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Client Alert: The Final Outpatient Prospective Payment Rule

The Final Outpatient Prospective Payment Rule Reaffirms CMS' Commitment to Site Neutrality as it Drastically Cuts Outpatient Clinic Reimbursement for Excepted Off-Campus Provider-Based Hospital Departments

The Centers for Medicare & Medicaid Services dealt a blow to excepted off-campus provider-based hospital departments ("PBD") recently by reducing reimbursement for clinic visits provided in these settings, effectively reducing reimbursement for some PBDs by as much as 40%. In the 2019 Outpatient Prospective Payment System ("OPPS") final rule issued November 2 ("Final Rule"), CMS applied the concept of site-neutral payments to PBDs that had previously been excepted from site-neutral payments by making payment for the clinic visit service (HCPCS code G0463) equivalent to the Physician Fee Schedule payment (the Final Rule is available here). The Final Rule comes despite letters from the Senate and House of Representatives asking CMS to rethink its proposal and questions from the American Hospital Association about whether CMS could legally make such a change.

Under Section 603 of the Bipartisan Budget Act of 2015, as of January 1, 2017, PBDs that began furnishing and being paid for services on or after November 2, 2015, were no longer eligible to receive full payment under OPPS. Section 603 sought to introduce "site neutral" payments for outpatient hospital services, meaning that the same set of services would receive the same reimbursement whether provided at a hospital outpatient department or a standalone clinic. However, PBDs that were already billing and being paid by Medicare when the law passed on November 2, 2015 (along with a handful of other outpatient hospital settings), were exempt from the site neutral payment provisions. The most recent Final Rule chips away at the exemption for those PBDs by reducing reimbursement for the clinic visit service.

Under the Final Rule, PBDs will be paid for the clinic visit service at a rate equivalent to the PFS. The clinic visit service is the most common service billed under OPPS. The PFS rate is 40% less than reimbursement under OPPS for the same type of visit.

Clinic Visit Service at PBD		
	Approximate Medicare Payment	**Average Medicare beneficiary copayment**
Current Reimbursement Rate	$116	$23
Future Reimbursement Rate After Two-Year Phase In	$81	$16

In reaction to the Final Rule, the American Hospital Association ("AHA") issued a statement that along with Association of American Medical Colleges it would "promptly bring a court challenge" to the site-neutral payment

provisions. AHA previously questioned the legality of the rule when CMS first issued the proposal earlier this year. Similarly, in September, a bipartisan group of 48 senators sent a letter to CMS asking the agency to revise its approach and in October a bipartisan group of 138 representatives followed suit (the letter from the senators is available here and the letter from the representatives is available here). In the Final Rule, CMS states that it could not "adequately address the unnecessary increases in the volume of clinic visits" without applying the clinic visit service site neutral payment to excepted and nonexcepted PBDs and that the agency has the authority to do so. Given the nature of the payment cuts, this is likely to be a litigation-driven area for the foreseeable future.CMS plans to phase in the reduction for the clinic service visit across two years. In 2019, applicable PBDs will be paid 70% of the OPPS rate for the clinic visit service. In 2020 and beyond, applicable PBDs will be paid the site-specific PFS rate for the clinic visit service, i.e. 40% of the OPPS rate. CMS has estimated that this site neutral payment will save Medicare as much as $380 million in 2019 and lower out-of-pocket costs for beneficiaries.

CMS did, however, back away from constraints on expanding clinical services at excepted PBDs. CMS had proposed a policy that exempt PBDs would only be paid at OPPS rates for items and services in 19 proposed "clinical families of services" if the PBD had furnished and billed for the items and services prior to November 2, 2015. CMS has decided not to finalize this portion of the proposed rule but noted that it will continue to monitor the expansion of services in off-campus PBDs.

340B Cuts Continue

Also of note, as part of the Final Rule, CMS maintained a payment reduction for most covered outpatient drugs billed by 340B-participating hospitals implemented for 2018. For separately payable, nonpass-through drugs and biologicals acquired pursuant to Section 340B of the Public Health Service Act ("340B") and furnished by non-excepted off-campus PBDs paid under the FPS, CMS will pay Average Sale Price ("ASP) minus 22.5% (prior to 2018 payment had been ASP plus 6%). AHA is already suing the Department of Health and Human Services over the 340B cuts implemented as part of the 2018 rulemaking. AHA refiled its lawsuit in September after a federal judge dismissed its initial complaint.

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