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A (TEMPORARY) SIGH OF RELIEF FOR HOSPITAL EXPANSION: CMS RELEASES FINAL RULE REGARDING PROVIDER-BASED DEPARTMENTS

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When Congress enacted the Bi-Partisan Budget Act of 2015 (the Act) on November 2, 2015, Section 603 of the Act effectively halted the development of any new off-campus hospital outpatient departments, also referred to as provider-based departments (PBDs). Pursuant to Section 603, effective January 1, 2017, all PBDs are ineligible for the increased provider-based reimbursement under the Outpatient Prospective Payment System (OPPS) unless they existed and were billing for services as of November 2, 2015. On November 1, 2016, almost a year to date after the enactment of the Act, CMS released its final rule, finalizing regulations to implement Section 603 as well as finalizing other OPPS changes for 2017, which are beyond the scope of this bulletin.

Prior to the release of the final rule, Section 603 contained three primary ambiguities. First, it was unclear whether PBDs were prohibited from expanding their scope of services to include new service lines, with the services in the new lines also receiving reimbursement under the OPPS. Initially, CMS proposed to except only those services that fit into the existing "clinical families of services" that a PBD was billing as of November 2, 2015, such that any new services in an otherwise excepted PBD would be subject to Section 603's payment limitations. CMS's concern, which still exists, is that without any limitation on the expansion of services, hospitals can continue to purchase physician practice groups and add those physicians (and their new service lines) to the existing PBDs, in turn receiving increased reimbursement under the OPPS. Such a scheme arguably circumvents the intent of Section 603.

In spite of this concern, due to the comments received, CMS did not limit such expansion. Thus, as of now, PBDs can expand into service lines that they did not operate as of November 2, 2015 and receive reimbursement under the OPPS for those new service lines. This comes as welcome news to hospitals that were planning to expand their scope of services but had yet to implement the new services when

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Congress passed the Act. However, CMS intends to monitor service line growth in PBDs and look into different ways to limit the expansion of services in accordance with the intent of Section 603. CMS is accepting comments on this issue until December 31, 2016. At this point, while hospitals have temporary relief, it is unclear what restrictions, if any, CMS may ultimately impose on new service lines within existing excepted PBDs.

Second, it was unclear whether PBDs could relocate and continue to receive payment under the OPPS. In the final rule, CMS finalized an approach that allows for relocation of PBDs for extraordinary circumstances beyond a hospital's control, *e.g.* natural disasters, seismic building code requirements and significant public health and safety issues, each of which would necessitate a PBD to move to a new building. CMS will consider other exceptions on a case by case basis.

Third, it was unclear what happens if a PBD's ownership changes. To this end, CMS finalized its proposal to allow PBDs to change owners so long as the new owner accepts the existing Medicare provider agreement from the prior owner. Thus, if a hospital merges with, or is sold to, another hospital, provider-based status transfers to the new owner so long as the transfer does not result in any material change to the provider agreement. However, individually excepted PBDs cannot maintain provider-based status if they are transferred from one hospital to a new hospital, even if the new hospital's off-campus location currently possesses provider-based status.

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