Order Code RS22852
April 1, 2008

CRS Report for Congress

Medicaid and Outpatient Hospital Services

Elicia J. Herz and Sibyl Tilson
Specialists in Health Care Financing
Domestic Social Policy Division

Summary

On September 28, 2007, a proposed Medicaid rule was published that would (1) change the definition of outpatient hospital and rural health clinic services and (2) change the methods states must use to demonstrate compliance with the federal upper payment limit on outpatient hospital services provided in private outpatient facilities. A number of groups have expressed concern that this rule will have a significant negative impact on coverage of certain services, which may harm Medicaid beneficiaries. This report summarizes the details of this rule, CMS's justifications for the proposed changes, and arguments against the rule.

Outpatient Hospital Services

Hospitals provide a range of outpatient health care services in different settings (such as outpatient departments, clinics, and ambulatory surgery centers) under various organizational and ownership arrangements. These outpatient facilities may be located on or off the hospital campus or in satellite facilities. A range of different health care professionals and practitioners treat patients in these settings. Simply, the way that the various health care services are categorized, covered, and reimbursed will vary by payor.

Under the Medicaid program, outpatient hospital (OPH) services are a mandatory benefit for most beneficiaries.[1] In FY2006, expenditures for outpatient hospital services totaled roughly $11.5 billion, or 3.9% of total Medicaid spending (about $299.0 billion).[2] Current Medicaid regulations broadly define hospital outpatient services to include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided under the direction of a physician or a dentist in the hospital. States use a number of different reimbursement methods for different types of services provided in outpatient hospital departments and clinics. For example, some states pay a flat per-visit rate for a clinic visit, use a fee schedule for surgery, and pay on a cost-basis for certain specialized

[1] Medicaid statute identifies mandatory services (e.g., inpatient and outpatient hospital services) that must be covered by all states and optional services that states may choose to cover (e.g., physical therapy, psychologist services).

[2] Estimates based on preliminary CMS-64 expenditure report (October 2007).

services. In 2002, about half of the states based their OPH reimbursement largely on hospital-specific costs (e.g., actual costs or prospective rates based on historic costs with a limit on annual increases, or paid a fixed percentage of actual costs).[3] In addition, more recent 2006 data indicate that 11 states used Medicare groupings and/or methodologies for determining reimbursement rates for some OPH services.[4]

Finally, in general, Medicaid payments for institutional services (e.g., hospitals and nursing homes) cannot, in the aggregate, and within three provider categories (state government, non-state government,[5] and private), exceed a reasonable estimate of what Medicare would pay for the same services. This is called the Medicaid upper payment limit (UPL) rule. This UPL rule is applied separately to inpatient and outpatient care.

Under the Medicare program, hospitals are paid for certain services provided to outpatients through Medicare's outpatient prospective payment system (OPPS), which uses a fixed payment rate that reflects expected resource use for specific ambulatory patient classifications or APCs (which groups sets of hospital outpatient diagnoses and procedure codes into broader categories, which are reimbursed by specified Medicare payment amounts). Generally, the OPPS payments cover the facility costs associated with a procedure performed in an outpatient department. Other services are provided by hospitals in outpatient settings that are not paid under OPPS. These include professional services provided by physicians and health practitioners (e.g., psychologists, social workers, physical therapists) paid under the physician fee schedule, as well as clinical diagnostic services, ambulance services, dialysis services, and most durable medical equipment, all paid using different methods.[6] Off-campus or satellite outpatient facilities that meet certain provider-based requirements are treated as part of a hospital, not freestanding, independent entities, and are paid under alternative payment methods.[7] These determinations affect Medicare (and Medicaid) payment amounts, the scope of benefits available to a beneficiary (in or at the facility), and/or beneficiary out-of-pocket liability.

The Proposed Rule on Outpatient Hospital Services Under Medicaid

The proposed rule (72 *Federal Register* 55158, September 28, 2007) would limit the definition and scope of Medicaid outpatient services in a hospital clinic, hospital facility, or rural health clinic. Federally reimbursable Medicaid outpatient services would include

---

[3] See CRS Report RL32644, *Medicaid Reimbursement Policy*, by Mark Merlis.

[4] See *Benefits by Service: Outpatient Hospital Services (October 2006)*, Medicaid Benefits: Online Database, The Kaiser Commission on Medicaid and the Uninsured at [http://www.kff.org/medicaid/benefits/service.jsp?yr=3&cat=12&nt=on&sv=27&so=0&tg=0].

[5] The new final rule affecting government providers under Medicaid (72 FR 29748, May 29, 2007) changes the UPL for such providers from this Medicare benchmark to the Medicaid costs for each such individual government provider. Congress has placed a moratorium on implementation of this rule until May of 2008. See CRS Report RS22848, *Medicaid Regulation of Governmental Providers*, by Jean Hearne.

[6] See CRS Report RL30526, *Medicare Payment Policies*, for details on these payment methods.

[7] 42 CFR 413.65 contains the current provider-based classification requirements.

only those facility services (1) that Medicare would pay for under its OPPS or recognized by Medicare as an OPH service under an alternate payment methodology; (2) provided by an outpatient hospital facility, including only those entities that meet standards for provider-based status as a department of an outpatient hospital as defined in Medicare rules; and (3) not covered under the scope of any other Medicaid benefit category.

Under the proposed rule, the UPL for privately operated outpatient hospital facilities would remain tied to a reasonable estimate of what Medicare would pay for the same services. However, the calculations used to demonstrate compliance with this UPL would be required to include only services that (1) may be covered under the new Medicaid outpatient services definition and (2) are reimbursable under Medicare (i.e., appear on outpatient-specific Medicare cost report worksheets.) With respect to the second criterion, states would be required to base this UPL calculation on the hospital-specific ratios (cost-to-charge or payment-to-charge) as reported in the most recently filed Medicare hospital cost report, or an equivalent state cost report.

A different UPL calculation would apply to privately operated clinics that are not part of a hospital. For these entities, states would choose one of two UPL methods: (1) a defined percentage, not to exceed 100% of what Medicare pays under the non-facility fee schedule, or (2) a comparison by individual procedure code of Medicare payment amounts for equivalent Medicaid services when Medicaid reimbursements are based on a specific fee schedule or encounter rate. For this second method, the calculation may be conducted in the aggregate for clinic type or by specific facilities (for end stage renal disease, ambulatory surgical centers, etc.). Services for which the Medicaid statute defines a separate UPL (e.g., clinical diagnostic laboratory services[8]) must be excluded from this clinic UPL. Finally, for dentists providing services in such clinics, the UPL calculation may include payment amounts that Medicaid would otherwise pay outside the facility.

CMS stated that it cannot determine the fiscal impact of this proposed rule because of a lack of available data. However, CMS believes this rule would not significantly alter current practices in most states. In the preamble to this rule, CMS indicated it had approved outpatient hospital reimbursement methods submitted by 32 states over a four-year period, and only 1 state (not named) used methods that may be minimally affected by the rule. CBO estimates that this rule will reduce federal Medicaid outlays by $0.3 billion over 5 years and $0.7 billion over 10 years.[9] A recent congressional report indicates that this rule would result in a loss of roughly $2.1 billion over the next five years in four states that could provide such estimates.[10]

---

[8] The UPL on clinical diagnostic laboratory tests is based on what Medicare would pay for such tests for individuals enrolled in Medicare Part B.

[9] For proposed rules, CBO generally assigns a weight of 50% in its baseline to reflect the uncertainties of the administrative process. After a regulation is final, CBO fully incorporates the projected effects into the baseline (after any applicable moratorium ends). See Congressional Budget Office, *Medicare, Medicaid and SCHIP Administrative Actions Reflected in CBO's Baseline*, February 29, 2008.

[10] See *The Administration's Medicaid Regulations: State-by-State Impacts*, prepared for Chairman Henry Waxman by the Majority Staff, U.S. House of Representatives, Committee on

(continued...)

Justification for the Proposed Rule

CMS argues that the current definition of outpatient hospital services in regulations overlaps with other covered Medicaid benefits, so that identical services are sometimes paid a higher amount under the outpatient hospital benefit than would otherwise be available under other Medicaid benefit categories. CMS also finds the current definition to be overly broad, including services over which outpatient hospital departments have no oversight or control, and can include services outside the normal responsibility of outpatient hospital departments (e.g., non-facility physician and practitioner services, and non-traditional OPH services such as school-based and rehabilitation services). CMS noted that some states may need to move services that would no longer meet the new definition of outpatient hospital services to other appropriate coverage categories and payment methodologies under the state plan.

CMS noted that a number of states requested that the agency clarify in regulation the requirements for calculating Medicare comparable UPLs on outpatient and clinic services. In calculating the UPL for hospital and clinic services in private facilities, CMS argued that the current regulation does not indicate how this estimate should be made, and it does not address treatment of services that are not comparable to those provided under Medicare (e.g., dental services). In addition, CMS indicated that some states have used their own state-specific hospital cost reports to determine compliance with this UPL and such reports may not represent finalized data or accurately reflect Medicare payment and/or charge ratios. CMS considers the Medicare cost reports or equivalent state cost reports to be a more accurate measure of this UPL.

Opposition to the Proposed Rule

CMS has received a number of comments on this proposed rule.[11] Examples of some of those comments are summarized here. First, under current law, states make certain supplemental payments to selected providers that treat a large number of low-income and Medicaid patients for their uncompensated hospital services. Federal statute establishes a ceiling on such "disproportionate share hospital," or DSH, allotments for each state. States must identify hospitals qualifying as DSH hospitals and must specify DSH payment formulas. Opponents argue that the proposed rule's new definition of OPH services would exclude many of the costs that states now consider in calculating DSH payments, which could in turn limit such payments to hospitals.

Other arguments highlight the potential negative impact of the proposed rule on Medicaid children and children's hospitals. First, one argument notes that while Medicare serves as a benchmark for this new rule, Medicare covers very few children and would not cover preventive and screening services provided under "Early and Periodic Screening, Diagnostic, and Treatment Services" (EPSDT), a mandatory Medicaid benefit

---

[10] (...continued)
Oversight and Government Reform, March 2008.

[11] To access the full set of comments, go to [http://www.cms.hhs.gov/eRulemaking/ECCMSR/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1205317&intNumPerPage=10].

for most Medicaid beneficiaries under the age of 21.[12] The commenter also concludes that the regulation directly contravenes the Medicaid EPSDT provision by excluding federal matching dollars for OPH programs that provide required EPSDT diagnostic and treatment services that may not be covered under Medicare. More generally, other commenters observed that the OPH services no longer permitted under this rule may continue to be provided by hospitals in other ways, albeit at a reduced payment rate. Second, with respect to the rule's requirement to use Medicare's cost-to-charge and payment-to-charge ratios in calculating the UPL for private providers, other opponents of the rule argue that hospitals with a significantly different patient mix from Medicare, such as children's hospitals, would not have their costs appropriately accounted for in the new UPL. Children's hospitals that submit low-volume cost reports and other hospitals with nontraditional charge structures may not readily be able to comply with the new UPL requirements.

Other commenters raise additional concerns that the new definition of OPH services under the proposed rule will exclude coverage of various services previously offered through this benefit, which may limit beneficiary access to such services in some states. OPH services are a mandatory benefit under Medicaid and are likely to include, for example, physical therapy (PT) for outpatients. While Medicare also covers PT in OPH settings, these services are not reimbursed under the OPPS and thus would be excluded from the new definition of OPH services for Medicaid. Outside of EPSDT, PT may be otherwise available under Medicaid, but as an optional benefit. Data from 2005 show that eight states do not offer this optional PT benefit.[13]

Concerns about the proposed calculations for demonstrating compliance with the UPL for private facilities were also expressed. One comment letter noted that it was unclear whether compliance with the UPL for OPH services must be demonstrated in the aggregate, for each individual provider, and/or at the cost center level. Different descriptions of the proposed UPL calculations in both the preamble and the new regulatory language in the proposed rule contributed to this confusion.

Several commenters argued that specific provisions in the proposed OPH rule violate the one-year moratorium in P.L. 110-28 on implementation or further action on two other rules: (1) the final rule establishing Medicaid cost limits for public providers (72 *Federal Register* 29748, May 29, 2007) and (2) the proposed rule on graduate medical education (GME) expenditures under Medicaid (72 *Federal Register* 28930, May 23, 2007). Specifically, the proposed OPH services rule incorporates the new definition of hospital categories that was adopted in the final rule regarding cost limits on public providers, which eliminates references to provider ownership status; commenters argue that including this language directly contravenes the moratorium on implementing any provision of the public provider rule. Commenters also argue that the OPH services rule violates the moratorium on the GME rule, because the proposed UPL calculations use

---

[12] Sara Rosenbaum, J.D., *CMS' Medicaid Regulations: Implications for Children with Special Health Care Needs*, March 2008, at [http://www.firstfocus.net/Download/CMS.pdf].

[13] CMS, *Medicaid At-A-Glance*, 2005. (Based on approved state plans and waivers as of 3/31/05).

Medicare cost report calculations that have excluded GME costs.[14] Other procedural concerns have been noted. Specifically, commenters objected that the proposed rule was more than a clarification of existing policy and that implementation of the rule would impose substantial administrative changes on state Medicaid programs and significantly decrease hospital revenues. CMS's determination that no regulatory impact analysis was necessary was considered by commenters to be inaccurate and did not constitute appropriate notification or provide sufficient data to the affected parties. This shortcoming was compounded by the length of the comment period (30 days and not 60 days), which also undermined the ability of interested parties to submit informed comments.

Certain commenters raised substantive technical objections to the proposed UPL methodologies. For instance, a UPL calculated using the Medicare payment-to-charge ratio established from the cost report worksheets referenced in the proposed rule would not include the beneficiary co-payment and coinsurance amounts, which constitute at least 20% of Medicare's allowed payment amounts under OPPS. The other UPL calculation that would potentially limit Medicaid payments for OPH services to costs was challenged as well. The statement by CMS that the cost-to-charge ratio would produce the highest amount that CMS would pay for hospital outpatient services was seen as inaccurate, because under the Medicare OPPS, efficient hospitals are allowed to retain APC-based payments above service costs. Also, CMS did not address the application of this proposed rule to critical access hospitals, which receive Medicare payments based on 101% of their allowable costs. Finally, the proposed methodology to establish the UPL for freestanding clinic services was criticized, because it did not recognize the prevalence of cost-based reimbursement for private clinic services by Medicaid and would result in significant access problems for these services.

Latest Congressional Action

Both the House and the Senate have passed budget resolutions (H.Con.Res. 312 and S.Con.Res. 70, respectively) for FY2009 through FY2013. While the details of each resolution differ, both would allow the respective budget committees to offset any costs associated with any congressional action to prevent or delay administration actions, including action on the proposed OPH services rule, as long as such congressional actions are deficit-neutral (both bills) and surplus-neutral (House bill only).

Two other bills would affect the OPH services rule. S. 2460 would amend P.L. 110-28 by changing the existing one-year moratorium to a two-year moratorium (until May 2009) on further administrative action with respect to the rules on cost limits for public providers and GME. This bill would also add the OPH services rule to this new two-year moratorium. Similarly, H.R. 5613 would extend the existing moratorium in P.L. 110-173 to April 1, 2009, and would add to the prohibition on further administrative action several additional published rules, including the OPH services rule.

---

[14] The GME rule would eliminate federal reimbursement for both direct and indirect graduate medical education costs, and would also change the way in which the Medicaid upper payment limit for hospital services is calculated.