Provider-Based Status: What a Long, Strange Trip It's Been!

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Agenda

- Benefits and drawbacks of provider-based status
- Fundamentals of provider-based status
- Bipartisan Budget Act changes and CMS Final Rule
- Payment Rules for non-Grandfathered Facilities
- 21st Century Cures Act and “Mid-Build” exception
- 340B issues
- Under Arrangements billing
- Implications of Commingled Space

Advantages 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

Qualifying For Provider-Based Status

CMS' Overarching Goal

- CMS wants 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.

Basic Requirements

- Common Licensure
- 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

Additional Requirements for Off-Campus Entities

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

Obligations of Provider-Based Status for Outpatient Clinics

- Physician Billing. Physician services must be billed to Medicare with the correct site of service code

- Equal Billing Treatment. All Medicare patients must be billed a facility charge

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

Obligations of Provider-Based Status for Outpatient Clinics (cont'd.)

- DRG Payment Window.
- Beneficiary Notices.

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
- Management Contracts

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 C Cures Act

Approval Process (cont'd.)

- Material changes
  - Permits ("may report") notification to CMS to avoid retrospective reopenings
  - Disclosures

Section 603 of Bipartisan Budget Act of 2015 and CMS Implementation

Bipartisan Budget Act of 2015, Section 603

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

On-Campus not subject to SN

- On-Campus
  - Buildings or structures within 250 yards from main building
  - Some States have defined separate building or structure more than 250 yards from main ED entrance but connected to skybridge owned/operated by hospital is considered on-campus
  - N.B.: 250 yards from “remote location” also protected
  - Final Rule, no guidance for “on campus;” RO

DED not subject to SN

- 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 a 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.

Grandfathering of OCODP

- How does OCODP 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"
  - President Obama signed BiBA 2015, Nov. 2, 2015

Grandfathering of OCODP

- Important: exempt (grandfathered) sites:
  - Can't relocate
  - May add new services (expand clinical service families) without losing OPPS rates
  - Can't be separately sold, and transactions must retain provider agreement

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
  - Given the relaxation of the "APC group" rules (to be discussed), "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

Expansion of Services

- CMS proposed to limit provider-based departments to the services they were furnishing prior to the enactment of BiBA
- CMS relented in the Final Rule in recognition that the limits on relocation already addressed many of their concerns

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 propose to have 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.)*

- Will generally pay at 50% of the OPPS rate
  - Based on a "relativity" analysis using claims identified with the "PO" modifier
- Will apply the same packaging rules as applied under OPPS
- Exceptions for
  - OT/PT/ST
  - Separately payable drugs
  - Preventive services
- Coding rules for radiation therapy delivery and imaging will follow the MPFS
- No outlier payments, but silent as to bad debt
- Comments are 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

What's the Impact on 340B?

- 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
- There are still questions as to whether it is absolutely necessary for hospitals to bill under the new OPPS "lite" fee schedule in order for the site to qualify as a child site

"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

Space Layout & Co-Location Issues

Space Layout Issues

- Hospital outpatient department/non-hospital provider/supplier shared space arrangements
  - Provider-based status final rule
  - Different types of shared space arrangements
    - Time share arrangement
    - Time block arrangement
    - Suites within medical office building
    - Shared reception/waiting area

New Thinking on Co-Location

- July 2011 CMS Letter
- March 25, 2015, AHLA Medicare & Medicaid Law Institute presentation (Vernaglia & Ruskin)
  - CMS Staff consulted, participated in discussions
- May 5, 2015 David W. Eddinger AHLA Webinar
- Spring 2015 CMS trainings of:
  - Accrediting Agencies (*e.g.*, Joint Commission)
  - State Survey Agencies

Co-Location Principle

- General principle:
  - All certified hospital space, departments, services, and/or locations must be 100% hospital usage 24/7
  - “Hospitals are not permitted to “carve-out” areas as non-hospital space”
  - Cannot be “part time” part of the hospital and “part time” another hospital, ASC, physician office, or any other activity”
- Flagged co-location with physician offices as issue
- CoP and provider-based violations at risk

Co-Location Principle

- Sufficiently separated space is “indicated by”:
- Exclusive:
  - Entrance
  - Waiting
  - Registration areas
- Permanent walls
- In MOBs, distinct USPS designations

Co-Location Principle

- “indications that a purported hospital space may instead be a part of a larger component”:
  - Shared entryway
  - Interior hallways
  - Bathroom facilities
  - Treatment rooms
  - Waiting rooms and
  - Registration areas

- Query:
  - If hospital doesn’t split bill;
  - In provider-based space;
  - And wants to follow Co-Location principle . . .

Provider-Based Status . . .
A Long Strange Trip Indeed!

Any Questions?

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