APPELLATE COURT'S REVERSAL IN AHA V. AZAR POSES EXISTENTIAL THREAT TO MEDICARE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

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INTRODUCTION

On 17 July 2020, the U.S. Court of Appeals for the District of Columbia Circuit published its opinion in *American Hospital Association (AHA) v. Azar*,[1] in which it reversed the lower district court's ruling[2] and found that the U.S. Department of Health and Human Services (HHS) had properly exercised its authority in allowing the Centers for Medicare & Medicaid Services (CMS) to implement a service-specific, non-budget-neutral reimbursement cut under the Outpatient Prospective Payment System (OPPS). As a result, the practical effect of this outcome is that, CMS may be emboldened to devise increasingly aggressive interpretations of the provisions at issue here, which puts the delicate service and payment delivery systems under the OPPS in question.

BACKGROUND: CASE SUMMARY

Although the facts of this case are well-known, it is useful to recall the context that prompted its filing. Each year, CMS sets the rates at which Medicare will reimburse hospitals for providing outpatient services under the OPPS. The parameters of the system are set by statute;[3] one of the statutory requirements is that any changes to the OPPS must be "budget neutral," meaning that an increase or decrease in projected spending must be offset by other changes.[4]

While the payment rate for outpatient services is controlled by the OPPS, the quantity of services is not. Thus, an increase in the amount of services provided will cause an increase in overall Medicare expenditures. Congress addressed that possibility in subparagraph (2)(F) of the OPPS statute, which directs HHS to "develop a method for controlling unnecessary increases in the volume of covered [outpatient] services."[5]

As the quantity of outpatient services at hospital off-campus provider-based departments (PBDs) has increased in recent years, Congress addressed this issue by enacting section 603 of the Bipartisan Budget Act of 2015,[6] which reduced outpatient payment rates for all services furnished at off-campus PBDs coming into existence after the statute's enactment, but did not alter reimbursement rates for existing off-campus PBDs.

In the calendar year (CY) 2019 OPPS proposed rule, CMS proposed to exercise its subparagraph (2)(F) authority to "develop a method for controlling" the increase.[7] Specifically, CMS proposed to cut reimbursement rates for evaluation and management (E&M) services to all off-campus PBDs to the amount CMS pays to freestanding physician offices for providing the same service. Notably, CMS proposed to implement the E&M reimbursement cut in a non-budget-neutral manner—although the OPPS statute generally requires annual rate adjustments to be

budget-neutral, the agency indicated in the proposed rule that it did not believe that requirement applied to methods for controlling volume under subparagraph (2)(F).[8] CMS finalized the rule as proposed; AHA and litigants representing hospitals, individually, including K&L Gates LLP (K&L Gates) lawyers, filed suit shortly thereafter.

ANALYSIS

The appellate court noted that the central question at issue is whether CMS "may reduce the OPPS reimbursement for a specific service, and may implement that cut in a non-budget-neutral manner, as a method for controlling unnecessary increases in the volume of the service."[9] If the court were to find CMS has that authority, the logical end result is the potential for a dismantling of the key statutory component of the OPPS, which is that changes must be budget neutral. If CMS can select certain services for payment reductions merely based on the rationale of controlling volume increases, it is essentially no longer constrained by statute to do the careful recalibration of case rates, going forward, and can start pruning those services it disfavors with only a small showing sufficient to meet this much lower standard.The lower court understood this to be the key issue when it emphasized that "Congress provided great detail in directing how CMS should develop and adjust [OPPS] payment weights…This extraordinarily detailed scheme results in a relative payment system which ensures that payments for one service are rationally connected to the payments for another and satisfies specific policies considered by Congress. And so that this system retains its integrity, CMS is required to review annually the relative payment weights of [outpatient] services and their adjustments based on changes in cost data, medical practices and technology, and other relevant information."[10] When the OPPS was created by Congress, the main intent was to provide CMS with a system to better predict and manage program expenditures by assigning fixed payment amounts to groups of services similarly to the inpatient prospective payment system (based on Diagnosis-Related Groups).[11] The appellate court noted that process is extremely complex and requires CMS to complete a number of steps to ensure it meets the statutory requirements established by Congress.

Ultimately, the court concluded that CMS may reduce OPPS reimbursement for a specific service, and may implement that cut in a non-budget-neutral manner, because Congress did not "unambiguously forbid" the agency from doing so.[12] The court rested this conclusion on the rationale that the subparagraph (2)(F) provision "simply says nothing about budget-neutrality," and that "[t]he text Congress enacted thus lends considerable support to the agency's reading of the statute."[13] Furthermore, the court noted that the OPPS's budget neutrality requirement offers little protection that cost-control measures implemented by CMS will disproportionately affect only some service providers and beneficiaries, as warned by AHA.[14] The example the court provided was that whether CMS implements a reduction in reimbursements for cardiac catheterizations and then redistributes the savings across the OPPS, "that still hurts cardiologists much more than orthopedists even if cardiologists would get some money back in the form of slightly elevated reimbursements for other services they provide."[15]

The AHA has requested that the appellate court rehear the case, noting that the court "declined to strictly construe the statutory authority that binds the agency, [and] unaccountably deferr[ed] to impermissible agency decisions."[16] If that request is denied or a subsequent rehearing is unsuccessful, the AHA may appeal the decision to the Supreme Court. The question it faces will be how to make sure the Court accepts the appeal, and then to ensure its arguments frame the issue for the Court in a manner emphasizing that the appellate court's decision puts the delicate delivery system at risk. If the decision is allowed to stand, CMS will likely come up with increasingly aggressive interpretations of the provisions at issue here.

CONCLUSION

The appellate decision is a significant setback for the AHA and the hospitals it represents. If the decision is allowed to stand, it is likely to result in significant changes to how CMS establishes payment rates under the OPPS for other services given its broad ranging authorization to CMS in a manner that is arguably at odds with the fundamental methodology on which the OPPS is based.

We will continue to monitor developments in this case and provide updates as they occur. The firm's health care practice is available to provide guidance to providers and suppliers on these and other matters related to Medicare reimbursement. Contact the authors of this article or your K&L Gates lawyer for assistance with payment issues or to receive updates on Medicare reimbursement.

FOOTNOTES

[1] *Am*. Hosp. Ass'n v. Azar, No. 19-5352 (D.C. Cir. 17 July 2020).

[2] *Am*. Hosp. Ass'n v. Azar, 410 F. Supp. 3d 142 (D.D.C. 2019).

[3] 42 U.S.C. § 1395l(t)

[4] *Id*. § 1395l(t)(9)(B).

[5] *Id*. § 1395l(t)(2)(F).

[6] Pub. L. No.114-74, 129 Stat. 584, 597–98 (codified at 42 U.S.C. § 1395l(t)(21)).

[7] Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 83 Fed. Reg. 37,046, 37,142 (31 July 2018).

[8] *Id.* at 37,142–43.

9 No.19-5352 at 17.

[10] *Am. Hosp. Ass'n v. Azar*, 410 F. Supp. 3d 142, 157–58 (D.D.C. 2019), rev'd, No.19-5352, (D.C. Cir. 17 July 2020).

[11] Guidi, Teri, Medicare's Hospital Outpatient Prospective Payment System: OPPS 101 (part 1 of 2), J Oncol Pract. 2010; 321–24.

[12] No.19-5352 at 17.

[13] 72 Fed. Reg. at 66,611; No.19-5352 at 17–18.

[14] *Id.* at 20.

[15] *Id.*

[16] Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates, the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates, the Hospital Inpatient Prospective Payment System and FY 2008 Payment Rates; and Payments for Graduate Medical Education for Affiliated Teaching Hospitals in Certain Emergency Situations Medicare and Medicaid Programs: Hospital Conditions of Participation; Necessary Provider Designations of Critical Access Hospitals, 72 Fed. Reg. 66,580,

66,611 (27 November 2007).

[17] Michelle Stein, Hospitals Seek Rehearing Of Site-Neutral Lawsuit, Inside Health Policy (24 July 2020).

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