Provider-Based Clinics: What You Need to Know

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Agenda

- Background Information
- OPPS Final Rule – Off-Campus Provider-Based Locations
  - Statutory Exceptions from the Site-Neutral Payments for Provider-Based Locations
- Implications of Relocating an Excepted Off-Campus Provider-Based Department
- Implications of Expanding Services in an Excepted Off-Campus Provider-Based Department
- Change of Ownership
- 340B Impact
- Recent Experiences with Submitting Attestations
- Hypotheticals
- What's Next

Background Leading Up To Recent Changes in Provider-Based Rules

- Growth in hospital purchases of physician practices and integration of practices as HOPDs
- Total Medicare payment for service in a HOPD is generally higher than total payment for the same service in a physician office (2 claims) and can increase Medicare beneficiary copayments
- Claim "PO" modifier to identify services furnished in OC-HOPD within claims data mandatory 1/1/16, but does not distinguish between multiple OC-HOPDs of same hospital

OPPS Final Rule – Off-Campus Provider-Based Locations

The 2017 OPPS Rule & The Bipartisan Budget Act

- CMS issued the 2017 OPPS Final Rule on November 1, 2016, and the Final Rule contained language implementing the new rules for provider-based locations that were in Section 603 of the Bipartisan Budget Act of 2015.

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Bipartisan Budget Act of 2015, Section 603

- Bipartisan Budget Act of 2015 signed into law November 2, 2015
- Section 603 of the Budget Act was applicable to Provider-Based Departments
- As of 1/1/17, no off-campus hospital outpatient department (OC-HOPD) may bill under OPPS unless:
  1. It is a "dedicated emergency department" (DED), *or*
  2. It is excepted
- After 1/1/17, non-excepted OC-HOPDs will need to bill under another payment system

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CY 2017 OPPS Final Rule

- Final Rule included some good news:
  - Provides a mechanism for payment for 2017 non-excepted OC-HOPDs
  - Allows expansion of services at excepted OC-HOPDs
  - OC-HOPDs excepted if furnished OPPS services prior to November 2, 2016
  - Non-excepted OC-HOPDs can likely still qualify as 340B child sites

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Final Rule and Payment in OC-HOPDs

- CMS significantly modified and clarified its proposed payment rules in the Final Rule.
  - CMS believes MPFS is the fee schedule of choice for billing nonexcepted items and services
  - Allows hospitals to continue to bill on institutional claim forms and physicians to bill on physician claim forms
  - Rates for these services will continue to evolve for 2017, 2018, and 2019
  - Interim Final Rule with comment period through December 31, 2016

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Final Rule Payment Structure in OC-HOPDS

- For services furnished on or after 1/1/2017, hospitals will bill claims on a UB-04 institutional claim form with the new "PN" modifier
  - The modifier denotes these claims as receiving the new MPFS payment rate
- For services furnished on or after 1/1/2017, physicians will bill claims on a CMS 1500 form at the facility rate
- These rates are designed to appropriately capture service-provision resource costs

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Interim Final Rule Payment Rate in OC-HOPDS

- For CY 2017, CMS set a new MPFS rate for "PN" modified institutional claims to reflect the relative resource costs of furnishing MPFS-reimbursed claims through the hospital setting
- New MPFS reimbursement category for CY 2017 is 50% of OPPS rate for same services
  - Based on relative resource information from the "PO" modifier data and comparison of ASC rates to OPPS rates, but with OPPS-based geographic modifiers
- Exceptions include separately billable Part B drugs, majority of therapy/preventative services

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Other Elements of the Interim Final Rule for Payment in OC-HOPDs

- Cost Sharing – same as MPFS rules not OPPS
- CY 2018 rates will be determined similarly to CY 2017 rates (using PO modifier data, relative resource examinations, etc.)
- CY 2019 (and beyond) rates will be determined by using actual claim data from CY 2017 and 2018 to compare payment rates
- Long-term goal is to equalize nonexcepted PBD rates with physician offices, though specific procedure and service rates could differ

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On Campus vs Off Campus

- **Campus as defined in Provider-Based Rule**
  - Physical area immediately adjacent to provider's main buildings
  - Other areas and structures not strictly contiguous to the main buildings but within 250 yards of the main buildings
  - Any other areas determined on an individual case basis to be part of the main campus by the CMS Regional Office

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Final OPPS Rule/Budget Act Implications

- OPPS Final Rule/Budget Act does not apply to
  - Provider-based entities (such as rural health centers) – only applies to provider-based departments
  - Facilities not billed under OPPS
  - On-campus HOPDs

Statutory Exceptions from Site-Neutral Payments for Provider-Based Locations

- How does OC-HOPD get excepted?
  - The 2017 OPPS Final Rule grants excepted status to OC-HOPD if the OC-HOPD furnished any covered OPPS services prior to November 2, 2015 and billed under OPPS in accordance with timely filing limits.

Statutory Exceptions from Site-Neutral Payments for Provider-Based Locations

- Excepted OC-HOPDs
  - OC-HOPDs that were furnishing OPPS services prior to November 2, 2015 that have not impermissibly relocated or changed ownership
  - OC-HOPD that qualifies under the Mid-Build or Cancer Hospital exception
  - HOPDs on the campus or within 250 yards of the main hospital or a remote location of a multi-campus hospital
  - All services furnished at dedicated emergency departments

What is a Remote Location of Hospital?

- Remote location of a hospital means
  - A facility or organization either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider
  - Comprises both the physical facility that is the site of service and the personnel and equipment used to deliver the service
  - Does not include a "satellite facility"
- Remote locations are considered off-campus of the main hospital, but locations "within the distance" (250 yards) of a remote location are excepted under the Final Rule

What is a Dedicated Emergency Department?

- DED defined by EMTALA definition:
  - State license as an emergency room or emergency department
  - Held out to the public as a place that provides care for emergency medical conditions on an urgent basis without requiring an appointment; or
  - Provides at least one-third of all of outpatient visits for the treatment of emergency medical conditions

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Implications of Relocating an Excepted OC-HOPD

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Implications of Relocating an Excepted OC-HOPD

- The Budget Act did not address whether excepted OC-HOPDs can physically relocate and keep excepted status
- In the 2017 OPPS Proposed Rule, CMS proposed that if an excepted OC-HOPD moved from the address on its CMS enrollment form as of November 1, 2015 to a new address, including a change of unit or suite number, the entire OC-HOPD lost its excepted status
- CMS sought comments on a narrow exception for acts of God or other cases beyond the hospital's control

Final Rule and Relocation of Excepted OC-HOPDs

- CMS finalized Proposed Rule preventing excepted OC-HPDs from relocating and remaining excepted
- Concern is need to prevent hospitals from moving excepted OC-HOPDs to larger facilities to add purchased physician practices
- CMS believes the intent of the Budget Act was to except only OC-HOPDs as they existed prior to November 2, 2015

Final Rule and Relocation of Excepted OC-HOPDs

- Excepted OC-HOPDs can relocate only for natural disasters, seismic building code requirements or public health and public safety
- Not for business reasons (e.g., lost lease)
- CMS has issued subregulatory guidance on extraordinary circumstances process
- CMS Regional Offices will approve or deny relocation requests

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Extraordinary Circumstance Relocation Exception Subregulatory Guidance

- Application Review Process
  - CMS prioritizing relocations from 11/2/2015 – 12/31/2016
  - Decisions made by CMS Regional Office – no appeals
  - Approvals for relocations between 11/2/2015 – 12/31/2016 are effective 1/1/2017 – if requests are pending as of 1/1/2017, must report PN modifier for non-excepted services as of 1/1/2017 and once approved, contact the MAC for rebilling instructions
  - Relocations on/after 1/1/2017 – should submit request within 30 days of when the extraordinary circumstances occurred; Approvals will be effective the later of date request was made or date of relocation

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Final Rule and Relocation of Excepted OC-HOPDs Subregulatory Guidance

- Suggested Minimum Information
  - Basic Info: CCN, provider name/address, contact info
  - Current address and new address
  - Classification of current address and new address as: (i) on campus, (ii) DED, (iii) remote location, (iv) PPS-exempt cancer hospital, or (v) off-campus
  - Detailed explanation of the rare and unusual circumstances that necessitated or will necessitate the relocation
    - Date event occurred
    - Resulting damage to building
    - Ability to continue to furnish services in the building
    - Any laws/regulations that necessitate the move

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Expansion of Services at Excepted OC-HOPD

- Budget Act did not address whether an excepted OC-HOPD can expand number or type of services furnished and remain excepted
- The Proposed Rule excepted only those items or services furnished at the OC-HOPD as of November 1, 2015 (when Budget Act enacted)
  - Any items or services not in same "Clinical Family" would not be able to be billed by excepted OC-HOPD under OPPS as of January 1, 2017

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Expansion of Services at Excepted OC-HOPD

- Proposed Rule would have regulated what services are excepted at an excepted OC-HOPD by creating 19 Clinical Families
- Proposed Rule did not limit the *volume* of excepted items or services within a Clinical Family that an excepted OC-HOPD can furnish
- CMS did not finalize the proposed rule limiting expansion of services into new "Clinical Families"

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Expansion of Services at Excepted OC-HOPD

- Under the Final Rule, CMS will pay OPPS rates for all services furnished and billed by excepted OC-HOPDs
- CMS remains concerned about growth at excepted OC-HOPDs
- Concern is with hospitals adding purchased physician practices to excepted OC-HOPDs
- CMS sought feedback about how to limit the type and volume of services and is monitoring service line growth using the "PO" modifier

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Change of Ownership of OC-HOPDs

- Must acquire the entire hospital (not just the OC-HOPD) AND
- Agree to assignment of the main hospital's Medicare provider agreement
- If the buyer of the main hospital and OC-HOPD terminates the existing Medicare provider agreement instead of accepting it, OC-HOPD loses excepted status and will not receive OPPS rates
- An individual OC-HOPD cannot be transferred from one hospital to another and maintain excepted status

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Attestation of Provider-Based Status Recent Experiences with CGS

- Public awareness – signage
- Evidence of 855A change of information approval (approving new location)
- Straight line map measurement required even when driving distance less than 35 miles

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340B Concerns Under Proposed Rule

- 2017 OPPS Proposed Rule claim submission structure raised question about ability of non-excepted PBDs to continue to or newly qualify for 340B
  - Proposed Rule's lack of institutional claims/payments led to question of how cost report would have reflected non-excepted provider-based departments
  - Failure to appear as a reimbursable cost center on the cost report would have precluded registration as a 340B child site

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340B Resolution (Mostly)

- Under Final Rule CMS announced that "services provided at nonexcepted off-campus PBDs will continue to be reported on the hospital cost report"
  - Strong implication is that these locations will continue to or newly qualify for 340B child site status
  - Supports the conception of Section 603 as a payment rule not an elimination of provider-based status
- However, CMS says that HRSA has the final say regarding 340B

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Hypothetical 1 –New Services

- Excepted OC-HOPD providing x-ray, stress tests and nuclear testing prior to November 2, 2015
- Hospital would like to add CT scan and MRI at OC-HOPD
- Will OC-HOPD remain excepted if add CT and MRI?
- Will CT and MRI be paid under OPPS?

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Hypothetical 2- Remote Location

- January 2016 hospital opens diagnostic center
- December 2016 hospital constructs second building as a remote location, within 250 yards of diagnostic center
- How are the services at the diagnostic center billed and paid?

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Hypothetical 3- Emergency Departments

- In 2016, hospital builds an OC-ED that includes a CT scanner
- ED schedules some patients for CT scans as well as walk-in patients for ED services
- In 2017, how will CT scans be billed and paid?

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Hypothetical 4- Fire Sale of OC-HOPD

- Financially troubled Hospital A has two successful excepted OC-HOPDs
- In 2017 Hospital A closes and sells the two OC-HOPDs to Hospital B
- Can the two OC-HOPDs remain excepted after sold to Hospital B?

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Continued Concerns and Unanswered Questions After Final Rule

- CMS monitoring of service line and volume growth could result in future rulemaking limiting growth at excepted OC-HOPDs.
- Continually evolving payment rates under new MPFS category could change business calculations.
- Will HRSA issue any guidance regarding 340B?

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What To Do Now?

- Assess all provider-based locations for compliance with the provider-based elements.
- Determine whether the hospital added each location with a different physical address from the hospital to its Medicare Enrollment form (855).
- When adding new locations, ensure to use the correct suite number – not the entire building address.
- Identify which locations are on-campus (measure or have a determination by the CMS Regional office that the location is on-campus). More scrutiny now.
- Identify which locations are off-campus and whether they are excepted or not.

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Questions?

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