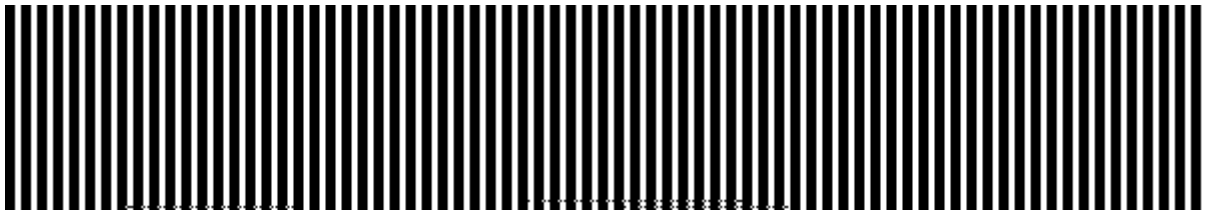

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Providers' Outpatie nt Blended Rate Challenges Rejected

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Following the implementation of Medicare outpatient PPS, a number of providers challenged CMS's continuation of payment using a blended rate methodology for outpatient hospital services between January 1, 1999 and August 1, 2000, when outpatient PPS went into effect. By statute, outpatient PPS was to have become effective January 1, 1999. Due to Y2K issues, however, CMS decided not to implement the statute at that time and, instead, elected to postpone the effective date for approximately a year and a half. During the interim period, CMS continued to pay hospitals for outpatient services based on the existing blended rate methodology. The providers argued that the statute gave CMS no authority to extend the blended rate methodology beyond January 1, 1999, and that CMS should have paid for the services on the basis of reasonable cost from then until August 2000. Two recent judicial decisions, however, have rejected those arguments.

The first case was decided by the United States District Court for the District of Columbia. Caritas Medical Center, et al. v. Johnson, CA No. 07-1889 (RMU) (March 26, 2009). Applying the well-known Chevron test, the court first rejected the argument that the blended rate extension (the "rule") violated the plain statutory language and legislative intent, which plaintiffs maintained was evidenced by Congress's having "expressly terminated" application of the blended rate methodology effective Jan. 1, 1999. The court ruled that the "plain text of the BBA, in which the termination language is contained, is silent as to what payment method would apply from January 1, 1999 through July 31, 2000 in the event the PPS was not implemented on January 1, 1999." This created a "gap as to what payment method applied, and the defendant properly promulgated a rule to fill the gap," said the court. Thus, under the first prong of the Chevron test, the court ruled against the providers' "plain language" assertion.

The court then moved to the second prong of Chevron and ruled that the extension of the blended rate was reasonable. The court observed that the blended rate, which had been in effect for over a decade, was consistent with Congress's intent that providers move seamlessly from the old blended rate approach to PPS. Returning to a reasonable cost methodology, by contrast, would have been inconsistent with this intent.

The court also rejected the notion that the rule had an impermissible retroactive effect. The court said that impermissible retroactivity occurs if a rule "attaches new legal consequences to events completed before its enactment," but here the blended rate had already been in effect. The court also rejected the contention that CMS's arguments amounted to post-hoc rationalizations not raised by the agency when the rule was published. The court said that the

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arguments made by the government merely expanded on points raised in the text of the final rule, and that the CMS position had not changed. Finally, the court dismissed the assertion that the government's position was arbitrary and capricious. The court ruled that CMS had responded in a reasoned manner to the central concerns raised during notice and comment rulemaking, even if the agency did not explicitly address every comment.

The second decision was Southwest Mississippi Regional Medical Center, et al. v. Leavitt, decided by the United States District Court for the Southern District of Mississippi. CA No. 3:08 cv 263 DJP-JCS (April 15, 2009). That court, relying on the D.C. District Court's Caritas decision, also rejected all of plaintiffs' arguments, noting among other things, that the statute had discontinued the reasonable cost payment for outpatient hospital services and had replaced such payments with the blended rate approach. Thus, the court ruled, it was illogical to assume that Congress intended for reasonable costs to be paid for hospital outpatient services during the "gap" period from January 1, 1999 through July, 2000.

Ober|Kaler's Comments: The two decisions reflect the uphill battle that providers face in mounting the "blended rate challenges." The providers in these cases have 60 days from the date of each decision to file an appeal.