Beyond the Hospital Campus II
New requirements for provider-based entities.

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This article is the sequel to “Beyond the Campus”, a piece published in the April/May 2000 issue.

Everyone who works in a system utilizing provider-based facilities should be aware of the important changes in the federal regulations governing provider-based status. These HCFA regulations became final on April 7, 2000 and will become effective on October 10, 2000.

A PROVIDER-BASED TREND

In an increasingly competitive healthcare environment, providers and systems can no longer rely on offering limited services in a single centralized location. To attract more patients, providers must expand both geographically and in the range of healthcare services they offer. One of the most popular and cost efficient ways for a provider to increase its presence in other geographic areas, as well as expanding its scope of offered services is though provider-based facilities.

Provider-based status for affiliated entities often confers both cost-saving efficiencies and favorable reimbursement rates. Generally, the high degree of integration between the main provider and a subordinate entity facilitates lower administrative costs. A provider that is otherwise too small may qualify for more favorable status with Medicare, Medicaid and other payors by combining bed counts with its provider-based subordinates.

Hospitals frequently and profitably purchased off-site physician practices and designate them as "provider-based." The availability of the provider-based designation has also allowed hospitals to operate off-site rehabilitation clinics in areas close to where the majority of their patients live.

Under cost-based reimbursement, the government, at least initially, looked favorably on provider-based status because the efficiencies achieved reduced provider's costs and hence the government's expense. However, when large numbers of PPS hospitals began to purchase physician practices and operate them as provider-based units, the government began to regard provider-based status as simply a method of cost shifting.

HCFA has also become concerned because beneficiaries are paying higher deductibles and copayments at provider-based facilities than would be the case at freestanding facilities. This situation arises out of the facility fee paid by the beneficiary to the main provider in connection with services rendered in a provider-based off-site physician clinic.

PROVIDER -BASED DESIGNATION: THE CURRENT SYSTEM

Although HCFA has recognized the concept of provider-based status for many years, the agency did so without benefit of any statutory authority and without promulgating any rules. As a consequence, some main facilities either acquired or created subordinate facilities that were officially designated as provider-based by HCFA under criteria issued in the form of program memoranda. Other main providers simply self-designated the subordinate facilities they created or acquired. This distinction is now important, because self -designated provider-based subordinates are treated differently under the new rules and are subject to potentially greater liability for overpayment.

PROVIDER-BASED STATUS: THE NEW REGIME

With the advent of the outpatient PPS system, HCFA decided to tighten up the provider-based rules. On April 7th, 2000, HCFA's outpatient PPS rules became final. Part of the new rules addressed provider-based designations.

In many cases, the new rules are merely codifications of the policies that had been in place for several years. Some of the new rules, however, depart from or add to the old policies. From a provider's standpoint, the new rules may create serious financial and compliance problems, administrative headaches, new opportunities, or all three.
For any new facilities for which provider-based designation is sought, HCFA will apply the old (program memoranda) criteria until October 10, 2000 and the new criteria (i.e., those set out in the new rules) thereafter. Note that HCFA, based on a claimed lack of staff and resources, is refusing to provide advance opinions on whether a proposed arrangement between a main provider and a subordinate will qualify for provider-based status.

The new rules are complex and susceptible to varying interpretations, and providers may wish to seek expert guidance to assessing their impact on the provider's particular situation. Here, in summary form, are the highlights of the new regulatory criteria that must be met as a condition of HCFA's designation of a facility or organization as provider-based:

REQUIREMENTS FOR PROVIDER-BASED ENTITIES

It is important to know the current HCFA requirements an entity must meet as well as the new regulations that will become effective October 10th of this year. Some of the "new" regulations are simply codifications of earlier HCFA policies. Others pose serious

financial and administrative nightmares for hospitals and health systems across the nation.

Hospitals that establish provider-based satellites will now have to seek the approval of HCFA in order to bill costs to one main provider. Starting in October 2000, all new facilities not located on the hospital campus that perform physician services that are ordinarily performed in physician's office are presumed to be free-standing facilities unless HCFA has granted the facility provider-based status.

There will be no mechanism in place to seek advance determination. Providers that establish new facilities commit huge expenditures and therefore would like some indication from HCFA that they are on the right track. Unfortunately, HCFA has stated that they haven't the staff or the facilities to provide advance approval for provider-based status.

HCFA has explained that they will not require existing provider based facilities to apply for status confirmation, but will hold them accountable to the new regulations. Current provider-based facilities will have to go through the application process when they decide to make any changes.

In the event a facility established before October 10th is found to be non-compliant, HCFA has indicated that billing adjustments will be made retroactively. Retroactive billing of this type can cost systems millions of dollars. Once a provider-based facility is found to be non-compliant, the makeup of an entire system is thrown out of whack. The main provider must then apply for new licenses and certifications as well as going through the process of new 855s. Reimbursement costs this substantial coupled with the administrative dilemmas of this magnitude make these new regulations important for all current provider-based facilities.

HCFA is currently developing an application process and intends to have it in place by the effective date. Regional offices will make provider-based determinations. Main providers must contact HCFA about creating new provider-based facilities. To be considered provider-based, an entity must be located in close proximity to where the main provider is based, and both facilities must serve the same patient population from the same geographic area.

The “Immediate Vicinity Standard” requires 75% of the patients served by the provider-based facility to reside in the same zip code as the patients served by the main provider. Because certain regions contain zip codes that are random and numerous, the new regulations alternatively allow 75% of the patients served by the satellite facility who require the type of care furnished by the main provider, received care from main facility. An example of that provision is that 75% of rural satellite facility patients who require inpatient care get it from the main provider. HCFA's new rules allow facilities to be located in adjacent states as long as the facilities can remain consistent with the laws of both states. This differs from the original rule, which denied provider-based status for any facility not in the same state as the main provider.

In order to share the same Medicare and/or Medicaid billing number, the facilities must obviously operate under the same license, which is HCFA's first requirement for provider based entities. The subordinate facility must be an integral part of the main provider, and, as such, must be operated with other departments of the provider under common licensure or Certificate of Need authority. There are exceptions for situations where a state law requires separate licenses for each entity.

The provider-based entity must also be 100% owned and operated by the main provider. The main provider must also operate the entity under common ownership and control, which is considered common governance, which includes being subject to common bylaws and operating decisions of the governing body of the main facility. Also the provider must have final responsibility for administrative decisions, personnel actions and medical staff appointments of the provider-based entity, the entity must function as a department of the main provider, with significant common usage of buildings, equipment, and service personnel on a daily basis.

The new regulations require that the following administrative functions of the satellite facility be integrated with those of the main provider: billing services, records, human resources, payroll, employee benefit package, salary structure and purchasing services. Either the same employees or the same group of employees must handle these administrative functions for both facilities.

Public awareness is another requirement. The subordinate entity must be held out to the public as part of the main provider. Patients should know that the entity is part of the provider and that they will be billed accordingly. As patients enter a provider-based entity, the signage and other mechanisms should clearly indicate that the entity is part of the main provider. For example, an informed consent form should state that the patient is a patient of the main provider, has the rights of a main provider patient, and will be billed for services by the main provider.

National accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Osteopathic Association must accredit the subordinate entity as part of the main provider.

The entity director must be under the direct day-to-day supervision of the main provider. HCFA requires the chief executive officer at the main provider to maintain a daily reporting relationship to each other. The medical director at the facility must be accountable to the CEO.

It is important to note that all provider-based facilities are subject to EMTALA. In the event that a specialty clinic is not capable of providing emergency services to a patient in need, it is the responsibility of the main-provider to transport the patient to a facility within the system that has emergency services.

The new HCFA regulations on provider based status raise important procedural, substantive and financial issues. Mistakes could cost health care providers millions of dollars in reimbursement costs. Healthcare organizations may wish to obtain compliance guidance from healthcare legal counsel or a qualified consultant in order to avoid costly errors and payment delays.

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