicare inpatient prospective payment system. Within individual hospitals, and even within individual hospital departments, in fact, different cost centers can and do have different cost-to-charge ratios. This, in turn, means that the cost-to-charge ratio that applies to one patient population may not be appropriate for estimating the cost of care for a different population that requires a different mix of services.

Medicare and Medicaid provide different services to different patient populations. Medicare is seldom called upon, for example, to reimburse outpatient providers for fetal ultrasounds, myringotomies, measles vaccines, and treatment for HIV. Consequently, the cost-to-charge ratios for the types of services that the Medicaid population requires often are very different from the cost-to-charge ratios calculated for the Medicare population.

Because of the problems posed by this proposed methodology for calculating the outpatient UPL, PEACH also believes this new approach may fail in what appears to be its most basic function: assuring that providers of Medicaid services are not paid more than what Medicare would pay for those services. ***Under the proposed approach, every single provider of Medicaid outpatient services in California could be paid according to the Medicare outpatient prospective payment system – not a penny more and not a penny less – and California could still exceed its UPL.*** In this regard, using Medicare cost-to-charge ratios to calculate state UPLs – or, alternatively, using payment-to-charge ratios – could end up costing Medicaid outpatient providers and depriving them of fair payment for the services they deliver.

For these reasons, PEACH believes the proposed methodology does not produce a "reasonable estimate of the amount the provider would be paid under Medicare payment principles" (*Federal Register,* September 28, 2007, p. 55160). We respectfully ask CMS to consider allowing states to seek approval for alternative methodologies for calculating this UPL.

The Overly Restrictive Definition of "Hospital Outpatient Facility" Used in the Calculation of the Upper Payment Limit for Outpatient Hospital Services

PEACH believes the proposed regulation is far too restrictive in how it defines "hospital outpatient facility" for purposes of calculating the UPL for hospital outpatient services. By employing restrictive Medicare provider-based requirements, CMS would effectively force outpatient facilities sponsored by hospitals into the non-hospital provider group for UPL calculation purposes.

Throughout California, hospitals operate, sponsor and have financial responsibility for outpatient facilities and programs that are recognized by Medi-Cal as hospital-affiliated but would not be recognized under the Medicare provider-based requirements proposed in this regulation. PEACH believes that if Medi-Cal recognizes a facility as hospital-based, CMS should do so as well when calculating the hospital-based provider UPL under this new regulation. PEACH urges CMS to modify the regulation to incorporate this concept. To do otherwise, would artificially lower the hospital specific Upper Payment Limits of the states and most certainly reduce the UPL in California.

Effect on the Calculation of Hospital-Specific DSH Limits

PEACH believes the proposed change in the definition of outpatient hospital facilities would affect hospitals' individual hospital-specific Medicaid disproportionate share (DSH) upper payment limits. Specifically, we are concerned that the costs to hospitals of providing care for many Medicaid recipients and medically indigent patients would no longer be considered hospital costs for the purposes of calculating the hospital-specific DSH limit. This would result in a reduction of those upper limits, thereby reducing the amount of Medicaid DSH payments for which many hospitals would be eligible. This would be a major change in policy that would hurt the very hospitals – including the private safety-net DSH hospitals represented by PEACH – that do the most to care for the low-income residents of their communities. In the long run, this practice could affect the financial condition of these hospitals and possibly jeopardize access to care in the California communities they serve.

Failure to Determine the Proposed Regulation's Impact

PEACH believes CMS has failed to meet its obligation to prepare a complete and meaningful analysis of this proposed rule's potential impact. The agency concedes this failure, writing that "Due to a lack of available data, we cannot determine the fiscal impact of this defined rule" (*Federal Register,* September 28, 2007, p. 55164). Despite this admission, CMS goes on to state that "We have reviewed the effects of the proposed rule and have determined that it would clarify current vague regulatory language but would not significantly alter current practices in most States" (*Federal Register,* September 28, 2007, p. 55164). In the absence of an analysis of the fiscal impact of the rule, it is not clear how CMS could reach such a conclusion.

This is not a sound way to make public policy. CMS opines – with no supporting data – that the changes brought about by this regulation would not be significant. PEACH – and others – believes that the changes could have dramatic adverse impacts. The only way to be sure is for the agency to undertake a more definitive analysis of the proposed rule's potential fiscal impact. The stakes in this matter are exceptionally high, and PEACH urges CMS not to implement this proposed rule until it can offer a more definitive conclusion about its impact.

Conclusion

Overall, PEACH believes the proposed methodology for calculating states' Medicaid UPL is overly restrictive. The new calculation methodology will make it more difficult for California to draw down federal matching funds while the division of outpatient providers into hospital-based and non-hospital for UPL calculation purposes will deprive our state of the flexibility it needs to ensure that some of its largest and most important private hospital providers can receive the level of reimbursement they need to preserve their financial health while still caring for significant numbers of Medicaid patients. The proposed rule also could affect – and we believe lower – the hospital-specific Medicaid DSH upper payment limit for hospitals that are major providers of care to the Medicaid population. Finally, we believe that no major change should be implemented without a thorough and reliable analysis of the potential impact on the objects of this regulatory proposal.

While PEACH understands CMS's desire to ensure that providers operate as efficiently and economically as possible and that states receive no more federal funds than they should, we believe the proposed approach is too restrictive and may hurt states' finances, hurt hospital-based providers' finances, and eventually jeopardize access to care for Medicaid recipients in some communities. It also would jeopardize California's current Medicaid reform efforts. We urge CMS to withdraw the proposed regulation and work to develop a more flexible approach that meets the needs of all involved parties: the federal government, state governments, providers, and of course, the millions of Americans who are eligible for Medicaid and need appropriate providers of Medicaid-covered services.

We appreciate your attention to these matters and welcome an opportunity to answer any questions you may have and to discuss our concerns and possible alternative approaches with you.

Sincerely,

Catherine K. Douglas
President & CEO

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

Organization : Massachusetts Office of Medicaid

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-2213-P-66-Attach-1.PDF

CMS-2213-P-66-Attach-2.PDF

#66

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

JUDYANN BIGBY, M.D.
Secretary

THOMAS R. DEHNER
Medicaid Director

October 29, 2007

Kerry Weems
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2213-P
P. O. Box 8016
Baltimore, MD 21244-8016

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

Dear Mr. Weems:

The Commonwealth of Massachusetts appreciates the opportunity to submit comments on the Proposed Rule regarding the Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit. Massachusetts would first like to express its support for the comments submitted by the National Association of Public Hospitals and Health Systems. Massachusetts also has a number of serious concerns about the impact of the proposed rule.

Moratorium: As a preliminary matter, we question CMS' authority to issue this NPRM given the Congressional moratorium[1] on rulemaking relating to proposed CMS regulations concerning Medicaid financing and governmental provider payment[2] ("Medicaid financing NPRM"), and graduate medical education[3] ("GME NPRM"). The provisions in this NPRM relating to upper payment limit calculations for private outpatient hospital and clinic services are inextricably linked to the proposed CMS regulations that are subject to the moratorium. Although the preamble indicates that CMS views the instant rulemaking as addressing "completely different policy matters" than those addressed in the Medicaid financing NPRM, the proposed outpatient hospital and clinic UPL regulation repromulgates 42 CFR 447.321 and cannot be implemented without reference to 42 CFR 433.50, both of which regulations are subject to the moratorium. Also, where CMS would appear to prohibit states from including graduate medical education (GME) costs in a cost-to-charge outpatient hospital upper payment limit calculation, the NPRM appears to violate the prohibition against restricting

[1] U.S. Troop Readiness Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, Section 7002(a).
[2] 72 Fed. Reg. 29748 (May 29, 2007)
[3] 72 Fed. Reg. 28930 (May 23, 2007)

payments for GME under the Medicaid program. CMS should withdraw this NPRM on this basis.

Effective Date: This NPRM could require major administrative and operational changes for any state whose current outpatient hospital payment method bundles payments to a greater degree than the bundling in Medicare's OPPS. It could be difficult, if not impossible, to segregate from the upper payment calculation any service whose Medicaid payment is bundled into a state's approved outpatient hospital payment methodology, but is not included in Medicare's OPPS. This could require restructuring current approved Medicaid payment methodologies, issuing amendments to state regulations, provider agreements, and State Plans, and recalculating upper payment limits. If this regulation becomes final, states should be given sufficient time to implement these major changes.

The regulation, if finalized, should also provide states sufficient time to make any future administrative and operational changes that may be needed as a result of future changes in Medicare outpatient hospital coverage policies or payment methods.

Direct Comparison from Medicaid to Medicare: We have serious concerns about the proposed rule's assertion that "the scope of outpatient hospital services as defined by Medicaid would be the same as those included in the outpatient hospital UPL." Medicare and Medicaid are fundamentally different programs with different purposes, populations, and covered services. As such, we believe it is in direct conflict with Congressional intent to limit services that can be reimbursed under the Medicaid outpatient services provision of the SSA to those that are reimbursed under the Medicare OPPS. Congress established two separate programs and did *not* go so far as to equate Medicaid services to Medicare services.

CMS proposes to draw a bright line between services provided by outpatient hospitals and services within the scope of other State Plan service categories. However, the preamble, the proposed rule and existing Medicare OPPS provisions as well as Medicaid regulations governing State Plan provisions for other service categories do not bear out such a precise parsing of services. CMS' attempt to distinguish OPPS services from other State Plan services creates ambiguity for states and internal inconsistencies in this proposed regulation. Also, the preamble indicates that the following are within the scope of services that may be reimbursed as Medicaid outpatient hospital services: "prosthetic devices, prosthetics, supplies, and orthotic devices, durable medical equipment, and clinical diagnostic laboratory services." However, prosthetic services and durable medical equipment are separate Medicaid State Plan service categories. Additionally, under Medicare OPPS rules, not all prosthetic and DME services are reimbursed under the OPPS system—only implantable prosthetics and DME are included costs. See 42 CFR 419.2(b)(10) and (11). Indeed, the very Medicare provisions that CMS cites as providing clarity and precision contain qualifications. 42 CFR 419.2(b) lists costs that are "generally" included as outpatient hospital costs, yet explicitly does not limit the costs that may be included to those specifically listed. As CMS notes, there are Medicaid covered services that do not appear among the list of services Medicare covers and CMS rules prohibit inclusion of costs within the OPPS for "services not covered by Medicare

by statute." See 42 CFR 419.22(p). Medicare generally does not cover services for people under the age of 21-- an entire segment of the federally mandatory Medicaid population under the SSA. We respectfully maintain that some overlap must exist between services eligible for reimbursement as outpatient hospital services and other State Plan service categories and that such overlap is not inconsistent with Medicare payment principles but rather is recognized within them.

We have previously understood that the purpose of the UPL is to allow states to reasonably *estimate* the amount that would be paid for Medicaid services under Medicare *payment principles*. The proposed rule changes the fundamental comparison behind the UPL from the theoretical question of what Medicare *would have* paid for a *Medicaid* service, to what would Medicare pay for a Medicare service. We understand CMS's desire to establish standard references that all States may use to calculate the UPL, but respectfully ask CMS to develop alternative means of achieving this end without disregarding fundamental differences between the two programs and the resulting need for flexibility in determining Medicaid upper payment limits.

Access to Services: Hospitals deliver on an outpatient basis certain services that states must provide under the Medicaid statute (e.g., EPSDT), or that are particularly difficult for Medicaid recipients to access (e.g., dental), but which would no longer be considered outpatient hospital services under this NPRM. It is not clear what upper payment limits, if any, would apply to these redesignated services. If payments to hospitals for services they provide were subject to community upper payment limits, it is likely that Medicaid payment levels could not recognize hospitals' necessary overhead in providing these services in their facilities. Artificially limiting the scope of outpatient hospital services in order to reduce payments to hospitals would not only undermine Congress' intent in designating outpatient hospital services as mandatory Medicaid services, it is also likely to create access problems if hospitals determine Medicaid payments are insufficient to support their provision of those services. We request that CMS regulations allow for payment levels to hospitals that recognize the value of the services they provide to our most vulnerable citizens, and foster continued access to those services.

In addition to these overarching concerns, Massachusetts has the following additional comments, questions, and concerns regarding the proposed rule.

Provisions of the Proposed Rule

1) Please clarify the effective date for this proposed rule in light of the moratorium on related Medicaid rules.

Part 440 – Services General Provisions

Outpatient clinic and hospital facility services and rural health clinic services (Proposed 42 CFR 440.20)

1) What, if any, overlap is there between **42 CFR 440.20,** and the recently proposed rule governing Medicaid coverage for rehabilitative services under **42 CFR 440.130(d),** and diagnostic services under **42 CFR 440.130(a)?** How may states reconcile these provisions?

2) If a service is included in the Medicare OPPS, but is also specified in Medicaid regulations as a separate State Plan category of service, is that service considered an outpatient hospital services under the new rule when furnished in an outpatient hospital facility? If not, what is the justification for treating a service as a hospital service under Medicare, but not under Medicaid?

3) Bundled outpatient hospital rates were developed to provide incentives to hospitals to deliver care in an efficient manner and to discourage overutilization of services—an incentive that is inherent to fee-for-service systems. Although Medicare's OPPS is a bundled rate method, some states' outpatient hospital payment methods achieve an even greater degree of bundling than Medicare's OPPS. The current proposed rule would negatively impact states' efforts to foster efficiency and promote appropriate incentives by effectively forcing states to separate from their bundled outpatient hospital payment methods, any service that could not be included in its outpatient hospital UPL under the NPRM. Please explain the rationale behind eliminating states' ability to pay hospitals bundled rates for outpatient services in a way that exceeds the efficiencies recognized by the Medicare OPPS.

4) While 42 CFR 440.20(a)(4) purports to limit the scope of outpatient hospital services to those services that Medicare pays for as outpatient hospital services, 42 CFR 440.20(a)(5) creates an ambiguity that appears to be inconsistent with that limitation. 42 CFR 440.20(a)(5) provides that outpatient hospital services "[m]ay be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of 'outpatient hospital services' those types of items and services that are not generally furnished by most hospitals in the State." That provision has been interpreted, in the context of eliminating optional benefits, to mean that Medicaid agencies may *not* exclude from the definition of outpatient hospital services those types of items and services that *are* generally furnished by most hospitals in the State.

Please explain how states should apply **42 CFR 440.20(a)(5)** when services generally provided by hospitals in the state are outside the Medicare outpatient hospital payment method, or are also specified in Medicaid regulations as a separate State Plan category of service. Are such services mandatory outpatient hospital services? Would the determination no longer be state-specific? Please clarify the rule to eliminate any inconsistency or ambiguity between 42 CFR 440.20(a)(4) and (a)(5).

5) Please clarify the difference, if any, between 'non-traditional hospital services' and services that are provided in hospital outpatient settings but are not included in the Medicare OPPS or alternative Medicare outpatient hospital payment method?

6) What is the significance of the revision to the title of 42 CFR 440.20 to add the word 'clinic' if the regulation itself has no changes regarding 'clinic services' and where 'clinic services' are defined at 42 CFR 440.90?

Part 447 – Payments For Services

Outpatient hospital and clinic services: Application of upper payment limits (Proposed 42 CFR 447.321)

1) This NPRM narrows the definition of outpatient hospital services and specifies only the upper payment limit ("UPL") that applies to that narrower set of outpatient hospital services and clinics. This leaves unaddressed what upper payment limits, if any, apply to services that would no longer be considered outpatient hospital services and for which an upper payment limit is not specified in the Medicaid statute or regulations. This raises a particular concern where, in the absence of a Medicaid UPL regulation applicable to a particular service (e.g., physician service), CMS has recently required states to utilize a specific and evolving UPL calculation that is not articulated in any statute, regulation, or even sub-regulatory material.

Please clarify what UPL, if any, applies to each service that is provided in hospital outpatient facilities, but which would not be within the scope of the definition of outpatient hospital services under 42 CFR 440.20.

Please clarify how a state should deal with clinic types that offer Medicaid services which have no Medicare equivalent—such as family planning clinics.

2) The preamble (though not the proposed regulation itself) requires uniform trending of all data to the current rate year using the Medicare Market Basket Index; however, the preamble also states that States must demonstrate their methodology for any proposed volume trending.

Please clarify what data (i.e. charges, payments, and/or costs) must be trended using the Medicare Market Basket Index and clarify whether this applies to Medicare data only, or to Medicaid data as well.

Please clarify whether volume measures should also be trended uniformly using the Medicare Market Basket Index, or whether states have discretion in what trend to apply to volume.

The impact of this proposed trend factor varies depending upon how CMS requires it to be applied. If the trend applies only to Medicare cost, charge and payment data, this would not appear to be problematic. However, it is not clear whether and why CMS would require a Medicare trend factor be applied to Medicaid cost, charge and payment data. Furthermore, as CMS has recently indicated to our state, it wants to see the hospital-

specific UPL calculations that support the class-wide UPL. Applying a uniform trend factor to Medicaid data or to volume data would contradict that guidance.

Any requirements CMS will impose on states regarding calculation of the UPL should be included in the regulation itself.

3) Please clarify how a state should account in its UPL calculation for mandatory outpatient hospital services pursuant to 42 CFR 440.20(5) that are not covered by Medicare as outpatient hospital services, or are also specified in Medicaid regulations as a separate State Plan category of service.

4) With respect to Option 1, the preamble, but not the regulation, indicates that under the first option a state with a percentage below 100% could make supplemental payments up to 100% of what Medicare pays, but would have to demonstrate per CPT code what Medicare would pay for the equivalent Medicaid services, and submit documentation for a clinic UPL demonstration. Any requirements CMS will impose on states regarding calculation of the UPL should be included in the regulation itself.

5) With respect to Option 2, the preamble, but not the proposed regulation indicates that (1) a UPL demonstration would be required under option 2 showing a comparison by CPT code of the amount paid by Medicare for Medicaid equivalent services, and (2) an option 2 state could pay more than Medicare for some services or facilities as long as the aggregate Medicaid payment was equal to or less than the amount Medicare would pay in the aggregate. Any requirements CMS will impose on states regarding calculation of the UPL should be included in the regulation itself.

Massachusetts appreciates the opportunity to comment on this proposed rule and looks forward to continuing to work with CMS to strengthen and improve the Medicaid program.

Sincerely,

/s/

Tom Dehner
Medicaid Director

Submitter : **Ms. Barbara Viskochil** **Date: 10/29/2007**

Organization : **University Health Care - Hospitals & Clinics**

Category : **Hospital**

Issue Areas/Comments

Clinic Upper Payment Limit

Clinic Upper Payment Limit

University Health Care Hospitals & Clinic (UUHC) is writing to express serious concern regarding the issuance of the above-referenced Proposed Rule. This Rule unnecessarily narrows the definition of outpatient hospital services, with a significant impact on disproportionate share hospital payments. UUHC is located within a low DSH state, but we depend heavily on the DSH payments that we do receive. In addition, the rule change on upper payment limit (UPL) methodologies is too restrictive. The Proposed Rule also appears to violate a recent legislative moratorium on implementation of a cost limit on payments to governmental providers or restrictions on Medicaid graduate medical education (GME) payments. For these reasons, UUHC urges CMS to withdraw the Proposed Rule immediately.

GENERAL

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The proposed rule is making major policy changes to the Medicaid program. We do not believe that a 30-day comment period is sufficient time period for public comment; and 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. UUHC urges CMS to withdraw this rule and submits these comments with strong opposition to the changes proposed.

Upper Payment Limits

Upper Payment Limits

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. UUHC strongly disagrees with these points. We have received and relied upon Medicaid support for the costs of training interns and residents for forty years. The State of Utah has always supported our education and patient care missions. This cannot represent a clarification of the rules. Utah has a waiver with CMS for the on-going funding of graduate medical education costs. The waiver established the Utah Medical Education Council (UMEC). This waiver relates not just to Medicare GME, but also to Medicaid GME. The chair of the UMEC Finance Sub-committee is from the Utah Department of Health, Health Care Financing Division, Institutional Payments Section.

Submitter : Mr. Donald Ching **Date:** 10/29/2007

Organization : University of South Alabama Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

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Teaching hospitals provide an environment in which clinical research can flourish and where highly specialized tertiary patient care such as burn care, trauma and cardiac care can be provided. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art services and equipment; and with residents and supervising physicians available around-the-clock. Teaching hospitals care for the nation s sickest patients. Most recently, teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Our hospitals are unique in the Mobile, Alabama region in that we not only provide services to safety net populations, but also provide services such as Level 1 Trauma, Burn Unit, and Neonatal Intensive Care that are otherwise not available within 150 to 200 miles.

Given their important roles and the current and future financial uncertainty for America s teaching hospitals, it is important that state Medicaid programs receive federal matching assistance for GME. We urge the Agency to rescind the proposed rule.

Upper Payment Limits

Upper Payment Limits

I am writing on behalf of University of South Alabama Hospitals to urge the Centers for Medicare & Medicaid Services (CMS) to rescind the September 28, 2007 proposed rule that seeks to redefine Medicaid outpatient hospital services and thereby removes GME cost from the proposed formula for computing the upper payment limit. Finalizing this rule would erode the financial condition of our teaching hospitals and jeopardize their abilities to continue to fulfill important teaching, patient care and other missions.

This proposed rule effectively prohibits states from inlcuding GME costs in the outpatient UPL by using the cost to charge ratios on the Medicare cost report that exclude the GME costs that are prospectively determined and paid elsewhere in the report. Although characterized by CMS as a clarification, the reality is that the proposed rule represents a major reversal of long-standing Medicaid policy (and likely violates the Medicaid GME Provision of the moratorium prohibiting changes to GME policy). For decades, most state Medicaid programs have supported the higher costs of teaching hospitals. CMS and its predecessor, the Health Care Financing Administration, have approved and matched these payments. According to a study commissioned by the Association of American Medical Colleges (AAMC), in 2005, 47 states and the District of Columbia provided direct GME and/or indirect medical education payments under their Medicaid programs. Teaching hospitals rely on these and other Medicaid payments to support our critical functions.

Medicaid GME payments help teaching hospitals sustain one of our core responsibilities: providing the clinical education of future physicians. Within a supervised patient care team of health care professionals, medical residents provide needed care to Medicaid and other patients as part of their training programs. Educating future physicians and other health care professionals has never been more important given the numerous studies predicting a physician shortage in the near future. The two hundred medical residents currently in our programs are engaged in a wide variety of medical specialties as well as primary care areas. Upon completion of our programs, many of our residents move on to practice in medically underserved areas in federally qualified clinics in our urban area and in rural areas of Alabama. Eliminating FFP for state Medicaid agency payments for outpatient GME could cripple our graduate medical education programs at a time when more physicians are needed throughout the country.

Because half of all Medicaid discharges are from the nation s nearly 1100 teaching hospitals and more than half of the nation s hospital charity care occurs in these institutions, a GME funding cut could also affect other services offered to Medicaid and other patients by reducing teaching hospitals total financial resources. In our own case, we provide over $100 million in medical care to Medicaid and indigent patients each year. The current regulatory trend denies the existence of costs our hospitals are incurring on the behalf of Medicaid patients and for Medicaid patients with exhausted benefits. The care must be provided by our hospitals and we must have anesthesiologists and emergency physicians staffed to do the job. Our hospitals have been forced to provide financial support to help close the gap between Medicaid physician reimbursement and physician costs. Under the proposed redefinition, these required expenses will be removed as not applicable to outpatient services.

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

Organization : PEACH, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

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See Attachment

CMS-2213-P-69-Attach-1.PDF

#69

October 29, 2007

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

Attention: CMS-2213-P

To Whom it May Concern:

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Summary of Views

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PEACH INC
Private Essential Access Community Hospitals, Inc.

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reimburse the state's participating providers. We also are concerned about the impact the proposed regulation could have on the hospital-specific Medicaid DSH upper payment limits of many PEACH hospitals that are essential providers of outpatient care to Medicaid patients. Finally, we are very concerned that the Centers for Medicare & Medicaid Services (CMS) seeks to implement this regulation without a meaningful analysis of its potential impact on providers that receive outpatient Medicaid payments. Combined, we fear that these problems could cause financial harm to many such providers and eventually affect access to care for some Medicaid recipients. They also would pose a significant obstacle to California's current effort to reform its Medicaid program.

We address these concerns separately below.

Concern About the Proposed UPL Calculation Methodology

Medicare and Medicaid, in PEACH's view, are not similar in many important ways that seem to be assumed, to a degree, in this proposed regulation. The result, we believe, is that Medi-Cal could be deprived of the flexibility it needs to expend its limited resources in the most productive manner possible.

PEACH is concerned, for example, about the proposal that states only be permitted to use Medicare cost-to-charge ratios (or payment-to-charge ratios – the same arguments basically apply to both ratios) to calculate what Medicare would pay for state-approved Medicaid services. We believe this is an overly restrictive approach. It assumes, for example, that such ratios are uniform within hospital-based outpatient provider organizations; this is not necessarily true. CMS has acknowledged this concept in the past when proposing a new methodology for calculating relative values for the Medicare inpatient prospective payment system. Within individual hospitals, and even within individual hospital departments, in fact, different cost centers can and do have different cost-to-charge ratios. This, in turn, means that the cost-to-charge ratio that applies to one patient population may not be appropriate for estimating the cost of care for a different population that requires a different mix of services.

Medicare and Medicaid provide different services to different patient populations. Medicare is seldom called upon, for example, to reimburse outpatient providers for fetal ultrasounds, myringotomies, measles vaccines, and treatment for HIV. Consequently, the cost-to-charge ratios for the types of services that the Medicaid population requires often are very different from the cost-to-charge ratios calculated for the Medicare population.

Because of the problems posed by this proposed methodology for calculating the outpatient UPL, PEACH also believes this new approach may fail in what appears to be its most basic function: assuring that providers of Medicaid services are not paid more than what Medicare would pay for those services. ***Under the proposed approach, every single provider of Medicaid outpatient services in California could be paid according to the Medicare outpatient prospective payment system – not a penny more and not a penny less – and California could still exceed its UPL.*** In this regard, using Medicare cost-to-charge ratios to calculate state UPLs – or, alternatively, using payment-to-charge ratios – could end up costing Medicaid outpatient providers and depriving them of fair payment for the services they deliver.

For these reasons, PEACH believes the proposed methodology does not produce a "reasonable estimate of the amount the provider would be paid under Medicare payment principles" (*Federal*

Register, September 28, 2007, p. 55160). We respectfully ask CMS to consider allowing states to seek approval for alternative methodologies for calculating this UPL.

The Overly Restrictive Definition of "Hospital Outpatient Facility" Used in the Calculation of the Upper Payment Limit for Outpatient Hospital Services

PEACH believes the proposed regulation is far too restrictive in how it defines "hospital outpatient facility" for purposes of calculating the UPL for hospital outpatient services. By employing restrictive Medicare provider-based requirements, CMS would effectively force outpatient facilities sponsored by hospitals into the non-hospital provider group for UPL calculation purposes.

Throughout California, hospitals operate, sponsor and have financial responsibility for outpatient facilities and programs that are recognized by Medi-Cal as hospital-affiliated but would not be recognized under the Medicare provider-based requirements proposed in this regulation. PEACH believes that if Medi-Cal recognizes a facility as hospital-based, CMS should do so as well when calculating the hospital-based provider UPL under this new regulation. PEACH urges CMS to modify the regulation to incorporate this concept. To do otherwise, would artificially lower the hospital specific Upper Payment Limits of the states and most certainly reduce the UPL in California.

Effect on the Calculation of Hospital-Specific DSH Limits

PEACH believes the proposed change in the definition of outpatient hospital facilities would affect hospitals' individual hospital-specific Medicaid disproportionate share (DSH) upper payment limits. Specifically, we are concerned that the costs to hospitals of providing care for many Medicaid recipients and medically indigent patients would no longer be considered hospital costs for the purposes of calculating the hospital-specific DSH limit. This would result in a reduction of those upper limits, thereby reducing the amount of Medicaid DSH payments for which many hospitals would be eligible. This would be a major change in policy that would hurt the very hospitals – including the private safety-net DSH hospitals represented by PEACH – that do the most to care for the low-income residents of their communities. In the long run, this practice could affect the financial condition of these hospitals and possibly jeopardize access to care in the California communities they serve.

Failure to Determine the Proposed Regulation's Impact

PEACH believes CMS has failed to meet its obligation to prepare a complete and meaningful analysis of this proposed rule's potential impact. The agency concedes this failure, writing that "Due to a lack of available data, we cannot determine the fiscal impact of this defined rule" (*Federal Register,* September 28, 2007, p. 55164). Despite this admission, CMS goes on to state that "We have reviewed the effects of the proposed rule and have determined that it would clarify current vague regulatory language but would not significantly alter current practices in most States" (*Federal Register,* September 28, 2007, p. 55164). In the absence of an analysis of the fiscal impact of the rule, it is not clear how CMS could reach such a conclusion.

This is not a sound way to make public policy. CMS opines – with no supporting data – that the changes brought about by this regulation would not be significant. PEACH – and others –

believes that the changes could have dramatic adverse impacts. The only way to be sure is for the agency to undertake a more definitive analysis of the proposed rule's potential fiscal impact. The stakes in this matter are exceptionally high, and PEACH urges CMS not to implement this proposed rule until it can offer a more definitive conclusion about its impact.

Conclusion

Overall, PEACH believes the proposed methodology for calculating states' Medicaid UPL is overly restrictive. The new calculation methodology will make it more difficult for California to draw down federal matching funds while the division of outpatient providers into hospital-based and non-hospital for UPL calculation purposes will deprive our state of the flexibility it needs to ensure that some of its largest and most important private hospital providers can receive the level of reimbursement they need to preserve their financial health while still caring for significant numbers of Medicaid patients. The proposed rule also could affect – and we believe lower – the hospital-specific Medicaid DSH upper payment limit for hospitals that are major providers of care to the Medicaid population. Finally, we believe that no major change should be implemented without a thorough and reliable analysis of the potential impact on the objects of this regulatory proposal.

While PEACH understands CMS's desire to ensure that providers operate as efficiently and economically as possible and that states receive no more federal funds than they should, we believe the proposed approach is too restrictive and may hurt states' finances, hurt hospital-based providers' finances, and eventually jeopardize access to care for Medicaid recipients in some communities. It also would jeopardize California's current Medicaid reform efforts. We urge CMS to withdraw the proposed regulation and work to develop a more flexible approach that meets the needs of all involved parties: the federal government, state governments, providers, and of course, the millions of Americans who are eligible for Medicaid and need appropriate providers of Medicaid-covered services.

We appreciate your attention to these matters and welcome an opportunity to answer any questions you may have and to discuss our concerns and possible alternative approaches with you.

Sincerely,

Catherine K. Douglas

Catherine K. Douglas
President & CEO

Submitter : **Ms. Kim Roberts** **Date: 10/29/2007**

Organization : **Santa Clara Valley Health and Hospital System**

Category : **Local Government**

Issue Areas/Comments

Upper Payment Limits

Upper Payment Limits

See Attachment

CMS-2213-P-70-Attach-1.PDF

#70

Dedicated to the Health of the Whole Community

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

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

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

Dear Mr. Weems:

On behalf of Santa Clara Valley Medical Center (SCVMC), I am writing to express our opposition to CMS' Proposed Rule CMS 2213-P, which limits the definition of outpatient hospital services and has a negative impact on DSH payments and the upper payment limit for Medicaid payments to public providers. SCVMC urges CMS to withdraw this proposed rule.

California's public hospitals, including Santa Clara Valley Medical Center, are a cornerstone of the State's health care system. We operate nearly 60% of California's top-level trauma centers, which are state-of-the-art emergency medical units that treat the most catastrophic, life-threatening injuries. We, and California's other public hospitals, participate in the Medicaid program by providing a comprehensive range of services to a substantial portion of the state's Medicaid population. While public hospitals account for only 6 percent of the acute care hospitals in California, we consistently provide over 35 percent of hospital care to the state's Medicaid beneficiaries, 50 percent of the hospital care to California's uninsured, and over 80 percent of the state's hospital care to the medically indigent.

SCVMC is the largest provider of care in Santa Clara County. In CY 2006, nearly 200,000 people, or 1 in 10 of the residents of the County of Santa Clara, received care at SCVMC. The number of

patients has increased more than 40% over the last five years as one hospital closed and others now turn away Medicaid patients, and SCVMC is the only remaining disproportionate share hospital (DSH). SCVMC is also the region's: *only* burn center; spinal cord and traumatic brain injury rehabilitation center; and pediatric and adult trauma center. More than 6,000 babies will be delivered this year, and 1 in 4 of the physicians providing care in this county were trained at SCVMC.

The proposed outpatient rule is yet another attempt by CMS to curtail Medicaid payments to public hospitals, which provide a significant amount of Medicaid services to eligible low-income and disabled patients. If this rule goes into effect, it will likely result in the reduction of critical outpatient clinic and hospital facility services that public hospitals such as ours are uniquely qualified to provide. This year SCVMC and its community clinic partners will provide over 1 million outpatient clinic visits at locations throughout the county; over 700,000 of these visits are specifically at SCVMC. This proposed rule would significantly decrease the already low payments SCVMC receives for the nearly half million Medi-Cal and uninsured outpatient visits projected to be provided this year, to patients who have nowhere else to go for services ranging from primary care, to managing chronic illness, to more complex specialty services.

We believe that this rule should be withdrawn for a number of reasons. First, it violates the moratorium that prevents CMS from implementing its restrictive cost-limit and GME rules.

Beyond its contravention of the moratorium, the rule has numerous harmful implications for Medicaid payments. Though the rule neglects to refer specifically to its negative impact on DSH payments, we are concerned that the uncompensated care costs associated with the disallowed services may no longer be included in our hospital's DSH cap. The DSH program recognizes the unique role that safety net hospitals play in the treatment of the Medicaid and uninsured patients, and any reduction to those payments will restrict our ability to continue to provide those services.

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. As Medicare pays separately for GME costs related to outpatient services of GME, those costs are not reflected on the cost report worksheets specified in the proposed methodology and the proposed methodology would result in the exclusion of GME costs from the DSH payments. We are concerned that CMS may attempt to apply this flawed methodology to governmentally operated hospitals.

Finally, there are a number of issues raised in the comment letter submitted by the California Association of Public Hospitals (CAPH), an organization of which we are a member, which we incorporate in these comments by reference. As discussed in the CAPH letter, the rule is not a "clarification" of existing law as CMS states, but instead involves substantive policy changes. Furthermore, the rule fails to provide an adequate Regulatory Impact Analysis, as required by

Executive Order 12886. In light of CMS' failure to accurately describe the action proposed in the rule and to provide an adequate Regulatory Impact Statement, the rulemaking notice is inadequate and the rule should be withdrawn.

Santa Clara Valley Medical Center opposes this Medicaid rule and strongly urges CMS to withdraw it. If the rule goes into effect, we will suffer harmful effects that will affect our ability to care for our patients and communities. CMS must recognize the damage that this rule will have to our community's health care system and withdraw its proposed rule.

Sincerely,

Kim K. Roberts
Chief Executive Officer
Santa Clara Valley Health and Hospital System