PUBLICATION

Proposed Provider-Based Changes Pose Significant Problems for Hospitals [Ober|Kaler]

2016

As we reported in a *Payment Matters* article last November 12, 2015, Section 603 of the Bipartisan Budget Act of 2015 changes the payment rules applicable to off-campus, provider-based locations that are new as of November 2, 2015.

More specifically, Section 603 specifies that off-campus sites that had not furnished services and submitted to Medicare "provider-based" billings as of November 1, 2015, will be considered "new" and, effective January 1, 2017, will no longer be able to bill Medicare under the Outpatient Prospective Payment System (OPPS). Congress specified that, effective January 1, 2017, these sites, instead, will be paid by Medicare for services as though they were free-standing locations. Section 603, standing alone, has created significant concerns for hospitals nationwide, some of which have created new provider-based sites since November 1, 2015, and others of which have plans to do so. There was some hope, however, that CMS, as part of its annual OPPS payment update, might provide some flexibility for hospitals in complying with the new requirements. Those hopes now appear to have been dashed.

On July 6, 2016, CMS posted its proposed OPPS rules containing CMS's plans on how it will implement Section 603. Those proposals reflect a very expansive view of Section 603's application and, if implemented, will create operational difficulties for thousands of hospitals in the very near term. More specifically, the proposals include the following:

1. **Relocation of Off-Campus Provider-Based Departments**
   CMS states that off-campus departments and the items and services that they furnish will be considered "new" if that department "moves or relocates from the physical address that was listed on the provider's hospital enrollment form as of November 1 2015." This statement is unqualified, and CMS goes so far as to propose that, if located in a building with multiple units, an "excepted" hospital department – that is, one that was in existence prior to November 2, 2015 – could not purchase and expand into other units of its building and remain excepted. Stated another way, any movement of the site, for any reason, means that the location will lose its ability to bill as provider-based as of January 1, 2017.

   CMS is soliciting comments on whether there should be a clearly defined, limited relocation exception similar to the disaster/extraordinary circumstances exception process that hospitals may use in the Hospital Value Based Purchasing Program. Even under such an exception process, however, the typical reasons for a hospital's relocating an off-campus department – reasons such as the loss of a lease, move to a more desirable location, outgrowing existing space, and the like – will likely not suffice as an acceptable excuse.

2. **Expansion of Services Furnished at Off-Campus, Provider-Based Departments**
   CMS also proposes that existing off-campus, provider-based departments will be considered excepted from the new payment limitations only to the extent that they furnish items or services that

they were furnishing and billing for under OPPS prior to November 2, 2015. CMS will measure this by determining whether the items or services currently being furnished are in the same clinical family of services as previously furnished. If the off-campus, provider-based location furnishes services from a clinical family of services that it did not furnish and bill for prior to November 2, 2015, CMS may not pay for the new services as OPPS services and instead will make payments in accordance with the new payment limitations.

CMS proposes to define the service types by some nineteen clinical families of hospital outpatient services, which it describes in a table that we provide as **Attachment A**. CMS has proposed no specific time frame prior to November 2, 2015, during which the "excepted" service lines would have to have been furnished and billed for under OPPS. CMS solicits public comments on whether such a specific time frame for billing should be adopted.

3. **Change of Ownership of Provider-Based Departments**
Responding to inquiries regarding what would happen if a hospital department were purchased by a new owner, CMS states that an off-campus, provider-based department would be transferred to new ownership but remain excepted only if the ownership of the main provider were also transferred and the Medicare provider agreement were accepted by the new owner.

4. **Payment for Services Furnished in Off-Campus Departments**
Perhaps the biggest complication reflected in the proposed rule has to do with how hospitals will be paid for services furnished in new off-campus departments, particularly in the coming year. As noted, Section 603 provides that such departments are to be paid as though they were free-standing. That is easily stated, but satisfying that mandate is proving difficult for CMS.

CMS states that currently it has no mechanism for an off-campus, provider-based department (PBD) to bill and receive payment for furnishing "nonexcepted" items or services under an applicable payment system that is not OPPS, and that the agency can find "no straightforward way to do that before January 1, 2017." Thus, CMS proposes to pay for nonexcepted items and services furnished in calendar year 2017 under the Medicare Payment Fee Schedule (MPFS), with that payment going to the physicians or practitioners who furnish the services. As stated by CMS: "Specifically, we are proposing that, because we currently do not have a mechanism to pay the off-campus PBD for nonexcepted items and services, the physician or practitioner would bill and be paid for items or services in the off-campus PBD under the MPFS at the non-facility rate instead of the facility rate.

Under CMS's proposal, the MPFS payments would cover physician services, diagnostic tests, preventative services, and radiation treatment services. Hospitals, however, could continue to bill for services that are not paid under OPPS, such as certain laboratory services. Additionally, each off-campus, provider-based department would have the option of enrolling as a free-standing facility or supplier, such as an ambulatory surgery center or physician group practice, in order to bill on its own. If the entity were to do that, it would then be able to bill and be paid for services under the payment system for the type of Medicare entity for which the location has newly enrolled.

Finally, CMS specifically requests comments regarding the application of the reassignment rules, the Medicare anti-markup prohibition, the physician self-referral rules, and the federal anti-kickback statute to the arrangements between hospitals and physicians and non-physician practitioners that will be entered into under its proposal. CMS is also requesting proposals on how provider-based

departments, which would still be considered part of the hospital, would be able to bill in calendar year 2018 and after for nonexcepted items and services.

Ober|Kaler's Comments

Section 603 has created substantial problems for hospitals across the country, and those problems have now been compounded by CMS's proposed rule. By greatly limiting – indeed, almost forbidding – existing provider-based locations from relocating no matter what the reason, CMS is turning a blind eye to the practical realities of hospitals' operations. Space needs are fluid, and the ability to satisfy those needs depends on a multitude of factors, some of which are beyond a hospital's control. Similarly, the new limitation on expansion of services seems to ignore the fact that many services are complementary to another and that providing a new service that complements an existing service is desirable from both the hospital's and the patient's standpoint. Beyond this, the new payment rules will require hospitals to track all services furnished, and then differentiate between "old" and "new" services, thereby creating significant operational headaches.

An even greater headache, and one that is more immediate, is posed by the proposed payment change for 2017. If Medicare is going to reimburse only the physicians and other practitioners for the services furnished in "new" hospital-owned and operated off-campus locations, the hospitals and the physicians who practice in the off-campus locations will need to determine the fair market value of those services and enter into appropriate contractual relationships. This could amount to thousands of agreements, and all of this will have to be done prior to those services being furnished.

Hospitals have until September 6, 2016, to comment on this proposed rule. Hospitals would be well advised to do so or, at a minimum, work with their state and federal associations in furnishing comments. Hospitals are also advised to reach out to their elected representatives to seek a legislative fix.

ATTACHMENT A
CMS-1656-P

TABLE 21.-PROPOSED CLINICAL FAMILIES OF SERVICES FOR PURPOSES OF SECTION 603 IMPLEMENTATION

Clinical Families	APCs
Advanced Imaging	5523-25, 5571-73, 5593-4
Airway Endoscopy	5151-55
Blood Product Exchange	5241-44
Cardiac/Pulmonary Rehabilitation	5771, 5791
Clinical Oncology	5691-94

Diagnostic tests	5721-24, 5731-35, 5741-43
Ear, Nose, Throat (ENT)	5161-66
General Surgery	5051-55, 5061, 5071-73, 5091-94, 5361-62
Gastrointestinal (GI)	5301-03, 5311-13, 5331, 5341
Gynecology	5411-16
Minor Imaging	5521-22, 5591-2
Musculoskeletal Surgery	5111-16, 5101-02
Nervous System Procedures	5431-32, 5441-43, 5461-64, 5471
Ophthalmology	5481, 5491-95, 5501-04
Pathology	5671-74
Radiation Oncology	5611-13, 5621-27, 5661
Urology	5371-77
Vascular/Endovascular/Cardiovascular	5181-83, 5191-94, 5211-13, 5221-24,5231-32
Visits and Related Services	5012, 5021-25, 5031-35, 5041, 5045,5821-22, 5841