D.C. Appeals Court Upholds CMS's Authority to Limit Payment for E&M Services at Off-Site Provider-Based Locations

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D.C. Appeals Court Upholds CMS's Authority to Limit Payment for E&M Services at Off-Site Provider-Based Locations

The United States Court of Appeals for the District of Columbia recently upheld CMS's authority to expand site-neutral payment reductions for evaluation and management (E&M) services provided at longstanding off-campus provider-based locations. *Am. Hosp. Ass'n, et al. v. Azar*, July 17, 2020.

Background

In § 603 of the Bipartisan Budget Act (BBA) of 2015, Congress imposed payment limits on the amounts that most newly established, off-campus provider-based departments (PBDs) would be paid under Medicare's Hospital Outpatient Prospective Payment System (OPPS). CMS issued regulations implementing these provisions effective January 1, 2017, providing that services furnished in off-campus, non-excepted outpatient departments (that is, departments that are not dedicated emergency departments and that were not grandfathered by providing services prior to November 2, 2015) are to be reimbursed at a percentage of the OPPS rate, with certain exceptions. *See* 81 Fed. Reg. 79,562, 79,726 (Nov. 14, 2016).

Then, without any additional statutory authorization, CMS put into place an additional payment limitation effective January 1, 2019. 83 Fed. Reg. 58,818, 59,004-15 (Nov. 21, 2018). Relying on other authority contained in the OPPS statute, CMS began applying the lower physician fee schedule amounts to hospital-billed E&M services furnished in excepted off-campus PBDs, so that the payment for E&M services provided in excepted off-campus PBDs, non-excepted off-campus PBDs and physician offices would be the same.

CMS's new policy was quite significant given that E&M services represent roughly 50 percent of all separately payable or conditionally packaged services furnished in outpatient departments every year. CMS directed that the payment reduction be phased in over a two-year period, taking place in 2019 and 2020, thereby saving CMS an estimated $300 million in 2019 alone.

Not surprisingly, the plaintiff hospital organizations and related trade groups almost immediately challenged the final rule. The United States District Court for the District of Columbia ruled for the plaintiffs, finding that CMS acted without authority and remanded the case to CMS. *Am. Hosp. Ass'n, et al. v. Azar,* No. 18-2841 (Sept. 17, 2019) The Secretary of Health and Human Services (Secretary) appealed and, as discussed below, the United States Court of Appeals for the District of Columbia reversed.

Appellate Court Arguments and Ruling

The Secretary first argued that the court was without jurisdiction to hear the case based on the statutory preclusion of judicial review related to the agency's establishment of certain methods for implementing OPPS. The Secretary argued that his actions were within his authority and thus could not be challenged. The court disagreed, finding that the issue before it was indeed whether the Secretary acted within his statutory authority, which was subject to challenge.

The court then turned to the merits of the challenge, whether the agency may reduce the OPPS reimbursement for a specific service and may implement that cut in a non-budget manner, as a "method for controlling unnecessary increases in the volume of" the service, as authorized by 42 U.S.C. § 1395l(t)(2)(F). Applying the *Chevron* two-step analysis, the court first examined whether Congress had directly spoken to the issue. The court determined it did not, as the applicable statute did not unambiguously forbid the agency's action.

Moving to step two in the *Chevron* analysis, the court asked whether the agency's interpretation was based on a permissible, or reasonable, construction of the statute. The court found the agency's reduction in reimbursement for E&M services provided by the off-campus PBDs qualifies as a "method for controlling unnecessary increases in the volume of covered [outpatient] services." Accordingly, because the agency acted within its statutory authority, judicial review of that action is precluded by the statute.

The plaintiffs argued, in the alternative, that the agency's action violated section 603 of the Bipartisan Budget Act of 2015, because Congress's decision to leave the rates paid to preexisting off-campus PBDs unaddressed in section 603 means that the statute should be read to bar the agency from reducing those rates. The court opined that it did not believe it had jurisdiction to entertain this argument because it believed the agency's action fell within its statutory authority, as discussed above. The court, however, went on to reject the plaintiff's alternative argument on its merits, finding the lack of discussion in the statute of payment rates to preexisting off-campus PBDs does not exempt them from adjustment to reimbursement.

Conclusion

The plaintiffs may request a hearing en banc or review by the United States Supreme Court. If they do not make such a request or any such request is denied, the appeals court's decision becomes final. However, in the meantime, the Secretary's site neutral provision, which went into effect January 1, 2019, will continue. Some hospitals may have received repayments for 2019 from CMS after the district court decision in plaintiffs' favor. *See* MLNConnects CMS newsletter (12/12/19). Hospitals should expect CMS to reprocess and reclaim those paybacks.

For more information or any question regarding these issues, please contact Leslie Goldsmith or any member of Baker Donelson's Reimbursement team.