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Health Care Flash

July 26, 2016

Off-campus hospital outpatient departments beware: CMS releases its proposed changes to the Outpatient Prospective Payment System

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On July 14, 2016, the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) published its Proposed Rule for the Calendar Year (CY) 2017 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System policy changes, quality provisions and payment rates (Proposed Rule). *See* 81 Fed. Reg. 45681.

The Proposed Rule, in part, implements Section 603 of the Bipartisan Budget Act of 2015 (Section 603) which establishes a site neutral payment policy for non-excepted, provider-based off-campus hospital outpatient departments (HOPDs). Effective January 1, 2017, CMS will cease paying OPPS rates for HOPDs (or "provider-based departments") that began billing as such on or after November 2, 2015. Instead, these facilities will be paid under other applicable Medicare Part B payment systems.

Pursuant to Section 603, there is an exception for services furnished at dedicated emergency departments. In the Proposed Rule, CMS broadly defines this exception and proposes to allow payment under the OPPS for all services furnished at a dedicated emergency department, not just emergency services, as well as exempting items and services furnished in a hospital department within 250 yards of a remote location of the hospital. In addition, those HOPDs billing under OPPS prior to November 2, 2015 will retain their excepted status.

Below are some key things to note about the Proposed Rule:

- **HOPDs under construction.** Significantly, CMS's Proposed Rule did not address the treatment of HOPDs under development. The Helping Hospitals Improve Patient Care Act (H.R. 5273), legislation that has been passed in the House of Representatives and is pending in the Senate, addresses HOPDs that are under construction. This legislation includes an exception for mid-build HOPDs that have a binding written agreement for construction, entered into prior to November 2, 2015, with an outside unrelated party and that submit a provider-based attestation by December 31, 2016. Godfrey & Kahn will continue to monitor this legislation as it moves through the Senate. For more information on the mid-build topic, please see our prior guidance here.
- **CMS proposes that relocated off-campus HOPDs will not maintain grandfathered status.** If an off-campus HOPD relocates, the HOPD and the items and services provided are no longer exempt and will no longer be reimbursed under the OPPS. CMS is soliciting comments on whether to develop "clearly defined, limited relocation exceptions" to this general rule related to disasters, extraordinary circumstances, or circumstances that are "completely beyond the control of the hospital."
- **CMS proposes that any services not offered by a HOPD prior to November 2, 2015 will not be reimbursed under the OPPS.** The Proposed Rule lists excepted services (*e.g.*,

"clinical families of services"), whereas Section 603 only states that a new department/facility can no longer qualify for provider-based status. CMS's stance on this issue is contrary to prior CMS policy. CMS has previously guided that "provider-based rules do not apply to specific services; rather, these rules apply to facilities as a whole." *See* 67 Fed. Reg. 50088 (August 1, 2002).

- **Proposed CY 2017 Payment.** CMS states that there is "no straightforward way" to implement by January 1, 2017 the payment changes under which a HOPD could bill and receive payment for furnishing non-excepted items and services—those services that do not meet the Proposed Rule's exceptions to bill under the OPPS—under a payment system that is not the OPPS. For CY 2017, CMS proposes a one-year, temporary solution whereby the majority of non-excepted items and services are paid under the Medicare Physician Fee Schedule (MPFS). Alternatively, CMS proposes that a HOPD could enroll as a freestanding facility or supplier that is eligible for payment for the non-excepted items or services. CMS is seeking comments to assist in the development of "other payment systems" for CY 2018, including hospital cost reporting. Cost reporting for 2017 remains an open issue. CMS's proposal for CY 2017 payment may cause payment delays for non-hospital facilities/suppliers (*e.g.*, surgical centers).
- **340B Drug Pricing Program.** Section 603 and the Proposed Rule may impact a hospital's ability to take advantage of 340B Drug Pricing Program (340B Program) moving forward and could also have significant implications for any future or under-development cancer treatment programs with drug purchasing to occur under the 340B Program. CMS did not mention the impact on 340B Program child site eligibility in the Proposed Rule. This issue will likely influence how and whether HHS Health Resources and Services Administration Office of Pharmacy Affairs adjusts its patient and child site eligibility criteria in the pending 340B Program Omnibus Guidance.
- **Mergers and acquisitions.** The Proposed Rule appears to permit excepted locations to retain their excepted status following a change of ownership, but only if ownership of the main hospital entity is transferred as well and the Medicare provider agreement is accepted by the new owner. In other words, individual off-campus HOPDs cannot be transferred from one hospital to another and still maintain their grandfathered status.

Godfrey & Kahn suggests hospitals consider submitting comments to CMS by the September 6, 2016 deadline. If you have questions regarding the Proposed Rule, Section 603, HOPD requirements or need assistance with comment submissions to CMS, please contact:

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The information in this article is based on a summary of legal principles. It is not to be construed as legal advice. Individuals should consult with legal counsel before taking any action based on these principles to ensure their applicability in a given situation.

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