

NEW LAW EXCLUDES NEW PROVIDER-BASED OFF-CAMPUS OUTPATIENT HOSPITAL LOCATIONS FROM OPPTS

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Health Care Alert

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On November 2, 2015, President Barack Obama signed into law a bill that significantly changes how Medicare pays for outpatient services furnished at certain hospital locations. The Bipartisan Budget Act of 2015 ("BBA")^[1] reflects a two-year budget agreement that resulted from weeks of negotiations between congressional leaders and the Administration. The primary provisions of the bill include a suspension of the federal debt limit through March 15, 2017, and an increase of \$80 billion in the spending caps imposed by budget sequestration over fiscal years 2016 and 2017.

Most notably for hospitals, BBA also imposes a "site-neutral" payment policy for new off-campus provider-based hospital outpatient locations established on or after November 2, 2015. The provision represents the latest effort by policymakers (including the Centers for Medicare and Medicaid Services ("CMS")^[2] and the Medicare Payment Advisory Commission ("MedPAC"),^[3] as well as Congress^[4]) to move toward eliminating differential payments for services based on the location where the service is delivered. Moreover, the proposal removes one incentive for hospitals to acquire physician practices and ambulatory surgical centers ("ASCs"). As a result, the provision could have a significant impact on the health care community going forward.

NEW SITE-NEUTRAL PAYMENT PROVISION

Prior to the BBA, Medicare generally paid more for outpatient services furnished in a hospital provider-based department, regardless of where it was located, than in a freestanding physician practice or ASC. The differential was a result of the hospital's ability to bill for a facility fee reimbursed under the Outpatient Prospective Payment System ("OPPS"). While both the Physician Fee Schedule ("PFS") and Ambulatory Surgical Center Payment System ("APC") include a facility component, the combined fees payable for physician professional services (with a place of service reduction for a hospital-based location) plus the OPPTS facility fee were generally greater in total than the PFS or APC payment with the facility fee component. As a result, physician practices and ASCs acquired by a hospital and converted to provider-based locations were reimbursed at a higher overall rate.

Section 603 dramatically changes this reimbursement regime by excluding new off-campus hospital provider-based outpatient departments established on or after November 2, 2015 (the date of enactment), from the OPPTS starting on January 1, 2017. Instead, these facilities will be reimbursed under the applicable non-hospital payment system — either the PFS or APC. ^[5] Off-campus hospital provider-based outpatient departments that were billing under the OPPTS prior to November 2, 2015, are excluded from this reimbursement change.

For purposes of the change, Section 603 of the BBA defines the term "off-campus outpatient department of a provider" through incorporating by reference current regulations from CMS.^[6] Under these regulations, provider-based off-campus hospital outpatient departments are generally those that are located more than 250 yards from the main buildings of a hospital or a remote location of a hospital. Hospital outpatient departments within 250 yards of the hospital's main buildings or a remote location of a hospital (i.e., on campus) would continue to be reimbursed under the OPSS. In addition, the change does not apply to dedicated emergency departments, even if off-campus.^[7]

Also unaffected by Section 603 are provider-based entities, such as rural health clinics, that are not within the scope of Section 603, which applies only to provider-based hospital departments, and are not otherwise reimbursed under the OPSS regardless.

To implement Section 603, BBA requires hospitals to report information, as determined by the Secretary of Health and Human Services ("HHS"), to identify the locations subject to the new reimbursement restriction. Although the statute does not require a specific mechanism for reporting such information, Section 603 suggests that the Secretary may require hospitals to use a code or modifier on hospital claims or provide information on Medicare enrollment applications.

Given the importance of the grandfathering provision, it is also noteworthy that BBA specifically provides that there shall be no administrative or judicial review for determinations made under the provision relating to applicable items or services, applicable payment systems, whether a location is subject to the change, or information a hospital is required to report.

WHAT PROVIDERS NEED TO DO

Providers should review the provisions closely with counsel and assess the impact Section 603 could potentially have on any plans, be they new locations or transactions.

Providers should also be on the alert for guidance from CMS interpreting and implementing Section 603 as it relates to key topics, such as the ability to create new off-campus provider-based locations even if not reimbursable under the OPSS, the ability to include such locations on a hospital's Medicare cost report (a key requirement for child site eligibility under the 340B Drug Pricing Program), the scope of the grandfathering provision, the impact of hospital changes of ownership and other transactions that involve the acquisition of existing provider-based hospital locations (e.g., associated with another tax identification number or Medicare provider number/CMS Certification Number) on that grandfathering. Given the potential impact of Section 603 on the 340B Program, providers should also be on the lookout for any additional guidance from the Health Resources and Services Administration ("HRSA") as to changes in its child site definition as a result of the BBA — a definition HRSA is already considering as a part of its "Omnibus Guidance" issued on August 28, 2015. [See K&L Gates Alert.](#)

Notes:

[1] Bipartisan Budget Act of 2015, Pub. L. No. 114-74.

[2] See Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule, 78 Fed. Reg. 43,282 (July 19, 2013).

Here, CMS offered a proposal, not ultimately adopted, to limit the payment for a physician office service to the payment for the same service when provided in a hospital outpatient department or ambulatory surgical center.

[3] See MedPAC, Report to the Congress: Medicare and the Health Care Delivery System 27-56 (2013) (discussing Medicare payment differences across ambulatory settings).

[4] For example, the Protecting Access to Medicare Act of 2014 ("PAMA") expanded the categories of information the federal government can use to determine costs under the PFS and provided an incentive to CMS to take action on potentially misvalued codes. PAMA, Pub. L. No. 113-93, § 220, 128 Stat. 1040, 1070 (2014).

[5] BBA § 603.

[6] *Id.* In particular, Section 603 provides that, "the term 'off-campus outpatient department of a provider' means a department of a provider (as defined in section 413.65(a)(2) of title 42 of the Code of Federal Regulations, as in effect as of the date of the enactment of this paragraph) that is not located —
 "(I) on the campus (as defined in such section 413.65(a)(2)) of such provider; or
 "(II) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section 413.65(a)(2))."

[7] *Id.* The bill relies on the current definition of "dedicated emergency department" under 42 C.F.R. § 489.24(b).

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