May 18, 1998

REGIONAL SURVEY AND CERTIFICATION (RS&C) LETTER NO: 98-07

To: All State Survey Agencies (Action)
    All Title XIX Single State Agencies (Information)

Subject: Guidance on Surveying Existing Hospice Sub-locations That Do Not Meet the Criteria for Provider-Based Designation

As a result of the States' and Regional Office's efforts to ensure hospice sub-locations are in compliance with the Medicare Conditions of Participation, we have become aware of several alternative delivery sites for hospices which do not meet the criteria for being hospice sublocations. (For information on the provider-based criteria, please see Attachment 1, Program Memorandum Intermediaries, HCFA Pub. 60A.) Several State Agencies have requested guidance on what should be done with the inappropriate hospice sub-locations. The Regional Office will handle the hospice sites in the same manner as the existing home health agency branches which do not meet the criteria to be a branch (outlined in RS&C letter 97-06).

The procedures to be used are:

1. Based on the information furnished by the State Agencies, the Dallas Regional Office will notify each hospice identified as having a sublocation(s) which does not meet the provider-based criteria of the following:
   A. that the specified sublocation(s) does not meet the criteria for provider-based designation. Also, effective with the date of the letter, the hospice provider has one calendar year in to comply with the requirements by either obtaining a separate Medicare provider number for each inappropriate hospice sublocation(s) or close the site(s). The letter will also inform the hospice provider that if it fails to bring the inappropriate sublocation(s) into compliance after one year, it risks termination from the Medicare program. The hospice provider will be given a period of sixty days in which to notify the State and HCFA whether or not it plans to close the inappropriate sublocation, or its decision to pursue a separate Medicare provider number for the site.
   B. within the same sixty-day period, the hospice must notify the State Agency and HCFA if it has any other sub-locations in addition to those listed in our letter. It must also notify the State Agency and HCFA of the date the other sublocation(s) was established and when it began billing Medicare.

2. A copy of each letter sent to a hospice provider will be forwarded to the State Agency.

3. Hospice sub-locations not meeting the criteria for provider-based and who wish to be in the Medicare program must complete the initial enrollment packet for hospice providers seeking Medicare certification. After the hospice has completed the appropriate forms and the Regional Fiscal Intermediary has given its approval of the HCFA 855, the State Agency will add the improper sub-locations to the survey schedule. Surveys of the sites should take precedence over the surveys of new hospice providers who have not yet been participating in the Medicare program.

4. At the completion of the survey, the State will follow the standard procedures for notifying HCFA whether or not the State plans to recommend Medicare certification. (Complete the HCFA 1539 and other pertinent paperwork, etc.)
The hospice agency may continue to bill Medicare for the care/services furnished by unsuitable site(s) listed in the letter to the provider during the one year transition period. If the State Agency is unable to complete all of the surveys of the inappropriate sub-locations seeking to obtain a separate Medicare provider number within one year (before June 1999) the State Agency should contact the HCFA. If you have any questions concerning this letter, please contact Karen Herbelin, at (214) 767-4422. Thank you for your time and attention to this matter.

Sincerely,

~Signature on File~

Calvin Cline, Branch Chief
Survey and Certification Operations

Attachments
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. The costs 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:
   - 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
   - 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.

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.
June 30, 1998

Administrator
Name of Hospice
Street Address
City, State, Zip Code

Dear Administrator:

It has come to the attention of the Health Care Financing Administration that your hospice, provider # ______________, has a sub-location based at ______________. This site does not meet the criteria to be a sub-location of your main hospice site located at ______________. The provider-based standards are outlined in Program Memorandum, Intermediaries, HCFA Pub. 60A. Effective the date of this letter your agency has one year to come into compliance with the provider-based criteria. Compliance may be achieved by either of two methods:

1. Your Agency may close the inappropriate sub-location(s).

2. The inappropriate site(s) must obtain its own separate Medicare provider number. You must contact your State Agency and arrange to complete the required paperwork and be scheduled for an initial Medicare survey, or

Within 60 days of the date of this letter, please notify your State Agency and HCFA in writing whether you plan to close or obtain a separate Medicare provider number for the inappropriate hospice site(s). The mailing address for HCFA is:

    Attention: Karen Herbelin
    Health Care Financing Administration
    1301 Young Street, Room 833
    Dallas, Texas 75202

If you choose to get a separate Medicare provider number, your agency may continue billing for the care/service furnished from the inappropriate sub-location listed in this letter during the one year transition. There will be no break in payments unless the sub-location is found to be out of compliance with Medicare's Conditions of Participation for hospice.

In addition, if your agency has any other hospice sub-locations which are situated more than one hour's driving time from the main hospice provider whose number they bill from, and/or are located in a different State than the main hospice, please notify the State Agency and HCFA in writing within 60 days of the date of this letter. The following data should be furnished:

a. location of the hospice sub-location
b. date the site became operational
c. date the site obtained its State license
d. name, provider number and location of the main hospice (the site whose Medicare provider number is used for billing purposes)
HCFA and your State Agency will review the information furnished and ascertain whether or not the sub-location/s meets the provider-based criteria. We realized that estimated driving time is necessarily approximate. The driving time is not the only criteria which will be considered when determining whether or not a hospice sub-location meets the provider-based standards.

Please note, HCFA is not required to reimburse a hospice provider for the care/services furnished from a hospice sub-location which:

a. was operated and billed Medicare at any time before they had the required State license.

b. was informed by the State Agency and/or HCFA that they did not meet the criteria for hospice sub-location and opened and/or continued to operate the site any way.

c. is not in compliance with the appropriate Medicare Conditions of Participation and requirements.

Failure of the hospice sub-location/s listed in this correspondence to come into compliance after one year from the date of this letter will result in the main hospice agency being terminated from the Medicare Program. If you have any questions concerning this letter, please contact Karen Herbelin, a member of the staff, at (214) 767-4422. Thank you for your time and attention to this matter.

Sincerely,

Calvin Cline, Branch Chief
Survey and Certification Operations