Provider-Based Services Face Significant Legislative Change

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On November 2, 2015, Congress enacted legislation through the Bipartisan Budget Act of 2015 (the "Act") that will have a significant impact on reimbursement for outpatient services provided at hospital off-campus sites. The provider-base rules (codified at 42 C.F.R. § 413.65) were modified by Section 603 of the Act. Specifically, the Act has altered reimbursement for most hospital-based services provided at any off-campus site established after November 2, 2015.

The changes implemented by the Act will affect all *new* off-campus hospital outpatient locations that were not billing as a provider-based location under the Outpatient Prospective Payment System ("OPPS") prior to November 2, 2015. While a new provider-based site can be established after November 2, 2015, reimbursement under the OPPS for those services at that site will cease on December 31, 2016. Off-campus hospital outpatient departments that were established and billing under the OPPS *prior to* November 2, 2015 will continue to be reimbursed under the OPPS. On-campus outpatient departments are not subject to the changes in reimbursement under the Act.

Medicare reimbursement is often based on the service provided to the beneficiary and the location at which that service is provided. When a Medicare beneficiary receives a physician office service in a hospital (or hospital-based) setting, Medicare will reimburse the professional service charge under the Physician Fee Schedule and the facility fee under the OPPS. However, if that same service is provided in a physician's office setting, the additional facility fee under the OPPS is not paid. This has led to hospitals receiving a facility fee and higher procedure fees for a service delivered in a hospital-based (or provider-based) setting compared to the service provided in an ASC or medical clinic setting.

The change in statutory language appears to be a budget-oriented response to concerns among policymakers and some providers regarding disparities in our health care reimbursement system that results in higher amounts paid for a professional service based solely on the location or type of provider. Adding to the magnitude of the issue for providers is the probability that any change in provider-based reimbursement adopted by Medicare will be followed by Medicaid and commercial payers.

The language in the Act is very limited, and it raises many questions about how CMS may develop regulations to implement this significant change. There are immediate questions for providers with projects that were at various stages of development when the Act was suddenly passed. The full effects are not scheduled to be felt until December 31, 2016, so providers will need to review current operations and plans to be prepared for what guidance may be provided in the coming months.

For the full text of Section 603 of the Bipartisan Budget Act of 2015, click here.