

## Provider-Based Regulations: Delay in Effective Date and Town Meeting

*On September 20, 2000, the Administrator released a letter to several provider associations regarding the provider-based regulations. The text of that letter follows.*

I am writing in response to your August 25 letter requesting that we delay implementation of the provider-based criteria that we published in a final rule on April 7, 2000.

The provider-based regulations were developed to help ensure that program payments and beneficiary copayments are appropriate while reassuring our beneficiaries that they are receiving health care services in appropriate facilities. If a physician practice meets certain criteria and is owned by a hospital, then that practice can be designated as "provider-based" and be paid under hospital outpatient department rates.

We do not want to discourage that practice under appropriate circumstances; however, as you know, the Health and Human Services Inspector General (IG) has concluded that many hospital purchases of physician practices appear to have been designed not to ensure services are provided to participants in the most appropriate setting, but rather simply to obtain higher Medicare payments. The IG strongly recommended that, if such arrangements continue, the Health Care Financing Administration (HCFA) must take steps to curtail such arrangements which is what we are seeking to do with the proposed provider-based regulations.

I want to emphasize that the new provider-based rule does not prevent hospitals from purchasing or owning individual physician practices. As recommended by the IG, however, the new rule clearly sets forth criteria that must be fulfilled before the practice is eligible to receive higher payments as a department of the hospital.

After carefully reviewing your concerns and various implementation challenges, I have concluded that it would be in the best interest of the Medicare program to delay the effective date of the provider-based criteria for three months, from October 10, 2000 to January 10, 2001. We intend to phase-in the criteria on the basis of the cost reporting period of the main provider over a 12-month period. We expect to announce this change in the *Federal Register* in the near future. This delay would give hospitals additional time to prepare for the implementation of the new regulations and allow HCFA to provide additional guidance. In addition, this delay and phase-in process would allow a more manageable distribution of work for hospitals, HCFA regional offices, and contractors.

HCFA will expand our ongoing outreach and education efforts on this issue. For example, we will hold a "town hall" meeting in Baltimore by the end of October. In addition, we will continue to hold training activities related to the new regulations and to

meet with provider associations as well as individual providers. Moreover, as indicated previously, we will post on the HCFA website answers to frequently asked questions and further guidance to clarify the provisions of the provider-based regulation. In the near future, we will post information about the town hall meeting, as well as our additional guidance, on the HCFA website.

Also at the town hall meeting, we will work with you, the rest of the provider community, and our regional offices to further explore and possibly develop sub-regulatory guidance on a number of issues that have arisen. As you point out in your letter, of particular concern are provisions relating to the common service area criterion (described as the 75/75 rule). In addition, we believe clarification is needed regarding the circumstances under which a hospital can contract with another party to manage and provide certain services in particular departments, such as psychiatric units.

I was concerned to learn that you have the impression that some HCFA staff do not think the regulation reflects HCFA's intention concerning which hospital departments would be covered by a provider-based determination. Based on your concern, you suggest that we need to re-propose certain aspects of the proposed rule. We have reviewed this situation and believe that the regulation correctly reflects the policy that any facility, organization, or department must be covered by a determination if it furnishes services where provider-based status would make a difference in payment rates or beneficiary liability. We expect to provide additional guidance and application procedures to explain HCFA's position further and remedy any confusion. At this time, we do not believe that re-proposing the rule will be necessary.

HCFA is committed to implementing the provider-based criteria in order to improve program integrity and protect beneficiaries. Michael Hash, the Deputy Administrator of HCFA, and I look forward to continuing to work with you to keep hospitals informed about the provider-based criteria and to assist hospitals as they prepare for implementation of the provider-based rules. Our collaboration throughout the months leading up to the successful implementation of the outpatient PPS on August 1 demonstrates how much we can achieve when we work together.