HCFA Releases Provider-Based Rules

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On April 7, 2000, the Health Care Financing Administration ("HCFA") released final regulations implementing the hospital outpatient prospective payment system ("PPS") established by the Balanced Budget Act of 1997. Included in these rules are the first regulations in which HCFA sets forth mandatory standards for a facility or organization to qualify for "provider-based" status.

Background

The Medicare program has always recognized that health care providers (entities referred to as "main providers" in the regulations) have owned and operated facilities separate from their main facility (either on the same campus or off-campus) that were administered financially and clinically by the provider. According to HCFA, such "subordinate" facilities would receive a provider-based designation to accommodate "financial integration" and "achieve certain economies of scale". A provider-based designation would allow a main provider to allocate overhead costs to the entity with provider-based status in the cost allocation process. By shifting operating costs the provider could receive greater reimbursement because the provider-based entities were PPS-exempt and paid on a reasonable cost basis. Additionally, some entities receive greater reimbursement by virtue of having a provider-based designation versus a freestanding designation. For example, physician offices that hold provider-based status are able to operate under a hospital’s Medicare certification resulting in greater Medicare reimbursement. Although the adoption of the outpatient PPS system lessens the advantages of a provider-based designation, attaining provider-based status will continue to be advantageous under certain circumstances.

Provider-Based Rules

With the publication of the final provider-based rules, HCFA established a regulatory framework with rules that all entities wishing to be considered provider-based must meet. The provider-based rules cover a number of different entities for which a main provider needs to obtain provider-based status. The entities are a provider-based entity, a department of a provider, a remote location of a hospital or a satellite facility. "Provider-based status" is the relationship between the main provider and the provider-based entity, department of a provider, remote location of the hospital or satellite facility.

To achieve provider-based status, the following requirements must be met:

1. Licensure. The entity for which provider-based status is sought and the main provider must be operated under the same license.
2. Ownership and Control. The entity for which provider-based status is sought must be owned and controlled by the main provider. In order to be owned and controlled by the main provider, this provision sets forth a number of requirements including 100% ownership of the entity by the main provider, the same governing body and the same organizational documents for both entities, and the main provider must have final responsibility for administrative decisions, contracts with outside parties, etc. of the entity.
3. Administration and Supervision. There must be a reporting relationship between the entity for which provider-based status is sought and the main provider that has the same characteristics as the relationship between the main provider and one of its departments. This includes: direct supervision by the main provider; the same monitoring and oversight relationship between the provider-based director and the main provider as that maintained between the main provider and the departments; and of the integration of administrative functions such as billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services.
4. Clinical Services. There must be integration of clinical services as evidenced by: the following professional staff of the facility or organization seeking provider-based status have clinical privileges at the main provider; the provider maintains the same monitoring and oversight of the facility as it does for any other department; the medical director of the facility has the same reporting relationship with the chief medical officer of the main provider as that officer maintains with medical directors of other departments of the main provider; the medical staff committees at the main provider are responsible for medical activities at the entity; medical records are integrated into a unified retrieval system with the main provider; and inpatient and outpatient services of the entity are integrated with the main provider.
5. Financial Integration. There must be financial integration between the entity and the main provider.
provider evidenced by shared income and expenses and the costs of the entity are reported in the cost center of the main provider with the financial status of the entity incorporated and readily identified in the main provider’s trial balance.

6. Public Awareness. The entity must be held out to the public and other payers as part of the main provider. Patients entering the entity should be aware that they are entering the main provider and are billed accordingly.

7. Location in Immediate Vicinity. The entity and the main provider must be located on the same campus except where certain requirements are met. For off-campus sites, there must be a high level of integration shown by the entity. This includes showing that the entity serves the same patient population.

The regulations also address other issues related to receiving a provider-based designation. Specifically, there are additional provider-based requirements for facilities operated under management contracts, there are specific obligations set forth for hospital outpatient departments and hospital-based entities and there is a section addressing facilities where all services are provided under arrangement. These sections of the regulations are outside the scope of this article, but they must be taken into account by main providers.

Advance Determination

The new rules provide that a provider-based determination must be received from the HCFA regional office prior to the main provider treating an entity as provider-based. It would therefore seem that all entities must obtain an advance determination from HCFA in order to be treated as provider-based. There is, however, some confusion because the regulations also state that if a main provider wishes to treat a "facility or organization" as provider-based, then the main provider must give HCFA enough information to make a provider-based determination if the facility or organization is off the main provider’s campus or if the inclusion of the on-campus facility or organization on the main provider’s cost report will increase by at least 5% the total costs on the cost report. This would appear to mean that a main provider would need not get an advance determination from HCFA in order to treat many on-campus entities as provider-based. This conclusion has been informally supported by HCFA representatives, but a formal clarification of this issue is needed. While it remains unclear as to when an entity must have an advance determination of provider-based status, what is clear are the penalties that may be assessed against a main provider that claims a facility as provider-based that is not entitled to such a designation. HCFA will notify the main provider that payments for past cost reporting periods may be reviewed and recovered, that future payments may be adjusted and that a determination of provider-based status will be made. In addition, HCFA will make a prospective determination regarding provider-based status for an entity that has not gotten a determination. If the facility subsequently receives provider-based status from HCFA, then future payments will be made in accordance with this provider-based status. If, on the other hand, provider-based status is denied, then payments will be terminated unless the main provider meets requirements to bill Medicare as a freestanding facility. For any period before October 10, 2000, recovery will not be made if a good faith effort had been made to operate the facility as provider-based.

The provider-based rules are effective October 10, 2000. While the effective date of an entity's provider-based status will be the date the entity files the application, main providers are advised to apply for provider-based determinations before this date. Applying for and receiving a provider-based designation prior to the October 10, 2000 effective date is the best way for main providers to avoid any future problems regarding the provider-based rules.

1. Office of Inspector General; Medicare Program

2. Prior to HCFA’s adoption of the provider-based rules, the main guidance for what was necessary for provider-based status was set forth at Program Memorandum A-96-7 published in August of 1996. This program memorandum set forth certain criteria such as proximity, common licensure, common accreditation and common ownership and control, but did not require HCFA to give prospective determination of provider-based status. Program Memorandum A-96-7 was subsequently reissued as Program Memorandum A-98-15 in May of 1998 and Program Memorandum A-99-24 in May of 1999.


4. For example, if the services are furnished in an entity with provider-based status it is not subject to the $1,500 cap on reimbursement. Also, in some circumstances the ability to receive Medicare reimbursement at all may depend on having provider-based status (e.g. partial hospitalization services not provided in a community mental health center).

5. A "main provider" is a provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership and financial and administrative control. 65 Fed. Reg. 18434, 18538 (2000) (to be codified at 42 C.F.R. 413.65(a)(2)).

6. A "provider-based entity" is a provider of health care services, or a rural health clinic or federally qualified health center, that is created by, or acquired by, a main provider for the purpose of furnishing health care services of a different
type from those of the main provider under the name, ownership and administrative and financial control of the main provider. Id.

7 A "department of a provider" is a facility or organization or a physician office that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership and financial and administrative control of the main provider. The department of the provider cannot be licensed to provide health care services in its own right or be qualified to participate in Medicare as a provider and Medicare's conditions of participation do not apply to a department as an independent entity. Id.

8 A "remote location of a hospital" is a facility created by or acquired by a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership and financial and administrative control of the main provider. A remote location of the hospital may not be licensed to provide inpatient hospital services in its own right and Medicare conditions of participation do not apply to the remote location as an independent entity. Id.

9 65 Federal Register 18434, 18538-18539 (2000) (to be codified at 42 C.F.R. 413.65(d)).

10 In the regulations, a "campus" is the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and other areas determined on an individual case basis by the HCFA Regional Office to be part of the provider's campus. 65 Fed. Reg. 18434, 18538 (2000) (to be codified at 42 C.F.R. 413.65(a)(2)).

11 To show that the same patient population is served, an entity must show that for every 12 month period: (i) at least 75% of the patients of the facility reside in the zip code areas as 75% of the patients of the main provider; (ii) at least 75% of the patients served by the facility or organization who require the type of care furnished by the main provider receive the care from that provider; or (iii) if the facility was not in operation during all of the 12 month period then the facility is located in a zip code area including among those that during the 12 month period accounted for at least 75% of the patients served by the main provider. 65 Fed. Reg. 18434, 18539 (2000) (to be codified at 42 C.F.R. 413.65(d)(7)).

12 65 Fed. Reg. 18434, 18540 (2000) (to be codified at 42 C.F.R. 413.65(c)).

13 HCFA has indicated that if an entity has already received a provider-based designation prior to the publication of the provider-based rules then such an entity need not obtain a provider-based designation under these rules. An entity previously receiving reimbursement as a provider-based entity without a specific designation does not meet this standard. Rather, entities must have received a written determination from HCFA stating that they are entitled to provider-based status. Comments of Thomas Gustafson, Director of the Purchasing Policy Group, Health Care Financing Administration, and Tzvi Hefter, Director of the Division of Acute Care, Health Care Financing Administration at American Health Lawyers Association Regulation, Accreditation and Payment Substantive Law Committee Teleconference: Provider-Based Designation Under the New Outpatient PPS Rule: What It Means and How It Will Be Determined (May 16, 2000).

14 65 Fed. Reg. 18434, 18538 (2000) (to be codified at 42 C.F.R. 413.65(b)).

15 Comments of Thomas Gustafson, Director of the Purchasing Policy Group, Health Care Financing Administration, and Tzvi Hefter, Director of the Division of Acute Care, Health Care Financing Administration at American Health Lawyers Association Regulation, Accreditation and Payment Substantive Law Committee Teleconference: Provider-Based Designation Under the New Outpatient PPS Rule: What It Means and How It Will Be Determined (May 16, 2000).

16 Under the regulations a "good faith effort" means that the provider-based requirements of common licensure and public awareness were met, facility services were billed as if they had been furnished by an entity with provider-based status, and all professional services of physicians and other practitioners were billed with the correct site-of-service indicator. 65 Fed. Reg. 18434, 18540 (2000) (to be codified at 42 C.F.R. 413.65(i)(3)).
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