Congress Changes Reimbursement Rules for Off-Campus Facilities

On November 2, 2015, President Obama signed into law the Bipartisan Budget Act of 2015 (BBA). While the law contains a number of budgetary changes that impact broader economic issues, including the debt ceiling and the federal tax code, the law also prohibits off-campus hospital outpatient departments (HOPDs), also called provider-based departments, created after November 2, 2015, from collecting Medicare reimbursement for non-emergency services under the outpatient prospective payment system (OPPS) starting on January 1, 2017. This change in hospital outpatient billing may impact current and future planning by providers in regard to establishing off-campus HOPDs. This Health Capital Topics article will detail the provisions of the BBA related to hospital outpatient reimbursement and discuss the impact of the BBA on hospital outpatient facilities.

The BBA’s hospital outpatient provisions alter previous reimbursement rules regarding off-campus provider-based departments. Currently, the Centers for Medicare and Medicaid Services (CMS) recognizes stand-alone facilities that are owned and operated by a main provider, such as an integrated health system, as part of the main provider’s group. These stand-alone facilities are given provider-based status, which allowed the facility to bill for services provided to Medicare under the hospital OPPS, regardless of whether the facility was located on the hospital’s campus. Instead, to qualify for OPPS reimbursement under the old rules, the facility must simply provide services that are of the same type as those furnished by the main provider, and must be under the main provider’s financial and administrative control.

Generally, reimbursement is considerably higher under the OPPS than other fee schedules, such as the Medicare Physician Fee Schedule (MPFS) or the Ambulatory Surgical Center Fee Schedule (AFCFS), because the OPPS provides both a facility fee and a higher conversion factor. The higher reimbursement level often given at HOPDs relative to other provider settings, such as ASCs, has created controversy in recent years. The American Hospital Association (AHA) has consistently argued that higher reimbursement for HOPDs is necessary because of the additional capabilities and regulations faced through the hospital affiliation. However, the Medicare Payment Advisory Commission (MedPAC) has encouraged Congress to level certain payments between provider-based departments and freestanding physician offices, arguing the services provided are of the same quality at both facilities. The passage of the BBA fundamentally altered the reimbursement environment for new HOPDs. Under §603 of the BBA, any off-campus HOPDs that expect to begin billing Medicare after November 2, 2015, will only be able to utilize the OPPS for reimbursement through December 31, 2016. From January 1, 2017, and beyond, these facilities will instead receive reimbursement under an alternative fee schedule, such as the MPFS or the ASCFS. In passing the BBA, Congress acted further than MedPAC’s recommendation, mandating site-neutral payments for all services and items furnished at off-campus HOPDs.

The BBA does not impact rural health clinics or federally qualified health clinics, nor does the BBA impact provider-based entities which furnish services of a different type from those of the main provider. In addition, the law explicitly states that it does not affect outpatient departments on the campus of the provider or within 250 yards of a hospital facility, as these facilities are classified as on-campus facilities.

The BBA provides two exceptions to the prohibition of OPPS reimbursement to HOPDs. First, the BBA does not affect reimbursement for provider-based facilities that operate as designated emergency departments. In order to qualify as a designated emergency department, the facility must meet at least one of the following requirements:

1. “The facility is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;”
2. The facility is held out to the public...as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or,
3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, the facility provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis.”

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The second exception applies to off-campus HOPDs that already receive reimbursement under the Medicare OPPS as of November 2, 2015. Under this exception, the BBA grandfathered any currently existing off-campus HOPDs, allowing them to continue to bill under the OPPS rather than an alternative fee schedule, such as the MPFS or the ASCFS.

The BBA’s HOPD reimbursement changes are expected to save Medicare $9.3 billion once implemented. However, the changes may deter hospitals from developing new off-campus HOPDs, including in underserved areas. In addition, the BBA HOPD reimbursement changes could affect 340B prescription drug discounts that are available to qualified hospital outpatient locations that report as Medicare-reimbursable outpatient locations on the hospital’s Medicare cost report.

For those facilities that are not grandfathered for OPPS reimbursement, administrators may consider other options. For example, new or planned HOPDs can either become freestanding physician offices or ASCs, with lower reimbursement rates. Some facilities that were not grandfathered under the BBA may consider the feasibility of becoming a stand-alone emergency department in order to retain the OPPS benefits; however, this change would likely require the facility to satisfy extensive regulatory hurdles, such as the Emergency Medical Treatment and Labor Act (EMTALA), which may not be feasible depending on the facility and services provided. Further, non-grandfathered provider-based departments seeking OPPS reimbursement may be able to reorganize as provider-based entities and provide different services from the main provider. Hospitals considering creating off-campus HOPDs may need to consider both the ability to provide quality patient care and the financial feasibility of such ventures in light of the BBA. It is possible that CMS will release additional commentary discussing the change, so hospitals may benefit from monitoring CMS guidance released over the next year.

2 Ibid.
3 Ibid; “Requirements for a Determination That a Facility or an Organization Has Provider-Based Status” 42 C.F.R. § 413.65(a)(2) (October 1, 2011).
4 “Requirements for a Determination That a Facility or an Organization Has Provider-Based Status” 42 C.F.R. § 413.65(a)(2).
5 Ibid.
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14 “Requirements for a Determination That a Facility or an Organization Has Provider-Based Status” 42 C.F.R. § 413.65(a)(2) (October 1, 2015).
15 “Requirements for a Determination That a Facility or an Organization Has Provider-Based Status” 42 C.F.R. § 413.65(a)(2).
16 “Bipartisan Budget Act of 2015” § 603(2)(B)(i), October 30, 2015; “Requirements for a Determination That a Facility or an Organization Has Provider-Based Status” 42 C.F.R. § 413.65(a)(2).
19 “Requirements for a Determination That a Facility or an Organization Has Provider-Based Status” 42 C.F.R. § 413.65(a)(2).
24 Ibid.
25 Nash and Sloane, November 2, 2015.
26 Ibid.
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