National Association *of* Public Hospitals *and* Health Systems

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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

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

Dear Mr. Weems:

The National Association of Public Hospitals and Health Systems (NAPH) writes to express our serious concern regarding the issuance of the above-referenced Proposed Rule.[1] This Rule (1) unnecessarily narrows the definition of outpatient hospital services, with a significant but unacknowledged impact on disproportionate share hospital (DSH) payments; and (2) is overly prescriptive in dictating upper payment limit (UPL) methodologies for private outpatient hospitals and clinics. Of more concern, however, the Proposed Rule violates a recent legislative moratorium[2] (the Moratorium) on implementation of a cost limit on payments to governmental providers or restrictions on Medicaid graduate medical education (GME) payments. For these reasons, NAPH urges CMS to withdraw the Proposed Rule immediately.[3]

NAPH represents more than 100 metropolitan area safety net hospitals and health systems. Our members are the primary hospital providers of care in their communities for Medicaid recipients, receiving on average 35% of their net revenues from Medicaid, and for many of the more than 46 million Americans without insurance. Member hospitals represent only 2% of the acute care hospitals in the country but provide 25% of the uncompensated hospital care. As a result, these hospitals rely upon Medicaid disproportionate share hospital (DSH) and other supplemental payments, including supplemental outpatient payments, for survival; without supplemental payments, overall NAPH member margins would drop to a negative 10.5 percent. NAPH members serve a

[1] 72 Fed. Reg. 55158 (Sep. 28, 2007).
[2] U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, Section 7002(a).
[3] NAPH does not concede through submission of these comments that CMS has the authority to propose these provisions, nor to request, receive or review related comments, during the period of the Moratorium.

critical role in their communities of ensuring access to ambulatory care for uninsured and Medicaid patients. In 2004, NAPH members provided more than 29 million non-emergency outpatient visits, which represented more than one-third of all ambulatory care visits at safety net providers (including community health centers). Of the non-emergency visits at NAPH members, approximately 59 percent were for specialty care services and 41 percent for primary care services. The vast majority of this ambulatory care is reimbursed as outpatient hospital services.

The attached comments detail the following policy and technical concerns with the Proposed Rule:

- CMS has violated the congressional Moratorium and, in any event, failed to clarify how this Proposed Rule interacts with the Moratorium.
- The Proposed Rule will have a potentially significant impact on DSH payments, which CMS does not acknowledge.
- The Proposed Rule discourages hospitals from expanding important ambulatory care services.
- 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, and in any event requires clarification.
- CMS' definition of outpatient hospital services to exclude services otherwise covered by the State Plan is not required by the Medicaid statute and is inconsistent with language in the preamble to the Proposed Rule.
- The overly prescriptive proposed outpatient UPL excludes the costs of interns, residents and supervising physicians, potentially resulting in millions of dollars in losses for providers in certain states, reduces state flexibility, and does not capture all Medicare-covered costs.
- The proposed private clinic UPL prohibits cost-based reimbursement without justification and includes a circular definition of the UPL for otherwise excluded dental services.

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,[4] the rule to eliminate Medicaid funding for graduate medical education,[5] and the proposed rule which has never been

[4] 72 Fed. Reg. 29748 (May 29, 2007).
[5] 72 Fed. Reg. 28930 (May 23, 2007).

finalized adopting narrow new DSH policies[6]—CMS' latest administrative action would be devastating to public, teaching and other safety net hospitals. Cumulatively these rules would eviscerate the health care safety net as well as jeopardize care for all Americans in communities across the country.

NAPH 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 train the next generation of doctors and health care professionals, to serve as the health care backbone of local emergency response systems, to provide critical yet under-reimbursed specialized services such as trauma care, burn care, neonatal intensive care and emergency psychiatric care, or to provide access where none would otherwise exist for the nation's poor, uninsured and underinsured individuals. Absent a more thorough analysis of real world implications of proposed policies and their impact on the health care system, we are relying on Congress to stop these policies in their tracks. We urge you to withdraw this regulation and all of the above mentioned pending regulations immediately. We need policies that strengthen, rather than dismantle, essential components of our nation's health care infrastructure.

If you have any questions, please contact Barbara Eyman or Charles Luband of NAPH counsel Powell Goldstein LLP at (202) 347-0066.

Respectfully,

Larry S. Gage
President

[6] 70 Fed. Reg. 50262 (Aug. 26, 2005).

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COMMENTS BY THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS ON PROPOSED RULE: CMS-2213-P-Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit

Prepared on Behalf of NAPH by Powell Goldstein LLP

MAJOR POLICY CONCERNS

I. The Issuance of the Proposed Rule Directly Violates the Recently Adopted Congressional Moratorium.

CMS' action in issuing the above-referenced Proposed Rule[1] violates a recent legislative moratorium[2] (the Moratorium) 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)[3] or similar provisions, or any rule restricting payments for Medicaid graduate medical education (GME). For this reason alone, the rule should be withdrawn immediately.

A. The Proposed Rule violates the Medicaid GME provision of the Moratorium.

The Proposed Rule effectively prohibits states from including GME costs in the outpatient UPL, thereby narrowing states' flexibility to support GME through outpatient payments and thus violating the Moratorium. 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 provisions restricting payments for graduate medical education under the Medicaid program."[4] CMS' detailed new requirements for calculating cost for purposes of the outpatient hospital UPL excludes GME costs from the equation, essentially prohibiting states from providing outpatient-related GME payments.[5] Because states have never before been prohibited from providing outpatient GME support, CMS' proposal directly violates the Moratorium.

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[1] 72 Fed. Reg. 55158 (Sep. 28, 2007).
[2] U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, Section 7002(a).
[3] 72 Fed. Reg. 29748 (May 29, 2007).
[4] Pub. L. No. 110-28, Section 7002(a).
[5] A more complete discussion of how CMS' proposed UPL methodology precludes states from reimbursing outpatient related GME costs is contained in technical section II.A.1. below.

B. The Proposed Rule violates the Moratorium by reissuing regulatory 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).[6] 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."[7] The Cost Limit Rule amended these categories to "State government operated facilities … Non-State government operated facilities … [and] Privately operated facilities," essentially removing all references to ownership.[8] The language of 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] ...."[9] In proposing to reissue the revised category language from the Cost Limit Rule in this Proposed Rule, CMS has violated Congress' directive not to take any action to implement any provision of that rule.

C. The Moratorium violations completely disregard the clearly-expressed views of Congress on Medicaid policy.

These violations of the Moratorium continue a pattern in which CMS has ignored Congress' statutory direction and contravened legislative intent regarding proper interpretation of the Medicaid Act. President Bush's FY 2007 and 2008 budget requests contained several Medicaid policy proposals to be implemented through administrative action.[10] Some of the proposals had previously been proposed as legislative measures but Congress declined to act on them.[11] In response to the administrative proposals, an overwhelming majority of both the House and Senate expressed public opposition to CMS' plans.[12] CMS moved forward nonetheless in issuing proposed cost limit and GME regulations. Congress responded swiftly by adopting the Moratorium in both areas, which was initially vetoed as part of a larger supplemental appropriations bill,[13] and later

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[6] *See* 42 C.F.R. § 447.321(a), as revised by the final Cost Limit Rule, 72 Fed. Reg. at 29835, and reissued in the Proposed Rule, 72 Fed. Reg. at 55165-66.
[7] 42 C.F.R. § 447.321(a).
[8] 42 C.F.R. § 447.321(a), as revised by 72 Fed. Reg. 29748, 29835 (May 29, 2007).
[9] U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, Section 7002(a).
[10] Budget of the United States Government, Fiscal Year 2007, at 125-27; Budget of the United States Government, Fiscal Year 2008, at 68-69.
[11] Budget of the United States Government, Fiscal Year 2005, at 149-50; Budget of the United States Government, Fiscal Year 2006, at 143; Letter from Michael O. Leavitt, Secretary of HHS, to the Honorable Richard B. Cheney, President, United States Senate, August 5, 2005 (transmitting legislative language to Senate implementing the fiscal year 2006 proposals); Letter from Michael O. Leavitt, Secretary of HHS, to the Honorable J. Dennis Hastert, Speaker of the House of Representatives, August 5, 2005 (transmitting legislative language to House of Representatives implementing the fiscal year 2006 proposals).
[12] In 2006, 55 Senators and 300 Members of the House publicly opposed the cost limit and IGT restrictions. In 2007, 65 Senators and 263 Members of the House have gone on record against these proposals and the proposed GME restrictions.
[13] H.R. 1591, 110th Congress (2007).

included in a revised bill that the President signed.[14] In an apparent rush to regulate and "beat the clock," CMS issued the final cost limit rule on May 25, 2007, the very day that CMS knew the President would sign the Moratorium into law. NAPH believes the issuance of the Final Rule itself violates the Moratorium, as by its terms the Moratorium took effect at 12:01 AM on May 25, the date of enactment.[15] Legalities aside, however, it is disconcerting to NAPH that an agency would deliberately disregard the clearly-expressed views of Congress in this manner. Unfortunately, the issuance of the Proposed Rule appears to indicate a troubling pattern.

II. The Proposed Rule Will Have a Potentially Significant Impact on DSH Payments.

Perhaps the most damaging aspect of this Proposed Rule is its indirect impact on disproportionate share hospital (DSH) reimbursement for private and governmental hospitals alike—an impact that is not even acknowledged by CMS. NAPH is concerned that to the extent the proposed outpatient hospital definition excludes services a state is currently treating as outpatient hospital services, CMS will take the position that the uncompensated care costs associated with those services could no longer be included in a hospital's DSH cap. Our members report that their states are currently including the costs of services that would be excluded under the proposed definition, including dental care (primarily care to children as required under the Medicaid EPSDT benefit), routine vision, psychiatric, observation, and physician services, and provider-based FQHC services.[16]

NAPH opposes any narrowing that will reduce the resources available to safety net hospitals to provide access to care for Medicaid and uninsured patients. The DSH program, over the years, has become the "lifeblood" for many safety net hospitals. DSH payments help to offset some of the unreimbursed costs that hospitals incur in caring for uninsured patients, but the adequacy of DSH allotments is declining as costs climb and insurance coverage drops. As a percentage of Medicaid expenditures, DSH has fallen dramatically in the last decade, declining from 14 percent of overall Medicaid expenditures in 1993 to approximately 6 percent in 2004. CMS has already proposed a rule that would cut back on what it would allow to be considered costs for DSH payment purposes.[17] Policy changes in DSH payments directly affect the ability of these hospitals to provide access to care for Medicaid and uninsured patients.

If this proposal would in fact narrow the costs reimbursable through DSH, CMS may have significantly underestimated the fiscal impact of the Proposed Rule, which it determined would not have "significant economic effects."[18] In that case, this Proposed

[14] Pub. L. No. 110-28, Section 7002(a).
[15] *See, e.g., Arnold v. United States*, 13 U.S. (9 Cranch) 104, 119 (1815); *United States v. Casson*, 434 F.2d 415, 419 (D.C. Cir. 1970).
[16] In the case of provider-based FQHC services, hospitals that have established FQHCs, which are paid at clinic rather than hospital rates, include the uncompensated costs of providing these services in their DSH cap.
[17] 70 Fed. Reg. 50262 (Aug. 26, 2005).
[18] 72 Fed. Reg. at 55158, 55164 (Sep. 28, 2007).

Rule potentially should have been a major rule, requiring a longer period after final publication before implementation and certainly warranting a longer comment period than 30 days.

III. The Proposed Rule Discourages Hospitals from Expanding Important Ambulatory Care Services.

In prohibiting states from reimbursing certain ambulatory services provided by hospitals as outpatient hospital services, CMS is effectively reducing the reimbursement rate for those services because reimbursement for non-hospital services cannot include hospital overhead. In addition, CMS has stated that hospitals may not receive DSH reimbursement for non-hospital services. Therefore, a narrowing of the definition of outpatient hospital services is essentially a cut in hospital Medicaid reimbursement. Moreover, restrictive upper payment limit policies similarly have a direct impact on hospital funding. The cut discourages safety net hospitals from providing exactly the type of community-based primary and preventive ambulatory care services that have proved so effective in driving down health care costs yet are in short supply in so many states. NAPH questions the policy basis for such a proposal.

NAPH members and similarly situated hospitals play a critical role in the provision of outpatient services, particularly for low-income Medicaid and uninsured patients. In response to increasing demand for accessible ambulatory care, NAPH hospitals have established elaborate networks of off-campus, neighborhood clinics with expanded hours, walk-in appointments, assigned primary care providers and access to appropriate follow-up and specialty care. In 2004 alone, 89 NAPH member hospitals provided 29 million non-emergency outpatient visits, with ambulatory care volume increasing by 49 percent between 1993 and 2003. These 89 hospital systems alone provided over one-third of all outpatient visits provided by safety net hospitals and community health centers (the other two-thirds were provided by 914 HRSA community health centers). The specialty ambulatory care provided by NAPH members is often the only such care available for patients referred from community health centers and other federally funded primary care clinics.

As explained in more detail below, this 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 our members to provide. It is inconceivable that CMS would adopt this policy when it admits that it has found no actual violations or problems with current state practices.[19]

[19] 72 Fed. Reg. at 55164 ("As part of our review process, we have determined that only one of the 32 States currently defines non-hospital services as part of the outpatient hospital Medicaid State plan service benefit. . . We believe the fiscal impact would be minimal.").

LEGAL AND TECHNICAL ISSUES

In addition to our broad policy concerns, NAPH has several technical concerns and questions about the Proposed Rule:

I. Narrowing the Definition of Outpatient Hospital Services *(II. D. Background, Medicaid Outpatient Hospital Services Definition; III.B. Provisions of the Proposed Rule, Proposed § 440.20)*

The Proposed Rule would limit the scope of services included in the definition of outpatient hospital services by: (1) excluding any services not reimbursed 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. This proposed narrow definition will result in less support for safety net hospitals and potentially significant losses in DSH funding. If, however, CMS insists on adopting a more precise definition, we believe that more clearly specifying that outpatient hospital services must be provided in a provider-based setting would adequately address any potential concerns.

A. CMS should remove the requirement to align Medicaid outpatient hospital services with Medicare, or at the very least provide necessary clarification.

1. Medicaid and Medicare legitimately include a different range of services in the outpatient hospital services benefit.

CMS justifies the requirement to include only Medicare-reimbursed outpatient hospital services as "provid[ing] greater consistency between the two federally funded programs" and aligning Medicaid outpatient hospital services with the "industry-accepted class of services" recognized as outpatient hospital under Medicare regulations.[20] 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. Moreover, NAPH questions 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 such as dental care for children or vaccinations that policymakers have determined are critical to the health of Medicaid populations. Medicare also does not include outpatient hospital reimbursement for vision, psychiatric services and observation that state Medicaid programs have seen the value of reimbursing at a hospital rate to meet specific needs of their patient populations.

Recommendation: The Proposed Rule should be amended to eliminate the requirement that the Medicaid definition be no broader than the Medicare definition.

[20] *Id.* at 55161.

2. CMS should provide clarification regarding reimbursement as an outpatient hospital service under alternate payment methodologies.

If CMS retains this requirement, additional clarification is necessary for states and providers on how to determine whether a service is reimbursed as an outpatient hospital service under an alternate Medicare payment methodology sufficient to be included under the proposed definition. For example, physician services provided in an outpatient hospital setting could conceivably be considered to be reimbursed as an outpatient hospital service—they are reimbursed under the physician fee schedule as the professional component of outpatient hospital services, which is an alternative payment methodology—but CMS explicitly excludes them from the proposed definition. Laboratory services are similarly reimbursed under a fee schedule, yet are explicitly included as outpatient hospital services under the proposed definition.[21]

Recommendation: CMS should provide clarification as to the scope of services paid under alternate Medicare payment methodologies as outpatient hospital services that would be included under this proposed definition.

3. CMS should clarify the interpretation of Medicare OPPS regulations as they apply to the proposed definition.

Title 42, Section 419.2(b) of the Code of Federal Regulations (CFR), as referenced in proposed section 440.20(a)(4)(i),[22] sets out an illustrative, but not exclusive, list of costs that may be included in the outpatient prospective payment system (OPPS).[23] Additional provisions list costs explicitly excluded from outpatient prospective payment rates,[24] and services excluded from payment under the hospital OPPS.[25]

Recommendation: CMS should confirm that costs for services not explicitly excluded from the OPPS are therefore includable (assuming that these services meet the other proposed criteria). If this is the case, NAPH requests that CMS clarify how it will permit states to factor these other costs into the highly prescriptive private hospital outpatient UPL.

[21] *See id.* (stating that "[f]or example, States may cover and reimburse prosthetic devices, prosthetics, supplies, and orthotic devices, durable medical equipment, and clinical diagnostic laboratory services as outpatient hospital services."). In addition, there is concern that Medicare criteria for coverage of hospital versus non-hospital laboratory services are themselves complicated and that more detailed guidance is necessary to determine appropriate Medicaid coverage.
[22] Proposed 42 C.F.R. § 440.20(a)(4)(i), *Id.* at 55165.
[23] 42 C.F.R. § 419.2(b) ("these costs include, but are not limited to…").
[24] *Id.* § 419.2(c).
[25] *Id.* § 419.22.

Title 42, Section 419.20(b) of the CFR also excludes certain categories of hospitals from the Medicare hospital OPPS.[26]

Recommendation: CMS should clarify that Medicaid outpatient hospital services in these categories of hospitals are includable under the proposed definition.

B. CMS should remove the exclusion of services covered elsewhere under the State Plan from the definition, or at the very least provide necessary clarification.

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,"[27] 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."[28]

1. This exclusion is not required by the language of the Medicaid statute.

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 referenced 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.[29] Because CMS' proposed insistence on discrete categories prohibits hospitals from receiving full outpatient hospital reimbursement for services that are clearly provided by outpatient hospital departments, CMS should abandon this unnecessary requirement.

Recommendation: CMS should amend the Proposed Rule to allow services covered elsewhere in the State Plan to be included in the outpatient hospital definition when provided to individuals receiving care in hospital outpatient settings.

2. CMS' proposed definition appears inconsistent and requires clarification.

If CMS nonetheless chooses to retain this requirement, CMS should clarify apparent inconsistencies between the requirement and preamble language listing outpatient hospital services under the proposed definition. CMS explicitly provides that "states may

[26] *Id.* § 419.20(b) (excluding Maryland hospitals, critical access hospitals, hospitals located outside of the 50 states, DC and Puerto Rico, and hospitals of the Indian Health Service).
[27] Proposed 42 C.F.R. § 440.20(a)(4)(iii), 72 Fed. Reg. at 55165.
[28] 72 Fed. Reg. at 55161.
[29] *Louisiana Dep't of Health and Hosps. v. CMS.*, 346 F.3d 571 (5th Cir., 2003) ("CMS analyzes the term 'hospital services' [as used in the DSH statute] with the premise that 'outpatient hospital services' and 'rural health clinic services' are mutually exclusive. CMS notes: (1) federal statutes and regulations distinguish the terms in at least two places, see 42 U.S.C. §§1396d(a)(2) (enumerating categories of medical assistance services, including outpatient hospital services and rural health clinic services)…CMS assumes, without explanation, that any service that a RHC renders may never be considered an outpatient hospital service even if the service fits within the regulatory definition of 'hospital outpatient service.'").

cover and reimburse prosthetic devices, prosthetics, supplies, and orthotic devices, durable medical equipment, and clinical diagnostic laboratory services as outpatient hospital services."[30] Yet, prosthetic devices,[31] laboratory services,[32] and rehabilitative services[33] are each separate benefit categories under section 1905(a) of the Social Security Act. NAPH agrees that these services should be encompassed by the outpatient hospital services definition; however, states and providers require consistent guidance in order to apply this requirement to other services.

C. Other details of the proposed definition require further clarification.

Our members also seek more specific clarifications related to the following aspects of the proposed outpatient hospital definition:

- CMS should confirm that rehabilitative services currently considered outpatient hospital services under Medicare would continue to be considered outpatient hospital services under Medicaid, clarifying potentially inconsistent guidance in the preamble and proposed regulations.[34]

- CMS should clarify that this Proposed Rule, in conjunction with current inpatient service regulations, would not prohibit state Medicaid agencies from reimbursing hospitals for services provided discharged patients waiting for an available skilled nursing facility (SNF) bed as hospital services (either outpatient or inpatient) under the state plan.[35]

[30] 72 Fed. Reg. at 55161.
[31] *See* SSA § 1905(a)(12) (42 U.S.C. § 1396d(a)(12) ("prescribed drugs, dentures, and prosthetic devices…").
[32] *See id.* § 1905(a)(3) (42 U.S.C. § 1396d(a)(3)) ("other laboratory and X-ray services"). It is possible that this reference could be interpreted to include only those services other than lab services provided as outpatient hospital services in (a)(2) (or inpatient in (a)(1)), and therefore that outpatient hospital lab services are not a distinct service category.
[33] *See id.* §§ 1905(a)(11) ("physical therapy and related services"), 1905(a)(13) ("other diagnostic, screening, preventive, and rehabilitative services…").
[34] The text of proposed section 440.20(a) explicitly defines outpatient hospital services to continue to include "rehabilitative services," and Medicare reimburses hospitals under an "alternate payment methodology" for therapy provided by hospital outpatient departments, in accordance with proposed section 447.321(a)(4)(i). In the preamble, however, CMS states that rehabilitative services may be an example of "non-traditional outpatient hospital services." 72 Fed. Reg. at 55160; *see also* 72 Fed. Reg. at 55159 ("outside the normal responsibility of outpatient hospitals").
[35] In at least one state, the Medicaid program pays hospitals based on a SNF rate for these patients, though Medicare apparently does not reimburse hospitals for these services. Covering these services under the Medicaid SNF benefit does not adequately address the issue for these hospitals, as they may then be faced with the substantial administrative burden of pursuing state licensure as a SNF in order to provide what would newly be defined as "non-hospital" services to these patients.

II. Restriction of the Outpatient Hospital and Clinic Upper Payment Limits

(II.E. Background, Upper Payment Limits—Proposed Rule; II.B. Provisions of the Proposed Rule)

A. The proposed outpatient hospital UPL methodologies are too prescriptive.

NAPH objects to the limitations that the Proposed Rule would impose on state flexibility in calculating the upper payment limit for outpatient hospital services provided by private hospitals. The flexibility available under the current regulation[36] permits states to accurately capture the costs (or payments) made to hospitals for outpatient care while ensuring compliance with statutory requirements. CMS could clarify the requirements for calculating the UPL by describing examples of acceptable methodologies, i.e. cost-to-charge and payment-to-charge calculations, without precluding the use of other methodologies. A state should be permitted to develop another methodology more tailored to its circumstances if it is a reasonable approximation of what would be paid under Medicare payment principles.

1. CMS should permit adjustments to the Medicare allowable costs on the cost report.

The Proposed Rule would require that services appear on the outpatient-specific Medicare cost report worksheets in order to be included in the outpatient hospital UPL,[37] and would not permit adjustment of these costs.[38] NAPH is extremely concerned that in dictating the specific sections of the Medicare cost report that a state may use in calculating cost information for the outpatient UPL, CMS effectively excludes GME costs from the outpatient costs that a state can include. The preamble explicitly references the "cost-to-charge ratios as found on Worksheet C, Column 9. . . of the CMS 2552-96."[39] However, the cost-to-charge ratios contained at Worksheet C, Column 9 are calculated by taking information from Worksheet B, Column 27—which explicitly excludes all costs related to interns, residents, and supervising physicians. Given that Medicare pays for GME separately from outpatient (and inpatient) reimbursement, it makes sense that for Medicare purposes these costs would not be included in the outpatient cost-to-charge ratios. Similarly, the Medicare outpatient cost-to-charge ratio also excludes costs for teaching physicians for those hospitals that have chosen the election under Title 42, Section 415.160 of the CFR. Although Medicare reimburses these costs separately, they remain outpatient hospital costs that should be reimbursable through Medicaid. Federal law does not prohibit states from covering these costs as part of Medicaid outpatient reimbursement.

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[36] *See* 42 C.F.R. § 447.321. Under current regulations, CMS has avoided a specific formal UPL, and instead negotiated UPL methodologies with states as long as payments to all private hospitals on an aggregate basis do not exceed a "reasonable estimate of the amount that would be paid for services furnished by the group of facilities under Medicare payment principles."
[37] Proposed 42 C.F.R. § 447.321(b)(1)(i)(A), 72 Fed. Reg. at 55166.
[38] 72 Fed. Reg. at 55162.
[39] *Id*.

Recommendation: CMS should clarify that outpatient costs related to interns, residents, and supervising physicians, as well as costs related to cost-based reimbursement for teaching physicians, can be included in calculating the private outpatient hospital UPL.[40]

In addition, some members have expressed concern that the cost report references specified by CMS may not be capturing all Medicare-covered outpatient hospital payments and charges, specifically related to physical therapy and durable medical equipment. ***NAPH requests that CMS review these references to ensure that the payments and charges for all outpatient hospital services reimbursed by Medicare under the OPPS or alternative methodologies are captured by these references.***

2. CMS must make allowances for "flat rate" hospitals that have exceptions for Medicare cost reporting purposes.

CMS' methodology, by prescriptively referencing the Medicare cost report methodology, is particularly inappropriate where Medicare has permitted exceptions to its cost report methodology. In particular, Medicare has allowed "flat rate" hospitals with alternative charge structures to complete their Medicare cost report by using statistics to allocate costs instead of using the cost-to-charge methodology usually used in the Medicare cost report. The rationale for these exceptions is because the cost-to-charge calculation does not make sense where the charge structure is not consistently maintained. A payment-to-charge ratio would be similarly distorted. CMS' inflexible proposed UPL methodologies appear not to not allow an exception where Medicare itself has allowed an exception from the rigorous use of charges.

Recommendation: CMS should allow states to use an alternative methodology to calculate the UPL related to flat rate hospitals.

3. CMS should clarify that the cost methodology proposed for UPL calculations does not apply to DSH cost limits.

CMS should confirm that the cost calculation described in this Proposed Rule for the purposes of calculating an outpatient hospital UPL is not mandatory for purposes of calculating either the DSH limit or the limit under the Cost Limit Rule. DSH explicitly covers a full range of covered and uncovered Medicaid services for both Medicaid recipients and the uninsured, and the restrictions imposed on the calculation of hospital costs for purposes of the outpatient UPL would be completely inappropriate with respect to DSH.

Recommendation: CMS should confirm that this role has no impact on DSH limit calculations.

[40] We reiterate the point made earlier, that the exclusion of intern, resident, and supervising physician costs from the UPL violates the Moratorium.

B. Elimination of Cost-Based Reimbursement for Private Clinics

NAPH is extremely concerned that the limited methodologies permitted for calculating the UPL for private clinic services under the Proposed Rule would in effect prohibit states from paying private clinics cost-based rates.[41] CMS provides no justification for allowing a cost-based UPL for hospitals but not clinics, simply stating that "Medicare does not typically pay for clinic services on the basis of cost as reported by the facility."[42] Furthermore, CMS does not appear to have considered that a cost-based UPL would be the most reasonable for services, such as dental services, that are not reimbursed under Medicare. Instead, CMS' proposed dental component of the UPL, defining the UPL as "that amount that Medicaid would pay," [43] is circular and, in effect, is no limit at all.

Recommendation: CMS should revise the proposed regulation to permit a cost-based UPL for private clinics.

C. Other UPL Clarifications

1. *The Proposed Rule fails to clarify the scope of the category of private providers that would be subject to the UPL during the period of the Moratorium.*

This Proposed Rule would apply a more restrictive UPL to "privately operated facilities," defined under Section 447.321 as revised by the cost limit rule. CMS should clarify that if this rule is finalized during the period of the Moratorium, the proposed, restrictive UPL will apply only to those hospitals and clinics considered private prior to issuance of the Cost Limit Rule. Specifically, ***CMS should clarify that the more flexible governmental UPL, not this revised UPL, will continue to apply to state or non-state government-owned and privately operated facilities until the expiration of the Moratorium.***[44]

2. *CMS should clarify that the provisions of this Rule will apply prospectively.*

CMS claims in the preamble that they currently require compliance with one of these outpatient hospital UPL methodologies when states submit State Plan Amendments related to outpatient hospital services.[45] CMS should clarify that the requirements of this Proposed Rule will only be prospectively applied after proper issuance of a final rule. Given the significant policy changes required by this proposed rule, it would be improper to implement these requirements without notice and comment rulemaking.

[41] *See* Proposed 42 C.F.R. § 447.321(b)(1)(ii), 72 Fed. Reg. at 55166.
[42] 72 Fed. Reg. at 55163.
[43] Proposed 42 C.F.R. § 447.321(b)(1)(ii)(C), *Id*. at 55166.
[44] We reiterate the point made above that CMS' modifications to the categories of providers subject to the UPL violates the Moratorium.
[45] 72 Fed. Reg. at 55162.