# PUBLICATION

## CMS Final Rule and 21st Century Cures Act Include Good and Bad News for Provider-Based Sites [Ober|Kaler]

**2016**

CMS recently published its final outpatient prospective payment system (OPPS) rule, which includes its new policies governing payment related to services furnished at off-campus provider-based departments (OPBDs). 81 Fed. Reg. 19752, 79699—729, 79879-80 (Nov. 14, 2016). We discussed the agency's proposed rules in an earlier *Payment Matters* article here.

The impetus for the change in the rules is Section 603 of the Bipartisan Budget Act of 2015, which barred CMS from continuing to pay hospitals the OPPS rates for services furnished in OPBDs beginning January 1, 2017. These new payment rules do not, however, apply in several situations. Specifically, OPPS will continue to be used to pay for services furnished: (1) in a dedicated emergency department, (2) in an *on-campus* provider-based department (i.e., within 250 yards of the main hospital buildings), (3) at, or within 250 yards of, a remote hospital location, and (4) by an OPBD that billed for services provided as of Nov. 2, 2015 (the date the law was enacted).

On December 13, 2016, additional legislation was signed into law, expanding the exception for OPBDs providing services as of Nov. 2, 2015. 21st Century Cures Act § 16001.

Key provisions from the final rules and the 21st Century Cures Act are discussed below.

### Dedicated Emergency Department (ED)

CMS adopted without change its proposal to exempt all items and services (emergency and nonemergency) furnished in an ED from the provisions of section 603. These will continue to be paid via the OPPS.

### Relocation of OPBDs

CMS also adopted its proposed rule that OPBDs that "impermissibly relocate" will be "new" OPBDs that will not be exempt from the new rules.

An off-campus department, and the items and services that it furnishes, will be considered "new" if that department "moves or relocates from the physical address that was listed on the provider's hospital enrollment form as of November 1 2015." In the final rule, CMS adopts one modification to the relocation bar: it will allow an exceptions process limited to extraordinary circumstances outside a hospital's control, such as natural disasters, significant seismic building code requirements or significant public health and public safety issues. CMS expects these will be rare occurrences. CMS states that it will provide subregulatory guidance on the extraordinary circumstances process.

In an MLN Matters article released December 5, 2016, CMS reminded hospitals to update their Medicare enrollment information for purposes of Section 603. MLN Matters No. MM9613.

### Expansion of Services Furnished at OPBDs

CMS had proposed that existing OPBDs will be considered excepted from the new payment limitations only to the extent that they furnish items or services that they were furnishing and billing for under OPPS prior to

November 2, 2015. CMS proposed to define the service types by nineteen clinical families of hospital outpatient services.

In the good news department, CMS is not finalizing its proposal to limit service line expansions. Therefore, an excepted OPBD will receive payments under OPPS for all billed items and services, regardless of whether it furnished them prior to the enactment of Section 603, as long as the OPBD remains excepted, i.e., meets the relocation and change of ownership requirements.

### Change of Ownership of OPBDs

CMS is finalizing as proposed its rule that an excepted OPBD that undergoes a change of ownership will remain excepted only if the ownership of the main provider is also transferred and the Medicare provider agreement is accepted by the new owner.

### Payment for Services Furnished in Non-Excepted OPBDs

Section 603 requires that non-excepted OPBDs shall not be paid under OPPS but shall be paid "under the applicable payment system." CMS had proposed paying for these services by paying just the physician or practitioner an all-inclusive amount, and paying the provider-based site nothing. As a result, physicians would have had to pay hospitals for the cost incurred by the hospital in providing the services. As discussed in numerous comment letters to the agency, this raised substantial concerns, including concerns regarding the physician self-referral law and Federal anti-kickback statute.. CMS considered those concerns and decided not adopt its proposal. Instead, the final rule provides that payment for CY 2017 will be made to the physician or practitioner for his/her professional fee, and payment will be made to the excepted OPBD for the facility fee (the technical component). Payment to the non-excepted OPBD will be at 50 percent of the OPPS rate, with some exceptions. Hospitals will be required to bill on a UB-04, using a modifier "PN" to indicate a non-excepted item or service. CMS will apply a geographic adjustment factor to the site-specific technical component rates. CMS anticipates that it will continue the same payment mechanism for CY 2018 to allow time to develop a new system to be applied thereafter.

### Expansion of the exception for OPBD services provided as of Nov. 2, 2015

The final rule included a modification to the agency's proposal to "grandfather" from Section 603, only OPBDs that had furnished services and billed for those services prior to November 2, 2015. CMS adopted a policy that would include within the grandfathering clause, those OPBDs that *furnished* OPBD services prior to November 2, 2015, so long as they are billed under the OPPS in accordance with timely filing limits, thereby making clear that the services did not have to be *billed* by November 2, 2015.

### 21st Century Cures Act

The 21st Century Cures Act, signed into law on December 13, 2016, expands the scope of the Section 603 exception for an OPBD that had been billing under OPPS for OPBD services furnished prior to November 2, 2015. Section 16001 of the 21st Century Cure Act states that for 2017, providers are deemed to have been billing under OPPS for OPBD services furnished prior to November 2, 2015, if the Secretary received a provider-based attestation for the site from the provider prior to December 2, 2015. Thus, if a provider that did not actually drop a bill but did provide OPBD services prior to November 2, 2015, and did file a provider-based attestation prior to December 5, 2015, would be grandfathered in and permitted to continue billing under OPPS. The legislation requires that the attestation must have been filed pursuant to 42 C.F.R. § 413.65(b)(3). Accordingly, attestations that do not meet all of the requirements of this regulatory provision likely would not be encompassed within the protections of this provision.

Section 16001 also includes provisions applicable to 2018 and subsequent years, which extend protections to certain OPBDs that were in mid-build status as of November 2, 2015. The criteria for a location to fall within the protection of these provisions are that: (1) the Secretary receives a proper provider-based attestation for the

site from the provider prior to December 31, 2016 (or, if later, within 60 days after enactment of this provision); (2) the OPBD is included on the provider's enrollment form; (3) prior to November 2, 2015, the provider had a binding written agreement with an outside unrelated party for the actual construction of the department; and (4) within 60 days after enactment of these provisions, the Secretary receives a written certification that the OPBD met these requirements from the chief executive officer or chief operating officer of the provider. As the law's date of enactment is December 13, 2016, items 1 and 4 above are **due February 14, 2017**.

### Ober|Kaler's Comments

The Section 603 rule, as finalized by CMS, provides a welcome reprieve from what was proposed. Still, the provisions regarding relocation are quite restrictive, providing an exception only in very limited and rare circumstances that are unlikely to provide much relief. Hospitals are encouraged to monitor CMS's subregulatory guidance for information on the exceptions process for extraordinary circumstances.

Hospitals that fall within the parameters of the mid-build criteria must be sure to file a complete and proper provider-based attestation and a written certification that it met the mid-build criteria by February 14, 2017.