Budget Deal Limits Payment to New Off-Campus Hospital Outpatient Departments

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On November 2, 2015, President Obama signed the Bipartisan Budget Act of 2015 (the “Act”) into law. The Act, widely hailed as a rare act of bipartisan cooperation, raises the federal debt ceiling and sets federal spending through the 2017 fiscal year. The Act also quietly makes a significant change in the way the Medicare program reimburses hospitals for outpatient services furnished in new off-campus departments, effectively ending an often favorable reimbursement scheme for newly created or acquired off-campus departments.

Summary of Key Changes
The Act amends Section 1833(t) of the Social Security Act, which governs Medicare payments for hospital outpatient department services, to add a new clause that excludes from the definition of covered services most items and services furnished on or after January 1, 2017, by an “off-campus outpatient department of a provider.” The term “off-campus outpatient department of a provider” is defined by reference to the provider-based regulations to include a department of a provider that is not located on the provider’s campus or within a 250-yard radius from a remote location of a hospital. Importantly, the Act excludes from the definition those departments that were billing Medicare for covered hospital outpatient department services furnished prior to the date of enactment. Thus, off-campus departments in operation prior to November 2, 2015, will receive “grandfathered” status and continue to be paid under the Medicare Hospital Outpatient Prospective Payment System (OPPS), but new off-campus departments will only be eligible for such reimbursement until January 1, 2017, at which time they will be paid under the Physician Fee Schedule (PFS) or the Ambulatory Surgical Center (ASC) Payment System, as applicable. In other words, new off-campus hospital outpatient departments will, beginning January 1, 2017, be paid at the same rate as if the departments were freestanding facilities unaffiliated with a hospital.

Several aspects of the changes made by the Act are particularly noteworthy. First, the payment limitation does not apply to on-campus hospital departments (i.e., those departments that are located in the physical area immediately adjacent to, and in any event within a 250-yard radius of, the hospital’s main buildings). In addition, the payment limitation does not apply to certain other off-campus facilities that are required to meet the Medicare provider-based regulations, including remote locations of a hospital, satellite facilities, and provider-based rural health clinics. No change in payment to these facilities will occur as a result of the Act, even if they are established or acquired on or after January 1, 2017; the payment limitation applies solely to off-campus hospital outpatient departments.

Second, the scope of the grandfathering provision is limited and somewhat ambiguous. The Act shields from the payment limitation off-campus hospital outpatient departments that were “billing [as a hospital outpatient department] with respect to covered [hospital outpatient department] services furnished prior to the date of the enactment.” No opportunity is given for hospitals to seek exceptions to this rule, nor does the Act include any allowance for rural or safety net hospitals, or for hospitals currently in the process of acquiring or creating a new off-campus department. It is also not entirely clear how the language applies to recently added off-campus departments. Consider, for example, the case of a hospital that added an off-campus outpatient department effective November 1, 2015, but did not see a Medicare patient until November 2, 2015 (or that saw a Medicare patient on November 1, 2015, but did not bill for services until November 2, 2015).
Third, the payment limitation will apply to all items and services rendered by new off-campus hospital outpatient departments, except for emergency department services. Not only does the Act limit payment for evaluation and management services, it also limits payment for procedures and surgical services. Previous proposals and recommendations from the Medicare Payment Advisory Commission and the Office of Inspector General had focused on reducing site-of-service differentials for a narrower range of services.

Fourth, the Act authorizes the Centers for Medicare and Medicaid Services (CMS) to collect more detailed information from hospitals about their off-campus hospital outpatient departments. Specifically, the Act directs hospitals to provide to CMS such information as CMS requires to implement the Act, which may include listing a code or modifier on claims for off-campus outpatient department services or reporting information about off-campus outpatient departments on enrollment forms. CMS may take this opportunity to require the reporting of information beyond that which is currently required (which includes listing off-campus departments as “practice locations” on Form CMS-855A and, beginning January 1, 2016, the addition of modifier “PO” to every HCPCS code for services furnished in off-campus departments).

Practical Takeaways
The Act almost certainly will affect hospitals’ and health systems’ development strategies. The change in payment methodology likely will have a chilling effect on the recent trend of acquiring and converting freestanding ancillary facilities to hospital outpatient departments. Because, in many cases, the payment made solely under the Medicare PFS or ASC Payment System is significantly less than the total payment made to providers that receive a facility fee under OPPS, hospitals will no longer have the same financial incentive to acquire off-campus ambulatory surgery centers, imaging centers, radiation therapy centers, physician practices, and other suppliers. As a result, the market for these ancillary facilities may shift, with entities other than hospitals and health systems pursuing development opportunities more aggressively.

The Act may prove particularly challenging for hospitals located in urban areas, where opportunities for on-campus development are limited, and for hospitals located in rural areas, where the development of off-campus locations is a vital means of providing services not otherwise available in the community to vulnerable patient populations. The Act also may cause hospitals in the process of acquiring or developing new off-campus departments to reconsider or restructure the projects, perhaps devising strategies to move the facilities on-campus by January 1, 2017. Hospitals may also focus on the development of remote locations (i.e., facilities that furnish inpatient hospital services).

It remains to be seen what, if any, regulatory gloss CMS will add to these statutory changes. Certainly the Act raises many questions, and the industry would benefit from the clarification, and the opportunity to comment, that is part of the rulemaking process. CMS may take up the Act in its annual OPPS rulemaking process, in which it generally issues a proposed rule mid-year and a final rule in the fourth quarter. In any event, hospitals and other industry participants should carefully consider the impact of the Act on their current operations and development strategies, and remain watchful for future legislation or agency guidance on the matter.