CMS Finalizes Revised Provider-Based Regulations

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Practice Area: Health Law

On August 1, 2002, CMS published final regulations that significantly change the previously established provider-based regulations. These regulations relieve some of the burden imposed by the provider-based requirements, but, in some cases, the relief does not come without a price. The regulations, which were proposed on May 9, 2002, were finalized with some changes. In these final regulations, CMS clarified or revised its position on some of the lingering issues that have plagued these regulations since they were first proposed on September 8, 1998.

Key elements of the final regulations:

- CMS will extend the "grandfather" exception to the provider's first cost-reporting period beginning on or after July 1, 2003.
- Providers can still benefit from the "temporary relief" rules for some sites by filing an application before October 1, 2002.
- The application requirement has been eliminated and replaced with a "voluntary" attestation process.
- The provider-based requirements for on-campus facilities have been significantly relaxed.

"Grandfathering" Exception and Temporary Relief

CMS extended the "grandfathering" provision. In the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"), Congress provided relief for facilities that were treated as provider-based on October 1, 2000. Pursuant to BIPA, these facilities would continue to be treated as providerbased until October 1, 2002. The regulations extend the grandfathering period until the beginning of the provider's first cost-reporting period beginning on or after July 1, 2003. CMS delayed the effective date to allow facilities more time for any necessary contractual or organizational changes that facilities might need to achieve compliance with the provider-based criteria.

Notably, the final regulations do not revise the "temporary relief" rules. The temporary relief rules provide that if a facility requests provider-based status before October 1, 2002, CMS will presume that the facility satisfies the provider-based criteria until it determines that the facility does not satisfy the provider-based criteria. This should limit CMS's ability to review and recover any payments to the provider prior to CMS's determination. As a result, facilities that opened between October 1, 2000 and October 1, 2002, may want to submit a provider-based application before October 1, 2002 in order to take advantage of the presumption of provider-based status that the temporary relief rule offers.

Application Process vs. Attestation Process

CMS replaced the "application" process with an "attestation" process. Providers are no longer required to submit an application before they bill for provider-based services. Instead, providers may request a determination from CMS by submitting an "attestation," although providers are not required to do so. In the attestation, the provider must explain how the facility satisfies the provider-based requirements and, if it is a hospital, the provider must attest that its facility fulfills the obligations of hospital outpatient departments and hospital-based entities as required by the regulations. Provider-based facilities that are located on the main campus of the provider are not required to submit supporting documentation with the attestation. However, these providers should compile and maintain the supporting documentation because this information must be provided to CMS, its fiscal intermediary, or its carrier if requested. Off-campus facilities must submit all documentation necessary to support the request to CMS.

The attestation process offers some protection. If CMS determines that a facility has been inappropriately billing as provider-based and the provider did not submit an attestation, CMS can recover overpayments for all prior cost reporting periods subject to reopening. If the provider submitted an attestation, treatment of the facility as provider-based would cease on the date that CMS determines the facility no longer qualifies for provider-based status, if the reason the provider-based criteria are not met was a material change in the provider-facility relationship that was properly reported to CMS.

Until CMS creates a uniform attestation form, the attestation should include (at a minimum) the identity of the main provider and the proposed provider-based facility, the exact location of the provider-based facility (street address and whether it is on or off-campus), the date on which the facility became providerbased, and supporting documentation for purposes of applying the provider-based criteria in effect at the time the application is submitted.

Comments to the proposed regulations requested that CMS specify a timeframe by which CMS or its contractors would have to respond to a providerbased request. Unfortunately, CMS would not define a timeframe for CMS' response. Instead, the regulations merely include a requirement that CMS will acknowledge all attestations in writing and subsequently make a determination as to the facility's provider-based status. CMS stated that it will work with the regional offices and intermediaries to ensure that providers that submit attestations receive a prompt response.

Other comments requested that CMS allow providers a period of time to provide additional documentation if CMS determines that the attestation is not complete. CMS would not revise the regulations which provide that CMS will issue a denial if the attestation is not complete. Consequently, providers will not be allowed to supplement their attestation if they inadvertently omit necessary information. CMS reasoned that if it determines that the provider does not satisfy the provider-based requirements, the provider can notify CMS within 30 days if the provider will seek a provider-based determination, then the provider has 6 months to provide documentation that it satisfies the criteria. Of course, CMS will pay for services at a reduced rate until the provider receives a providerbased determination.

Excluded Facilities

CMS expanded the list of facilities that are excluded from review under the provider-based regulations to include 1) independent diagnostic testing facilities furnishing only services paid under a fee schedule, such as facilities furnishing only screening mammography services, 2) departments of providers that perform functions that are not separately paid by Medicare (for example, laundry or medical records departments), and 3) ambulance services.

CMS also revised the exclusion for facilities providing only physical, occupational or speech therapy to ambulatory patients to provide that the exclusion only applies if the facility is not operated as part of critical access hospital. Therapy services provided in a critical access hospital are cost reimbursed, but if the therapy services are provided in a freestanding facility, they would be paid based on the fee schedule.

In response to comments, CMS clarified that if provider-based status affects Medicare payment in any way, it will require the facility to satisfy the providerbased criteria. For example, a facility will be required to satisfy the provider-based requirements even if provider-based status affects only direct graduate medical education payments or indirect medical education payments. CMS also clarified that the provider-based criteria do not apply to specific services, rather, the rules apply to facilities as a whole. In other words, the facility in its entirety must be a subordinate and integrated part of the main provider. This clarification likely only applies to off-campus facilities, because different on-campus services can qualify or not qualify for provider-based status.

On-Campus Facility Requirements

The final rule adopted the relaxed on-campus facility requirements described in the proposed rule. In response to persistent comments from providers, CMS acknowledged that it is appropriate to presume that on-campus facilities (within 250 yards of the main provider) will have a certain degree of integration necessary to satisfy some of the provider-based criteria. Accordingly, on-campus facilities do not have to demonstrate that they satisfy the control and ownership, common administration and supervision and the location requirement. Instead, on-campus facilities will only be required to show that they meet the licensure, clinical services, financial integration and public awareness requirements.

The final rules also revised the joint venture and management contract provisions to exclude these requirements/prohibitions from on-campus facilities. CMS clarified that for a joint venture entity to qualify as provider-based it must 1) be partially owned by at least one provider, 2) be located on the campus of a provider who is a partial owner, 3) be provider-based to that one provider whose campus on which the facility is located, and 4) meet all the provider-based requirements for on-campus facilities.

Conclusion

Based on the final regulations, we recommend the following:

- Providers should be sure to take advantage of the temporary relief rules for sites opened after October 1, 2000 by filing an application.
- Providers should review changes that will be required for grandfathered facilities, especially given the new differences between on-campus and offcampus sites.
- Providers should use attestations for new sites being opened off-campus and significant changes/expansions on-campus.
