

# Client Alert

Healthcare Practice Group

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## Budget Proposal Would Limit Provider-Based Status

### *New Off-Campus Departments Limited to Physician Fee Schedule or ASC Payment Beginning January 1, 2017*

On October 26, 2015, Congressional and White House budget negotiators released the legislative text of the Bipartisan Budget Act of 2015. The Act is aimed primarily at lifting the Federal debt limit and avoiding a looming spike in Medicare Part B premiums. In addition, section 603 of the Act includes a significant change in the way CMS reimburses hospitals for outpatient services furnished in off-campus departments established on or after the enactment date of this proposed legislation.

The proposal, if enacted, would direct CMS, effective as of January 1, 2017, to use either the Physician Fee Schedule or the Ambulatory Surgery Center Payment System to pay for most services furnished in any off-campus hospital department established after the date the proposal becomes law. Off-campus provider-based departments that are in existence as of the date the proposal is signed into law would continue receiving reimbursement under the Medicare Hospital Outpatient Prospective Payment System (“OPPS”).

As of this writing, it is unclear if the Act will be passed by Congress and signed into law by the President—but both the White House and Congressional leaders have expressed support for the Act’s passage. This Client Alert summarizes the key provisions of the proposed Act, including the types of departments and services that would be affected, as well as steps CMS may take to implement this Act.

### What Types of Departments Are Affected?

The Act would amend section 1833(t) of the Social Security Act, which governs payments to hospital outpatient departments (“OPDs”). The Act would insert a new clause to section 1833(t)(1) to state that hospital outpatient services **would not** include “items and services . . . that are furnished on or after January 1, 2017, by an off-campus outpatient department of a provider”—which the Act defines pursuant to Section 413.65(a)(2) of the Medicare provider-based regulation.

This definition, therefore, is applicable to most off-campus OPDs that satisfy the requirements of the Medicare provider-based regulation at 42

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C.F.R. § 413.65, such as provider-based clinics, physician offices and surgical centers located within a 35-mile radius of the main hospital. The definition **would not** apply to other off-campus organizations that are required to satisfy the provider-based regulation such as remote locations of a hospital (*i.e.*, inpatient campuses of a multicampus hospital), satellite facilities, and provider-based entities such as rural health clinics. Payments to these organizations—even those established or acquired on or after January 1, 2017—would not be affected.

The Act also would not apply to **on-campus** OPDs. The Act defines a hospital's campus as: (i) the location comprised of the hospital's main buildings plus the area located within a 250-yard radius around the hospital's main buildings (*i.e.*, the same definition as in the provider-based regulation); and (ii) any remote location of a hospital facility and the area located within a 250-yard radius from such remote location (*i.e.*, each campus of a multicampus hospital, plus the surrounding 250-yard area). This definition represents a departure from CMS's position in the provider-based regulation that a multicampus hospital must designate one "main" campus from which all OPDs are measured, even those located on a remote campus location. Under the Act's definition, a multicampus hospital could continue to acquire or construct on-campus OPDs within 250 yards of any of the hospital's campuses and continue to be paid OPSS rates into 2017 and beyond.

## What OPDs Are Not Affected?

In addition to excluding on-campus OPDs, the Act includes a grandfathering provision that would shield existing off-campus OPDs from the payment changes. The Act states that the payment provisions shall not apply to any off-campus OPD "that was billing [as a hospital OPD for] covered OPD services furnished **prior to** the date of the enactment of this paragraph." This provision would direct CMS to continue paying OPSS rates to those off-campus OPDs that had been billing for hospital outpatient services as of the date the Act becomes law.

This grandfathering period does not align with the date that CMS will actually cease paying OPSS rates for new off-campus OPDs. Taking the two provisions together, CMS will cease paying OPSS rates on January 1, 2017 to any off-campus OPD that was not billing as an OPD on the date the Act becomes law, likely sometime in November 2015. Theoretically, a provider could begin operating and billing for OPSS services at a new off-campus OPD after the date of enactment—but only receive OPSS payment through December 31, 2016. These new off-campus OPDs would then receive payment pursuant to the Medicare Physician Fee Schedule or the ASC Payment System.

## What Services Are Affected?

The Act would cease paying OPSS rates at off-campus OPDs for all "applicable items and services ... other than emergency department services" identified by HCPCS codes 99281-99285, as amended from time to time. This provision of the Act is more sweeping in its applicability than prior proposals. For instance, MedPAC has consistently recommended that Congress and CMS equalize payments across practice settings for evaluation and management services only. The Act would exceed that recommendation by including procedure and surgical codes as well. Provider-based emergency departments would not be affected by these changes.

## How Will CMS Implement this Provision of the Act?

Congress proposes to give CMS wide discretion in imposing reporting requirements from hospitals to implement these payment changes. The Act states that CMS may require "reporting of information on a hospital claim code or modifier or reporting information about off-campus outpatient departments of a provider on the [CMS] enrollment form" such as the 855A. In practice, hospitals are already including these OPDs as practice locations on the 855A and, beginning January 1, 2016, will be required to include modifier "PO" on all hospital bills for services furnished in off-campus OPDs.

However, the statute only includes these reporting mechanisms as options for CMS to consider. CMS could determine that in order to maintain a definitive list of all off-campus OPDs, it will require the submission and approval of provider-based attestations. CMS has long maintained that submission of a provider-based attestation is optional. However, this provision of the Act may prompt the agency to reconsider that policy. Hospitals that have not previously submitted attestations for all off-campus OPDs could find this requirement burdensome. And both Medicare Administrative Contractors and CMS Regional Offices have been slow in approving previously-submitted attestations. Hospitals should remain vigilant for any change in CMS policy on this subject.

The King & Spalding Healthcare and Government Affairs and Public Policy teams will continue to monitor these developments as the Act weaves its way through Congress.

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