The End of Off-Campus Provider-Based? Congress and CMS Weigh In

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Changes to Provider-Based Status

- Sec. 603 of BBA15 - enacted November 2, 2015
- Medicare payment for most items and services at **new**, **off-campus** hospital outpatient departments will be paid under the "applicable payment system" -- Medicare Physician Fee Schedule or ASC Payment System
  - Payment changes effective **January 1, 2017**
- Does not affect remote locations (inpatient campuses), provider-based entities (RHCs/FQHCs) and PPS-exempt satellites
- Off-campus provider-based departments billing as such prior to date of enactment are "grandfathered" – will continue to be paid OPPS

Changes to Provider-Based Status

- Many unanswered questions:
  - What makes an off-campus department "new"?
  - How do Congress/CMS define off-campus?
  - What services, if any, are exempt from the changes?
  - Even after the changes, can a new off-campus department still be considered "provider-based"?
  - What changes can an "excepted" off-campus department make – relocations, changes in service mix?
  - How (if at all) will CMS change its billing, cost reporting, and/or enrollment procedures?

EXCEPTED LOCATIONS

Excepted Locations

- "Grandfathered" off-campus PBDs that were billing Medicare under the OPPS prior to November 2, 2015
- Remote locations of hospitals (inpatient campuses)
  – PBDs within 250 yards of a remote location
- Provider-based entities (e.g., RHCs)
- PPS-exempt satellite facilities

Excepted Locations

- What constitutes "on-campus"?

- CMS does not change its existing regulatory definition:
  - Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

- PBDs within 250 yards of remote inpatient location are still "off-campus"

Excepted Locations

- Can an excepted PBD relocate?
  - No. CMS proposes that all PBDs listed on a hospital's CMS-855A as of November 1, 2015 are its excepted locations (including "unit" number)
- If an excepted PBD moves to a new address, the entire PBD loses grandfathered status
- Potentially limited exception for acts of God
  - Circumstances beyond provider's control?
  - "Substantially similar" test?
  - Footprint growth within the same address?

Excepted Locations

- Information collection on locations
  - CMS proposes to use the CMS-855A as of November 1, 2015
  - Also seeking feedback on a separate online form that would list all locations, date of operations, and clinical family of services as of 11/1/2015
  - *Provider-based attestations remain voluntary*

EXCEPTED SERVICES

Excepted Services

- All services – whether emergent or not – furnished by a dedicated ED are excepted and will receive OPPS payment

- Statute defines ED based on EMTALA regulation – 42 C.F.R. § 489.24(b). ED is:
  - Licensed by state as an emergency department;
  - Held out to the public as providing unscheduled emergency services; or
  - During prior calendar year, at least one-third of ED's services were for emergency medical conditions

- Would still be subject to EMTALA requirements

Excepted Services

- "Clinical families of services" furnished by an excepted PBD as of November 1, 2015
- Table 21 of Proposed Rule groups APCs into "clinical families"
- Only those services lines that a PBD furnished prior to 11/2/15 will continue to be excepted and paid OPPS rates beginning 1/1/17
  - Notable that department will still receive OPPS payments for excepted services

Excepted Services

- Policy rooted in the statute?
  - BBA15 exception states that "off-campus outpatient department of a provider shall not include a department of a provider (as so defined) that was billing under this subsection with respect to covered OPD services furnished prior to the date of enactment of this paragraph"
- Emphasis is not on excepting *services*, but only on excepting *departments*
- If billing any "covered OPD services" the department is excepted

Excepted Services

- CMS says that statute refers to provider-based regulation as it was in effect November 2015

- CMS claims that regulation defines a PBD not only as a facility but also "the personnel and equipment needed to deliver services at that facility"

Excepted Services

- No provision of provider-based regulation specifically governs service mix

- So long as "equipment and personnel" are integrated with main hospital, then all services they deliver are OPD services

- CMS policy since 2002 (67 FR 50088):

> "[W]e emphasize 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."

Excepted Services

- Current regulation does not consider changes in service mix as material to provider-based status
- PBDs with approved attestations must send CMS notice of a "material change" in order to retain attestation benefits
- What constitutes a "material change"?

> "A main provider … may report to CMS any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that would affect the provider-based status of the facility or organization."

PAYMENT FOR SERVICES

Payment for Services

- How will a non-excepted PBD receive payment?
- CMS states that it cannot pay institutional providers under any "applicable payment system" other than the OPPS
- Therefore, proposes a "temporary, one-year" solution:
  - **No hospital payment for CY 2017. All non-excepted items and services paid under the Medicare Physician Fee Schedule to the treating physician**
  - Physician bills at the (higher) nonfacility rate
  - Presumably some remittance from physician to hospital
  - CMS states it will have billing process for CY 2018

Payment for Services

- Poses significant payment, operational and legal challenges
- No "technical component only" reimbursement for hospitals unless PBD re-enrolls as another provider/supplier type
  - Outpatient surgical center to ASC
  - PHP clinic to community mental health center
    - Long delays in survey/enrollment may result in no payment at all
- Renegotiate/draft new agreements with volunteer physicians?
- 340B Drug Pricing Program concerns