PROGRAM MEMORANDUM
INTERMEDIARIES

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. A-99-24 Date MAY 1999

This Program Memorandum re-issues Program Memorandum A-98-15, dated May 1998. The only change is the discard date and contact person; all other material remains the same.

This Program Memorandum re-issues Program Memorandum A-96-7

SUBJECT: Policy Clarification: Provider-Based Designation

PURPOSE:

The purpose of this Program Memorandum (PM) is to consolidate and clarify the Health Care Financing Administration's (HCFA's) policy regarding provider-based and free-standing designation decisions. The various elements of this policy have been issued previously in regulations, program manuals, and letters to HCFA regional offices (ROs) or providers. This policy applies to all such designation decisions regarding any provider of services under Medicare, including physicians' practices or clinics that state they are part of a provider.

BACKGROUND:

The term or designation "provider-based" is an outgrowth of the Medicare cost reimbursement system. The main purpose of the provider or facility-based designation is to accommodate the appropriate accounting and allocation of costs where there is more than one type of provider activity taking place within the same facility/organization, e.g., a hospital-based skilled nursing facility. This cost allocation and cost reimbursement more often than not results in Medicare program payments that exceed what would have been paid for if the same services were rendered by a free-standing entity.

With the growth of integrated delivery systems, HCFA has received numerous requests from entities requesting provider-based status. These requests, if approved, increase the portion of the facility's general and administrative costs that are supported by the Medicare program with no commensurate benefit to Medicare and its beneficiaries. Therefore, it is critical that HCFA designate only those entities that are unquestionably qualified as provider-based.

For example, some hospitals are purchasing physicians' clinics and multiple clinics in areas far from the licensed hospital and designating the clinics as "outpatient departments" of the hospital. If Medicare were

to approve such designation as an "outpatient department" the hospital would then be allowed to increase Medicare payments by shifting overhead costs to the "outpatient department" and by increasing payments for indirect medical education. In addition to the payment impact, the Medicare coverage of "incident-to" services would also be affected if a physician's office is redesignated as a hospital outpatient department.

Medicare beneficiaries are also subject to an increased financial liability. In the example above of a hospital acquired physician practice, the beneficiary pays the usual deductible and co-insurance for physician services which are capped by the physician fee schedule. He is also responsible for a second deductible and co-insurance for a "clinic visit" or "facility fee" to the hospital. These charges are not subject to the Medicare allowable charge or limiting charge restrictions of a physician's office.

Moreover, it should be noted that it is the intent of existing statutory and regulatory criteria for Medicare to operate as a prudent purchaser of services that enhance the care of beneficiaries. Medicare must comply with Congressional intent as reflected in §1861(v)(1)(A) of the Social Security Act to pay only for those costs that are necessary for the efficient delivery of needed health services. The statute at §1861(v)(1)(A) also provides general and specific criteria for developing payment rules to carry out the basic intent of the law as well as provisions when aggregate reimbursement produced by existing methodologies proves to be inadequate or excessive.

POLICY STATEMENT:

It is HCFA's policy that the following applicable requirements must be met before an entity can be designated as part of a provider for payment purposes:

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 (i.e., 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:

o The entity director or individual responsible for 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

o 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:

o Professional staff of the provider-based entity have clinical privileges in the provider where it is based;

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o 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;

o 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;

o 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;

o Patients treated at the provider-based entity are considered patients of the provider and have full access to all provider services; and

o 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:

o The entity and the provider where it is based have an agreement for the sharing of income and expenses; and

o 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.

DETERMINATIONS:

Determinations concerning whether an entity is provider-based (e.g., common licensure, governance, professional supervision criteria, reimbursement and accounting information) will be made by the

appropriate HCFA RO components, i.e., the RO Division of Health Standards and Quality and the RO Division of Medicare with the assistance of the State survey agencies and the fiscal intermediary.

Please note that the issuance of this clarifying instruction may result in identification of previous provider-based decisions that would not be in accordance with the criteria described in this PM. In those instances, the ROs are not precluded from taking a corrective action on such erroneous designation/determinations. However, any corrective action is to be applied prospectively.

This Program Memorandum may be discarded May 31, 2000.

For further information, please contact George Morey at (410) 786-4653.

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