HCFA Town Hall Meeting Fails to Resolve Provider-Based Issues

On October 31, the Health Care Financing Administration (HCFA) held a “Town Hall Meeting” in Baltimore, Maryland in order to clarify existing ambiguities in the provider-based designation portion of the new prospective payment system for Medicare outpatient hospital services slated to go into effect early next year. The meeting included a panel of HCFA officials, including Tom Gustafson, Director of the Purchasing Policy Group, Tzvi Hefter, Director of the Division of Acute Care (one of the three divisions within the Purchasing Policy Group), and George Morey, HCFA’s official contact for the provider-based regulation. Hooper, Lundy & Bookman Attorney Jon Neustadter attended the all-day meeting.

On October 31, HCFA officials attempted to address various significant issues during a Town Hall Meeting focusing on the provider-based regulation, including specifically which hospital “departments” must apply for provider-based designation. However, the HCFA panel failed to adequately clarify many of the important issues and concerns raised.

The provider-based regulation is slated to go into effect January 10, 2001, and it will be applicable to providers with their first cost reporting period beginning on or after that date. The regulation establishes requirements that facilities must meet in order to have clinics, home health agencies and other programs treated as provider-based for purposes of Medicare reimbursement.

The regulation was initially scheduled to become effective October 10 of this year. Prior to scheduling the Town Hall Meeting, however, HCFA acknowledged that it still must clarify a number of administrative, procedural and technical issues and that hospitals still needed additional guidance in interpreting the regulations.

While the meeting was intended to supply that guidance, many of the estimated 100-150 attendees of the Town Hall Meeting left without the concrete clarification they sought on some issues, while others voiced strong opposition to aspects of the regulation that HCFA officials specifically stated would not be revised at this point.

One of the most confusing aspects of the regulation to hospitals has been determining which units and departments of a hospital are required to obtain provider-based designation. The regulation is very broad and appears to extend to both inpatient and outpatient departments.

With two important exceptions, HCFA officials at the meeting agreed that any entity not specifically included in the following list will be required to obtain provider-based designation: ambulatory surgical centers; comprehensive outpatient rehabilitation facilities; home health agencies; skilled nursing facilities; facilities, such as independent diagnostic testing facilities...
that furnish only clinical diagnostic laboratory tests; and facilities only furnishing physical, occupational and speech therapy, as long as the $1,500 annual cap on coverage for such services remains suspended by subsequent legislation.

One major exception the HCFA panelists agreed on was that there is no need for a provider-based designation with respect to any entity or department that would not experience a Medicare reimbursement impact by being provider based, as long as beneficiaries’ co-insurance is likewise not affected. Thus, according to the HCFA panelists, entities that provide services paid on the same fee schedule, whether designated as provider-based or not, will not need to seek provider-based determination and will not need to comply with the regulation.

In addition, Tom Gustafson, director of HCFA’s Purchasing Policy Group, told attendees that any prior HCFA determination would stand unless HCFA specifically changes that determination.

The topic that brought perhaps the most heated opposition from attendees during the meeting was the employment requirements when a facility, unit, or department is managed by an outside company. According to HCFA official George Morey, the management company may employ only management staff when an outside company manages an entity. HCFA panelists acknowledged that they have received numerous comments regarding the common practices of “leasing” employees and having prospective payment system-exempt units run by management companies. However, the only response the HCFA panelists supplied was that they are “thinking about” the comments they received.

One of the more confusing aspects of the provider-based rule is the so-called 75/75 proximity rule. Under this rule, one of the ways to show the necessary proximity between an entity and a “main provider” is to demonstrate that at least 75 percent of patients served by the provider-based entity reside in the same zip codes as at least 75 percent of the patients served by the main provider.

Tzvi Hefter presented a strongly criticized example of how he thought the 75/75 proximity rule should work. Essentially, Hefter appeared to require that there be a 100% overlap in the top 75% of zip codes associated with the residences of the provider’s and the provider-based entity’s patients.

Even after the Town Hall Meeting, the provider-based regulation remains ambiguous in a number of significant ways. Whether or not the pending legislation passes (see related article, page 3), hospitals will be faced, sooner or later, with difficult choices over which, if any, of their facilities, units, and departments need to have a formal provider-based approval.

For additional information please contact Mr. Neustadtter at (310) 551-8151.

Final Hospital Outpatient PPS Rule Published

The Health Care Financing Administration (HCFA) has issued its final rule on the new Medicare prospective payment system (PPS) for hospital outpatient services.

The system replaced the earlier cost-based reimbursement payment methodology for outpatient services with a prospective payment methodology devised to encourage more efficient delivery of care.

The outpatient PPS (PPS) was mandated by Congress in the Balanced Budget Act of 1997, and modified in the Balanced Budget Refinement Act of 1999 (BBRA). While most of the rule has gone into effect with the final publication, one remaining aspect of the rule, provider-based designation for hospital outpatient units, is slated to go into effect January 10, 2001.

The Balanced Budget Act of 1997 required HCFA to replace the cost-based system with the outpatient PPS, which pays hospitals specific predetermined payment rates for outpatient services. The Outpatient PPS payment is based on the ambulatory payment classification (APC) system, which bundles all outpatient services included in the new payment schedule into almost 600 procedural groups. The law also changed the way beneficiary coinsurance is determined for services under the outpatient PPS. Generally, under the outpatient PPS, coinsurance amounts are based on 20 percent of the national median charge billed by hospitals for the service. Eventually, coinsurance will be 20 percent of the prospective payment amount.

The outpatient PPS covers all Medicare participating hospitals, except critical access and Indian Health Service hospitals. Community mental health centers that provide partial hospitalization services to Medicare beneficiaries are also paid under the PPS. In addition, antigens, vaccines, casts and splints furnished by home health agencies; antigens, splints and casts furnished by hospices; and vaccines furnished by comprehensive outpatient (continued on page 4)
Regulatory Analysis

Careful Analysis of Provider-Based Designation Status Could Avoid Costly Future Repayments

As the deadline looms for seeking determinations of provider-based status for hospital departments, it is imperative that hospitals carefully analyze each of their programs in order to minimize the risk of costly Medicare repayments in the future, according to HLP Principal and provider-based designation expert David P. Henninger. The requirement for formal provider-based designation will become effective with each hospital’s first reporting period beginning after January 10, 2001.

Mr. Henninger, who has represented a number of clients in provider-based designation issues before the Health Care Financing Administration, was among the experts chosen to appear recently in a teleconference sponsored by the American Bar Association analyzing the current status of the provider-based designation portion of new regulations implementing the outpatient prospective payment system for hospitals (see related stories, p. 00. p. 00).

HCFA recently stated at a town hall meeting regarding the new regulations that it does not expect to have a uniform application form for seeking provider-based designation before May 2001 at the earliest. Until then, HCFA officials are suggesting that providers submit letters to their regional offices requesting provider-based designation status for their departments prior to the effective date of the regulations for their facilities, and contact the HCFA regional offices about documents that should be submitted.

According to Mr. Henninger, Region IX is currently using a questionnaire it had developed for use under HCFA’s prior provider-based guidelines, with an addendum to capture additional information needed for determinations under the new provider-based regulations. However, this questionnaire may not be sufficient to demonstrate compliance with the new HCFA requirements, according to Mr. Henninger, who warned that hospitals providing inaccurate or incomplete information face a significant risk of repayments at a later date. Mr. Henninger pointed out that HCFA will approve provider-based status retroactive to the time a hospital submits an application and provides information sufficient to demonstrate that the provider-based standards are met.

However, the agency has no deadline to take action on an application, and in light of the volume of applications that will be submitted determinations will likely take many months or even longer. There is a considerable risk for providers if an application is ultimately not approved and the hospital has continued to bill for the services of the entity as provider-based. The hospital could be forced to pay back to HCFA the difference between what it received as provider-based and what it would have received as free-standing for the entire period from the effective date of the regulations until the denial of provider-based status. Consequently, Mr. Henninger suggested that hospitals consider supplementing Region IX’s questionnaire with additional information as necessary to clearly establish compliance with the provider-based requirements.

This new application process will be a massive undertaking for hospitals. “It is important to analyze the gray areas of compliance and to carefully determine whether a hospital department is likely to meet the criteria before each application is submitted,” Mr. Henninger said, noting that part of what makes the process so difficult is that many departments are unique and must be analyzed on an individual basis. Hospitals may frequently find that their best option for some of their departments is to treat them as free-standing rather than to pursue provider-based designation.

Mr. Henninger also noted that legislation currently pending in the Senate (HR 5543, which was recently integrated into HR 2614), would grandfather for two years all existing entities currently treated as provider-based, which HCFA is interpreting to cover all entities which are currently being billed as provider-based. If the pending legislation passes, hospitals will be afforded some breathing room. However, even if the bill is passed, hospitals will still need to seek provider-based status on or before October 1,
PPS Rule Published
(continued from page 2)
rehabilitation facilities are paid under the PPS.

The PPS includes most hospital outpatient services and Medicare Part B services furnished to hospital inpatients who have no Part A coverage. Excluded from the PPS are ambulance services, for which a new fee schedule is being developed. HCFA will continue to pay physician services separately under Medicare's physician fee schedule. HCFA will also continue to use existing fee schedules to pay for physical, occupational, and speech therapies; durable medical equipment; clinical diagnostic laboratory services; and nonimplantable orthotics and prosthetics.

Regulatory Analysis
(continued from page 3)
2002 for any entity that has been treated, or which they wish to be treated, as provider-based and billable under the hospital's provider number. The bill would also provide relief from the onerous geographic location requirements in the provider-based regulations for all off-campus entities which are less than 35 miles from a hospital and for entities operated by governmental hospitals.

At press time, however, President Clinton has threatened to veto the measure based on unrelated tax aspects of the bill. If the legislation does not pass, hospitals will immediately face difficult questions regarding when to apply for designation, which entities need such designation, and how to properly bill for services provided in entities that do not have a formal provider-based approval. Since the safest course appears to be to submit applications sooner rather than later, Mr. Henninger recommended that hospitals ensure that all of their applications are thoroughly reviewed prior to submission so that they will likely stand up under scrutiny by HCFA and future Medicare repayments can be minimized or avoided altogether.

For more information, or to find out if your application includes significant risk, contact Mr. Henninger at (310) 551-8177.