

Client Alert

Healthcare Practice Group

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CMS Proposes Changes to Provider-Based Status in CY 2017 OPSS Rule

Agency takes aggressive view of Section 603 of Bipartisan Budget Act of 2015, limits off-campus provider-based departments

On July 6, 2016, the Centers for Medicare & Medicaid Services (CMS) issued its CY 2017 Outpatient Prospective Payment System (OPSS) Proposed Rule. The Proposed Rule includes several provisions regarding how CMS will implement Section 603 of the Bipartisan Budget Act of 2015 (BBA15), which limited OPSS payments beginning January 1, 2017 to only those off-campus provider-based departments billing as hospital departments on or before November 1, 2015.

The Proposed Rule, if adopted, could significantly limit how hospitals operate off-campus provider-based departments (PBDs). For those off-campus PBDs that were being paid for services under the OPSS on or before November 1, 2015 (so-called “excepted” PBDs), CMS proposes to continue making OPSS payments only if the PBD remains in the same physical address and furnishes the same service lines as of November 1, 2015. A PBD that relocates to a new (presumably off-campus) address would lose its excepted status, and any new services lines offered at an excepted PBD – even at the same location – would be paid Medicare Physician Fee Schedule (MPFS) rates.

For PBDs that were not billing as hospital departments as of November 1, 2015 (so-called “non-excepted” PBDs), CMS proposes to not pay hospitals *at all* for their services during CY 2017. CMS claims that it does not have the systems capabilities to pay hospitals under the MPFS and instead proposes that physicians who furnish services in a non-excepted PBD bill for all services furnished therein on a CMS-1500 claim form using the nonfacility Place of Service (POS) code. CMS states that it will aim to have a mechanism in place by CY 2018 to pay hospitals directly. In the meantime, this proposal presumably leaves the hospital and the physician to decide how payment should be divided between the two.

These proposals present significant legal and operational challenges to both hospitals and physicians. We discuss these proposals and their implications below in this Client Alert. Comments on the Proposed Rule are due to CMS no later than September 6, 2016. The Final Rule will be issued no later than November 1, 2016.

For more information, contact:

Mark D. Polston

+1 202 626 5540

mpolston@kslaw.com

Christopher Kenny

+ 1 202 626 9253

ckenny@kslaw.com

Allison F. Kassir

+1 202 626 5600

akassir@kslaw.com

King & Spalding
Washington, D.C.

1700 Pennsylvania Avenue, NW

Washington, D.C. 20006-4707

Tel: +1 202 737 0500

Fax: +1 202 626 3737

www.kslaw.com

Background on the Bipartisan Budget Act of 2015

On November 2, 2015, the president signed BBA15 into law. Section 603 of BBA15 amended section 1833(t) of the Social Security Act governing payments for hospital outpatient services. The amended provision states that OPSS services would not include “items and services ... that are furnished by an off-campus outpatient department of a provider” as defined in the Medicare provider-based regulation. Rather, hospitals will be paid for these services pursuant to another “applicable payment system” such as the MPFS or Ambulatory Surgical Center (ASC) Payment System. These payment changes take effect January 1, 2017.

There are several limitations and exceptions to Section 603 that maintain OPSS payment for certain PBDs and other provider-based facilities. First, these changes do not apply to *on-campus* PBDs, as well as other off-campus facilities 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. In addition, any PBD located within 250 yards of a remote inpatient location also will continue to receive OPSS payment rates.

Second, Section 603 states that the payment changes will not apply to any off-campus PBD “that was billing [as a hospital PBD for] covered services furnished prior to the date of enactment” of BBA15 – November 2, 2015. These PBDs are commonly referred to as “grandfathered” PBDs or, as CMS calls them in the Proposed Rule, “excepted” PBDs. Any off-campus PBD not billing as a hospital department prior to November 2, 2015 would be non-excepted and subject to the payment changes beginning January 1, 2017.

Third, Section 603 also exempts all items and services furnished by a dedicated emergency department (as defined in the EMTALA regulations at 42 C.F.R. § 489.24(b)). These services also will continue to be paid as OPSS services.

Section 603 did not address how a non-excepted PBD could bill and be paid pursuant to the MPFS or ASC Payment System, and to what extent an excepted off-campus PBD could relocate or alter its service mix. CMS provides mostly unsatisfactory answers to these questions in the Proposed Rule.

Relocation of an Excepted Off-Campus PBD

CMS proposes that an excepted off-campus PBD that relocates to a new off-campus location would lose its excepted status and would no longer be paid OPSS rates for any services furnished at the new location. CMS believes that permitting relocations would enable hospitals to move into larger facilities, acquire additional freestanding physician practices, and move those practices into OPSS-reimbursed departments, which CMS believes Section 603 was intended to preclude. Therefore, it proposes to end excepted status for relocated off-campus PBDs.

CMS states that the excepted location will be “the physical address that was listed on the provider’s hospital enrollment form [CMS-855A] as of November 1, 2015.” CMS states that the physical address includes any “unit number” such as a suite or other designation within a multi-office building. This implies that any excepted PBD that lists a suite number when identifying its practice location on the CMS-855A cannot relocate to another suite number of the same office building without risking its excepted status.

CMS does not otherwise specify whether a hospital can expand its footprint within the physical address listed on the CMS-855A. For instance, the Proposed Rule does not expressly prohibit a hospital from adding a floor or a wing on to an excepted PBD so long as the entire PBD maintains the same physical address and the floors or wings are not specified by a suite or other unit in the address. CMS does state that a hospital “could not purchase and expand

into other units in [a multi-unit office] building, and remain excepted.” Presumably in this example, CMS is contemplating a PBD with a specific unit number listed on its CMS-855A that then begins operating in another unit number within the same office building. This scenario is different than a hospital simply adding floor space within an existing physical address identified as the practice location on the hospital’s CMS-855A.

Addition of New Services within an Excepted Off-Campus PBD

The Proposed Rule attempts to distinguish between excepted off-campus PBDs – that is, physical off-campus departments – and what CMS calls “excepted items and services” furnished by such PBDs. In other words, CMS views Section 603 as excepting only those PBDs that were actually billing under the OPSS prior to November 2, 2015 and only for those service lines that the PBD actually billed prior to November 2, 2015. Table 21 of the Proposed Rule establishes 18 “clinical families of services” such as advanced imaging, medical oncology, and diagnostic tests that are defined by APC group number. CMS proposes that if an excepted off-campus PBD was not billing for any service within a particular clinical family prior to November 2, 2015, then CMS will not make OPSS payment for any services within that clinical family furnished by the off-campus PBD beginning January 1, 2017. Instead, these services will receive MPFS payment only.

CMS’s logic on this point rests on shaky ground. As a threshold matter, BBA15 makes no such distinction. Section 603 simply states that any off-campus PBD billing under the OPSS “with respect to covered [outpatient] services” prior to November 2, 2015 shall be excepted from the payment changes. A straightforward reading of the statute requires that an off-campus PBD that billed any covered outpatient hospital service may continue to bill for any covered outpatient hospital service. CMS does not cite any specific provision of Section 603 that supports its interpretation and even acknowledges that there is no legislative history from which it can determine Congress’s intent.

CMS instead bases its proposal generally on the fact that Section 603 refers to the Medicare provider-based regulation as a whole, which the agency believes defines a PBD as both the physical facility as well as “the personnel and equipment needed to deliver the services at that facility.” This argument is a non-sequitur. While the regulation requires that personnel and equipment needed to deliver services at a PBD must be integrated with those of the main hospital, CMS has never prohibited or otherwise regulated specific services those personnel and equipment may furnish. Indeed, in Federal Register preamble language from 2002, CMS explicitly “emphasize[d] that the provider-based rules do not apply to specific services; rather, these rules apply to facilities as a whole. That is, the facility in its entirety must be a subordinate and integrated part of the main provider.” 67 Fed. Reg. 49982, 50088 (Aug. 1, 2002). CMS’s longstanding practice, therefore, has been that so long as the entire PBD satisfies the integration requirements set forth in the regulation, all OPSS-covered services furnished within that PBD will be paid as hospital outpatient services. CMS does not attempt to reconcile its prior policy and longstanding practice with its statements in the Proposed Rule.

The Proposed Rule does acknowledge, however, that Section 603 requires that all services – whether emergent or not – furnished by a dedicated emergency department must continue to be paid OPSS rates. And, CMS states that it does not propose to limit the *volume* of services an excepted off-campus PBD furnishes so long as the *type* of services were billed by the off-campus PBD prior to November 2, 2015.

Billing at Non-Excepted Off-Campus PBDs

Even though Congress directs CMS to make payment to non-excepted PBDs pursuant to an “applicable payment system” – either the MPFS or ASC Payment System – CMS states in the Proposed Rule that it does not have the systems capabilities to “allow an off-campus PBD to bill and be paid as another provider or supplier type.”

Therefore, CMS is proposing that all services furnished in a non-excepted PBD be billed solely by the treating physician at the nonfacility MPFS rate using POS code 11 on the CMS-1500 claim form. CMS states that this proposal is a “temporary, 1-year solution” that CMS will employ while it reengineers its claims processing systems to permit a hospital to bill and be paid according to MPFS rates in CY 2018.

This temporary solution presents several challenges. First, Section 603 is clear that hospitals shall still receive payment for services furnished at non-excepted PBDs, even if that payment amount is equal to the MPFS payment rate. CMS’s proposal prevents hospitals from receiving payment for services furnished in such departments. Those hospitals that employ treating physicians and own the Tax Identification Number to which CMS makes payment for physician services will receive payment through reassignment, but those hospitals that rely on medical staffs that are responsible for their own professional billing will now be forced to seek payment from these physicians for the overhead expenses the hospital incurs. This payment mechanism may raise concerns under the federal Stark Law and/or Anti-Kickback Statute if physicians receive payment at the nonfacility rate but do not remit payment to the hospital for use of hospital facilities, equipment and staff.

Second, this mechanism assumes that all off-campus PBDs function like physician practices. In reality, many hospitals operate different PBDs such as surgical centers that, if freestanding, would be paid pursuant to the ASC Payment System. Only entities enrolled as ASCs may bill for ASC services. A physician who uses his/her NPI cannot bill for and be paid for ASC services. In that case, the hospital has no NPI or other billing number it can use to be paid for the facility expense of surgical services. CMS states that hospitals can choose to re-enroll such facilities as freestanding ASCs. However, the enrollment process is lengthy and any surgical center that attempted to enroll as an ASC almost certainly would not receive an ASC billing number before January 1, 2017.

CMS is soliciting comments on potential mechanisms for hospitals to bill for services furnished in a non-excepted PBD. One possible solution is to repurpose the claims modifier “PO” that hospitals are already using at off-campus PBDs as a systems edit that triggers a reduced technical component payment to the hospital while physicians continue to bill for their professional services using a facility POS code. The two combined payments would equal the nonfacility MPFS rate.

Conclusion

CMS repeatedly seeks comments from stakeholders on its proposals. Hospitals should consider how these proposals may affect their operations and physician relationships when deciding whether to submit comments. The deadline to submit comments is 5:00 p.m. EDT on September 6, 2016. The King & Spalding Healthcare and Government Affairs and Public Policy teams will continue to monitor these regulatory developments as hospitals prepare for January 1, 2017.

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