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Congress Considers Broader Hospital Site-Neutral Payment Exceptions and Other Payments Changes

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New legislation would create broader exceptions under much maligned legislation enacted in 2015 that will equalize Medicare payments furnished in new off-campus outpatient facilities.

In Depth

The House Ways and Means Committee next week is expected to consider and approve the Helping Hospitals Improve Patient Care Act of 2016, legislation that would create broader exceptions under much maligned legislation enacted in 2015 that will equalize Medicare payments furnished in new outpatient facilities not on a hospital's campus beginning in 2017. The legislation, if enacted, would provide much needed and sought after relief for hospitals that were caught by surprise by the 2015 legislation. Although the future of the legislation is uncertain, hospitals affected by the 2015 legislation should consider taking steps now to protect potentially affected interests. Hospitals and other providers not affected by the 2015 legislation also should examine the bill because it proposes to make nearly a dozen other payment and regulatory changes that could be relevant.

Site-Neutral Payments for Off-Campus Provider-based Hospital Services

Section 603 of the Bipartisan Budget Act of 2015, enacted November 2, 2015, limits Medicare payments for items or services (other than services furnished by a dedicated emergency department) furnished at an off-campus outpatient department of a hospital, unless that location was billing as an outpatient department of a hospital prior to the date of enactment. Beginning January 1, 2017, Medicare will pay for such items and services under either the Medicare Physician Fee Schedule (MPFS) or Ambulatory Surgical Center (ASC) fee schedule, as applicable to the service provided, instead of under the Hospital Outpatient Prospective Payment System (OPPS). Payment rates under OPPS typically provide the hospital with a considerably higher payment amount than when services are paid under MPFS or the ASC fee schedule.

Almost immediately after that legislation was approved, hospitals besieged Congress with complaints about projects—some requiring substantial capital investment—that were already underway, and that were undertaken with the expectation of higher Medicare payments under the OPPS. Many of these

hospitals complained that implementation of Section 603, as enacted, would disrupt long-standing plans and result in discontinued services.

The legislation that likely will be considered next week extends grandfather protection to some of these projects. Under the original legislation, a project would not be subject to the site-neutral payment policy if the hospital was *billing* Medicare for services furnished at that off-campus outpatient department location on or before November 2, 2015. Under the new bill, an off-campus outpatient department also could continue to be eligible for higher OPPS payments in 2017 if the host hospital submitted a voluntary provider-based attestation to the Centers for Medicare and Medicaid Services (CMS) pursuant to 42 C.F.R. § 413.65(b)(3) before December 2, 2015. Under guidance from CMS governing submission of provider-based attestations, for a hospital to have taken this step, the construction of the new off-campus outpatient department would have had to be complete and accepting or poised to accept patients.

While this new exception would affect only a few hospitals with complete projects that fell just short of the billing deadline, another exception may apply to more facilities. For services furnished on or after January 1, 2018, the proposed legislation would except from the site-neutral policy off-campus outpatient department locations that had a “binding written agreement with an outside unrelated party for the actual construction” of the new off-campus outpatient department before November 2, 2015. To be eligible under this alternative exception, the host hospital must also: (1) file a provider-based attestation for the new off-campus outpatient department before July 1, 2016; (2) submit a certification to CMS before July 1, 2016, that the hospital had a binding written construction agreement; and (3) add the off-campus outpatient department to the host hospital's Medicare enrollment form.

Whereas the narrower relief for off-campus outpatient departments with provider-based attestations filed before December 2, 2015 would be applicable only for 2017, the broader relief for off-campus outpatient departments with construction agreements in place as of November 2, 2015 (which would include hospitals eligible for the 2017 exception) would not be available until January 1, 2018. This means that hospitals able to take advantage of only the broader relief would not be eligible for OPPS payments during 2017, and would be subject to lower MPFS or ASC payments until January 1, 2018. The proposed legislation also would provide an exemption for off-campus outpatient departments of certain cancer hospitals that file provider-based attestations within 60 days of the date of enactment of the legislation (for departments meeting provider-based requirements between November 2, 2015 and the date of enactment) or within 60 days of the date of meeting provider-based requirements.

Notably, the legislation does not seek to provide CMS with further direction or clarification on other questions hospitals have raised about the original bill, such as how and whether the site-neutral payments would apply when a grandfathered off-campus department relocates or expands services, or undergoes a change in ownership. CMS is expected to publish proposed regulations to implement the original bill in coming weeks.

Of course, this relief will be available only if this legislation is approved by Congress and signed by the president. While approval by the House Ways and Means Committee is an important and notable step in that direction, it is but one step in a long, difficult process. Nonetheless, hospitals that were caught unaware and disadvantaged by the 2015 legislation, and that had a binding written agreement with an outside unrelated party for the actual construction of a facility before November 2, 2015, and that proceeded with the project, should consider whether to submit an attestation to the CMS pursuant to 42 C.F.R. § 413.65(b)(3) before July 1, 2016.

Additional Provisions

In addition to the proposed revisions to the Section 603 site-neutral payment policy, the legislation includes provisions that would make a variety of other important Medicare payment changes, including the following.

Rural Community Hospital Demonstration Program

The Rural Community Hospital Demonstration Program (RCH Demo) provides Medicare cost-based reimbursement to certain small rural hospitals that do not quality for cost-based reimbursement under the Critical Access Hospital designation. The legislation would extend the RCH Demo for an additional five years (through the end of calendar year 2021) and reopen the application process to hospitals in any state, but giving priority to hospitals in low population density states.

Long Term Care Hospital Moratorium and High Cost Outliers

The legislation would provide an exception to the current moratorium on new long term care hospitals (LTCHs) to allow for an expansion in the number of LTCHs beds at existing LTCHs and LTCH satellite facilities with expansion projects in place as of April 1, 2014. The legislation would also increase the cost threshold necessary for LTCHs to receive high cost outlier payments.

Hospital Inpatient Short-stays

Policymakers have in recent years wrestled with how to respond to an increased frequency of one-day inpatient admissions and extended observation stays in outpatient cases. This legislation takes an important step toward eliminating the financial incentives that drive these trends. Specifically, the legislation requires CMS to develop HCPCS codes (used to code outpatient services) associated with 10 surgical MS-DRGs that commonly have a one-day length of stay. While not stated expressly in the legislation, the purpose of establishing these HCPCS codes is to facilitate a crosswalk that will better connect inpatient and outpatient coding and payment systems for hospitals with the goal of identifying surgeries appropriate for site-neutral payment between inpatient and outpatient settings.

Ambulatory Surgical Centers and the Meaningful Use Program

Under the Medicare Meaningful Use program, physicians must conduct a threshold amount of patient encounters in settings with Certified Electronic Health Record Technology to meet program requirements. Patient encounters in the Ambulatory Surgical Center setting are included to determine whether the physician’s threshold is met, but because ASCs were not included in the original Meaningful Use program, there is no CEHRT option available in the ASC setting. As such, in these instances, the physician adds to the denominator without adding to the numerator of the ratio. The ASC community has argued that this dynamic discourages physicians from furnishing Medicare cases in ASCs.

The legislation before the House Ways and Means Committee would prohibit CMS from penalizing physicians under the current Meaningful Use program or its equivalent under the new Merit-Based Incentive Payment System. This protection will be available to eligible professionals who furnish “substantially all” of their Medicare covered professional services in an ASC. The protection will be available until such time as CMS certifies an EHR system for ASCs.

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