The Evolving Environment for Outpatient Hospital Services: Medicare's Site-Neutral Reimbursement for New Off-Campus Locations

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1. What changed in Fall 2015 regarding outpatient hospital services?

On November 2, 2015, the Bipartisan Budget Act of 2015 was enacted. Section 603 provides that "effective January 1, 2017, Medicare payments for most items and services furnished at an off-campus department of a hospital that was not billing as a hospital service prior to the date of enactment will be made under the applicable non-hospital payment system."[1]. In other words, new off-campus Hospital Outpatient Departments (HOPDs) will be reimbursed at the lowest possible rate. The new provision attempts to address concerns raised by policymakers that Medicare should not be paying varying amounts for the same services based on the location or provider, and that incentives to acquire practices as outpatient departments may have been improper due to the availability of higher service rates in outpatient settings.

2. Are there exceptions for off-campus HOPDs?

The only exceptions are the services provided by a dedicated off-campus emergency department. As defined in Title 42 C.F.R. Section 489.24(b), a dedicated emergency department must meet at least one of the following requirements:

1. "It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
2. "It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. "During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment." [2]

Freestanding EDs face certificate-of-need (CON) limits in most states.

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[1] McDermott Will & Emery LLP, Congress Takes Step Toward Site-Neutral Medicare Payments in Bipartisan Budget Act of 2015, October 29, 2015, retrieved from www.mwe.com/publications on February 12, 2016.

[2] Federal Register, Title 42 of the Code of Federal Regulations, Chapter IV, Subcategory G, § 489.24(b), *Special responsibilities of Medicare Hospitals in emergency cases,* (1994).

3. Why is this change so threatening to hospitals?

Hospitals have enjoyed a Medicare reimbursement premium for many outpatient services, when compared to other entities. As shown below, this premium could exceed 100%:

Medicare Reimbursement for Common Outpatient Procedures As of: **1/1/16** **Atlanta**

Site-of-Service Differential

Specialty	Service	CPT	Total Medicare Reimbursement (MD & Facility) by Setting: Physician Office	ASC / Other	Outpatient Hospital	**Health System** Premium over lower-cost setting		Comments
All	Office visit, established patient, Level 4	99214	$108	n/a	$181	$73	67%	
Imaging	MRI Joint Lower Ext w/o contrast	73721	$239	$222	$343	$121	54%	
	MRI Lunbar spine w/o contrast	72148	$225	$224	$349	$126	55%	
Physical Therapy	PT evaluation	97001	$76	n/a	$76	$0	0%	
	Manual therapy (per 15 minutes)	97140	$30	n/a	$30	$0	0%	
	Therapeutic exercises	97110	$33	n/a	$33	$0	0%	
	E-Stim 1/>not Wnd Care Part	G0283	$14	n/a	$14	$0	0%	
Cardiology	Cardiac Rehab	93798	$25	n/a	$118	$93	365%	
	Echo	93306	$231	n/a	$481	$250	108%	
	Nuclear Stress Test/TMST	78452	$495	n/a	$1,189	$694	140%	
	Pulmonary stress test / simple	94620	$57	n/a	$122	$65	115%	
	Stress ECHO	93351	$275	n/a	$503	$228	83%	
G I	Diagnostic Colonoscopy	45378	$386	*$620*	$952	$332	54%	*GIs will typically own an ASC*
Orthopedics	Knee arthroscopy / surgery	29881	n/a	$1,896	$2,952	$1,056	56%	
	Wrist endoscopy / surgery	29848	n/a	$1,337	$1,979	$642	48%	
Pain Management	Inj foramen epidural l/s	64483	$225	*$443*	$701	$258	58%	*MDs will usually try to perform these procedures in an (owned) ASC*
	Inj foramen epidural add-on	64484	$90	$54	$54			
	Inject spine c/t	62310	$246	*$439*	$697	$258	59%	
	Inject spine l/s (cd)	62311	$227	*$419*	$677	$258	61%	
	Inject trigger points =/> 3	20553	$65	*$79*	$268	$189	238%	
Pulmonary	Sleep Lab	95810	$633	n/a	$980	$347	55%	

As noted by the Government Accountability Office, this reimbursement difference has encouraged the acquisition of physician practices by hospitals, since hospitals could earn a "reimbursement arbitrage" on acquired ancillary services.[3]

For example, by acquiring a cardiology practice with in-office diagnostics, the purchasing health system would be paid $1,189, rather than $495 (for an increase of $694, 140%), per Nuclear Stress Test / TMST procedure using the same facility and staff after designating the diagnostics rooms as an HOPD. See the Technical Appendix for details.

[3] Government Accountability Office, *Increasing Hospital - Physician Consolidation Highlights Need for Payment Reform,* December, 2015, retrieved from www.gao.gov on February 24, 2016.

The hospital outpatient services that are affected by Section 603 are those that are rendered in a new off-campus location and for which Medicare paid via the Outpatient Prospective Payment System (OPPS). Below are some common outpatient services that are/were not paid under OPPS and hence are not affected by Section 603:

- Ambulance services
- Clinical diagnostic laboratory
- Physical, Occupational, and Speech Therapy
- Routine dialysis service for ESRD patients
- Diagnostics and screening mammography

4. When does the new policy apply?

This new payment policy is effective on January 1, 2017. It applies to off-campus outpatient departments of a hospital that were NOT billing as a hospital department prior to November 2, 2015. This policy does not apply to dedicated emergency departments ("freestanding EDs").

5. What impact will it have on hospitals?

From a reimbursement perspective:

a. There is no change to off-campus locations that were operating prior to November 2, 2015.

b. For new off-campus locations, which includes newly-developed sites and acquisitions of physician practices, Medicare reimbursement will be reduced to the lowest applicable amount (i.e., physician practice (known as "non-provider") or ASC). This does not apply to free-standing EDs.

From a business perspective, the magnitude of these Medicare reimbursement reductions may be sufficient to make many prospective outpatient initiatives financially non-viable, particularly if the patient mix is heavily-weighted toward Medicare and the "reimbursement arbitrage" would have been significant.

6. **Can hospitals open new outpatient facilities and bill Medicare?**

There is no restriction on the ability for hospitals to open new outpatient facilities and bill Medicare.

7. **For such new facilities, what is the impact from the new Medicare reimbursement rules?**

Setting aside the free-standing ED exclusion, the impact from the new Medicare reimbursement rules varies substantially by service, as the above table illustrates. In general, Medicare rates will drop for many common services, except for Physician Therapy:

Service	At new HOPDs, reduction in total Medicare reimbursement
Cardiac diagnostics	~ 50+ %
Office visits	~ 30-50 %
Pain management	~ 40 %
Surgery	~ 35 %
Imaging	~ 30 %
Physical Therapy	0 %

The above percentages include physician reimbursement. The percentage reductions in the "hospital" (or "facility") portion is often much larger, as illustrated in the Technical Appendix.

For services whose patients are primarily Medicare (e.g. cardiac diagnostics), off-campus growth (either via practice acquisition or new construction) is likely non-viable.

8. **Why was this change enacted?**

Numerous entities recommended this reimbursement change for a number of reasons:

1. The Medicare Payment Advisory Commission (MedPAC) has recommended since 2012 that Medicare pay hospitals at the same rates as other entities, for certain outpatient services. MedPAC initially focused on evaluation and management services ("office visits"), and the recommendation was expanded in 2013 to other outpatient services. MedPAC estimated in 2015 that these policy changes would save

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$1.4 billion per year, although it is unlikely that this estimate accounted for the "grandfathering" of existing HOPDs.[4]

2. The Congressional Budget Office (CBO) estimated that Section 603 will save $9.3 billion over 10 years.
3. The Government Accountability Office reported in December 2015 that hospital acquisition of physician practices was correlated with the higher reimbursement for hospitals, and that due to trends in increased hospital-physician consolidation, CMS should "equalize payment rates between settings."
4. Trade associations represent competitors to hospitals, including the American Medical Association[5], likely because physicians wanted to have their ancillary services paid at the same rate as hospitals.

9. What changes to Section 603 is the American Hospital Association recommending?

The AHA is not trying to change the reimbursement impact that will be effective on January 1, 2017. Rather, its focus with Congress is merely on a "technical correction" with two objectives:

1. "Hospitals that have made substantial investments in new facilities that were under development when the Bipartisan Budget Act was signed into law should be protected consistent with past precedent."
2. Clarifying that "changes in ownership of a facility do not impact the grandfathered status of a provider-based HOPD and that grandfathered HOPDs may relocate." [6]

[4] Medicare Payment Advisory Commission (MedPAC), *Payment Basics: Outpatient Hospital Services Payment System,* October 2015, retrieved from www.medpac.gov on February 24, 2016.

[5] American Medical Association, *H-330.925 Appropriate Payment Level Differences by Place and Type of Service,* (no date), retrieved from www.ama-assn.org on February 24, 2016.

[6] American Hospital Association, *AHA Factsheet: Site-neutral HOPD Technical Corrections,* November 16, 2015, retrieved from www.aha.org on February 11, 2016.

10. What new rules apply to outpatient services regarding modifiers, codes, et cetera?

In 2014, as part of the CY 2015 Outpatient Prospective Payment System Final Rule, CMS required a new billing modifier on a facility ("provider") claim and a new place of service code on professional claims for services furnished in any off-campus provider-based outpatient departments (e.g., HOPDs). This rule only applies to Medicare patients, and was mandatory as of January 1, 2016. Use of the modifier (by the hospital) and place of service code (by the physician) was voluntary during 2015. Hence, this billing change should not have been a surprise to providers during late 2015. However, the billing rule and Section 603 are complementary, as CMS could not implement some form of "grandfathered" site-neutral reimbursement without being able to differentiate off-campus from on-campus HOPDs or identify those off-campus HOPDs that are already (as of January 1, 2016) billing Medicare.

The billing modifier itself is not directly tied to reimbursement. Rather, it was (and is) CMS' method for segmenting off-campus from on-campus HOPD activity for future policy-setting. It was seen by many (including Progressive), prior to the 2015 Budget Agreement, as a sign that within a few years CMS would eliminate or greatly reduce the site-of-service premium that HOPDs enjoy. This has been the recommendation of MedPAC. Thus, many expect that CMS will study the volume data in 2017 and recommend reimbursement reductions to some or all "grandfathered" HOPDs in 2018 or 2019. Since such a change would affect "existing" hospital margins (and not just planned or potential HOPDs), the change would in turn be very political.

11. What is the "35 mile rule", and does it still apply?

In general, acute care hospitals (other than critical access hospitals) can operate outpatient departments within 35 miles "as the bird flies" from the inpatient campus and structure them as "provider-based" hospital outpatient departments. Section 603 does not affect this rule.

12. What is the outlook with other payors?

This likely varies by segment:

- Medicare Advantage. Typically, MA plans pay providers a slight (3-5%) premium on Medicare reimbursement. Thus, MA plans will likely be able to leverage Medicare's effective rate reduction on *new* sites in 2017. However, since the vast majority of

services will be provided by either campus-based or grandfathered off-campus locations, there will likely be little change in actual total payments made by MA plans. Note: the means by which CMS' Fiscal Intermediaries will identify grandfathered off-campus sites has not been promulgated by CMS, since the payment system must reimburse "new" sites at the site-neutral rates beginning January 1, 2017.

- Commercial. What commercial payors actually do is dependent upon negotiations between hospitals and payors, and cannot be mandated. However, hospital outpatient departments already face pricing competition from lower-reimbursed providers, and this shift in Medicare policy will heighten awareness of the rate premium. We have already seen in many clients that commercial payors do not recognize the site-of-service differential for the evaluation and management code (e.g. "facility fee" for "office-visits").
- Medicaid – Historically, Medicaid has followed Medicare policy in many reimbursement areas. However, this will be state-specific.
- The biggest risk for hospitals may be increased patient knowledge regarding reimbursement rate differentials across locations. Those differences are present today across type of entity (HOPD/ASC/physician office), but beginning on January 1, 2017, HOPD rates for Medicare will differ between new sites and those on campus or in grandfathered locations. "Transparency" is the mortal enemy of large rate differences for apparently-identical services.

In summary, it is difficult to develop a logical scenario whereby Section 603, *by itself*, leads to lower negotiated rates with health plans (for all segments).

13. What are the strategic implications on hospitals and health systems of this legislation?

A. Practice acquisitions or new outpatient locations by hospitals that depend upon Medicare "reimbursement arbitrage" to make the investment financially-viable will be hard to justify.

B. Outpatient growth for services that need relatively-high Medicare reimbursement will be focused in existing HOPD locations and on campus.

C. New HOPD site growth will be limited to services that:
   a. Are still profitable across all payers (such as Physical Therapy, for which reimbursement rates have not changed)
   b. Drive downstream volume. Examples include:
      i. Primary care, including urgent care
      ii. Low-end imaging
      iii. Specialist care (for their non-diagnostic office visits)
      iv. Physical Therapy
      v. Medical specialists offices and chronic condition clinics (for 340B margins on scripts written)
   c. Meet "system" care management needs even if the HOPD itself is not profitable. Such needs include:
      i. Geographic coverage
      ii. Low-cost facilities across the entire continuum of care
      iii. Care management intervention services (rendered while performing a fee-for-service task), such as:
         1. Medication dispensing (and medication therapy management) to patients with chronic conditions; or
         2. Physical Therapy re-evaluations at milestones during an orthopedic bundled payment episode (e.g., pre-surgery; 30 days post-surgery; 270 days post-surgery (for Medicare mandatory bundled payments for hips/knees at 800 hospitals)), which could assist with managing and improving reported outcomes, which drives the bonus payment.
   d. Complement free-standing EDs.

14. What happens next?

Many tactical issues are unresolved and will require clarification from CMS, such as[7]:

- What changes can a "grandfathered" off-campus department make?
    i. Can an off-campus department add different services (e.g., add cardiac diagnostics to a site that currently only offers physical therapy)?
    ii. Could an off-campus department change locations and keep its status?
    iii. Will the facility be able to expand its footprint? If so, by how much?
- How (if at all) will CMS change its billing, cost reporting, and/or enrollment procedures?
    i. How will CMS identify new/grandfathered departments?
    ii. Is split-billing still required? If not, how do hospitals get paid?
- What kind of leniencies will be afforded to free-standing EDs?
    i. How will CMS handle reimbursements for scheduled non-emergency services furnished in a dedicated ED facility?

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[7] Russo, Greg; Hettich, Daniel J.; Kenny, Christopher; Dressel, Peter; Polston, Mark D., *How Does Medicare Reduce Payments? Let Us Count the Ways*, King & Spalding, 2016 Health Law & Policy Forum, Section 603.

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Technical Appendix: Reimbursement Details

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Medicare reimbursement can be complex when comparing sites of service. This appendix disentangles the details of Medicare reimbursement.

In the "physician office" setting, which CMS refers to as "Non-Facility", Medicare's reimbursements for professional and facility services are paid via a Global fee, as a Part B claim. In the ASC or HOPD ("provider") setting, a Part A facility fee is paid to the facility and the Part B fee is reduced to the physician.

The table below illustrates how Medicare reimburses physicians and hospitals, by setting, for a common cardiac diagnostic:

Example: Nuclear Stress Test/TMST

		Medicare Reimbursement by Setting			
Entity	Claim type	Physician Office ("non-provider")	HOPD ("provider")	Difference	
Physician organization	Part B	$494.91	$80.16	($414.75)	-84%
Hospital	Part A	n/a	$1,108.46	$1,108.46	n/a
Total		$494.91	$1,188.62	$693.71	140%
Attribution by function					
Physician's professional service		$80.16	$80.16	$0.00	0%
Diagnostics		$414.75	$1,108.46	$693.71	167%
Total		$494.91	$1,188.62	$693.71	140%

Medicare's total payments increase by $694, or 140%,when a case is shifted from the physician office to the HOPD setting. The physician group loses $415 for the "technical component" of the Part B claim, but in return the HOPD is paid $1,108 for a diagnostic test. This is a $694 (167%) increase in the payment for the diagnostic itself.

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Below are the detailed reimbursements by CPT and related APC:

Medicare Reimbursement to Facilities and Physicians, by Setting and by Medicare Benefit

As of: **1/1/16** **Atlanta**

			Part B		Part A			
			Physician Fee		Facility Fee			
Specialty	Service	CPT	Non-Facility (Global)	Facility (Prof-only)	ASC	Outpatient Hospital	APC	SI
All	Office visit, established patient, Level 4	99214	$108.18	$79.03	$0.00	$102.12		B
	Hospital outpt clinic visit	G0463		$79.03	$0.00	$102.12	5012	J2
Imaging	MRI Joint Lower Ext w/o contrast	73721	$238.83	$69.39	$152.96	$273.54	5581	Q3
	MRI Lunbar spine w/o contrast	72148	$225.13	$75.82	$147.94	$273.54	5581	Q3
Physical Therapy	PT evaluation	97001	$75.96	$0.00	$0.00	$75.96		A
	Manual therapy (per 15 minutes)	97140	$30.13	$0.00	$0.00	$30.13		A
	Therapeutic exercises	97110	$32.62	$0.00	$0.00	$32.62		A
	E-Stim 1/>not Wnd Care Part	G0283	$13.98	$0.00	$0.00	$13.98		A
Cardiology	Cardiac Rehab	93798	$25.45	$14.30	$0.00	$103.92	5771	S
	Echo	93306	$230.98	$64.43	$0.00	$416.80	5533	S
	Nuclear Stress Test/TMST	78452	$494.91	$80.16	$619.83	$1,108.46	5593	S
	Pulmonary stress test / simple	94620	$57.01	$31.12	$0.00	$91.18	5734	Q1
	Stress ECHO	93351	$274.76	$86.27	$0.00	$416.80	5533	S
G I	Diagnostic Colonoscopy	45378	$385.87	$199.12	$420.93	$752.76	5312	T
Orthopedics	Knee arthroscopy / surgery	29881	$556.64	$556.64	$1,339.58	$2,395.59	5122	T
	Wrist endoscopy / surgery	29848	$523.69	$523.69	$813.76	$1,455.26	5121	T
Pain Management	Inj foramen epidural l/s	64483	$224.56	$116.25	$327.22	$585.17	5442	T
	Inj foramen epidural add-on	64484	$89.60	$53.62	$0.00	$0.00		N
	Inject spine c/t	62310	$245.79	$111.93	$327.22	$585.17	5442	T
	Inject spine l/s (cd)	62311	$226.83	$92.25	$327.22	$585.17	5442	T
	Inject trigger points =/> 3	20553	$64.82	$44.31	$35.10	$223.76	5441	T
Pulmonary	Sleep Lab	95810	$633.49	$123.81	$0.00	$856.44	5724	S

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Below are reimbursements by procedure for the Facility Fee (in an ASC or HOPD) or for the Technical Component of a global fee paid for services in a physician office:

Medicare Reimbursement for Common Outpatient Procedures: Facility Fee or "Technical Component (TC)" of Global Fee

Site-of-Service Differential

As of: **1/1/2016** **Atlanta**

Specialty	Service	CPT	Reimbursement by Setting: Physician Office (TC only)	Facility Fee: ASC / Other	Facility Fee: Outpatient Hospital	**Hospital** Premium over lower-cost setting		Comments
All	Office visit, established patient, Level 4	99214	$29	n/a	$102	$73	250%	
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	MRI Lunbar spine w/o contrast	72148	$149	$148	$274	$126	83%	
Physical Therapy	PT evaluation	97001	$76	n/a	$76	$0	0%	
	Manual therapy (per 15 minutes)	97140	$30	n/a	$30	$0	0%	
	Therapeutic exercises	97110	$33	n/a	$33	$0	0%	
	E-Stim 1/>not Wnd Care Part	G0283	$14	n/a	$14	$0	0%	
Cardiology	Cardiac Rehab	93798	$11	n/a	$104	$93	832%	
	Echo	93306	$167	n/a	$417	$250	150%	
	Nuclear Stress Test/TMST	78452	$415	n/a	$1,108	$694	167%	
	Pulmonary stress test / simple	94620	$26	n/a	$91	$65	252%	
	Stress ECHO	93351	$188	n/a	$417	$228	121%	
G I	Diagnostic Colonoscopy	45378	$187	*$421*	$753	$332	79%	*GIs will typically own an ASC*
Orthopedics	Knee arthroscopy / surgery	29881	n/a	$1,340	$2,396	$1,056	79%	
	Wrist endoscopy / surgery	29848	n/a	$814	$1,455	$642	79%	
Pain Managemen	Inj foramen epidural l/s	64483	$108	*$327*	$585	$258	79%	*MDs will usually try to perform these procedures in an (owned) ASC*
	Inj foramen epidural add-on	64484	$36	$0	$0			
	Inject spine c/t	62310	$134	*$327*	$585	$258	79%	
	Inject spine l/s (cd)	62311	$135	*$327*	$585	$258	79%	
	Inject trigger points =/> 3	20553	$21	*$35*	$224	$189	537%	
Pulmonary	Sleep Lab	95810	$510	n/a	$856	$347	68%	

Service	At new HOPDs, reduction in **facility-related** Medicare reimbursement
Cardiac diagnostics	~ 60+ %
Office visits	~ 50-60 %
Pain management	~ 40-50 %
Surgery	~ 40-50 %
Imaging	~ 40-50 %
Physical Therapy	0 %

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Overview of Progressive Healthcare

Founded in 1997, Progressive Healthcare is a healthcare advisory services firm that provides:

- Consulting (strategic, financial, operational)
- Outsourced Services (ambulatory clinic set-up and management, Medicare CCM, ACO management).

We focus on Integration:

- Physician-hospital
- Clinical, financial, and programmatic
- Provider and payors / employers

Our offices are located in Nashville and Atlanta.

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