



**VIA ELECTRONIC SUBMISSION**

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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

Attention: **CMS-2213--P**

Dear Mr. Weems:

On behalf of the Association of American Medical Colleges (AAMC or the Association), I write to urge the Centers for Medicare & Medicaid Services (CMS or the Agency) to rescind the proposed rule entitled "Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit" (September 28, 2007). The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 adult nonfederal major teaching hospitals and health systems and 19 children's hospitals that receive Medicaid funding. The AAMC also represents all 125 accredited U.S. allopathic medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical students and residents.

In brief, the proposed rule seeks to narrow the definition of outpatient hospital services with a resultant payment cut for many important services that are provided in hospital outpatient departments, as well as a potentially significant impact on disproportionate share (DSH) payments. The rule also proposes changes in the outpatient upper payment limit (UPL) calculation. While labeled a "clarification," the proposed rule in reality represents major changes to long-standing existing policies. We believe these changes could significantly reduce important funding for teaching hospitals--institutions that provide significant amounts of care to Medicaid and uninsured patients.

We also believe that the proposed rule violates the one-year legislative moratorium passed last May forbidding Agency action on implementation of a cost limit on payments to governmental providers or restrictions on Medicaid graduate medical education (GME). Consequently, we believe the Agency's best course of action is to withdraw the proposed rule, at least until the moratorium expires in May, 2008. In this letter we also are providing the Association's views on specific provisions of the proposed rule. However, these specific comments should not be interpreted to acknowledge any authority for CMS to propose this rule. Rather, we write to

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express our concerns about the wisdom of these changes and urge CMS to reconsider the need for this entire rulemaking, even after the moratorium ends

## **THE PROPOSED RULE AND THE MORATORIUM**

As you are aware, section 7002(a) of the Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (Pub. Law 110-28) prohibits, for one year, implementation of a May, 2007 final rule to impose a cost limit on Medicaid payments to governmental providers (Cost Limit Final Rule). Moreover, it prohibits the Agency from promulgating "any rule or provisions" restricting Medicaid payments for graduate medical education (GME). The publication of the proposed rule violates the moratorium on both of these fronts.

First, the proposed changes to the UPL methodology are based on new definitions of the categories of providers (state, non-state governmental and private) that were first contained in the Cost Limit Final Rule-the rule that is the direct subject of the moratorium. 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 Cost Limit Final Rule redefines the categories by removing ownership status. The new definitions are restated in the proposed rule on pages 55165-16658 of the Federal Register: "State government operated facilities . . . Non-State government operated facilities . . . privately operated facilities." These proposed provisions directly contravene Congress' directive not to implement any provision of the Cost Limit Final Rule.

Second, as discussed in the next section, the proposed rule is in violation of the moratorium because the UPL calculations would contravene current policy by not including GME costs.<sup>1</sup> While we believe that CMS's actions could have resulted from an inadvertent misunderstanding of the Medicare cost reports, nonetheless the result is that the proposed rule must be withdrawn and reissued.

## **THE UPL CALCULATION AND GME COSTS**

States currently have some measure of flexibility in calculating the outpatient UPLs for the various provider groups (government, private, etc) because the states can best reflect their own Medicaid programs. The proposed rule, however, would limit states' flexibility by specifying only two methods for calculating the UPL for private providers. The first method would use hospital-specific Medicare outpatient cost-to-charge ratios that would be multiplied by Medicaid charges and aggregated to create a Medicare "cost-based" UPL. The second method would use Medicare payment-to-charge ratios multiplied by Medicaid charges and aggregated to create a Medicare "payment-based" UPL.

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<sup>1</sup> The exact text of the moratorium language states "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." P.L. No. 110-28, Section 7002(a).

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The proposed rule sets forth specific line items from hospitals' Medicare cost reports that states should use to calculate the UPL. For the cost-to-charge ratio, the proposed rule specifies column 9 of Worksheet C, Part 1 or Worksheet D, Part V, column 1.01 (which carries over the ratio from worksheet C). As set forth on Worksheet C, the cost portion of the ratio is obtained from Worksheet B, Part 1, column 27. However, this column does not include direct GME costs; the cost amount that includes GME costs is found in column 25.

As the Agency is aware, the vast majority of states make GME payments under their Medicaid programs. We understand that for a number of states, these payments are allocated between the inpatient and outpatient settings. Thus, in order for the outpatient UPL to function as intended, GME must also be reflected in the Medicare outpatient calculation.

Because the proposed rule fails to include GME costs in the calculation, we believe it must be withdrawn because it is in violation of the moratorium. However, we believe this problem can be rectified by modifying the requirement to ensure that the cost value used in the ratio calculation includes GME costs, which we believe is column 25 of Worksheet B, Part 1. We ask CMS to verify and confirm this assumption.

Even if the GME issue is addressed, we have other concerns about CMS specifying a specific methodology for determining the outpatient UPL. At the outset it is important to recognize that the UPL will be reduced, inappropriately we believe, if CMS narrows the definition of hospital outpatient services. In addition, children's hospitals would not have their costs appropriately accounted for in the new UPL methodology, particularly the Medicare payment-to-charge ratio, because they have little to no Medicare volume. The proposed rule states that changes in the UPL methodology will apply only to private outpatient hospital UPLs. However, it is not possible to assess the impact of this provision because the definition of a governmental hospital remains unresolved because it falls within the scope of the Cost Limit Final Rule that is subject to the moratorium. It is possible that the number of private hospitals might increase as a consequence of that new definition if and when the Cost Limit Final Rule is implemented, which would increase and expand the impact of this proposed rule.

Finally, some members have questioned whether the CMS is capturing all Medicare-covered outpatient hospital payments and charges because apparently payments for some services, such as physical therapy and durable medical equipment, are not reflected on the cost reports. We ask CMS to investigate this matter and clarify whether the payments and charges for all outpatient hospital services reimbursed by Medicare are captured by cost report lines referenced in the proposed rule.

## **SCOPE OF HOSPITAL OUTPATIENT SERVICES**

Currently, the Medicaid regulations broadly define hospital outpatient services to allow states to tailor their programs to best meet the needs of Medicaid patients. Such services include vision, specified psychiatric services, and dental care for children. The proposed rule would severely limit the scope of this definition, by aligning it with the definition of hospital outpatient services

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under the Medicare program, resulting in a number of services provided in hospital outpatient departments being paid at lower, non-facility Medicaid rates.

It is unclear why such an “alignment” is necessary or desirable from a policy standpoint. The programs serve very different populations, with Medicare focusing on elderly population and Medicaid targeting a population comprising significant pediatric patients. Moreover, because teaching hospitals often are the primary source of all care for Medicaid patients, such a decision unfairly penalizes these institutions for providing necessary care to a vulnerable population.

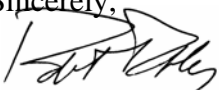
Further, while not mentioned in the proposed rule, a narrowing of the definition of allowable hospital outpatient services could have a significant impact for Medicaid disproportionate share hospital (DSH) payments. The DSH methodology recognizes only those uncompensated costs associated with providing inpatient and outpatient hospital services. If the Agency decides to apply its new definition of hospital outpatient services in the DSH context, significant costs could no longer be included in a hospital’s DSH cap, thus reducing important funding to help offset these otherwise unreimbursed costs.

## CONCLUSION

The AAMC urges CMS to withdraw this proposed rule and suspend any further regulatory activity that affects the issues encompassed under the Congressional moratorium. If at some point in the future, the Agency would like to proceed with rulemaking in this area, we urge that the comments in this letter be seriously considered during the development of a proposed rule.

If you have questions concerning these comments, please do not hesitate to contact me or Karen Fisher, Senior Associate Vice President. We may be reached at (202) 828-0490, or [rdickler@aamc.org](mailto:rdickler@aamc.org) and [kfisher@aamc.org](mailto:kfisher@aamc.org).

Sincerely,



Robert M. Dickler  
Senior Vice President  
Division of Health Care Affairs

cc: Karen Fisher, AAMC