HCFA "Clarifies" Provider-Based Designation

Oct 01 1996

Practice Area: Health Law

HCFA recently issued a Program Memorandum that revised the criteria that intermediaries should use to make provider-based and freestanding determinations. In its Program Memorandum, HCFA stated that it was merely "consolidating" and "clarifying" its policy regarding these designations. In fact, the revised criteria will make it more difficult for entities to receive a provider-based designation.

HCFA's revised criteria will have a wide-spread impact because they will apply to all provider-based designation decisions regarding any provider of services under Medicare, which will include, but will not be limited to, physician practices and clinics, home health agencies, and skilled nursing facilities that assert they are "provider-based."

Provider-Based Designation

Previously, HCFA considered factors such as location, accreditation, central administration and other signs of integration separately in determining provider-based status. These "general" guidelines could be applied differently depending on the type of entity, *e.g.*, home health agencies, outpatient departments, etc. For example, prior to this Program Memorandum, the only regulatory guidelines available in making a provider-based versus freestanding determination for home health agencies were summarized in a June 5, 1980, *Federal Register* notice. This notice stated that for a home health agency to be hospital-based, it must be "an integral and subordinate part" of the hospital, subject to the same bylaws and operating decisions, and financially integrated "as evidenced by a cost report which must reflect allocation of hospital overhead to the home health agency."

The Program Memorandum lists eight multi-faceted requirements that an entity must satisfy before HCFA will designate the entity as provider-based. Many of these criteria are ambiguous. Yet, HCFA's Central Office has indicated that the Regional Offices will be given the authority to interpret and apply the requirements. The requirements are:

1. The entity is physically located in close proximity of the provider where it is based, and both facilities serve the same patient population (e.g., from the same service, or catchment, area);

2. The entity is an integral and subordinate part of the provider where it is based, and as such, is operated with other departments of that provider under common licensure (except in situations where the State separately licenses the provider-based entity);

3. The entity is included under the accreditation of the provider where it is based (if the provider is accredited by a national accrediting body), and the accrediting body recognizes the entity as part of the provider;

4. The entity is operated under common ownership and control (e.g., common governance) by the provider where it is based, as evidenced by the following:

- The entity is subject to common bylaws and operating decisions of the governing body of the provider where it is based;
- The provider has final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the provider-based entity; *and*
- The entity functions as a department of the provider where it is based with significant common resource usage of buildings, equipment and service personnel on a daily basis.

5. The entity director is under the direct day-to-day supervision of the provider where it is located, as evidenced by the following:

- The entity director or individual responsible for the day-to-day operations at the entity maintains a daily reporting relationship and is accountable to the Chief Executive Officer of the provider and reports through that individual to the governing body of the provider where the entity is based; *and*
- Administrative functions of the entity, *e.g.*, records, billing, laundry, housekeeping and purchasing, are integrated with those of the provider where the entity is based.

6. Clinical services of the entity and the provider where it is located are integrated as evidenced by the following:

- Professional staff of the provider-based entity have clinical privileges in the provider where it is based;
- The medical director of the entity (if the entity has a medical director) maintains a day-to-day reporting relationship to the Chief Medical Officer or other similar official of the provider where it is based;
- All medical staff committees or other professional committees at the provider where the entity is based are responsible for all medical activities in the provider-based entity;
- Medical records for patients treated in the provider-based entity are integrated into the unified records system of the provider where the entity is based;
- Patients treated at the provider-based entity are considered patients of the provider and have full access to all provider services; *and*
- Patient services provided in the entity are integrated into corresponding inpatient and/or outpatient services, as appropriate, by the provider where it is based.

7. The entity is held out to the public as part of the provider where it is based (*e.g.*, patients know they are entering the provider and will be billed accordingly);

8. The entity and the provider where it is based are financially integrated as evidenced by the following:

- The entity and the provider where it is based have an agreement for the sharing of income and expenses; *and*
- The entity reports its cost in the cost report of the provider where it is based using the same accounting system for the same cost reporting period as the provider where it is based.

Provider-based designation could significantly impact Medicare cost reporting and reimbursement. In some cases, a provider-based entity, such as a hospital outpatient department, is cost reimbursed – and is reimbursed for hospital administrative and general and other overhead costs. If this same entity loses its provider-based designation, it will be designated a physician's office or a freestanding clinic and, accordingly, will be paid based on the physician fee schedule. In other cases, cost reimbursement will occur regardless of provider-based or freestanding designation, but the designation will affect the entity's ability to include overhead costs.

HCFA's Goal Is To Save Money

HCFA's position is that the Medicare program pays more for services furnished in a provider-based entity than it would if the same services were rendered in a freestanding entity. This is sometimes, but not always, true.

Additionally, because of the growth of integrated delivery systems, HCFA has received an increasing number of requests from entities requesting provider-based status. HCFA's position is that if they approve these requests, the Medicare program will support a larger portion of a facility's general and administrative costs with no commensurate benefit to the Medicare program and its beneficiaries. HCFA asserts that Medicare beneficiaries are also subject to an increase in financial liability.

HCFA provided the following example to illustrate its position. Some hospitals are purchasing physician clinics in areas far from the licensed hospital and designating the clinics as part of the hospital "outpatient department." As a result, the hospital would be allowed to increase Medicare payments by shifting overhead costs to the "outpatient department" and by increasing payment for indirect medical education. In addition, the Medicare coverage of "incident to" services would be affected if a physician's office were redesignated as a hospital "outpatient department." The beneficiary pays the usual deductible and coinsurance for physician services that are capped by the physician fee schedule, but would be responsible for a second deductible and coinsurance for a "clinic visit" or "facility fee" to the hospital. These charges are not subject to the Medicare allowable charge or limiting charge restrictions.

Determinations

HCFA's Regional Offices will make determinations concerning whether an entity is provider-based. Entities that previously have been designated provider-based should not feel safe. HCFA believes these designations or determinations may have been erroneous. HCFA's Program Memorandum stated that previous provider-based decisions that are not in accord with the revised criteria can be changed. In these circumstances, a change in designation is to be applied prospectively.

Perhaps the greatest concern involves services performed in space outside the four walls of the main hospital building that is being treated as an outpatient department but has not received written approval from HCFA to recognize that status. In this case, HCFA can be expected to, at a minimum, seek retroactive recoupment. These circumstances should be reviewed very carefully.
