

The Issue

The Bipartisan Budget Act (BiBA) of 2015 enacted site-neutral payment reductions for Medicare services that are furnished in newer off-campus “nonexcepted” provider-based hospital outpatient departments (HOPDs) that are not dedicated emergency departments (DEDs). The legislation defines nonexcepted HOPDs as departments that are not on the main campus of a hospital and are located more than 250 yards from the hospital’s main buildings. A “new” nonexcepted HOPD is defined as an entity that first furnished and billed for Medicare hospital outpatient services after the date of enactment (Nov. 2, 2015), but is not a DED. BiBA states that nonexcepted HOPDs would not be eligible for reimbursements from the Centers for Medicare & Medicaid Services’ (CMS) outpatient prospective payment system (OPSS) beginning Jan. 1, 2017, and instead would be paid under another applicable Part B payment system.

Under CMS’s recently proposed regulations for implementing the site-neutral policies in BiBA, as of Jan. 1, 2017, these new off-campus HOPDs would be paid nothing; only the physician performing the service at the HOPD would be paid for his or her services at the “nonfacility” physician fee schedule (PFS) rate. These nonexcepted HOPDs would receive no direct reimbursement from Medicare for services such as nursing, laboratory, imaging, chemotherapy, surgical and many other reasonable and necessary services provided to Medicare beneficiaries. Further, the agency’s proposal to limit flexibility in relocation and expansion of excepted HOPDs, in combination with its proposal to withhold hospital payments altogether, will mean that hospitals and health systems that have planned to provide or expand much-needed hospital level outpatient care in urban and rural communities with limited access to care will not be able to do so.

AHA Position

The CMS has proposed a short-sighted and unworkable set of policies that do not provide any form of reimbursement to hospitals for the services they provide to Medicare beneficiaries. The agency’s proposals will prevent hospitals from being able to provide necessary, innovative and high quality health care to their communities and cannot be reasonably implemented. **CMS must delay these site-neutral policies until it can adopt much needed changes in order to provide fair and equitable payment to hospitals.** Among these needed changes: the agency must ensure that patients continue to have access to the services they need at the facilities where they seek treatment by protecting hospitals’ ability to offer an expanded range of services and to relocate excepted HOPDs, without experiencing a loss of reimbursement. Further, CMS should allow individual HOPDs to be transferred from one hospital to another and maintain their excepted status.

Why?

- **Hospitals already suffer negative margins treating Medicare patients in HOPDs.** According to the Medicare Payment Advisory Commission (MedPAC) June 2015 data book, Medicare margins were negative 12.4% for outpatient services in 2013. Additional cuts to HOPDs threaten beneficiary access to these services.
- **Hospital-based clinics provide services that are not otherwise available in the community to vulnerable patient populations.** The reduction in outpatient Medicare revenue to hospitals will threaten access to critical hospital-based services, such as care for low-income patients and underserved populations. For example, relative to patients seen in physician offices, patients seen in HOPDs are:
 - 2.5 times more likely to be Medicaid, self-pay or charity patients
 - 1.8 times more likely to be dually eligible for Medicare and Medicaid
 - 1.8 times more likely to live in high-poverty areas
 - 1.7 times more likely to live in low-income areas
 - 1.7 times more likely to be Black or Hispanic
 - 2 times more likely to receive care from a nurse in addition to a physician.

- **Patients who are too sick for physician offices or too medically complex for ambulatory surgery centers (ASCs) are treated in the HOPD.** Physicians refer more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, HOPDs treat patients who are suffering from more severe chronic conditions and, in Medicare, have higher prior utilization of hospitals and EDs.
- **HOPDs have more comprehensive licensing, accreditation and regulatory requirements than do freestanding physician offices and ASCs.**
- **Payment should reflect HOPD costs, not physician or ASC payments.** HOPD payment rates are based on hospital cost report and claims data. In contrast, the PFS (and specifically the practice expense component) is based on physician survey data. ASCs do not even report costs.

CMS'S Proposal

CMS says it cannot pay hospitals directly under a non-OPPS Medicare Part B payment system in 2017 because “at a minimum, numerous complex systems changes would need to be made to allow an off-campus provider-based department to bill and be paid as another provider or supplier type.” However, CMS currently pays hospitals, through the hospital bill, at the PFS rate for a wide variety of services and situations, including screening mammography, physical therapy and other types of therapy, and certain preventive services. It also reimburses hospitals via the Critical Access Hospital Optional Payment Method (Method II) at PFS rates. While it may not be simple, CMS has a mechanism at its disposal that it could use to pay hospitals directly for nonexcepted services under the PFS.

Beyond suspending payment for services at HOPDs, the proposed rule brings up other issues:

Relocation and Rebuilding. Under the OPPS proposed rule, CMS limits flexibility in relocation and expansion, not allowing an HOPD to retain its exception if it relocates in any way, even if it changes suite numbers within the same building. Any relocation would cause the HOPD to lose payment, as this then triggers the part of the rule that proposes paying nonexcepted HOPDs nothing. HOPDs may need to relocate for a variety of reasons: being located on an earthquake fault line or a revised flood plain and needing to come up to building codes, having a lease expire, becoming obsolete or damaged, becoming too small because of population shifts and increased patient loads, or a number of other circumstances. In the past, HOPDs when moving would do so within the community, or build in the parking lot next-door and transition treatment over without a gap in availability. The likely outcome of this restriction would likely be a gradual closing of community-based HOPDs with services migrating only to the main hospital campus – a significant geographic consolidation.

Expansion of Services. CMS proposes that, if an excepted HOPD expands the types of services it provides on or after Nov. 2, 2015, those services would be paid at the site-neutral rate (no payment to the HOPD in 2017). This would be problematic for HOPDs needing to expand or change the items and services that they offer in order to meet changes in clinical practice and the changing needs of their communities as doing so would result in losing their ability to be reimbursed. Given the rapid pace of technological advances in medicine, the treatments and services offered by HOPDs today will inevitably evolve into newer, innovative and more effective care in the future. Nothing in BiBA requires that CMS treat expanded services in an excepted HOPD in this way. In fact, the plain language of the law does not address relocation or expansion at all.

Change of Ownership. CMS's proposal would not permit an excepted off-campus HOPD to retain its excepted status if it is individually acquired by another hospital. Often, hospitals in financial difficulty that plan to close their inpatient hospital beds will offer to transfer their HOPDs to better-performing hospitals in order to ensure that critical hospital-based outpatient services are still accessible to patients in the community. Such acquisitions would not be financially feasible if the HOPD were to lose its payment.

The OPPS proposed rule was published July 6, 2016. A final version of the rule, after the comment period and changes, will be published on or about Nov. 1, 2016, with changes taking effect on Jan. 1, 2017.