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Big Changes and Uncertainty Looming for Off-Campus Provider-Based Departments

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On November 1, 2016, the Centers for Medicare & Medicaid Services (CMS) released the Hospital Outpatient Prospective Payment System (HOPPS) - Final Rule with Comment and Final CY2017 Payment Rates ("Final Rule").

As part of the Final Rule, the agency implemented Section 603 of the Bipartisan Budget Act of 2015 (BBA), which establishes new limitations on "provider-based" reimbursement for certain off-campus provider-based departments (PBDs) under the HOPPS.

These changes could have a significant impact on the way that off-campus PBDs are reimbursed and may even be a factor in hospital decisions about changes in location and ownership for PBDs.

In this article, we provide a brief background on Medicare PBDs and the policy debate surrounding these facilities, a summary of BBA Section 603 and CMS's Final Rule implementing its requirements and the probable implications for providers.

Background

Under the Medicare program, a hospital's facilities and locations can be considered part of the hospital when they are designated as "provider-based." This designation may be given to a facility or organization that is on the main campus of a hospital or that is off-campus.

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CMS established criteria to determine whether a facility, including a hospital department, is provider-based. A facility that meets these criteria is considered to be functioning as a single entity with the hospital, or the "main provider."

Provider-based facilities are reimbursed under the HOPPS and bill for their outpatient services in the same manner that other hospital-based outpatient services are billed and reimbursed.

Generally, the total Medicare payment for a service provided in a provider-based facility is higher than when a beneficiary receives the same service at another site, such as a physician's office.

This difference in reimbursement also usually results in higher beneficiary cost-sharing liability under Medicare Part B.

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Over the years, there has been a marked increase in hospitals acquiring physician practices and converting them into PBDs. Much attention has been given to the impact of this phenomenon on taxpayers and Medicare beneficiaries.

The Medicare Payment Advisory Commission (MedPAC), the Government Accountability Office (GAO) and the Department of Health and Human Services Office of Inspector General (OIG) all have examined this issue.

Also, since January 1, 2016, CMS has required hospitals to append the claims modifier "PO" to identify ser-

vices furnished in off-campus PBDs in order to help the agency collect data on the types and costs of services typically furnished in off-campus PBDs.

Furthermore, both MedPAC and the Obama Administration have crafted legislative proposals that would equalize Medicare payments between hospital PBDs and other sites of service, such as ambulatory surgical centers (ASCs) and physician offices. These ''site neutrality'' policies have been estimated to reduce both Medicare spending and beneficiary cost-sharing liability.

Section 603 of the Bipartisan Budget Act of 2015

Section 603 of the BBA states that, as of January 1, 2017, Medicare payment for items and services furnished in most off-campus PBDs must be made under a payment system other than the HOPPS. (The defined term in the law is ''off-campus outpatient department of a provider''; in this article, we use the more familiar term ''outpatient provider-based department'' or ''off-campus PBD,'' which CMS also uses from time to time.)

It defines an off-campus PBD as a ''department of a provider . . . that is not located (I) on the campus . . . of such provider; or (II) [within 250 yards of] a remote location of a hospital facility.'' (*See* 42 C.F.R. § 413.65(a)(2) A ''remote location of a hospital'' is a ''facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider'' and that meets certain other criteria.)

There are a number of exceptions to the application of Section 603.

There are a number of exceptions to the application of Section 603. First, an off-campus PBD ''shall not include a department of a provider . . . that was billing under [the HOPPS for] covered [outpatient] services furnished prior to the date of the enactment,'' November 2, 2015.

Therefore, the items and services furnished in such an off-campus PBD (also called ''excepted items and services'') would continue to be payable under the HOPPS. These grandfathered off-campus PBDs also are referred to as ''excepted off-campus PBDs.''

Second, it defines ''applicable items and services'' (meaning that they cannot be reimbursed under the HOPPS) as items and services other than items and services furnished by a dedicated emergency department.

A ''dedicated emergency department'' is ''any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public . . . as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) [In the previous calendar year], it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.'' (42 C.F.R. § 489.24(b))

Finally, an off-campus PBD does not include a PBD that is located on the campus of the provider or within 250 yards of the provider's remote location.

Section 16001 of the 21st Century Cures Act

Section 16001 of the recently-enacted 21st Century Cures Act, Pub. L. 114-255, provides for additional exceptions to section 603 of the BBA. First, this law allows additional off-campus PBDs to meet the exception for off-campus departments that billed under the HOPPS before November 2, 2015. These off-campus PBDs also qualify for the exception even if they were not billing under the HOPPS before November 2, 2015 as long as they submitted a provider-based attestation before December 2, 2015. These off-campus PBDs will be deemed to have met the requirements of this exception and therefore may bill under the HOPPS in 2017.

Second, section 16001 provides for an additional exception for off-campus PBDs that were ''mid-build'' before the BBA was enacted on November 2, 2015. In order to qualify for this exception, the following requirements must be met:

(1) A provider-based attestation is submitted not later than 60 days after the date of enactment of the 21st Century Cures Act. The agency has since released subregulatory guidance stating that the attestation must be submitted by February 13, 2017.

(2) The off-campus PBD is included as part of the provider on its Medicare enrollment form; and

3) The off-campus PBD meets the definition of ''mid-build'' and the provider's Chief Executive Officer or Chief Operating Officer submits a certification that the off-campus PBD meets the definition of mid-build prior to 60 days after the date of enactment of the 21st Century Cures Act. In the subregulatory guidance, CMS stated that the certification must be submitted by February 13, 2017. For an off-campus PBD to meet the definition of ''mid-build,'' the provider must have had a binding written agreement with an outside, unrelated party for the actual construction of the off-campus PBD before November 2, 2015.

Off-campus PBDs that meet these requirements will receive the full HOPPS payment rate beginning on January 1, 2018.

CMS Final Rule Implementing Section 603 of the Bipartisan Budget Act of 2015

In the Final Rule, CMS generally defines ''applicable items and services'' for purposes of determining which items and services are payable under the HOPPS and which must be paid for under another ''applicable payment system,'' defines ''off-campus PBD,'' and establishes policies for payment for nonexcepted items and services furnished by an off-campus PBD.

Of note are the restrictions that the agency places on the future ability of excepted off-campus PBDs to change their physical location or ownership and the

   ISSN 1049-7986

payment methodology for nonexcepted items and services.

Restrictions on Excepted Off-Campus PBDs

Although excepted off-campus PBDs will be able to continue billing and receiving reimbursement under the HOPPS after January 1, 2017, CMS has finalized a number of restrictions on a provider's ability to change an excepted off-campus PBD's physical footprint or ownership.

CMS established these requirements to prevent hospitals from circumventing the intent of Section 603 by purchasing physician practices, converting them into PBDs and billing under the HOPPS after January 1, 2017.

Failure to comply with these requirements will result in the loss of the excepted off-campus PBD's ability to continue billing and receiving reimbursement under the HOPPS.

- Restrictions on moving, expanding or relocating an excepted off-campus PBD

Under the Final Rule, if an off-campus PBD moves or relocates from the physical address that was listed on the provider's hospital enrollment form as of November 1, 2015, then it no longer would be an excepted off-campus PBD, and no items or services furnished there would be payable under the HOPPS going forward.

CMS did create a limited relocation policy under which an off-campus PBD would not lose its excepted status if it relocated (either temporarily or permanently) because of ''extraordinary circumstances outside of the hospital's control, such as natural disasters, significant seismic building code requirements, or significant public health and public safety issues.''

These exceptions will be determined by the CMS regional offices on a case-by-case basis, and CMS will issue subregulatory guidance on this process.

An excepted off-campus PBD also cannot expand into other units in its building or move to a larger suite in the same building and remain excepted.

Therefore, as long as the excepted off-campus PBD does not move, expand its physical footprint or relocate, and otherwise continues to meet the definition of an excepted off-campus PBD, it will be able to receive reimbursement under the HOPPS.

At the point it moves, expands its physical footprint or relocates, it no longer can bill under the HOPPS for any items or services.

- Expansion of items and services provided at an excepted off-campus PBD

CMS is not finalizing its proposal that an off-campus PBD would be limited to seeking payment under the HOPPS for only the types of items and services it furnished before November 2, 2015. (It had proposed that if an off-campus PBD furnishes items or services outside of the ''clinical families of services'' it was furnishing before enactment of Section 603, the new types of items or services would not be payable under the HOPPS.) Because CMS did not finalize this proposal, excepted off-campus PBDs will be able to expand the items and services they provide. Although the agency is not finalizing its original proposal at this time, it indicated that it would continue to monitor the issue of service expansion and could revisit the issue in future rulemaking.

- Limitations on changes in ownership of excepted off-campus PBDs

CMS finalized its proposal that ''excepted'' status for an off-campus PBD would be transferred to a new owner only if ownership of the main provider also is transferred and the Medicare provider agreement is accepted by the new owner. If the provider agreement is terminated, or if the off-campus PBD alone is transferred to a new owner, the items and services furnished at the off-campus PBD would cease to be excepted from the definition of ''applicable items and services'' and no longer would be payable under the HOPPS.

Payment for Nonexcepted Items and Services as of January 1, 2017

According to Section 603, nonexcepted items and services must be paid for under an ''applicable payment system'' other than the HOPPS, but Congress did not define that term.

CMS originally proposed a one-year solution for CY 2017 while the agency explored options for future years. Under this one-year solution, effective January 1, 2017, the applicable payment system would be the Medicare Physician Fee Schedule (PFS).

For items and services for which payment can be made to a physician or nonphysician practitioner (NPP) under the PFS, the physician or NPP furnishing such services in the off-campus PBD would bill under the PFS at the nonfacility rate.

However, under this proposal, the hospital would not be able to bill directly or receive reimbursement under the PFS, so there would be no accompanying Medicare facility payment to the hospital unless the item or service could be billed under a different payment system.

In response to the numerous stakeholder comments raising concerns about this proposal, CMS did not finalize this proposal and instead issued an Interim Final Rule with Comment Period (IFC) on November 1, 2016, that specified a new payment methodology for CY 2017.

Under the new payment methodology, CMS established a distinct set of payment rates in the PFS that specifically apply to nonexcepted off-campus PBDs.

Under the new payment methodology, CMS established a distinct set of payment rates in the PFS that specifically apply to nonexcepted off-campus PBDs.

This new payment methodology is based on HOPPS payment rates and reflects the relative resource costs of furnishing the technical component of a broad range of services to be paid under the PFS specific to the off-campus PBD.

Also, in order to ensure overall relativity between items and services provided at nonexcepted off-campus PBDs and other sites of services paid under the PFS, these new HOPPS-based PFS payment rates will be ''scaled down'' by a relativity adjustment of 50 percent.

Nonexcepted off-campus PBDs also will be required to report modifier ''PN'' on each claim to indicate a nonexcepted item or service.

CMS anticipates continuing to use the same payment methodology for CY 2018 ''in order to allow for the operational changes necessary to design and implement a long-term payment approach for nonexcepted off-campus PBDs under the [PFS].'' (This may change if there is significant push-back from stakeholders in comments on the IFC.)

For CY 2019 and beyond, although CMS intends to adopt an approach with PFS-based rates instead of HOPPS-based rates, the agency did raise the possibility of continuing to use a methodology similar to what will be in place for CY 2017.

Implications for Providers

Section 603 of the BBA and CMS's implementing regulations do not restrict the creation of new off campus-PBDs or curtail CMS's authority to designate facilities as provider-based.

Nor do the law and regulations prohibit existing off-campus PBDs from adding new services or changing the types of services offered in those departments. However, these new requirements add additional considerations for hospitals with off-campus PBDs.

Restrictions on Excepted Off-Campus PBDs

Significant changes in reimbursement because of relocation, expansion or changes in ownership likely will pose challenges to hospitals with excepted PBDs.

Hospitals have argued that it will be difficult to meet the growing and changing demands of the communities they serve if an excepted off-campus PBD is constrained to its current location and footprint.

Reimbursement Changes

Nonexcepted off-campus PBDs face new reimbursement challenges. Reimbursement rates for items and services furnished in nonexcepted off-campus PBDs are based on reduced HOPPS payment rates and may be considerably lower than what the rates would have been had Congress not passed BBA Section 603.

However, HOPPS rates that are reduced 50 percent across the board still may exceed the corresponding physician office rates.

In the IFC, CMS notes that on a procedure-by-procedure basis, the new rates may be more than physician office rates in some instances and less in others.

In the end, hospitals will have to take into consideration the items and services provided under these new payment rates.

Uncertainty in the Early Years

In addition to preparing for new payment rates starting in January 1, 2017, excepted off-campus PBDs face the possibility of further reimbursement changes in the next couple of years.

Changes may be made in CY 2018, and then CMS may shift to a whole new payment methodology in CY 2019. This adds an additional layer of uncertainty for excepted off-campus PBDs.

All that is certain is both Congress and CMS are keeping a watchful eye on the proliferation of off-campus PBDs—and their relatively higher reimbursement rates—and that the rate of growth for new off-campus PBDs likely will not match that of the past.

MCR ISSN 1049-7986