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COVID-19's impact on provider-based departments

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The one constant in healthcare is change, and the COVID-19 public health emergency (PHE) brought rapid change to how and where hospitals deliver services to patients. Healthcare entities may have relocated or temporarily shifted provider-based departments (PBDs) to provide flexibility for patient care purposes. When the PHE ends (and the associated 1135 waivers), will your organization still have a solid physical inventory of all your hospital spaces and PBDs? Do those temporary relocations become permanent changes? Will the new location become "non-excepted" and affect reimbursement? Who in your organization is providing oversight and a road map for these changes? Does your organization's leadership have a master list of each provider-based location? If you answered yes to any of these questions, continue reading, as the discussion will focus on important considerations to Medicare's requirements for PBDs considering the COVID-19 pandemic.

Understanding PBDs

PBDs are defined under 42 C.F.R. § 413.65(a)(2) as facilities or organizations "either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider." Also under it, campus is defined as the "physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS [Centers for Medicare & Medicaid Services] regional office, to be part of the provider's campus." These two definitions are vital to understanding how the changes shape facilities and organizations alike. PBDs can either be on or off the main provider's campus. The provider-based status is a Medicare payment designation that was established by the Social Security Act permitting healthcare facilities to bill Medicare as a hospital outpatient department. Therefore, it is important that hospitals adhere to Medicare's provider-based requirements. The provider-based requirements are categorized as:

- Licensure: The department/facility in question may operate under the same license as the main provider unless state law requires the department/facility to have a separate license. Is the location associated with the main provider's form CMS-855A ("Medicare Enrollment Application - Institutional Providers")?
- Clinical services: The department/facility must be clinically integrated with the main provider. Does the

main provider have monitoring and/or oversight authority of the department/facility as it would with any other department of the main provider?

- Financial integration: The department/facility must be wholly integrated with the main provider from a financial standpoint. For example, does the department/facility share income and expenses with the main provider?
- Public awareness: The department/facility must be held out to the public as part of the main provider. When patients visit the department/facility, do they know they are in a facility that is part of the main provider? Also, do patient bills and wall signage affirm that the patient is receiving care from the main provider?
- Hospital obligations: There are many hospital obligations that must be met before obtaining provider-based status. Does the department/facility satisfy the hospital outpatient department requirements? Do the physicians within the department/facility comply with the nondiscrimination requirements, as outlined in 42 C.F.R. § 489.10(b) ?

In addition to the requirements explained above, off-campus departments/facilities must also adhere to the following requirements:

- Operate under the ownership and control of the main provider:
    - Is the facility exclusively owned by the main provider?
- Maintain administration and supervision integration:
    - Does the department/facility share the same reporting relationship as the main provider such that it is accountable to the governing body of the main provider in the same manner as any department head of the provider?
- Location:
    - Is the department/facility located within a 35-mile radius of the hospital campus?
    - Is the department/facility owned and operated by a hospital that has a disproportionate share adjustment greater than 11.75%, as described in 42 C.F.R. § 412.106(c)(2) ?[1]
    - Does the department/facility demonstrate a high level of integration with the main provider such that it meets all the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records that show the integration during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS?

For the comprehensive listing of all provider-based requirements, review the full regulations at 42 C.F.R. § 413.65 .