Hospital-Based Status Post BBA Section 603: Is Expansion Still Possible?

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Agenda

- Benefits and drawbacks of provider-based status
- Provider-based status overview of requirements
- CMS' implementation of Section 603 of the Bipartisan Budget Act
- What changed; what is still the same
- Industry's reaction; strategies for expansion to meet community needs

Provider-Based Status Overview

CMS' Overarching Goal

- CMS intends to pay for services under OPPS only when the hospital maintains the proper level of control over the quality of care and finances of the provider-based site.

Benefits and Drawbacks of Provider-Based Status

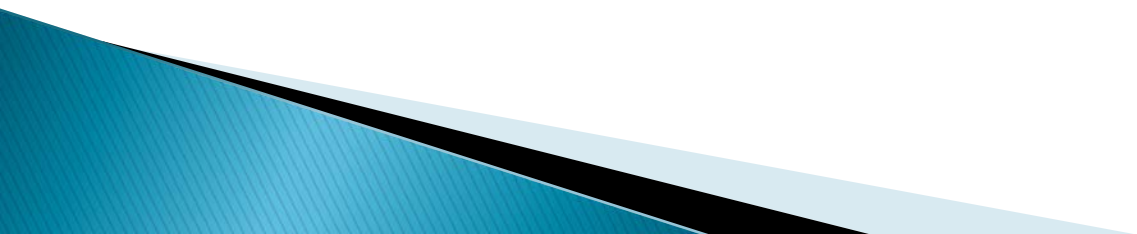
Benefits of Provider-Based Status

- Medicare/Medicaid payment amounts
- 340B drug discount program eligibility
- Bad debt payments
- Main provider/remote location DSH and IME payments
- Inclusion in main provider's third party payer contracts

Disadvantages of Provider-Based Status

- Duplicate coinsurance
- Physician dissatisfaction
- Ever evolving regulatory landscape
- Patient dissatisfaction

Overview of Requirements



Provider-Based Status Requirements: All Outpatient Clinics

- Common Licensure (if allowed by state law)
- Clinical Integration
  - Common medical staff privileges
  - Reporting to chief medical officer
  - Unified medical records
- Financial Integration
  - Proper location on the cost report
  - Consolidated revenues and expenses
- Public Awareness
  - Held out as part of the provider to public and third parties

Provider-Based Status Requirements: All Outpatient Clinics

- Physician Billing.
  - Correct site of service code
  - Shared/split visits but no incident to pro fees

- Equal Billing Treatment.
  - All Medicare patients treated as hospital outpatients
  - Facility fee billed on UB-04; professional fee is billed on a1500 with POS 19, 22, or 23

- Provider Agreement. Provider-based sites must comply with the terms of the provider agreement

Provider-Based Status Requirements: All Outpatient Clinics

- DRG Payment Window
- Beneficiary Notices
- Meet Hospital COPs

Additional Requirements: Off-Campus Entities

- Ownership and control
  - Hospital owns 100% of the business enterprise
  - Common governing body and policies
- Administrative Integration
  - Reporting to hospital chief administrative officer
  - Provider-based site obtains the following services from the hospital (or a third party servicing the hospital and clinic): billing; records; human resources; payroll; employee benefit package; salary structure; and purchasing

Additional Requirements: Off-Campus Entities

Location

- 35 Mile Rule. Off-campus sites may qualify as provider-based if they are within 35 miles of the hospital.

- 75 Percent Tests. Determine whether servicing the same patient population.

Special Cases – Special Rules

- Joint Ventures
  - On-campus JV allowed if:
    - On campus of provider/owner
    - Provider-based to that owner only
    - No minimum ownership required
- Management Contracts
  - Provider must be in control
  - Provider employs all patient care personnel
  - Policies of provider control
  - Periodic written reports
  - On-site personnel subject to provider approval

Approval Process

- Prior approval of provider-based status is not required

- "Attestation" process
  - Voluntary*
  - Eliminates risk of retrospective recoveries
  - Available only when there is a differential in payment

* Note 21st Cures Act

BBA Section 603 Implementation
What has Changed
What Stayed the Same

Bipartisan Budget Act of 2015, Section 603

- As of 1/1/17, no "off-campus outpatient department of a provider" may bill under OPPS unless:
  1. It is a "dedicated emergency department"(DED) *or*
  2. It is grandfathered
- Non-grandfathered sites need to bill under another payment system – Final Rule takes care of this (for now)

DED not subject to Site Neutrality

- DED: Must meet at least one of the following:
  - State licensure as an emergency room or emergency department; ***or***
  - Holding out to the public as a place that provides care for emergency medical conditions on an urgent basis without requiring an appointment; ***or***
  - Provision of at least one-third of all of outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
- Final Rule: All services in the DED are exempt from site-neutrality, not just emergency services.

"On-Campus" Definition has New Importance

- On-Campus not subject to site neutrality
  - Buildings or structures within 250 yards from main building – Final Rule clarifies that 250 yards can be measured from anywhere at the building
  - 250 yards from "remote location" also protected
  - Final Rule provides no guidance for "on campus" – remains an RO determination

On-Campus Definition

"This definition would encompass not only institutions that are located in self-contained, well-defined settings, but other locations, such as in central city areas, where there may be a group of buildings that function as a campus but are not strictly contiguous and may even be crossed by public streets."

Fed Reg Vol. 65, No.68/April 2, 2000


Hospital Road
Main Hospital
615 S New Ballas Rd
Patient Parking
Hospital Road
Hospital Road
County Maintained Rd
Behavioral Health
No Access Road
County Maintained Rd
New Building Locating

Grandfathering of Off-Campus Sites

- How do off-campus sites get grandfathered?
  - If the "department of a provider . . . was billing under [OPPS] with respect to covered OPD services furnished prior to the date of the enactment of this paragraph" [*i.e.*, 11/2/15]

Relocations

- Proposed and final rule generally preclude relocations
- CMS purports to base its policy on the definition of "department," which incorporates the physical facility (as well as the personnel and equipment)
  - Claims that therefore the location must remain "fixed"
- Overarching concern is with acquiring new physician practices
  - Fear is that, if relocate to a larger space, a site could bring in new physicians
- Must remain at site listed on 855
  - Specific down to the suite number (but no limitation as to how many interior walls can be torn down)
  - Exception proposed for natural disasters and changes in law

Relocations *(cont.)*

- CMS' explanation is unsatisfactory
  - The definition of "department" states:

Department of a provider means a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A department of a provider may not by itself be qualified to participate in Medicare as a provider under § 489.2 of this chapter, and the Medicare conditions of participation do not apply to a department as an independent entity.

Relocations *(cont.)*

- CMS had the following to say about why it was adding this text:

  We proposed this change because we believed it would help to clarify that we would make determinations with respect to entities considered in their role as sources of health care services and not simply as physical locations.

  67 Fed. Reg. at 50080 (Aug. 1, 2002)
- So why is the emphasis now flipped?
- And does CMS have the authority to preclude maintenance of grandfathered status for relocated facilities?

Relocations *(cont.)*

- Final rule attaches great importance to the location identified in PECOS on 11/1/15
- CMS rejected the 75% test used for CAHs
- CMS did not consider capping square footage – This one is worth continued, vigorous discussion

Relocations *(cont.)*

- In the final rule, CMS identified that CMS ROs are to make the final determination, based on concerns relating to "significant public health or public safety issues."
  - Process has been described in informal guidance
  - CMS has issued an application
  - Must be submitted within 30 days of the date of the "extraordinary circumstance"
- CMS ROs are likely to implement inconsistently, and will likely be very hesitant to use authority, especially at first

Relocations *(cont.)*

- So what now?
  - It's always worth asking the CMS RO if a relocation is acceptable whenever a relocation is necessary
  - Expansions should be acceptable if they do not entail changing the site's address
  - "Recycling" of provider-based sites should also be acceptable
  - Relocations to the campus of a main provider or a remote location are acceptable
  - Provider-based status is still available for relocated sites

Judicial Review Preclusion

- No administrative or judicial review of:
  - Whether the services furnished are services of a dedicated emergency department
  - Whether a provider-based clinic is off-campus or on-campus
  - Whether a provider-based clinic benefits from grandfathered status
- Should still be able to appeal whether a site qualifies, and has always qualified, as provider-based
  - Remote locations have different appeal rights, depending upon the reason they are denied remote location status

Payments for Non-Grandfathered Sites

- Ability to qualify for provider-based status has never been in question
- Originally proposed that physicians would bill for services at non-grandfathered sites
  - Even CMS recognized that this wouldn't work due to Stark/AKS/anti-reassignment rules
- Now hospitals bill under a new system
  - Use the 1450, not the 1500
  - Physicians still bill for the professional fee on the 1500
  - Non-grandfathered sites are to use the modifier "PN"
  - Grandfathered off-campus sites are to use the modifier "PO"
  - Two copays will continue to be generated

Payments for Non-Grandfathered Sites *(cont.)*

- Generally paid at 50% of the OPPS rate
  - Based on a "relativity" analysis using claims identified with the "PO" modifier
- Apply the same packaging rules as applied under OPPS
- Exceptions for
  - OT/PT/ST
  - Separately payable drugs
  - Preventive services
- No outlier payments, but silent as to bad debt
- Comments were due on 12/31

21st Century Cures Act

- Mid-Build Protections
  - February 13, 2017 filing deadlines (certifications and attestations)
- Cancer Hospitals
  - 60-day deadlines for filing an attestation.

Implications for 340B Program of Provider-Based Status

Implications for 340B Program

- 340B is a drug purchasing program, not a payment program
- Hospitals must qualify as "covered entities" in order to purchase drugs under the 340B program
- HRSA's historic guidance has stated that 340B drugs can only be administered in space that is on a reimbursable cost center
  - Must be identified as such on the cost report
  - Current view is that prescriptions filled at a contract pharmacy need to be written in provider-based space

Implications for 340B Program

- Non-grandfathered sites will still qualify as provider-based
  - They will be identified on a reimbursable line on the cost report
  - They will have charges associated with services furnished at their location
- Questions remain as to what is absolutely necessary to qualify as a “reimbursable cost center”

"Under Arrangements"

- CMS did not respond to comments regarding whether under arrangements billing is acceptable, even as to a new site
- CMS has for many years accepted that diagnostic services could qualify for OPPS billing even if furnished under arrangements
  - This is consistent with the governing statute
- No reason to view the site where an under arrangements service is furnished as an off-campus provider-based department

Expansion Opportunities?

- On-campus
  - Relocation of administrative and physician office space off-campus
  - Explore opportunity to maximize contours of main provider campus
  - Consider creating remote locations

Expansion Opportunities? *(cont.)*

- Off-campus expansion limited
  - May add new services or expand existing services in existing grandfathered locations
  - Must remain in same site listed on 855 including at the same suite number
  - Consider use of “under arrangements” billing for diagnostic services

Questions?

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