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Health Care Law Monthly

November 2018
Volume 2018 * Issue No. 11

Contents:

Recent Reimbursement-Rate Trends for Hospital Off-Campus Provider-Based Departments 1
Timothy J. Fry and Amanda K. Roenius

Mealey's Corner 11

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Recent Reimbursement-Rate Trends for Hospital Off-Campus Provider-Based Departments

Timothy J. Fry and Amanda K. Roenius

Recently, policymakers, including Congress, have focused on site-neutral Medicare payments for healthcare providers, especially in the context of hospital off-campus provider-based departments ("PBDs").[1] Site-neutrality is seen by some policy-makers as a way to reduce program spending, reduce beneficiary copayments, and help ensure basic fairness within a competitive industry. In response, the Centers for Medicare & Medicaid Services ("CMS") has consistently shrunk reimbursement rates for PBDs, which, prior to 2017, were historically paid under the outpatient prospective payment system ("OPPS"). Reimbursement under the OPPS provided a financial advantage to PBDs because the OPPS generally reimburses at higher rates as compared to the Medicare physician fee schedule ("PFS"), the payment system under which certain providers and suppliers, such as physician offices and Non-Excepted PBDs (as later defined in this article), are now typically reimbursed. In rationalizing its tightened grip on reimbursement for off-campus PBDs, CMS explained that "it is not prudent for the Medicare program to pay more for these services in one setting than another."[2] This is a school of thought shared by many policymakers, including members of Congress and the current Trump administration.[3]

Given policymakers' strong inclination to further site-neutral payments, both providers and healthcare attorneys should expect changes in reimbursement to continue. To prepare providers and healthcare attorneys for potential reimbursement changes, this article: (i) provides background on the historic reimbursement changes and Congressional mandates regarding PBDs; (ii) analyzes historic and proposed changes issued by CMS regarding reimbursement for PBDs under the PFS and the OPPS; and (iii) discusses potential, future trends that both healthcare providers and healthcare counsel should closely monitor.

1. Background – An Overview of Off-Campus PBD Reimbursement

The concept of site-neutrality payments has gained momentum amongst policymakers, including Congress, for the past several years. By way of brief background, CMS utilizes a variety of payment systems to reimburse services that are furnished to Medicare beneficiaries on an outpatient basis. For example, if a beneficiary receives services in a physician's office, Medicare will reimburse under the PFS, whereas if the beneficiary received those same services in a hospital-owned PBD office setting, Medicare would, in addition to making a professional payment under the PFS, reimburse a facility fee under the OPPS. Typically, the total reimbursement rate is higher when CMS pays both the professional fee under the PFS and a facility fee under the OPPS, as opposed to just making one payment. Accordingly, policymakers have consistently raised concerns regarding the disparity in reimbursement rates when the same service being rendered in one provider setting varies versus that of another. Policymakers argue and are concerned that hospitals may be improperly incentivized to acquire physician practices (or other provider types) and label them as PBDs to obtain a higher reimbursement rate.

[1] PBDs are owned and operated by a single, main provider, which, for purposes of this article, is a hospital. PBDs can be located on the same campus as the main provider or located off-campus. For Medicare payment purposes, except as described herein, PBDs are treated as part of the main hospital when the hospital maintains control over the quality of care and finances of the location. There are numerous qualification requirements set forth at 42 C.F.R. § 413.65. Hospitals are able to submit a voluntary attestation to their PBD status for their facilities.

[2] *See* Ctrs. for Medicare & Medicaid Srvs.; Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, 83 Fed. Reg. 37046, 37142 (July 31, 2018), *available at* https://www.gpo.gov/fdsys/pkg/FR-2018-07-31/pdf/2018-15958.pdf.

[3] *See, e.g.*, Evan Sweeney, *Verma: CMS is Exploring Ways to Expand Site-Neutral Payments*, FierceHealthcare (Oct. 3, 2018, 12:14 PM), https://www.fiercehealthcare.com/payer/seema-verma-cms-site-neutral-payments-post-acute-care-medicare.

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As further discussed in this section of the article, policymakers have recently addressed these concerns through statutory change, and, following this congressionally paved path, CMS has followed suit, implementing rules that help achieve this overarching goal. This section provides a brief overview of the recent history regarding changes in site-neutrality payments that has helped shape CMS's recent reimbursement-rate cuts for PBDs.

a. *Mandates Influencing Site-Neutrality*

i. *Bipartisan Budget Act of 2015*. In recent years, policymakers and CMS alike have expressed concern that off-campus PBDs were being paid as hospital sites while oftentimes only providing low acuity services that are most typically offered in non-hospital-based facilities. Acting on these concerns, Congress passed Section 603 of the Bipartisan Budget Act of 2015 ("Bipartisan Budget Act"), which substantially changed how (and how much) Medicare would pay for outpatient services furnished in a hospital PBD. In an effort to move toward site-neutral payments, this Congressional mandate prohibited off-campus PBDs that first began billing Medicare after Nov. 2, 2015 ("Non-Excepted PBDs") from billing and being paid under the OPPS, absent limited circumstances.[4]

Prohibiting payment under the OPPS essentially stripped Non-Excepted PBDs of the financial advantages that locations holding provider-based status previously held.[5] As mentioned, providers typically receive higher reimbursement when CMS makes a payment for professional services under the PFS and a payment for the facility fee under the OPPS as opposed to a single PFS payment. For example, a mid-level office visit billed as CPT code 99213 may receive $70.49 under the PFS outside of a "facility" while receiving $49.69 under the PFS inside a "facility" plus $72.19 under the OPPS, yielding a total of $121.88.[6] Accordingly, by passing Section 603 of the Bipartisan Budget Act, Congress furthered policymakers' site-neutral payment goals by requiring Non-Excepted PBDs to receive payment under another payment system.

ii. *21st Century Cures Act*. On Dec. 13, 2016, then-President Barack Obama signed the 21st Century Cures Act into law ("Cures Act"), which provided some welcome relief to certain categories of off-campus PBDs.[7] The Cures Act revised the site-neutral payment policy contained in Section 603 of the Bipartisan Budget Act by establishing two exceptions for off-campus PBDs.[8] The first exception involved off-campus PBDs that: (1) were under development but not billing as provider-based for services rendered as of Nov. 2, 2015; and (2) submitted a voluntary provider-based attestation to CMS before Dec. 2, 2015.[9] Under this exception, if an off-campus PBD met these two requirements, it would be temporarily grandfathered, joining other excepted facilities (primarily those that billed as provider-based prior to Nov. 2, 2015) ("Excepted PBDs") and receive OPPS payments through CY 2017.[10] The second exception involved off-campus PBDs that were "mid-build" prior to Nov. 2, 2015. "Mid-build" meant that the provider entered into a binding, written agreement with an unrelated third party for the actual construction of an off-campus PBD. Beginning Jan. 1, 2018, these off-campus PBDs would be permitted to bill for services under the OPPS if they: (1) submitted a certification to CMS from their chief executive officer or chief operating officer by Feb. 13, 2017, certifying that the off-campus PBD met the definition of "mid-build"; (2) submitted an attestation to CMS by Feb. 13, 2017, stating that the off-campus PBD met the requirements of being provider-based; and

[4] For example, services provided in a dedicated emergency department would still be paid under the OPPS. *See* L. Dyrda, *12 things to know about site-neutral payments*, Becker's Hospital Review (Feb. 9, 2017), https://www.beckershospitalreview.com/finance/12-things-to-know-about-site-neutral-payments.html.

[5] *See* T. Fry & A. Roenius, *Reimbursement changes for Hospital Off-Campus Provider-Based Departments*, McGuireWoods LLP (Jan. 18, 2017) (explaining the 2017 OPPS Final Rule), https://www.mcguirewoods.com/Client-Resources/Alerts/2017/1/New-Rule-Reimbursement-Hospital-Off-Campus-Provider.aspx. One relevant exception further discussed in this article is off-campus emergency departments qualifying as PBDs.

[6] *Differences in Billing for Private vs. Hospital-Owned Practices*, Am. College of Cardiology (June 29, 2012), https://www.acc.org/latest-in-cardiology/articles/2012/06/29/16/35/practice-vs-hosptial-owned-practice-billing (reporting numbers that have likely increased).

[7] Pub. L. 114-255.

[8] *See Note Regarding Implementation of Sections 16001 and 16002 of the 21st Century Cures Act*, Ctrs. for Medicare & Medicaid Srvs., (clarifying the exceptions) *available at* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Sections-16001-16002.pdf.

[9] *Id.*

[10] *Id.*

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(3) added the new off-campus PBD to the hospital's Medicare enrollment form.

b. *CMS Implements Section 603 of the Bipartisan Budget Act*

As mentioned above, prior to 2017, off-campus PBDs were eligible for reimbursement under the OPPS; however, this changed in 2017, when CMS finalized its calendar year ("CY") 2017 final rule regarding the OPPS ("2017 OPPS Final Rule").[11] The 2017 OPPS Final Rule implemented Section 603 of the Bipartisan Budget Act. CMS explained that this change was guided by Congress's desire to curb the incentive for hospitals to acquire physician practices and receive enhanced reimbursement under the OPPS (i.e., taking advantage of differential payment systems to receive more for the same service at the same site merely due to ownership).[12] Despite requests from parts of the healthcare industry to postpone adoption of Section 603, CMS implemented it with the 2017 OPPS Final Rule, retaining many controversial aspects from the proposed rule but clarifying some key elements (e.g., that Section 603 does not apply to on-campus PBDs, dedicated emergency departments (as defined at 42 C.F.R. § 489.24(b)), remote locations of a hospital (i.e., those located within 250 yards of the hospital's main buildings), or off-campus PBDs that were billing and operating as outpatient departments prior to Nov. 2, 2015, collectively referred to herein as "Excepted PBDs").[13]

As further discussed below, the 2017 OPPS Final Rule was the first of several subsequent rules that CMS finalized to further policymakers' site-neutrality goals.

2. <u>Historic and Proposed Changes in Reimbursement</u>

Since implementing Section 603 of the Bipartisan Budget Act, CMS has attempted to further Congress's site-neutrality mandates; however, CMS has been left to grapple with how best to reimburse off-campus PBDs because Congress did not provide an alternative mechanism, which ultimately resulting in slashed reimbursement rates. This section provides an overview of the recent CMS rules regarding off-campus PBD reimbursement and examines some of the key changes set forth in each such rule.

a. *2017 OPPS Final Rule*

As touched on in section 1 of this article, the first major wave of reimbursement changes for off-campus PBDs stemmed from CMS's 2017 OPPS Final Rule, which resulted in only Excepted PBDs remaining eligible for reimbursement under the OPPS. Section 603 of the Bipartisan Budget Act forced CMS to establish a reimbursement mechanism for Non-Excepted PBDs who could no longer receive payment under the OPPS but, on the other hand, could not simply bill under the PFS as physicians would bill for those services. In an effort to set forth a resolution for this issue yet remain budget neutral and further Congress's/policymakers' site-neutrality goals, CMS established a temporary solution in the 2017 OPPS Final Rule.

In the 2017 OPPS Final Rule, CMS determined that Non-Excepted PBDs would bill under the PFS while utilizing the OPPS rules; however, payment for Non-Excepted PBDs under the PFS would be based on a "relativity adjuster" to the OPPS rate. In other words, such Non-Excepted PBDs would follow all of the OPPS rules but receive a reduced payment amount under the PFS that would be equal to the OPPS rate multiplied by the relativity adjuster. In the 2017 OPPS Final Rule, CMS set the relativity adjuster at 50% of the OPPS, which, at the time, CMS thought would strike "an appropriate balance" while avoiding a potential underestimate of the resources involved in furnishing services in Non-Excepted PBDs as compared to other provider settings for which payment is made under the PFS.[14] In establishing the relativity adjuster, CMS reviewed the technical-component portion of the PFS rates and compared that number to the OPPS payments for twenty-two

[11] Ctrs. for Medicare & Medicaid Srvs.; Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, 81 Fed. Reg. 79562 (Nov. 4, 2016), *available at* https://www.gpo.gov/fdsys/pkg/FR-2016-11-14/pdf/2016-26515.pdf (hereinafter Nov. Fed. Reg.).

[12] *Id.*

[13] *See generally id.*

[14] Nov. Fed. Reg., *supra* note 11, at 79,723.

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(22) of the most commonly billed PBD codes.[15] Notably, however, CMS admittedly did *not* include the most commonly billed OPPS code in its calculation.[16] CMS expressly indicated that it was aware this arrangement could be an overestimate that proved problematic, opening the door to future changes in the years to come and soliciting comments on this new payment methodology.[17]

In addition to establishing the PFS as the appropriate payment system for Non-Excepted, PBDs, the 2017 OPPS Final Rule also introduced some additional changes. For example, CMS mandated that beginning on or after January 1, 2017, PBDs that billed for Non-Excepted items or services furnished at Non-Excepted PBDs or Non-Excepted items at *Excepted* PBDs must use a new claim-line modifier "PN," that triggered payment under the newly adopted site-of-service-specific PFS rates.[18] Further, CMS's proposed limit on relocation proved to be one of the more contentious elements set forth in the 2017 OPPS Final Rule. CMS stood its ground, implementing its initial proposal that if an Excepted PBD relocated from its existing physical address, which included changes in suites within the same building, it could no longer maintain excepted status and, accordingly, could no longer bill under the OPPS as an Excepted PBD.[19] Although CMS indicated that regional offices could consider exceptions for "extraordinary circumstances," it expressly stated that these exceptions would be "both limited and rare."[20]

Overall, CMS's 2017 OPPS Final Rule set the stage for future changes and shook the ground on which PBDs relied for their financial advantages.

b. *2018 PFS Final Rule*

In furthering its goal to achieve site-neutrality payment rates, CMS further slashed reimbursement rates for Non-Excepted PBDs in its 2018 final rule regarding the PFS ("2018 PFS Final Rule").[21] As discussed above, CMS initially set the relativity adjuster for Non-Excepted PBDs at 50% of the OPPS rate, indicating, however, that this relativity would be temporary. In its 2018 interim rule, CMS proposed slashing that relativity adjuster in half to 25% of the OPPS—a proposal that would have greatly impacted reimbursement for non-excepted PBDs.[22]

After receiving copious comments that this change in the relativity adjuster went too far, CMS slightly backed away from its initial proposal and, instead, finalized a 20% reduction for CY 2018. Specifically, Non-Excepted PBDS would now be reimbursed at 40% of the OPPS, as opposed to 50%, beginning January 1, 2018.[23] CMS believed that this reduction more closely reflected its estimate regarding the average payment difference for the top twenty-two (22) codes paid in PBDs. Notably, this time, CMS included the most commonly billed code for clinic visits (CPT code 60463), which it excluded in calculating the 2017 OPPS Final Rule's relativity adjuster. Notwithstanding the foregoing, CMS indicated that this relativity adjuster was, like its predecessor, temporary in nature because CMS had not yet had an opportunity to review new claims data.[24]

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[15] *See* T. Fry & A. Roenius, *CMS Proposes Reimbursement cuts for Certain Hospital Provider-Based Departments*, McGuireWoods LLP (Sept. 1, 2017), https://www.mcguirewoods.com/Client-Resources/Alerts/2017/9/CMS-Reimbursement-Cuts-Hospital-Provider-Based-Departments.aspx.

[16] *See id.*

[17] *See* Fry & Roenius, *supra* note 5 (explaining CMS's reasoning behind setting the initial relativity adjuster at 50% of the OPPS).

[18] *Id.* When Excepted PBDs bill for excepted items, the hospital must use claim-line modifier "PO."

[19] *Id.*

[20] Nov. Fed. Reg., *supra* note 11 at 79705; *see also Extraordinary Circumstances Relocation Guidance for an Off-Campus Provider-Based Department (in accordance with regulations at 42 CFR 419.22 and 419.45)*, Ctrs. for Medicare & Medicaid Srvs. (providing guidance for hospitals on how to request a relocation exception for an off-campus PBD due to extraordinary circumstances and detailing examples of what constitutes an extraordinary circumstance (e.g., natural disasters, significant seismic building code requirements, or significant public health and public safety issues that are outside of the hospitals' control)), *available at* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Subregulatory-Guidance-Section-603-Bipartisan-Budget-Act-Relocation.pdf.

[21] Ctrs. for Medicare & Medicaid Srvs.; Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 82 Fed. Reg. 59216 (Dec. 14, 2017) (noting that the initial rule was published in the Nov. 13, 2017 issue of the Federal Register, but that it was reprinted due to an accidental section omission).

[22] *See* T. Fry & R. Roenius, *2018 Reimbursement Cuts for Some Off-Campus Hospital Provider-Based Departments*, McGuireWoods LLP (Dec. 13, 2017) (explaining that although payment rates were further cut by close to 20%, CMS backed away from its initial proposal of slashing payment rates in half by 50%, a proposal that would have drastically impacted reimbursement for non-excepted PBDs), https://www.mcguirewoods.com/Client-Resources/Alerts/2017/12/2018-Reimbursement-Cuts-Off-Campus-Hospital-Provider-Based-Departments.aspx.

[23] *Id.*

[24] *Id.*

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Given CMS's express statements that this new relativity adjuster was transient in nature, providers and healthcare attorneys alike cautiously awaited CMS's next proposal regarding reimbursement for Non-Excepted PBDs—who had already seen reimbursement rates cut nearly 60% since implementation of the Bipartisan Budget Act.

c. *2019 Proposed OPPS Rule*

In July 2018, CMS released its CY 2019 proposed rule regarding the OPPS ("2019 Proposed OPPS Rule").[25] This came on the heels of the CY 2019 proposed rule for the PFS, in which, to some surprise, CMS did not propose a new relativity adjuster, meaning Non-Excepted PBDs would continue to be reimbursed at 40% of the OPPS.[26] In maintaining the relativity adjuster from the 2018 PFS Final Rule, CMS reasoned that more specific data regarding the appropriate setting for the relativity adjuster was not yet available.[27] Accordingly, although the relativity adjuster will remain the same for CY 2019 if CMS does not alter its proposal, CMS stated that it will continue to consider updated data and other considerations regarding the appropriate level of reimbursement, which may foreshadow future changes.[28]

Although the payment rate remains the same, under the 2019 Proposed OPPS Rule, CMS introduced new, as well as previously proposed, changes that further CMS's (as well as Congress's) goal for site-neutrality payments and reducing government spending as it relates to hospitals. For example, perhaps one of the most controversial proposals in the 2019 Proposed OPPS Rule is CMS's plan to pay CPT code G0463 (the "Code"), which covers a "hospital outpatient visit," at the reduced, Non-Excepted rate for *all* off-campus PBDs.[29] In making this proposal, CMS reasoned that the services billed under the Code could be provided in a non-hospital setting for less cost. CMS cites its authority to do so under the Social Security Act[30] as a means of controlling unnecessary increases in volume of outpatient services, as opposed to Section 603 of the Bipartisan Budget Act for the other Non-Excepted PBD changes described herein. Notwithstanding the foregoing statutory authority, it is pertinent to note that Congress explicitly provided for a distinction in site-neutrality payment mandate for Non-Excepted and Excepted PBDs. Accordingly, given the substantial impact that this proposal presents, significant comments against this proposal are expected,[31] and, if finalized, potential litigation. If implemented, this change could significantly impact Excepted PBDs, which Congress appeared to expressly carve out when passing Section 603 of the Bipartisan Budget Act.

Additionally, CMS re-introduced a previous proposal related to the expansion of service lines. Specifically, CMS proposes that if Excepted PBDs expand their paid range of services beyond the same "clinical families" of services that they already offer, as of 2015 when the Bipartisan Budget Act was enacted, such expanded service lines will only be eligible to receive the reduced payment rate equal to the 40% of the OPPS relativity adjuster.[32] CMS initially proposed this concept in 2017 but backed away as it agreed with commenters that implementation

[25] Ctrs. for Medicare & Medicaid Srvs.; Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, 83 Fed. Reg. 37046 (July 31, 2018), *available at* https://www.gpo.gov/fdsys/pkg/FR-2018-07-31/pdf/2018-15958.pdf (hereinafter July Fed. Reg.).

[26] *See* T. Fry and A. Roenius, *CMS Proposes More Payment Cuts for Hospital Off-Campus Provider-Based Departments*, McGuireWoods LLP (Aug. 28, 2018), https://www.mcguirewoods.com/Client-Resources/Alerts/2018/8/CMS-Proposes-More-Payment-Cuts-Hospital-Off-Campus-Provider-Based-Departments.aspx.

[27] *Id.*

[28] CMS expressly requested commenters provide additional information and data for CMS's consideration with regard to the relativity adjuster.

[29] Fry & Roenius, *supra* note 22.

[30] Specifically, CMS cites Section 1833(t)(2)(F) of the Social Security Act, which reads "the [HHS] Secretary shall develop a method for controlling unnecessary increases in the volume of covered [outpatient department] services."

[31] *See, e.g.*, American Hospital Association Letter to Seema Verma, Administrator, Ctrs. for Medicare & Medicaid Srvs., Am. Hospital Ass'n (Sept. 24, 2018), *available at* https://www.aha.org/system/files/2018-09/180924-comment-letter-cms-outpatient-pps-asc-proposed-rule-cy2019.pdf ("AHA is deeply disappointed in certain proposals [including both the G0463 proposal and the clinical families proposal] that CMS has chosen to set forth in this rule, which run afoul of the law and rely on the most cursory of analyses and policy rationales. . . . CMS lacks statutory authority to reduce payments to [E]xcepted PBDs to the level of [Non-Excepted] PBDs, particularly in a non-budget-neutral manner.") (hereinafter American Hospital Association).

[32] Fry & Roenius, *supra* note 22.

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would, operationally, be difficult to achieve.[33] Additionally, CMS once again proposed changes in reimbursement rates for 340B drugs provided at Non-Excepted PBDs in an effort to treat Non-Excepted PBDs in the same manner as excepted PBDs.[34]

The 2019 Proposed OPPS Rules appears in trend with the recent rules CMS implemented; namely, CMS continues to further its site-neutrality goals and reduce financial advantages currently enjoyed by excepted PBDs. If finalized, this proposed rule will likely force providers to rethink where and through what avenue to furnish certain items and services.

3. Potential Future Trends

a. *Additional Payment Cuts Likely*

Throughout the past several years, CMS has consistently slashed reimbursement rates for Non-Excepted PBDs, and these payment cuts are likely to continue. In its 2019 Proposed OPPS Rule, CMS made clear that although it was keeping the relativity adjuster at 40% of the OPPS, it had not yet had the opportunity to review new data that would warrant a change. Notwithstanding the foregoing, CMS is soliciting comments on this proposal. Additionally, CMS asked commentators for other suggestions to utilize Social Security Act Section 1833(t)(2)(F) to reduce overall OPPS spending. In response, the Medicare Payment Advisory Commission ("MedPAC") reiterated a 2013 recommendation that CMS: (i) review what services are performed in a physician office more than 50% of the time; (ii) have minimal packaging differences, (iii) are provided infrequently with an emergency department visit; (iv) have similar patient acuity whether in PBD and a physician office and (v) are not part of 90-day global surgical rates as criteria to pay the same.[35] Other commentators seeking reductions may point to past MedPAC guidance on aligning certain OPPS payments with those paid under the ASC payment rate.[36] In addition, we anticipate comments surrounding emergency department services, which we describe in detail in the next section.

Given the history of reductions in reimbursement, coupled with the fact CMS has support from many policymakers in its efforts to achieve site-neutrality payments, healthcare counsel and providers alike should monitor changes in reimbursement over the coming years.

b. *Freestanding Emergency Departments and Site Neutrality in Emergency Departments: CMS's Proposal in 2019 Proposed OPPS Rule*

In addition to the changes detailed above, CMS suggests further reform for emergency departments in the 2019 Proposed OPPS Rule, reflecting similar site-neutrality concerns.[37] In the 2019 Proposed OPPS Rule, CMS proposed to add a billing modifier for services rendered in hospital off-campus emergency departments ("OCED") in response to MedPAC's 2017 recommendation.[38] CMS agreed with MedPAC's concern that additional, low-acuity services are shifting out of a hospital's on-campus emergency department in exchange for higher reimbursement fees. To understand the scale of this shift, the proposed modifier "ER" would be appended to all OCEDs in an effort to allow an assessment of such data. This first step may be followed by others.

MedPAC and other commentators have expressed concerns that OCEDs and independent freestanding emergency centers ("IFEC") that are unaffiliated with hospitals increase emergency care utilization for lower acuity services. There has been significant growth in these types of centers. In 1978, there were approximately 55 locations physically separate from an acute care hospital in the United States, increasing to an estimated 222 at the end of 2008, and now exceeding

[33] We anticipate similar reactions to this revised proposal. *See, e.g.*, American Hospital Association, *supra* note 31 ("[W]e strongly oppose and urge the withdrawal of CMS's proposed policy to pay for services from expanded clinical families that are furnished in [Excepted] PBDs at the PFS-equivalent rate. This proposal is . . . arbitrary and capricious – it lacks statutory authority and relies on inaccurate speculation regarding Congress's legislative intent.").

[34] Fry & Roenius, *supra* note 22.

[35] MedPAC Comment Letter to Seema Verma, Administrator, Ctrs. for Medicare & Medicaid Srvs., MedPAC (Sept. 21, 2018) (citing MedPAC, June 2013 Report to Congress 37-38).

[36] *See, e.g.*, MedPAC, March 2017 Report to Congress 142 (reporting that ASC payment rates are appropriate, despite being significant less than OPPS rates) (hereinafter MedPAC March 2017 Report).

[37] July Fed. Reg., *supra* note 25.

[38] *See* MedPAC, March 2017 Report, *supra* note 36 at 78.

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580 in 2018.[39] This corresponds to a 14.1% increase in Medicare patient visits from 2010 to 2016 in emergency departments as compared to a 3.9% growth in physician visits during this same period.[40]

At the same time, studies suggest OCEDs and IFECs may increase lower acuity care utilization at higher costs. One study found that 13 of the most common procedure codes and 15 of the most commonly associated codes with regard to freestanding emergency departments were among the most commonly used codes at urgent care clinics. However, "prices for patients with the same diagnoses were on average almost 10 times higher at freestanding and hospital based EDs relative to urgent care centers."[41] This spending differential appears true for Medicare, too.[42] Researchers cited growth and cost differential as key reasons for Medicare-beneficiary-spending increases, which, on average, increased by $55.00 if there was a freestanding emergency department in the community.[43] Similarly, United Health Group reported that $3.1 billion could be saved annually in Texas by shifting the lower acuity emergency care to physician offices and urgent care centers.[44]

With these critiques in mind, MedPAC has gone beyond its initial modifier recommendation (now proposed by CMS) and suggested Congress change payment rates in urban areas. MedPAC notes that OCEDs are paid the same as on-campus emergency departments under the hospital OPPS, with a 24/7 facility receiving higher rates.[45] MedPAC's data suggests that OCEDs have acuity comparable to emergency facilities that do not offer 24/7 care, and, therefore, in its June 2018 report, MedPAC proposed paying OCEDs within six miles of the nearest emergency department 30% less than an on-campus emergency department would be paid as a 24/7 facility. MedPAC also recommended an adjustment for rural OCEDs, allowing them to be more than 35 miles from their affiliated hospital, as well as paying such facilities up to $500,000.00 a year as a grant to cover the cost of maintaining a rural emergency department for an underserved community.

Prior to the 2018 recommendations and in light of OCEDs' growth, MedPAC also gave some potential avenues for policymakers to consider.[46] In its June 2017 report, MedPAC thought that policymakers could consider amending Section 603 of the Bipartisan Budget Act "so that services provided at physician's offices connected to standalone EDs do not receive higher hospital outpatient department payment rates" (i.e., limiting the emergency exception to only the OCED's emergency services and not other services located in the facility).[47] MedPAC believes this exemption inappropriately allows some hospitals to develop OCEDs and connect non-emergency offices to receive the higher OPPS rates, such as a connected imaging center. Of course, the broad statutory language was, in part, to avoid the concerns with parsing what services and their respective CPT codes are for emergencies when other services (e.g., imaging) support such emergency care.

Such recommendations are not without critics who believe maintaining and expanding emergency care is necessary. When patients need emergency care,

[39] *See Freestanding Emergency Departments: Do They Have a Role in California?*, Cal. Healthcare Found. (July 2009); MedPAC, June 2018 Report to Congress 43.

[40] MedPAC, June 2018 Report to Congress 39.

[41] Vivian Ho et al., *Comparing Utilization and Cost of Care in Freestanding Emergency Departments, Hospital Emergency Departments, and Urgent Care Centers*, 70 Annals of Emergency Med. 846 (Dec. 2017). Of course, this could simply reflect that coding needs to be updated to more clearly segregate emergency care from urgent care.

[42] *See, e.g.*, MedPAC, June 2017 Report to Congress 252 (reporting a difference for one service as $259.00 in 2016 compared with a $109.00 charge in a physician office for the same service).

[43] Nitish Patidar et al., *Freestanding Emergency Departments are Associated with Higher Medicare Costs: Panel Data Analysis*, 54 J. of Healthcare Org., Provision & Fin. 1 (Aug. 2017).

[44] *Freestanding Emergency Departments: Treating Common Conditions at Emergency Prices*, United Health Group (Dec. 2017), https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2017/Freestanding-ER-Cost-Analysis.pdf. Critics have also pointed to studies finding that such facilities focus on zip codes with better care mixes for higher reimbursement. Jeremiah D. Schuur et al., *Where do Freestanding Emergency Departments Choose to Locate? A National Inventory and Geographic Analysis in Three States*, Annals Emergency Med. (Apr. 2017).

[45] CMS distinguishes between Type A emergency departments that are open 24/7 and Type B facilities open less than 24 hours per day. Generally, Type B facilities receive 30% less than Type A facilities for the same services (although there are some anomalies with respect to Level 1 services in these two types of facilities). Data suggests the Type B facilities have lower acuity cases than Type A facilities. MedPAC believes OCEDs' acuity is comparable to Type B facilities.

[46] IFECs do not typically get paid hospital affiliated OPPS rates. Instead they receive the Medicare Physician Fee Schedule rate as if the service was in the office. However, if such IFECs convert to hospital-affiliated OCEDs, potentially through new partnerships, they would see the increased rates described above. Indeed, MedPAC has seen such partnerships in anecdotal review of the evidence according to their June 2018 report. MedPAC, June 2018 Report to Congress.

[47] MedPAC, June 2017 Report to Congress 2060.

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mere minutes can be the difference between life and death.[48] MedPAC's own reporting shows that the growth in freestanding emergency departments between 2013 and 2016 helped reverse a trend during the prior two decades where median emergency department wait times increased from 22 minutes to 33 minutes.[49] Scholars believe increased wait time was due to population growth and reduced primary care access, in addition to emergency department closures. Freestanding emergency departments, thus, may be serving an important role to reverse such a trend. Indeed, the American Hospital Association has pointed out flaws in MedPAC's analysis with respect to OCEDs, noting that no such data exists prior to CMS finalizing its new modifier proposal that supports MedPAC's conclusions. Nevertheless, nationally, hospitals' outpatient margins are negative.[50]

We anticipate these discussions will continue. If policymakers continue to seek site-neutral payment options to reduce the federal budget deficit, they may focus on appropriate site of service for a patient's acuity. Furthermore, as more IFECs convert to OCEDs, including those affiliated with micro-hospitals, limiting reimbursement growth may become a priority. Of course, such actions could reduce availability of needed care—a concern with other site neutrality changes. It could also limit patient choice, which policymakers often disfavor.

c. *Furthering Site Neutrality Goals*

Given Congress's (and other policymakers') intent to further site-neutrality, it is likely that additional rules and limitations will be implemented not only for off-campus PBDs, but other provider types as well. Multiple organizations, including the American Medical Association ("AMA"), the American Health Care Association, Brookings, Alliance for Site Neutral Payment Reform, and MedPAC, have consistently expressed support for site-neutral payments.[51] For example, MedPAC has long called for site-neutral payments, even before CMS released its 2017 OPPS Final Rule, noting that "[s]ite-neutral payments are an important theme in MedPAC's work" and that "[t]he Commission believes that, as a prudent purchaser, Medicare should not pay more for a given service just because it is provided in a more costly setting."[52] Similarly, the AMA has historically supported CMS's advances to further site-neutral payments.[53]

Notwithstanding the foregoing, various trade associations, such as the American Hospital Association ("AHA") have vehemently opposed site-neutrality payments. Since CMS first published the 2017 OPPS Final Rule, the AHA has spoken out about its strong opposition to CMS's site-neutrality proposals, indicating that it believes the proposals '"run afoul of the law and rely on the most cursory analyses and policy rationales'" and '"[t]aken together, . . . would have a chilling effect on beneficiary access to care and new technologies while also dramatically increasing regulatory burden."'[54] The AHA has

[48] *See, e.g.,* Michelle Andrews, *Medicare Advisors Recommend Payment Cuts to Many Freestanding ERs,* Health Inc. (Apr. 17, 2018) (reacting to the MedPAC proposals described herein with a patient story in suburban Denver whose physician stated she may have died had she not reached a freestanding emergency department).

[49] MedPAC June 2017 Report to Congress 248 (citing Horowitz L. I. and E. H. Bradley, *Percentage of U.S. Emergency Department Patients Seen Within the Recommended Triage Time*: 1997 – 2006, 169 Archives of Internal Med. 1857 (Nov. 9, 2009); CMS' Comparison Data).

[50] *See* letter from Ashley D. Thompson, American Hospital Association to Jim Mathews (Mar. 29, 2018).

[51] The Republican Study Committee also included site-neutrality proposals in their fiscal year 2019 budget proposal. *See A Framework for Unified Conservatism* 68, Republican Study Comm., *available at* https://rsc-walker.house.gov/sites/republicanstudycommittee.house.gov/files/wysiwyg_uploaded/RSC%20Budget%20FY2019%20-%20Narrative%20-%20FINAL.PDF.

[52] *See March report highlight: MedPAC recommends site neutral payment for IRFs and SNFs*, MedPAC (May 7, 2015), http://www.medpac.gov/-blog-/medpacblog/2015/05/07/march-report-highlight-medpac-recommends-site-neutral-payment-for-irfs-and-snfs.

[53] *See Dyrda*, *supra* note 4 (explaining that "the American Medical Association supports site-neutral payments as an initiative to align payment policies for hospitals and independent physicians").

[54] *See, e.g., AHA Commenting on OPPS/ASC Proposed Rule for CY 2019*, Am. Hospital Ass'n (Sept. 24, 2018) (quoting the AHA), https://www.aha.org/news/headline/2018-09-24-aha-comments-oppsasc-proposed-rule-cy-2019; A. Ellison, *CMS releases final OPPS rule for 2017: 11 Things To Know*, Becker's Hospital CFO Report (Nov. 2, 2016), https://www.beckershospitalreview.com/finance/cms-releases-final-opps-rule-for-2017-11-things-to-know.html (citing an AHA representative's opposition to the 2017 OPPS Final Rule).

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recently indicated that it is "deeply disappointed in certain proposals that CMS has chosen to set forth in [its] proposed rule for the CY 2019 . . . OPPS, which run afoul of the law and rely on the most cursory analyses and policy rationales."[55]

Currently, the support CMS is receiving from policymakers with regard to its site-neutrality payment changes seems to be more far-reaching than that of its opponents. Accordingly, health care attorneys and providers alike should monitor CMS's approach to site neutrality in the coming years with regard to different provider types, such as ambulatory surgery centers and post-acute care centers (i.e., skilled nursing facilities and inpatient rehabilitation facilities).

4. Conclusion

Throughout the past several years, CMS has consistently tightened the reins on reimbursement rates for off-campus PBDs, and it does not appear that CMS intends to loosen its grip in the coming years. One thing is clear: CMS appears committed to furthering site-neutrality payments and reducing government spending as it relates to hospitals. Accordingly, future policies and rules will likely address this commitment, leading not only hospitals, but physician groups and other providers to feel significant financial impact. Healthcare counsel should closely monitor, review, and examine current and future reimbursement trends so as to best advise clients on potential ramifications in this space.

[55] *AHA Comments on CMS Outpatient PPS /ASC Proposed Rule for CY 2019*, Am. Hospital Ass'n, *available at* https://www.aha.org/letter/2018-09-24-aha-comments-cms-outpatient-pps-asc-proposed-rule-cy-2019.