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CMS Aims To Curb Hospital Access To Provider-Based Billing


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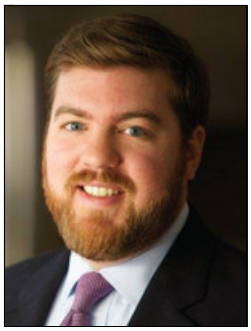
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Law360, New York (July 8, 2016, 11:29 AM ET) -- Since the passage of Section 603 of the Bipartisan Budget Act of 2015 (BBA) in November, hospitals have been waiting for the Centers for Medicare and Medicaid Services to issue guidance on how the agency plans to enforce the BBA's site-neutral payment policies related to provider-based departments. On July 6, 2016, CMS released its prepublication version of the fiscal year 2017 outpatient prospective payment system (OPPS) proposed rule, which includes long-awaited guidance on many questions surrounding the enforcement of Section 603.

Background

For years, the Medicare Payment Advisory Commission and the Office of Inspector General have expressed concerns regarding the disparity between Medicare payments for services provided in physician offices and payments for similar services provided in hospital outpatient departments (HOPDs). Generally, services rendered in physician offices are paid under the Medicare physician fee schedule (MFPS), while services provided in a HOPD are paid under the OPPS (the facility fee) and the MFPS (the professional fee). The combined payment for services provided in a HOPD is generally greater than the MPFS payment for the same service provided in a physician office setting. Similarly, if a beneficiary receives a surgical service in an ambulatory surgical center (ASC), the Medicare payment is always less than if the beneficiary receives that same service in a HOPD.

On Nov. 2, 2015, Congress passed the BBA, which included new site-neutral payment policies in Section 603 to prohibit newly created off-campus HOPDs from being paid under the OPPS. Instead, new off-campus HOPDs would be paid under other payment systems (such as the MPFS or ASC fee schedule). Section 603 excepted on-campus HOPDs, freestanding emergency departments, and off-campus HOPDs (as long as the location was billing as of Nov. 2, 2015) from the new payment policy.

CMS' Proposals

In the proposed rule, CMS sets forth its interpretation of Section 603 and its plans for how the agency will operationalize the site-neutral payment policy, including certain exceptions. Overall, CMS' interpretation of the law is narrow and based on the agency's belief that Section 603 was "intended to curb the practice of hospital acquisition of physician practices that then result in receiving additional Medicare payment for similar services." CMS stated,

for example, that it interprets Section 603 to apply to off-campus HOPDs "as they existed at the time of enactment and only excepts those items and services that were being furnished and billed by off-campus PBDs prior to Nov. 2, 2015." For this reason, CMS proposed to interpret the law to prohibit grandfathering of relocations of HOPDs or the expansion of services offered by a grandfathered off-campus HOPD beyond the services offered at the time of Section 603's enactment.

- **Emergency Departments:** CMS proposes to exempt all services furnished by a dedicated emergency department (ED) (whether or not they are emergency services) from the application of Section 603.

- **On-Campus HOPDs:** CMS proposes to exempt services provided at an on-campus HOPD from the application of Section 603, based on the existing definition of "on campus" under the provider-based rules (250 yards).

- **Remote Location HOPDs:** CMS proposes to exempt services provided at off-campus HOPDs that are within 250 yards (straight-line distance) from any point of a remote location of a hospital.

- **Relocation:** CMS proposes that grandfathered off-campus HOPDs (those billing prior to Nov. 2, 2015) "would no longer be excepted if the excepted [HOPD] moves or relocates from the physical address that was listed on the provider's hospital enrollment form as of Nov. 1, 2015." CMS is soliciting comments on whether it should develop a limited relocation exception process for disasters or other extraordinary circumstances.

- **Expansion of Services:** CMS states that a grandfathered off-campus HOPD (those billing prior to Nov. 2, 2015) may only be reimbursed under OPPS for the provision of items and services it was furnishing prior to the date of enactment of Section 603. Items and services that are not part of a clinical family of services furnished and billed by the grandfathered off-campus HOPDs prior to Nov. 2, 2015, would be subject to payment outside of OPPS. CMS states that it expects hospitals to maintain documentation showing what lines of service were provided at each off-campus HOPD prior to Nov. 2, 2015, and that such documentation must be available to CMS and its contractors upon request.

- **Change of Ownership:** CMS proposes to allow the excepted status for an off-campus HOPD to be transferred to new ownership only if ownership of the main provider is also transferred and the Medicare provider agreement is accepted by the new owner.

- **New Payment Methodologies:** CMS proposes that the Medicare physician fee schedule will be the "applicable payment system" for the majority of nonexcepted items and services furnished in an off-campus HOPD for calendar year 2017. CMS stated that due to the complexity of the OPPS and MPFS payment systems, it does not believe there is a way to allow off-campus HOPDs to transfer to billing under the MPFS by CY 2017. Therefore, physicians performing services in off-campus HOPDs would be paid based on the professional claim and at the nonfacility rate. CMS noted that if an off-campus HOPD meets all requirements, it may enroll as a different provider or supplier type (such as an ASC or group practice), and become eligible to bill under the applicable payment system. CMS is soliciting comments regarding the establishment of a separate payment policy specific to off-campus HOPDs for CY 2018.

Impact on Hospitals and Next Steps

CMS' proposals are intended to curtail hospitals' ability to utilize provider-based billing to the greatest extent possible. This is made clear by CMS' proposed policy for the relocation of "grandfathered" off-campus HOPDs, or those off-campus HOPDs that were billing Medicare prior to Nov. 2, 2015. Unless CMS creates an exceptions process, any relocation of a "grandfathered" off-campus HOPD in the future (e.g., when a lease ends, a building becomes obsolete, or any other reason) would result in the hospital forfeiting its ability to bill that location as a provider-based department.

Instead, the relocated HOPD would be reimbursed at lower rates under the MFPS or ASC fee schedule. Hospitals should continue to refrain from relocating "grandfathered" off-campus provider-based departments until CMS publishes the final rule. In the meantime, hospitals should consider submitting public comments to CMS requesting that CMS consider an exceptions process, under which CMS would permit hospitals to relocate "grandfathered" off-campus HOPD under special circumstances without the threat of losing the HOPD's provider-based status.

Another example of CMS' effort to curb hospitals' access to provider-based reimbursement for off-campus services is found in CMS' proposal that hospitals will not be permitted to receive provider-based reimbursement for expanded service offerings at each "grandfathered" off-campus HOPD outside of the family of services offered at the HOPD as of Nov. 2, 2015. CMS suggests in the proposed rule that hospitals will likely be required to maintain documentation to support the scope of services provided at each off-campus HOPD as of Nov. 2, 2015. Hospitals should start developing a procedure now for collecting and documenting this information.

If they have not done so already, hospitals with off-campus HOPDs that opened after Nov. 2, 2015, should take steps to determine how these locations will be structured from a Medicare reimbursement standpoint after Jan. 1, 2017. Hospitals may be required to enroll these locations as physician group practices or ASCs to receive continued reimbursement from Medicare, so hospitals should prepare for the financial impact of some services moving to different reimbursement systems.

A recent legislative proposal, H.R. 5273, the Helping Hospitals Improve Patient Care Act of 2016 (HHIPCA), could provide some relief for hospitals that had HOPDs under development at the time the BBA was enacted. The House of Representatives passed the bill on June 7, and there has been no further action since that time. Currently the bill is with the Senate Finance Committee and it is unclear whether the committee will recommend the bill's passage in the Senate.

Even if HHIPCA gives relief to hospitals that had HOPDs under development when the BBA was enacted, many more hospitals will be affected by CMS' proposed interpretation of Section 603. The proposals CMS set forth in the 2017 OPPS proposed rule could change by the time the final rule is published later this year based on feedback from hospitals and other stakeholders.

Importantly, CMS is struggling to create a process for determining what items and services HOPDs were offering as of Nov. 2, 2015. CMS has signaled that it may require hospitals to self-report all individual grandfathered off-campus HOPDs, the date that each location began billing, and the clinical families of services that were provided at the location prior to the Nov. 2, 2015, date of the BBA's enactment. CMS is actively seeking public comment on this and other provisions of the proposed rule, which are due by Sept, 6, 2016.

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