



**American Hospital  
Association**

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October 29, 2007

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

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

Dear Mr. Weems:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule changing Medicaid policy for federal reimbursement of Medicaid hospital outpatient services.

CMS describes the Medicaid hospital outpatient proposed policy changes as clarifications to current rules. CMS further states that because these changes will not result in a significant financial impact, the proposed rule is not considered a major rule and, therefore, a 30-day comment period is sufficient. The AHA disagrees on all points.

The proposed rule is making major policy changes to the Medicaid program; therefore, a 30-day comment period is an insufficient time period for public comment. Moreover, 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. The AHA urges CMS to withdraw this rule and submits these comments in opposition to the changes proposed.



## **MORATORIUM**

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

First, the agency proposes changes to the hospital outpatient upper payment limit (UPL) methodology. The proposed changes are based on a new definition of the categories of providers (state, non-state governmental and private) found in the final rule subject to the moratorium. The definition of these categories is important because each category has a different aggregate UPL calculation. Current regulations define the three categories as: state government-owned or -operated facilities; non-state government-owned or -operated facilities; and private-owned and -operated facilities. (42 C.F.R. Section 447.321 (a)) The May 28 final rule redefines the categories by removing ownership status and the proposed rule relies on this new definition and restates it as, "State government-operated facilities ... Non-state government-operated facilities ... privately operated facilities" (pp 55158, 55165-66).

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

## **SCOPE OF HOSPITAL OUTPATIENT SERVICES AND UPL CALCULATIONS**

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

**Scope of Services.** Current Medicaid regulations broadly define allowable hospital outpatient services to include preventative, diagnostic, therapeutic, rehabilitative or palliative services provided under the direction of a physician or dentist in a hospital. Under the proposed rule, the types of services that are at risk for not being reimbursed through hospital outpatient programs include Medicaid's early and periodic screening and diagnostic treatment dental services for children; physician emergency department services; physical, occupational and speech therapies; outpatient clinical diagnostic laboratory services; ambulance services; durable medical equipment; and outpatient audiology services. However, CMS does not

identify a problem with current state Medicaid programs that would justify this policy change. In fact, the agency states in the proposed rule's preamble that in examining 32 state plan amendments over the last four years, CMS found only one state that defines non-hospital services as part of the outpatient hospital Medicaid set of services. (72 Fed. Reg. at 55161) In addition, while CMS states that the services no longer reimbursed through hospital outpatient departments will be paid for through other parts of the Medicaid program, the agency fails to demonstrate that there is access to such services within the community outside of the hospital outpatient department.

Further, CMS' attempt to narrow the definition of allowable hospital outpatient services poses serious implications for Medicaid disproportionate share hospital (DSH) payments. A hospital's uncompensated care costs help determine a hospital's DSH reimbursement. Currently, CMS views only the costs for providing inpatient and outpatient hospital services as allowable for determining a hospital's uncompensated care costs. The agency's proposed narrow definition would exclude many costs now included in hospitals' Medicaid DSH calculations, potentially limiting DSH payments to already financial strapped hospitals.

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

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

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

## **CONCLUSION**

CMS states in the preamble that the fiscal impact of this rule would be minimal because the rule is a clarification of existing policy and would not result in the elimination of coverage. The AHA believes that the agency has failed to perform the due diligence necessary to make

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these statements. Furthermore, we would contend that these policy changes not only will have a significant fiscal impact on many state Medicaid programs, but could potentially affect coverage for outpatient hospital services.

**The AHA urges CMS to withdraw this rule and suspend any further regulatory activity that affects the issues encompassed under the moratorium secured by P.L. 110-28.**

These proposed policy changes will result in cuts to state Medicaid programs, cuts in payments to hospitals, and reduced access to needed services for potentially millions of vulnerable people served by the Medicaid program.

If you have any questions, please feel free to contact me or Molly Collins Offner, senior associate director for policy, at (202) 626-2326 or [mcollins@aha.org](mailto:mcollins@aha.org).

Sincerely,

Rick Pollack  
Executive Vice President