



October 29, 2007

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

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

Dear Mr. Weems:

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

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

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

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

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

Graduate Medical Education

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

Cost Limit Rule

The Proposed Rule also violates the Moratorium with the reissuing of Cost Limit Rule language that redefines the provider categories that are subject to the UPLs, despite explicit Congressional mandate that it not take action to implement any provision of that rule. The outpatient UPL in effect at the time of the Moratorium applied to three categories of providers: “State government owned or operated facilities...Non-State government-owned or operated facilities...[and] Privately-owned and operated facilities,” The Cost Limit Rule removed from the definitions all references to ownership. Since the Moratorium prohibits CMS from “tak[ing] any action (through promulgation of regulation...) to...finalize or otherwise implement provisions contained in the Cost Limit Rule...”, CMS is violating Congress’ directive not to take any action to implement any provision of that rule by proposing to reissue the revised category language in this Proposed Rule.

Congressional Intent

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

A handwritten signature in cursive script, appearing to read "Jerry W. Friedman". The signature is written in black ink on a white background.

Jerry W. Friedman
Executive Director