# CMS PROPOSES SUBSTANTIAL PAYMENT REDUCTIONS IN CY 2018 FOR OFF-CAMPUS HOSPITAL OUTPATIENT DEPARTMENTS SUBJECT TO THE SITE-NEUTRAL RULE

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On July 20 and 21, 2017, respectively, the Centers for Medicare & Medicaid Services ("CMS") released a proposed rule addressing changes to the hospital Outpatient Prospective Payment System ("OPPS Proposed Rule") and Medicare Physician Fee Schedule ("MPFS Proposed Rule") [1] for CY 2018. [2] Notwithstanding CMS' solicitation in the CY 2017 final rule of comments related to the site-neutral rule implementation in areas such as service lines expansion, volume expansion, and the potential shifting of services to excepted locations [3], CMS did not propose any changes or provide any substantive guidance as to its interpretation of the site-neutral rule in the OPPS Proposed Rule. In the MPFS Proposed Rule, CMS proposes substantial reductions in payments for items and services subject to the site-neutral rule in CY 2018.

As discussed in our earlier alert, beginning January 1, 2017, CMS implemented a new site-neutral payment mechanism for services furnished at certain off-campus hospital outpatient provider-based departments ("PBDs"), pursuant to Section 603 of the Bipartisan Budget Act of 2015 ("Section 603"). In its final rule discussing OPPS billing and reimbursement for CY 2017 ("2017 OPPS Final Rule"), CMS established a mechanism by which hospitals with PBDs subject to the site-neutral rule continued to submit claims for nonexcepted items and services on the institutional claim form as they had traditionally done. [4] However, the hospital was required to append a new "PN" modifier to line items for the nonexcepted items and services, which flagged that these items and services would be paid at an MPFS rate. [5] For CY 2017, CMS established that rate as 50 percent of the OPPS rate with certain exceptions. [6]

For CY 2018, CMS is proposing to reduce that rate to 25 percent of the OPPS rate.

## OVERVIEW OF SITE-NEUTRAL RULE

Generally, Section 603 imposes a "site-neutral" payment policy for new off-campus PBD locations established on or after November 2, 2015. Medicare has historically reimbursed services provided at off-campus PBDs at a higher rate as compared to freestanding facilities and practices as a result of the ability to bill for a facility fee reimbursed under the OPPS in addition to professional services reimbursed under the MPFS. Section 603 works to neutralize this additional reimbursement for new off-campus PBDs, excluding dedicated emergency

departments. Under Section 603, off-campus PBDs billing for services under OPPS furnished prior to November 2, 2015, have "excepted" status and are not subject to the site-neutral payment rule, unless they undergo an impermissible change of ownership or relocation. [7] Items and services furnished in PBDs established on or after November 2, 2015 or PBDs that have lost excepted status are considered "nonexcepted" and are subject to the site-neutral payment rule. Under the 2017 OPPS Final Rule, CMS instructed hospitals that they should bill on an institutional claim form and append a "PN" modifier to nonexcepted items and services. [8]

## FURTHER REDUCTIONS IN REIMBURSEMENT PROPOSED

In the MPFS Proposed Rule, CMS proposes a modified PFS Relativity Adjuster for CY 2018. Whereas the 50 percent rate in CY 2017 was intended to be a transitional policy until more precise data could identify and value such nonexcepted items and services furnished by nonexcepted PBDs, CMS continues to indicate it lacks the data to establish a more precise rate for nonexcepted items and services, but nevertheless proposes to reduce the PFS Relativity Adjuster to 25 percent for CY 2018. [

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] CMS reaches the 25 percent rate by comparing the OPPS payment rate for HCPCS code G0463, clinic visit, to the difference between the nonfacility and facility PFS payment amounts using CY 2017 rates for the weighted average of outpatient visits billed by physicians and other professionals in an outpatient hospital place of service. CMS indicates it selected this code as the basis for the comparison for CY 2018 as it is the most commonly billed service in the off-campus PBD setting, reflecting more than 50 percent of services billed. [10] Interestingly, CMS recounts its methodology for establishing the CY 2017 rate and notes that the weighted average of the estimated nonfacility PFS rate to the estimated OPPS rate for the next 22 major codes (after excluding 2 codes) was 45 percent. [11] CMS nevertheless indicates that the comparison of relative payments for outpatient visits is a better approach to equalizing payments than the methodology it used in CY 2017. CMS is soliciting comments both on its methodology, as well as the PFS Relativity Factor, such as whether taking a more middle-of-the road approach, such as setting it at 40 percent, would be appropriate. [12] While proposing a reduction in the payment rate, CMS is not proposing any changes to the method hospitals use to bill for nonexcepted items and services in CY 2018. CMS continues to instruct hospitals that they should bill on an institutional claim form and to append the "PN" modifier to nonexcepted items and services as similarly required for CY 2017. [13] CMS acknowledges that, at present, it has does not have sufficient data from the use of the "PN" modifier to better identify and value nonexcepted items and services, but anticipates having such data after the end of CY 2017. CMS notes its intention to use the data gained from the first full year of claims reported with the "PN" modifier for use in the PFS rate-setting for CY 2019, which may include further modifying the PFS Relatively Adjuster as well as setting additional adjustments to the methodology to move towards CMS' ultimate goal of site-neutral payment between nonexcepted PBDs and physician offices — while still allowing nonexcepted PBDs to bill in a straight-forward way. [14]

In addition to setting the payment rate for nonexcepted items and services, the MPFS Proposed Rule maintains the geographic adjustments for site-specific technical component rates will continue to apply to apply. [15]

Further, CMS is not proposing any changes to payment methods for partial hospitalization services, supervision rules, and beneficiary cost-sharing rules. [16]

## APPLICATION OF THE SITE-NEUTRAL RULE

In the OPPS Proposed Rule, CMS surprisingly did not provide any further substantive comment on key elements of its interpretation of the site-neutral rule. For example, CMS did not provide any additional commentary on application of the 2017 OPPS Final Rule as it relates to relocation of PBDs, changes of ownership, or the relationship between the site-neutral rule and child site eligibility under the 340B Drug Pricing Program.

CMS did, however, respond to a number of comments on the initially proposed, but never finalized, limitation on expansion of services furnished at excepted PBDs. As originally envisioned, CMS would have prohibited hospitals from receiving OPPS reimbursement for additional types of services provided even within existing excepted PBD locations. [17] CMS proposed to accomplish this by requiring hospitals to identify the CPT/HCPCS codes billed for a certain then-unspecified period of time prior to November 2, 2015, for each off-campus PBD and then mapping them to corresponding ambulatory payment classifications, which were then grouped into "clinical families." [18] Any items or services outside these clinical families subsequently provided at an excepted PBD location would have been subject to the site-neutral payment reduction, while only items and services within the same clinical families would continue to enjoy the benefits of excepted status. However, CMS ultimately declined to finalize its proposed limitation on service line expansions for excepted PBDs. While CMS is not proposing any limitations in the OPPS Proposed Rule, CMS addressed new comments on potential limitations on the volume or types of services offered by excepted PBDs.

A number of commenters urged CMS to consider imposing limitations on excepted PBDs. CMS affirmed its prior position that it has the statutory authority to take such action and indicated it would monitor claims data, particularly as to use of the "PO" and "PN" modifiers, and would consider potential limitations in the future. [19] CMS also recognized, however, that any such limitations would need to be implemented in a practical manner that is not unduly burdensome to providers and the government. [20]

## NEXT STEPS

While the final OPPS and MPFS rules are not typically published until the last quarter of the year, hospitals that are considering next year's budget and additional service locations or acquisitions will nevertheless need to assess the extent to which a reduction in reimbursement impacts their decision-making as to the structure of those locations and acquisitions. This includes the potential that reimbursement for nonexcepted services in CY 2018 could actually be less than in a freestanding setting, depending on the service mix if CMS ultimately adopts the proposed 25 percent PFS Relativity Adjuster.

CMS is seeking comments on its analysis resulting in the reduction to 25 percent of OPPS rates, whether a

 

different PFS Relativity Adjuster should be selected, and potential changes of the methodology to better account for specialty specific patterns. Given the ramifications of such a significant payment reduction, providers may wish to comment on one or both proposed rules, which comments are due no later than 5 p.m. on September 11, 2017.

**Notes:**

1. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 82 Fed. Reg. 33,558 (proposed July 20, 2017) [hereinafter "OPPS Proposed Rule"].

2. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program, 82 Fed. Reg. 33,950 (proposed July 21, 2017) [hereinafter "MPFS Proposed Rule"].

## 3. MEDICARE PROGRAM: HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT AND AMBULATORY SURGICAL CENTER PAYMENT SYSTEMS AND QUALITY REPORTING PROGRAMS; ORGAN PROCUREMENT ORGANIZATION REPORTING AND COMMUNICATION; TRANSPLANT OUTCOME MEASURES AND DOCUMENTATION REQUIREMENTS; ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAMS; PAYMENT TO NONEXCEPTED OFF-CAMPUS PROVIDER-BASED DEPARTMENT OF A HOSPITAL; HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM; ESTABLISHMENT OF PAYMENT RATES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE FOR NONEXCEPTED ITEMS AND SERVICES FURNISHED BY AN OFF-CAMPUS PROVIDER-BASED DEPARTMENT OF A HOSPITAL, 81 FED. REG. 79,562, 79,707 (NOV. 14, 2016) [HEREINAFTER "2017 OPPS FINAL RULE"].

## 4. *ID.* AT 79,721–22.

## 5. *ID.* AT 79,725.

## 6. *ID.*

## 7. *SEE* 42 C.F.R. § 419.48.

## 8. 2017 OPPS FINAL RULE, 81 FED. REG. AT 79,710.

 

**9. MPFS PROPOSED RULE, 82 FED. REG. AT 33,982–83.**

**10. *ID.***

**11. *ID.* AT 33,980.**

**12. *ID.* AT 33,983.**

**13. *ID.* AT 33,984.**

**14. *ID.* AT 33,985.**

**15. *ID.* AT 33,983.**

**16. *ID.* AT 33,984–85.**

**17. MEDICARE PROGRAM: HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT AND AMBULATORY SURGICAL CENTER PAYMENT SYSTEMS AND QUALITY REPORTING PROGRAMS; ORGAN PROCUREMENT ORGANIZATION REPORTING AND COMMUNICATION; TRANSPLANT OUTCOME MEASURES AND DOCUMENTATION REQUIREMENTS; ETC., 81 FED. REG. 45,604, 45,685–86 (PROPOSED JULY 14, 2016).**

**18. *ID.***

**19. OPPS PROPOSED RULE, 82 FED. REG. AT 33,647–48.**

**20. *ID.* AT 33,647.**

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