Provider-Based Requirements: Still Not There?

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Practice Area: Health Law

In the May 9, 2002 *Federal Register*, CMS issued proposed regulations concerning provider-based status determinations. CMS has asked the public to provide comments on these regulations by July 8, 2002. Final regulations should be released in August, 2002.

The initial "final" regulations issued on April 7, 2000 left open many significant issues, including: how the application requirement applied to existing operations and whether the application requirement applied at all to operations for which provider/hospital status had no impact on Medicare or beneficiary payments. Subsequent CMS guidance has helped clarify these matters, but several important changes in direction have kept the industry guessing about where this issue is ultimately headed. First, CMS deferred the October 10, 2000 effective date. Then, Congress enacted legislation providing for "grandfather" and "temporary relief" exceptions, and revising the location criteria. Subsequent CMS regulations have created exceptions for a number of operations for which provider-based status does not have a payment impact.

The aspect of the May 9th regulations that may garner the most publicity is their proposed extension of the "grandfather" rule. However, the biggest surprises are the proposed elimination of the prior application and pre-approval requirement, and a potentially significant relaxation of how the requirements apply to on-campus operations.

The May 9th regulations propose to eliminate the requirement in the existing regulation that providers submit an application and obtain a provider-based determination from CMS for all new facilities becoming operational after the grandfathering date before treating such facilities as provider-based. In response to comments from the provider industry regarding the current application process, CMS now proposes a new voluntary "attestation" process under which providers, at their discretion, may elect to receive an advance provider-based determination from CMS for a proposed facility by submitting an attestation that the facility meets all applicable provider-based criteria.

While providers may still elect to receive an advance determination from CMS to verify that a new facility meets the applicable provider-based requirements, there would no longer be a requirement to submit an application and receive a provider-based determination in advance of treating a new facility as provider-based. CMS suggests in the comments to the proposed rules that it is still weighing whether the mandatory application and pre-approval process should be abolished in the final providerbased rule. On this important point, hospitals should consider submitting comments to CMS regarding the benefits of the proposed attestation procedure.

The May 9th proposed regulations further reflect a significantly greater degree of flexibility in applying the substantive requirements to on-campus operations to qualify for provider/hospital based status. Previous revisions to the provider-based requirements have not made drastic changes to these operational requirements. However, this aspect of the proposal would effectively reverse the position CMS has taken on the requirements for provider/hospital based status since issuing its first Program Memorandum on the subject in 1996.

Although the May 9th regulations extend the grandfather rule, they do not change the temporary relief exception. Providers should continue their efforts to take advantage of the temporary relief rule by October 1, 2002 and should review how the potential for greater flexibility for on-campus operations affects existing arrangements and offers new opportunities for on-campus shared service arrangements through joint ventures and management contracts.

Application Requirements

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Congress created "grandfather" and "temporary relief" exceptions. The May 9th regulations extend the "grandfather" provision. Under BIPA, facilities that were treated as provider-based on October 1, 2000 would continue to be treated as provider-based until October 1, 2002. The May 9th regulations propose extending the grandfather date to the beginning of the provider's first cost reporting period on or after July 1, 2003. This extension offers up to an additional 19 months for some providers to comply with the provider-based requirements.

The May 9th regulations do not propose any revisions to the temporary relief rules for facilities not in operation prior to October 1, 2000. As a result, providers that have opened or first treated new facilities as provider-based after October 1, 2000, should continue their efforts to submit applications to CMS before October 1, 2002 to take advantage of the presumption of provider-based status that the temporary relief rule offers. By submitting an application prior to October 1, 2002, for any facility opened between October 1, 2000 and October 1, 2002, provider-based status will be presumed until CMS notifies the provider otherwise.

Since the original April 7th regulations, CMS has taken a number of steps to narrow the scope of sites/departments to which the provider-based requirements apply. These changes have been in the direction of: "no harm, no foul." That is, if provider/hospital based status does not affect Medicare payment or beneficiary liability (co-pays or deductibles) then the requirements do not apply. Thus, the November 30th, 2001 amendments to the regulations exempted ASCs, CORFs, HHAs, SNFs, hospices, exempt inpatient rehab units, IDTFs, and sites/departments furnishing only clinical diagnostic lab services or outpatient PT/OT/ST so long as the moratorium on the $1,500 coverage cap remains in effect (currently until January 1, 2003).

The May 9th regulations expand this list in two ways. First, sites/departments that only provide screening mammography services are specifically added to the exemption list. Second, a broader exemption is defined for departments that perform functions necessary for the successful operation of the provider, but do not furnish services of a type for which separate payment could be claimed under Medicare or Medicaid. This exemption is intended to apply to overhead or support departments such as laundry, medical records, housekeeping, etc.

Finally, as noted above, the May 9th regulations propose to create a procedure for receiving an advanced determination of provider-based status by submitting an "attestation" of compliance with the provider-based requirements. Please be aware, though, that as a "quid pro quo" for no longer requiring advance approval, CMS is proposing that it will recoup any excess payments as a result of provider-based status, if it subsequently determines that the requirements are not met, even though the attestation has been timely submitted. Exceptions to retroactive recoupment are provided for the periods before the effective date, and those covered by the grandfather and temporary relief rules.

Relaxed Operational Requirements – On-Campus

Another significant proposal in the May 9th regulations involves relaxing the requirements for on-campus provider-based sites/departments. Facilities are considered on-campus if the facility is located within 250 yards of the main provider. Currently, all facilities seeking provider-based status must meet seven main requirements: common licensure with the main provider (unless state law requires separate licensure or does not license the facility); operation under the control and ownership of the main provider; common administration and supervision; integration of clinical services; financial integration; public awareness of the facility as part of the main provider; and location in the immediate vicinity of the main provider. In addition, provider-based status is not available to facilities operated as part of a joint venture or pursuant to management contracts that do not meet explicit requirements. These seven requirements have effectively been in place since CMS first published a 1996 Program Memorandum on the subject. The only change that has occurred was BIPA's creation of a presumption that facilities within 35 miles meets the location requirement.

In the May 9th regulations, CMS agreed with comments from providers that a facility that is located on the main campus of the provider can be presumed to have the degree of integration necessary to meet the provider-based requirements for control and ownership, common administration and supervision, and the location requirement. Oncampus facilities will only be required to show that they meet the licensure, clinical services, financial integration and public awareness requirements. In addition, on-campus facilities are not subject to the joint venture prohibition or the management contract requirements. This presumption will not carry to off-campus facilities, which will remain obligated to meet all the requirements listed above, as well as the existing joint venture prohibition and management contract requirements. The relaxation of the requirements for on-campus facilities may provide new provider-based opportunities for on-campus facilities operated in joint ventures or under management contracts that are not possible under the current provider-based regulations.
