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Final "Clarification" of Medicaid Outpatient Hospital Services Definition Issued; Will be Challenged by AHA

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CMS has issued a rule that could have the effect of reducing Medicaid reimbursement services provided in an outpatient hospital setting. The American Hospital Association (AHA) plans to ask Congress to pass legislation blocking the new rule.

On November 7, 2008, CMS issued a final rule (effective December 8, 2008) aligning the definition of outpatient hospital services (OHS) in the Medicaid and Medicare programs. 73 Fed. Reg. 66187. CMS described the rule as a "…new initiative to preserve the fiscal integrity of the Medicaid program."

Under the new rule, OHS are defined as "preventative, diagnostic, therapeutic, rehabilitative, or palliative" services that:

> (1) Are furnished to outpatients;
>
> (2) Are furnished by or under the direction of a physician or dentist;
>
> (3) Are furnished in a facility that–
>
> > (i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
> >
> > (ii) Meets the requirements for participation in Medicare as a hospital;
>
> **(4) Are limited to the scope of facility services that–**
>
> > **(i) Would be included, in the setting delivered, in the Medicare prospective payment system (OPPS) as defined under § 419.2(b) of this chapter or are paid by Medicare as an outpatient hospital service under an alternate payment methodology;**

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(ii) Are furnished by an outpatient hospital facility, including an entity that meets the standards for provider-based status as a department of a provider set forth in § 413.65 of this chapter;

(iii) Are not covered under the scope of another Medicaid Assistance services service category under the State Plan; and

(5) May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State.

42 C.F.R. § 440.20 (emphasis added). The bolded language sets forth the new requirement.

In other words, a Medicaid OHS will no longer be considered an outpatient hospital service unless it is *both* covered as such under Medicare and is *not* covered as any other type of service under Medicaid, such as a physician's office service.

Despite many comments challenging the new definition, CMS insisted that this "clarification" is necessary to: "…establish consistency between the definition of Medicaid outpatient hospital services and the applicable upper payment limit for those services, to provide more transparency in determining available hospital coverage in any State, and to generally clarify the scope of services for which Federal financial participation (FFP) is available…." Specifically, CMS noted that it has taken issue with a practice of some states to permit certain services to be classified as OHS even though "some or all of these services were provided in settings that did not involve the high overhead costs of a hospital facility." These inflated payments, according to CMS, are then included in the calculation of the outpatient hospital upper payment limit and used by the states to "…justify targeted supplemental payments to hospitals that would otherwise violate applicable upper payment limits." The new rule will prevent states from treating these services as OHS, even where they are provided in a provider-based or rural health clinic setting, and thus also prevent the "targeted" supplemental payments described by CMS.

Importantly, the preamble to the rule explains that CMS expects that states will likely adjust reimbursement rates (upwards) so that services currently provided in hospital settings that will no longer be covered as OHS under this rule can be reimbursed at levels similar to or equal to those currently in place. In response to comments pointing out that this new rule will discourage the provision of necessary services in a more expensive hospital outpatient setting (where they are often provided to Medicaid beneficiaries who may otherwise lack access to providers), CMS explained that states remained free to increase the amount that they paid for physician office services — increasing them, for instance, only for services provided in outpatient hospital settings. CMS also noted that it would permit states to exempt facilities that have a waiver from Medicare's outpatient prospective payment system (a concession that may exempt, for instance, Maryland hospitals and critical access hospitals).

In sum, CMS has taken the position that the new rule will not affect the ability of hospitals to provide all of the services they now provide (presuming, of course, that states take the initiative to adjust payment rates for services provided in an outpatient hospital setting) — they will simply be required to do so under different Medicaid "benefit categories" such as Physician Services. CMS further explained that most states are already in substantial compliance with the rule, noting that it has identified only one state that it believes is currently in violation. Accordingly, CMS has taken the position that the change in policy should have a minimal fiscal impact on hospitals, and will not impede the provision of important safety net services.

The AHA, however, disagrees with CMS' "minimal fiscal impact" forecast. Citing a House Oversight and Government Reform Committee report issued

March 3rd, the AHA notes that states' calculations of losses due to the "clarification" will run into the hundreds of millions of dollars. Accordingly, the AHA intends to ask Congress to pass legislation during the current legislative session to block application of the rule.

Ober|Kaler's Comments: It is difficult to predict, at this stage, either the effect this new rule will have on hospitals or whether the AHA's push for responsive legislation will be successful. It seems unlikely that states will be willing to dramatically alter their reimbursement rates during these difficult economic times. At the same time, it seems unlikely that Congress will turn a blind eye to a "clarification" that will likely result in a dramatic contraction of services available to vulnerable Medicaid populations. For now, the rule has become effective, and hospitals should prepare themselves as best they can for a decline in their Medicaid-related reimbursement.