The Provision of Healthcare Beyond the Campus:

Complying with Provider-Based Requirements

By

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Rehabilitation providers today must operate in an increasingly competitive environment. Providers have historically focused solely on improving the quality of healthcare. However, today's healthcare climate demands that a significant amount of attention be paid to business development. New product lines and care venues must be developed to attract new patients and retain current patients. In this regard, provider-based entities may be an effective way to both diversify venues of care and to attract additional patients.

Provider-based entities provide healthcare services under the name, ownership, administrative control and Medicare provider number of a "main" provider. They function as a part of a main healthcare provider even if they are not on their main provider's campus. For example, a hospital may elect to start an outpatient rehabilitation clinic but locate the clinic across town from the hospital's campus. Such an arrangement can offer the hospital the benefit of increasing its presence in the community and offer needed healthcare services to patients who are nearby the clinic and who would have difficulty travelling to the hospital's main campus. The arrangement would also be attractive to patients who are offered continuity of care between inpatient hospitalization and outpatient care that is all provided by the same healthcare organization. Finally, economies of scale can be achieved by operating provider-based entities in concert with a main provider.

In addition to increasing a provider's presence in the community and attracting patients, provider-based entities also can offer other financial benefits concerning Medicare reimbursement. For example,

some provider-based entities, such as physician clinics, receive a facility fee from Medicare that would not be available if the entities are unaffiliated with main providers.

Because of these financial advantages, the Health Care Financing Administration (HCFA) has prescribed specific criteria which healthcare entities must meet to be considered provider-based for reimbursement purposes. Healthcare providers must ensure that their provider-based entities meet these criteria to fully realize their appropriate level of reimbursement and to avoid the entities from later being found to be free-standing, unaffiliated providers. Healthcare providers must also be aware of proposed provider-based regulations that have been issued by HCFA.[1] If these regulations become effective provider-based entities must comply with requirements that may be different than those put forth in this article.

Requirements for Provider-Based Entities

HCFA has defined criteria which healthcare entities must meet to be considered provider-based.[2] The criteria prevent providers from claiming advantages of provider-based status when they are not functionally nor organizationally integrated with their entities. The criteria ensure that close integration between a main provider and its provider-based entity exists.

Whether a healthcare entity qualifies as provider-based depends, in part, upon its proximity to its main provider and its state's healthcare facility licensure laws. The entity must be geographically close enough to the provider that they both serve the same patient population. In addition, some states provide common licensure for entities and the providers at which they are based. In these states, provider-based entities must comply with both the HCFA requirements and state requirements for common licensure.

Similar to gaining state approval by common licensure, provider-based entities must meet the requirements of the national accrediting organizations that accredit the main provider. The provider-based

[1] 63 Federal Register 47552, 47587 (September 8, 1998).
[2] Program Memorandum, HCFA-Pub. 60A No. A-99-24, May 1, 1999.

entity must be included in the accreditation of the provider where it is based and be recognized as part of the provider. For example, if a Joint Commission on Accreditation of Healthcare Organizations-accredited hospital wishes to have a provider-based outpatient rehabilitation clinic, the clinic must be recognized by the Joint Commission as part of the hospital and must comply with the Joint Commission's accreditation requirements. The Joint Commission will issue a single accreditation award for the hospital and the hospital-based clinic. However, the hospital and clinic must be integrated operationally, organizationally and for performance improvement purposes.

HCFA requires that provider-based entities be operated under common ownership and control as their main providers. To comply with this requirement, the entity must be subject to the same bylaws and organizational documents that govern the provider. In addition, the provider must have the final authority to approve or reject decisions impacting the entity. For example, a hospital would have the authority to determine which personnel and medical staff could work at the hospital's provider-based entity. The entity must function as a department of the main provider. As a department, the entity should commonly use the same equipment, service personnel and, where possible, buildings of the main provider on a daily basis.

A provider-based entity must not merely be under the control of the provider where it is based. The entity's director, if is has one, and personnel must be under the direct day-to-day supervision of the provider where it is based. To evidence this day-to-day supervision, the entity director must be required to have a daily reporting relationship with the chief executive officer of the provider. Compliance with this requirement can be illustrated by using daily call logs and written reports of the entity's activities which are then forwarded to the chief executive officer. Other administrative functions of the entity such as laundry and housekeeping should be integrated with the main provider.

Similar to the requirement that entities and their main providers are administratively integrated, provider-based entities must also be integrated with their main providers clinically. To become clinically integrated, it is necessary that the professional staff of the entity have

clinical privileges at the main provider. In addition, the entity's medical director or clinical leadership should have a daily reporting relationship with the medical director of the provider.

Clinical integration of the entity and its main provider impacts patients as well as the professional staff. Medical records of patient that are treated at the entity must be integrated with those of the main provider. Patients of the entity are considered patients of the main provider and, as such, must have full access to the healthcare services offered by the main provider.

Another provider-based requirement that concerns patients involves the way in which the entity is presented to the public. Provider-based entities must be held out to the public as part of the main provider so that patients know they are actually patients of the main provider and that they will be billed as patients of the main provider. Patients may be informed that they are being treated in part of the main provider in various ways. For instance, informed consent forms, patient rights forms and advance directives could all include clauses that they are actually patients of the main provider.

As discussed above, a provider-based entity and its main provider must be both organizationally and clinically integrated. However, they must also exhibit financial integration as well. This means that a provider-based entity and its main provider have an agreement in place for sharing the income and expenses of their operations. When seeking Medicare reimbursement, the provider-based entity must also report its costs in the main provider's cost report and use the same accounting system and cost reporting period as the main provider.

Other Implications of Provider-Based Designation

Clearly, there a many criteria with which providers must comply to achieve provider-based designation for their entities. Providers must not believe, however, that their compliance efforts end with achieving provider-based designation. Two prominent issues that arise for provider-based entities and their main providers involve compliance

with the Emergency Medical Treatment and Labor Act (EMTALA) and the Medicare conditions of participation.

EMTALA imposes a number of duties on Medicare-participating hospitals that have emergency departments. The act requires hospitals to provider a medical screening examination and stabilizing medical treatment to any individual that “comes to the emergency department” and requests emergency medical treatment regardless of their insurance status or ability to pay for the care. “Comes to the emergency department” has been defined very broadly. A patient is considered to come to the emergency department whenever he or she is on hospital property.

A provider-based entity of a Medicare-participating hospital with an emergency department is part of the hospital’s property. As such, the entity, even if miles away from the hospital, must be prepared to respond to individuals who come onto the property where the entity is located and request emergency medical treatment. In fact, HCFA has issued proposed provider-based regulations that clearly mandate that provider-based entities of Medicare-participating hospitals with emergency departments comply with EMTALA. Thus, a provider-based outpatient rehabilitation clinic whose main provider is a Medicare-participating hospital with an emergency department must comply with EMTALA requirements if a patient comes to the clinic and requests emergency medical treatment.

Another compliance concern for provider-based entities concerns Medicare conditions of participation. Medicare requires hospitals, rehabilitation facilities, skilled nursing facilities and other types of providers to comply with various conditions to participate in the Medicare program. Provider-based entities of the provider must also comply with the conditions of participation that are applicable to them. For example, a provider-based entity of a rehabilitation hospital or unit must comply with the conditions of participation that are applicable to their main providers. These conditions encompass such items as medical direction and patient diagnoses.

Conclusion

As presented in this article, healthcare entities must comply with a wide range of requirements to obtain provider-based designation. However, their compliance efforts must reach beyond the provider-based requirements. Provider-based entities must also contemplate EMTALA's requirements, their main providers' applicable Medicare conditions of participation and a host of other compliance concerns. A full consideration of these issues should only be made with regulatory and legal consultation.

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