



**American Hospital
Association**

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May 29, 2009

Charlene Frizzera
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-P2) Medicaid Program; Rescission of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit (Vol. 74, No.86), May 6, 2009

Dear Ms. Frizzera:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) rescission of the final rule changing Medicaid policy for federal reimbursement of Medicaid hospital outpatient services. The AHA applauds CMS' decision to rescind this rule.

In previous correspondence the AHA disputed CMS' assertion that the policy changes in the rescinded rule were mere clarifications. In fact, those policy changes substantially departed 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 upper payment limit (UPL)

CMS based its dramatic policy shift on the need to align Medicaid outpatient policies with Medicare outpatient policies, although these programs serve very different populations. Medicaid beneficiaries are largely a pediatric population while Medicare serves an elderly population. Yet despite these differences, CMS narrowed the definition of Medicaid hospital outpatient services, limiting that definition to those services covered under Medicare. The only rationale for aligning the hospital outpatient policies for both programs seemed to be to limit Medicaid federal spending for hospital outpatient programs and state Medicaid programs overall.



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The final rule put at risk for not being reimbursed through hospital outpatient programs the following types of Medicaid services: 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. CMS never identified a problem with current state Medicaid programs that justified the policy changes in the final rule.

CMS further attempted to change the UPL methodology and apply those changes only to private outpatient hospital UPLs. The new formula for calculating UPL would have had a major impact on hospitals. For example, children's hospitals would not have had their costs appropriately accounted for in the new UPL methodology, particularly the Medicare payment-to-charges ratio, because they have little or no Medicare volume. Graduate medical education costs also would not have been accounted for in this new UPL methodology using the cost-to-charge ratio based on the Medicare cost report.

The AHA is pleased that CMS rescinded this rule. We urge, that going forward, the agency apply the due diligence necessary before making such significant policy changes that could result in 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.

Sincerely,

Rick Pollack
Executive Vice President