Site-Neutral Payment: Legislation, Regulation, and Litigation

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 would 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 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 began 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.

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

The final rule established a policy to pay for outpatient clinic visits furnished in excepted off-campus PBDs at 40% of the OPPS payment rate, the same rate that these services are paid in non-excepted off-campus PBDs. The agency phased-in the policy over two years, reducing payment to 70% of the OPPS rate in 2019 and 40% of the OPPS rate in 2020.

AHA/AAMC Lawsuit and CMS Response

Lawsuit

In December 2018, the American Hospital Association (AHA), joined by the Association of American Medical Colleges (AAMC) and several member hospitals, filed a lawsuit against the Department of Health and Human Services challenging these payment reductions as violating the Administrative Procedure Act and as exceeding the agency's statutory authority. The lawsuit argued that the Trump administration exceeded its authority 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."

The U.S. District Court for the District of Columbia in September 2019 sided with AHA and the other hospital organizations that challenged the cut, ruling that CMS exceeded its statutory authority when it reduced payments for hospital outpatient clinic visit services provided in off-campus PBDs excepted under the Social Security Act. The next month, the court rejected CMS'

motion to reconsider or issue a stay on the ruling. Notably, the district court ruling affected only the policy contained in the 2019 OPPS final rule.

However, in July 2020, a three-judge panel of the U.S. Court of Appeals for the District of Columbia reversed the district court ruling, upholding CMS' clinic visit cuts. The full court declined to reconsider the ruling in October 2020. In its decision, the appeals court determined that the policy is within CMS' statutory authority and that in this instance CMS is not required to make payment cuts in a budget-neutral manner.

Under federal law, CMS has the authority to control unnecessary increases in volume, according to the appeals court ruling. Because the payment cuts are designed to control unnecessary increases in volume by removing the financial incentive, it would defeat the policy's purpose if the funds were redistributed to other covered services at the affected grandfathered PBDs. In addition, the appellate judges said that Congress would not find the increases in volume at grandfathered PBDs during 2016–2017 acceptable; therefore, the payment cuts do not violate Congress' intent when it grandfathered certain PBDs.

In February 2021, the American Hospital Association asked the U.S. Supreme Court to review the appeals court decision. In a May 2021 filing, the Biden administration urged the Supreme Court to pass on the case, arguing that the AHA/AAMC coalition "have not identified any 'specific prohibition in the statute that is clear and mandatory' that HHS' action contravenes." Rather, the appellate court had correctly determined that "the reduction was a permissible exercise of HHS' statutory authority," the agency wrote.

On June 28, 2021, the U.S. Supreme Court of the United States declined to consider AHA's lawsuit asking the court to reverse the federal appeals court decision.

"We are disappointed that the U.S. Supreme Court has declined to hear the compelling arguments in our case on payment cuts for hospital outpatient visits," Melinda Hatton, general counsel for the AHA, said in a statement. "These cuts to hospital outpatient departments directly undercut the clear intent of Congress to protect them because of the many real and crucial differences between them and other sites of care. Hospital outpatient departments are held to higher regulatory standards and are often the only point of access for patients with the most severe chronic conditions, all of whom receive treatment regardless of ability to pay," she said.

CMS Response

In response to the September 2019 district court ruling, CMS reprocessed the 2019 claims to pay them at 100% of the full OPPS rate. However, despite the ongoing litigation and because the ruling only applied to the CY 2019 rule, CMS moved forward with policy's second phase in the CY 2020 OPPS final rule.

In January 2021, CMS announced that, as a result of the July 2020 U.S. Court of Appeals ruling in its favor, it will begin reprocessing claims for outpatient clinic visits furnished in calendar year (CY) 2019 from excepted off-campus provider-based departments (PBDs) to reduce payment for clinic visits from 100% to 70% of the full outpatient prospective payment system (OPPS) rates. This reprocessing is scheduled to begin by July 1, 2021.

Site Neutral Payments – Timeline

November 2015	President Obama signs into law Sec. 603 of BBA 2015.
November 2016	CMS finalizes site-neutral policies for non-excepted HOPDs.
November 2017	CMS proposed reducing payments for non-excepted HOPDs from 50 percent to 25 percent; the agency ultimately settles on 40 percent of the OPPS rate.
November 2018	CMS applies 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.
December 2018	AHA/AAMC file lawsuit, claiming site-neutral payments for E&M services is executive overreach.
September 2019	D.C. District Court sides with AHA, ordering CMS to reprocess 2019; ruling only applies to CY 2019 rule.
October 2019	D.C. District Court rejects CMS' motion to reconsider and denies a stay on the decision.
December 2019	HHS appeals to the U.S. Court of Appeals for the District of Columbia.
November 2019	Despite ongoing litigation CMS moves forward with the site-neutral policy's second phase – reimbursing E&M services at 40% of the OPPS rate.
January 2020	CMS orders MACs to automatically reprocess claims paid at the reduced rate to reimburse affected providers at 100% of the full OPPS rate.
July 2020	U.S. Court of Appeals reverses the D.C. District Court decision.
January 2021	CMS announces that, by July 1, it will begin (re-)reprocessing 2019 claims at the reduced rate.
February 2021	AHA/AAMC appeals to the U.S. Supreme Court.
June 2021	U.S. Supreme Court declines to hear AHA/AAMC's appeal.
July 2021	CMS begins reprocessing 2019 claims at 70% of the OPPS rate.