PUBLICATION

CMS Proposes Major "Site-Neutral" Changes to Payments for Off-Campus Locations

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CMS recently published its proposed Medicare outpatient prospective payment system (OPPS) rule for calendar year (CY) 2019. The rule contains a number of "site-neutral" proposals that, if adopted, will result in lower hospital payments for many services furnished in off-campus departments and currently reimbursed under full OPPS rates. These include "clinic visits" and certain new or "expanded" services that excepted off-campus locations had not furnished prior to the enactment of the Bipartisan Budget Act of 2015 (BBA 2015). Additionally, as discussed in an accompanying article, the rule contains a proposal to pay significantly less for 340B-acquired drugs and biologicals furnished in non-excepted, off-campus hospital departments. Comments to the rule must be filed by September 24, 2018.

The impact of these changes could be quite large. According to CMS estimates, the clinic visit policy change alone could reduce Medicare OPPS payments to hospitals by 1.2 percent, with that impact being greater for some hospitals, and other proposed changes will certainly result in further reductions. Hospitals, therefore, should give the proposed rule their close attention.

Background

Hospitals have long tried to expand their footprints by developing, or in many instances acquiring, physician practices and other medical operations to furnish "hospital" services beyond the immediate vicinity of the hospital's campus. The hospitals have seen many advantages in doing this, including expanding the hospital's name recognition with existing and potential patients, providing "hospital-level" services across a wider geographic area, cementing relationships with a broader network of physicians, and of course, obtaining "hospital-level" reimbursement.

These expansion efforts have come under increased criticism. Over the years, MedPAC, beneficiary groups, and the OIG have all observed that Medicare generally pays significantly more for services furnished in a provider-based setting than in a freestanding setting. Additionally, because the provider-based setting typically results in beneficiary liability for two co-payments, the total beneficiary liability for provider-based services is usually higher than for corresponding services furnished in a freestanding setting. Moreover, critics have asserted that these higher cost "hospital" services often provide patients with little additional benefit when compared to comparable services furnished in free-standing settings. As a result, since 1999, the OIG has recommended elimination of provider-based status so that Medicare payments become "site-neutral." Similarly, MedPAC, in 2012, recommended that CMS payments for E&M services furnished in hospital outpatient departments be reduced from the OPPS level to the Medicare physician fee schedule rate.

Both CMS and Congress have acted on these recommendations. In 2015, CMS added HCPCS modifier "PO" for hospital claims related to off-campus provider-based services and, in 2016, began tracking place of services by requiring different codes for off-campus versus on-campus hospital outpatient services. Then, in a development that caught many by surprise, Congress enacted § 603 of the BBA 2015 that changed the payment rules applicable to "new" off-campus, provider-based locations. Section 603 specified that off-campus sites that had not furnished services and submitted "provider-based" billings to Medicare prior to November 2, 2015, would be considered "new" and, effective January 1, 2017, would no longer be paid by

Medicare at OPPS rates. Rather, those locations would be paid under the "applicable payment system" associated with a corresponding free-standing operation. Congress, however, excluded from this payment reduction items and services furnished by dedicated emergency departments as defined in 42 C.F.R. § 489.24(b) and provided an exception for off-campus locations that were billing Medicare under the OPPS system prior to November 2, 2015, that is, that were "grandfathered."

The provisions of § 603 required implementing regulations, and in the summer of 2016 CMS published its proposed rules implementing that section. Among the proposals was one to expand § 603 payment reduction to include not just "new" off-campus locations, but also "new" services furnished in grandfathered or excepted locations. More specifically, CMS proposed that if an excepted off-campus, provider-based location furnished services that it had not furnished and billed for prior to November 2, 2015, and if those services were not from the same clinical family of services that it had furnished and billed for prior to November 2, 2015, CMS would not pay for the new services at OPPS rates, but instead would make payments in accordance with the new payment limitations. CMS then proposed to define service types by referring to 19 clinical families of hospital outpatient services. Ultimately, CMS did not adopt this "new" service proposal. Thus, under the CY 2017 rule and continuing in 2018, excepted off-campus, provider-based departments have been paid OPPS rates for all billed items and services furnished in the excepted locations, regardless of whether those services were furnished in those locations prior to the enactment of § 603. (For background, see our earlier article, "CMS Final Rule and 21st Century Cures Act Include Good and Bad News for Provider-Based Sites.")

CMS'S CY 2019 Proposals

As part of its CY 2019 proposed OPPS rule, CMS has offered for comment substantial changes that, while perhaps benefiting beneficiaries and Medicare program expenditures, will likely have a severe adverse impact on hospital outpatient departments' budgets and operations. Among those proposals are the following.

1. Hospital-based Clinic Services Reimbursed Under OPPS

For much of the past decade, the Medicare program expenditures for OPPS have continued to increase at a rate of roughly eight percent per year, making OPPS the fastest growing Medicare payment system of all payment systems under Medicare Parts A and B. In its CY 2019 proposed rule, CMS opined that this rate of growth suggests that payment incentives, rather than patient acuity or medical necessity, may be affecting the choice of site-of-service. In support, CMS cited to past MedPAC reports in which MedPAC observed that much of the growth and spending on services furnished in hospital outpatient departments has appeared to result from an unnecessary shift of services from lower cost physician office settings to higher cost hospital outpatient departments. MedPAC also observed that one-third of the growth in outpatient volume from 2014 to 2015 was due to an increase in the number of E&M visits billed as hospital outpatient services, and from 2012 to 2015, hospital-based E&M visits per beneficiary grew by 22 percent. Supported by these MedPAC statistics, CMS stated in the proposed rule its belief that (1) the increase in the volume of hospital clinic visits has been due to the payment incentives to provide services in a higher cost setting; (2) the services generally could be safely provided in a lower cost setting; and (3) the growth, therefore, has been unnecessary.

To address this "unnecessary" growth, CMS has proposed to use its authority under § 1833t(2)(F) of the Social Security Act (42 U.S.C. § 1395(t)(2)(F)) to lower payments for clinic visits furnished in excepted off-campus hospital departments. As proposed, this reduction will result in payments to the excepted off-campus locations of an amount equal to the payment rate for items and services furnished by non-excepted, off-campus, provider-based departments. In other words, hospital clinic visits for the assessment and management of patients, if furnished in an off-campus, outpatient department, will be paid at the adjusted physician fee schedule amount regardless of whether that department is a "new" location under § 603 of BBA 2015 or an "excepted" location. Further, CMS's proposal may not end there. The agency is seeking comments on how it might apply its authority to limit "unnecessary" volume increases to additional items or services.

2. Payment Limits on Expansion of Services Furnished in Excepted Locations

As noted above, in the 2016 proposed regulation implementing § 603 of BBA 2015, CMS put forward the idea that services furnished in excepted outpatient departments would be reimbursed under the OPPS rates only if they were in the same clinical family of services that the particular location had provided and billed for prior to November 2, 2015. Most commenters were strongly opposed to this suggestion, raising both legal and practical concerns relating to its implementation. Hearing these concerns, CMS backed away from its proposal in the CY 2017 final rule but signaled that it might later revisit the issue. CMS has now done so.

In the CY 2019 proposed rule, CMS has stated that it does not believe that Congress intended § 603 to allow for new service lines in excepted locations to be paid under OPPS rates. Acting on this belief, CMS has proposed that if an excepted ("grandfathered"), off-campus, provider-based department furnishes new or expanded services that it had not furnished in the 12-month period prior to BBA 2015's enactment (Nov. 1, 2014 – Nov. 1, 2015), and if the new/expanded service is not from one of 19 clinical families of services that the location had furnished in that prior 12-month time period, the "new" items and services would not be excepted and thus would not be paid under OPPS, but instead would be paid under an adjusted rate available under the physician fee schedule. This is essentially the same proposal that CMS floated but then abandoned in 2016. And, just as in 2016, this proposal, if adopted, could raise many issues for off-campus locations.

3. Collecting Data Related to Services Furnished by Off-Campus, Provider-Based Emergency Departments

In recent years there has been significant growth in the number of off-campus facilities that are devoted to furnishing emergency department services. This growth has raised questions among regulators and others regarding whether hospitals may be moving services to the higher acuity/higher cost emergency department settings largely to obtain the higher payment rates for those services and to take advantage of the exemption under § 603 of BBA 2015 for services provided in dedicated emergency departments. MedPAC has recommended that CMS learn more about this and direct hospitals to append a modifier to all claims for all services furnished in off-campus, provider-based emergency departments so that CMS can track the growth of OPPS services provided in that setting. In the proposed rule, CMS has agreed and has proposed to require, effective January 1, 2019, that hospitals add a new HCPCS modifier "ER" on the UB-04 form for hospital outpatient services furnished in off-campus emergency departments. Critical Access Hospitals will not be required to do this.

CMS's actions could lead to lower OPPS payment rates for ED services in the coming years. Prior to the enactment of § 603 of the BBA 2015, CMS required that hospitals identify, through the use of a modifier, hospital outpatient services furnished in the provider-based, off-campus departments. Then in the BBA 2015, Congress reduced reimbursement for a number of those off-campus services. One might anticipate, therefore, that CMS may use the information that it collects from the use of this new modifier to seek future statutory or regulatory limitations on hospitals' receipt of full OPPS payment amounts for services provided in provider-based, off-campus emergency departments.

4. Reductions in Payments to Non-Excepted Departments for 340B-Acquired Drugs and Biologicals

CMS also proposed to extend its "ASP minus 22.5 percent" payment policy for 340B-acquired drugs and biologicals, currently applicable to excepted off-campus locations, so that it applies to non-excepted, off-campus locations as well.

Implications for Providers

In the proposed OPPS rule, CMS has put forward changes that, if adopted, will have a significant impact on hospital outpatient payments and the development of off-campus, provider-based departments.

- First, the proposal would substantially cut payment amounts for clinic services furnished in the hospital outpatient department setting if that setting is off the hospital's main campus. This change alone could reduce hospitals' OPPS payment by 1.2 percent or more.
- Second, the rule has reintroduced the proposal that certain off-campus departments might be providing both excepted ("grandfathered") and non-excepted ("new") services at a grandfathered location, and that only the grandfathered services will receive OPPS rates. This proposal, if adopted in the final regulation, could, at a minimum, create reimbursement and billing headaches for hospitals.
- Third, CMS has proposed to track services provided in hospital off-campus emergency departments, suggesting that services in those areas, too, might become subject to future payment cutbacks.
- Finally, CMS has proposed to extend its controversial payment limit for 340B-acquired drugs and biologicals so that the limit applies not just to excepted, off-campus locations but to non-excepted locations as well.

All of this should concern hospitals greatly, and they should work with their counsel and associations to craft meaningful responses.