Site-Neutral Payment: Legislation, Regulation, and Litigation

WSC Policy Brief

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Overview

Medicare payment policies use two different payment methodologies for outpatient procedures based on the site of service. The hospital-based procedures performed at hospital outpatient departments (HOPDs) are paid through the Hospital Outpatient Prospective Payment System (OPPS) while freestanding clinics are paid much lower amounts through the Medicare Physician Fee Schedule (PFS).

Due to this distinction, hospital-based procedures have historically received higher Medicare reimbursement than ambulatory and office-based procedures. In 2016, for example, ambulatory surgical centers (ASCs) received roughly 53 percent of the amount paid to HOPDs. Notably, HOPDs are paid the same OPPS rate whether the clinic itself is located on the parent hospital's main campus or is located somewhere offsite (known as an off-campus outpatient department of a provider, off-campus provider-based department, or off-campus PBDs; referred to in this report as "off-campus HOPDs").

For several years, policymakers, independent providers, and other stakeholders have expressed concern that off-campus HOPDs were being paid as if they were located within a larger hospital. Critics of this practice have argued that off-campus facilities typically do not face the same administrative and facility costs as their on-campus counterparts and that they often have more favorable payer mixes than departments located within acute care hospitals.

Concerned about rising health care costs and cost differences between sites of care for the same procedures, the U.S. Congress and the Centers for Medicare and Medicaid Services (CMS) in recent years have begun implementing legislation and regulatory policies that would lower reimbursement for certain off-campus HOPDs to a level comparable with freestanding and/or non-hospital facilities.

The practice of reimbursing HOPDs (on- or off-campus) at the same rate as freestanding clinics is known as "site-neutral" payment, and are intended to close the payment gap between off-campus HOPDs and other freestanding facilities.

Legislative History

2015 marked a seismic change in site-neutral payment policy when, on November 2 of that year, President Barack Obama signed into law the ***Bipartisan Budget Act (BBA) of 2015*** (Pub. L. No. 114-74). Section 603 of BBA 2015, entitled "Treatment of Off-Campus Outpatient Departments of a Provider" and often referred to as just "Sec. 603," amended Sec. 1833(t) of the Social Security Act, which governs Medicare payments for HOPD services. Sec. 603 added a new clause that excludes

from the definition of covered services most items and services furnished on or after January 1, 2017, by an "off-campus outpatient department of a provider."

The statute defines the term "off-campus outpatient department of a provider" to include a department of a provider that is not located on the provider's campus or within a 250-yard radius from the main campus of a hospital.

Under this new definition, with the exception of dedicated emergency department (ED) services, services furnished in off-campus HOPDs that began billing under the Medicare OPPS on or after Nov. 2, 2015 would, beginning in 2017, be paid instead under another applicable Part B payment system. These payment systems include the Medicare Physician Fee Schedule (PFS) or, less frequently, the Ambulatory Surgical Center (ASC) Payment System, both of which reimburse providers at rates that are significantly lower than those of the OPPS.

Importantly, Section 603 excluded from the definition those HOPDs that were billing Medicare for covered services furnished prior to the date of the law's enactment. Thus, off-campus departments in operation prior to Nov. 2, 2015, receive grandfathered or "excepted" status and continue to be paid under the OPPS, but new, or "nonexcepted," off-campus departments were only be eligible for such reimbursement until Jan. 1, 2017, at which time they were transitioned to payment under the lower PFS or ASC payment system.

In short, the site-neutral payment provisions of Sec. 603 do not apply to:

- On-campus outpatient departments, whether old or new;
- Off-campus HOPDs that were billing under the OPPS prior to Nov. 2, 2015;
- Certain separately certified departments, such as hospital-based home health agencies (HHAs) and critical access hospitals (CAHs);
- Inpatient remote locations of a hospital; and
- Dedicated emergency departments (DEDs).

On December 13, 2016, President Obama signed into law the ***21st Century Cures Act*** (Pub. L. No. 114-255), which established exceptions for certain off-campus HOPDs that were under construction at the time BBA 2015 was passed. Specifically, Sec. 16001 of the Cures Act provided two exceptions to allow certain off-campus HOPDs to be reimbursed under the OPPS:

(1) HOPDs that were furnishing services but were not billing those services under the OPPS as of Nov. 2, 2015; and
(2) HOPDs that were "mid-build" when BBA 2015 was signed.

The first exception applied to a relatively small group of HOPDs and only granted temporary grandfathered status to applicable facilities – those departments were allowed to continue billing under the OPPS for CY 2017 only. The second exception, for HOPDs that were under construction at the time of the law's enactment, allowed those facilities to begin billing under the OPPS beginning January 1, 2018, and continue billing at the higher rate thereafter. To meet the mid-build requirements, the hospital must have had a "binding written agreement" with an "outside unrelated party" for the "actual construction" of the off-campus department before November 2, 2015. This exception also applies to HOPDs that had already been built but had not yet begun accepting patients as of the date of the law's enactment.

Implementation of Sec. 603

CY 2017 Payment Rules

Despite requests from industry stakeholders to postpone the Sec. 603 provisions to allow for preparation and clarification, CMS implemented the site-neutral payment policies as part of the ***CY***

2017 Medicare Outpatient Prospective System (OPPS) and ***CY 2017 Medicare Physician Fee Schedule*** final rules.

For CY 2017, CMS finalized the PFS as the applicable Part B payment system for services at non-excepted HOPDs and set payment for most nonexcepted services at 50 percent of the OPPS rate (i.e., a 50 percent PFS relativity adjuster). Notably, CMS opted not to finalize a provision of the proposed rule that would have required off-campus HOPDs to offer the same services they did on Nov. 2, 2015, in order to be excluded from the site-neutral payment policies. This proposal had received heavy industry pushback and was ultimately cut in response to public comments.

However, CMS did adopt its initial proposal to terminate an off-campus HOPD's exempted status if the facility relocated. The move covers changing physical addresses, including moving suites within the same building, and such facilities would no longer be able to bill under OPPS unless the move occurred under "extraordinary circumstances" such as natural disasters.

In the preambles of the CY 2017 final rules, CMS estimated that implementing Sec. 603 will reduce Medicare Part B expenditures by approximately $50 million in 2017 alone.

CY 2018 and CY 2019 Payment Rules

In its CY 2018 PFS proposed rule, CMS proposed reducing payments for non-excepted HOPDs from 50 percent to 25 percent. CMS arrived at this proposed payment rate based solely on a comparison of the payment rate for a hospital outpatient clinic visit to the payment rates for similar outpatient visit services under the PFS. In response to industry pushback and public comments, however, the agency ultimately settled on a site-neutral payment rate of 40 percent of the OPPS rate.

In the calendar year (CY) 2019 PFS final rule, the agency continues to identify the PFS as the applicable payment system for most non-excepted services at off-campus HOPDs and again set payment for most non-excepted services at 40 percent of the OPPS rate.

CY 2019 OPPS: Clinical Services Rule

On November 2, 2018, CMS finalized the CY 2019 Medicare Hospital OPPS and Ambulatory Surgical Center (ASC) Payment System rule. In the rule, CMS has opted to apply site-neutral payments for certain clinical services provided at off-campus HOPDs – even those facilities that are statutorily excepted form site-neutral payment policies under Sec. 603.

According to CMS, the most frequently billed service with the "PO" modifier is described by HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient), which is paid under APC 5012 (Clinic Visits and Related Services). From 2005 to 2015, the outpatient services volume per beneficiary grew by 47 percent. One-third of the growth in outpatient volume from 2014 to 2015 was due to an increase in the number of **evaluation and management (E&M)** visits bill as outpatient services.

CMS believes that the higher payment that is made under the OPPS, as compared to payment under the physician fee schedule (PFS), is likely incentivizing providers to furnish care in the hospital outpatient setting rather than the physician office setting.

Therefore, given what the agency considered to be an "unnecessary" increase in the volume of clinic visits in hospital outpatient departments, CMS is now applying a payment amount equal to the site-specific PFS payment rate for nonexcepted items and services furnished by a nonexcepted off-campus provider-based departments (PBDs) for the clinic visit service, as described by HCPCS code G0463, when provided at an off-campus PBD.

In other words, evaluation and management visits, *even when provided in an excepted off-campus PBD*, will be paid the lower PFS rate. This will reduce payments by $70 per visit, and CMS will implement this change without consideration of budget-neutrality (i.e., savings will not be redistributed across Medicare Part B).

CMS will phase in the reduction over a two year period; in 2019, it will only apply 50 percent of the total reduction in payment. CMS expects this to save $380 million in 2019.

AHA/AAMC Lawsuit

On December 4, AHA and AAMC, along with three independent hospitals, filed a lawsuit in response to the site-neutral E&M cuts included in the CY 2019 OPPS final rule, arguing that the administration is overstepping its legal bounds by extending the site-neutral cuts to HOPDs otherwise excepted from the site-neutral provisions of BBA 2015. The lawsuit, filed in the U.S. District Court for the District of Columbia, challenges the "serious reductions to Medicare payment rates" as executive overreach.

"This court should reject CMS' attempts to replace Congress's unequivocal directives with the agency's own policy preferences," the hospitals wrote in their complaint. "CMS may not contravene clear congressional mandates merely because the agency wishes to make cuts to Medicare spending."

Alliance for Site Neutral Payment Reform

While hospitals and hospital associations have been working tirelessly against the passage, promulgation, and expansion of site-neutral payment policies, one industry group – led by several prominent physician organizations – has emerged as a leading voice in favor of these policies. The Alliance for Site Neutral Payment Reform is "a coalition of patient advocates, providers, payers and employers who support payment parity across site of service in order to decrease Medicare and commercial spending, ensure patients receive the right care in the right setting, lower taxpayer and beneficiary costs and increase patient access." As of March 2019, the Alliance includes the following members:

- American Academy of Family Physicians
- American College of Physicians
- American Health Care Association
- America's Health Insurance Plans
- Blue Cross and Blue Shield Association
- National Brain Tumor Society
- National Restaurant Association
- Community Oncology Alliance
- Lung Cancer Alliance
- Men's Health Network
- The US Oncology Network

Recent Research

A September 2018 study, conducted for the American Hospital Association by KNG Health Consulting LLC, found that Medicare patients who receive care in an HOPD are more likely to be poorer and have more severe chronic conditions than Medicare patients treated in an independent physician office.

Another recent AHA analysis showed that costs are significantly higher for HOPDs due to additional capabilities (e.g., 24/7 ED standby) and regulations. These roles are not explicitly funded; instead they are built into a hospital's overall cost structure and supported by revenues received from providing direct patient care. Other care sites don't share these roles or bear these costs, yet some policymakers want to make total payment for a service provided in a hospital the same as when a service is provided in a physician office.