Medicare Provider-Based Status

I. Overview

A provider-based entity is an entity that is operationally integrated with a main hospital such that it is permitted to bill for services under the hospital’s Medicare provider number. An entity will seek provider-based status primarily for payment purposes as the provider-based entity will receive substantially more payment than a free-standing facility. There are a number of requirements that an entity must satisfy in order to be considered by CMS to be sufficiently integrated to be deemed provider-based. There are several kinds of provider based entities, each of which must meet different criteria to be deemed provider-based. In addition there are separate requirements for on-campus and off-campus facilities (more than 250 yards away from the main hospital).

II. Provider-Based Requirements – All Provider Based Facilities

All entities that seek to obtain provider-based status, regardless of whether the entity is located on-campus or off-campus as defined by the provider-based regulations, must meet a series of requirements in order to qualify as a provider-based entity.

(a) Licensure

For all types of provider-based facilities, CMS requires that the provider-based entity and the main hospital be operated under the same license. There is an exception for circumstances where the state requires the provider-based facility to have a separate license, or where the law does not permit licensure of the hospital and the provider-based facility under a single license. Documentation maintained by the provider may include a copy of the state license, including the license number and the expiration date. The provider may need to maintain documentation of whether the State requires a separate license.

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1 42 C.F.R. §413.65(d)(1).
(b) Clinical Services

The Hospital and the provider-based entity must integrate their clinical services by meeting the following criteria:

- The professional staff of the provider-based entity must have clinical privileges at the Hospital.
- The Hospital must maintain the same monitoring and oversight of the entity as the Hospital does for any other Hospital department. Documentation may include a description of the level of monitoring and oversight of the provider based department by the main provider as compared to oversight for other departments of the main provider.
- The medical director of the provider-based entity must (1) maintain a reporting relationship with the chief medical officer or other similar official of the Hospital that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a Hospital department and the chief medical officer or other similar official of the Hospital and (2) be under the type of supervision and accountability as any other director, medical or otherwise, of the Hospital.
- Medical staff committees and other professional committees at the Hospital are responsible for medical activities in the provider-based entity, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the provider-based entity and the Hospital. Documentation may include a description of the responsibilities and relationships between the medical director of the remote location, the chief medical officer of the main provider, and the medical staff committees at the main provider.
- Medical records for patients treated at the provider-based entity are integrated into a unified retrieval system (or cross reference) of the Hospital. Documentation may include a copy or description of the policy utilized in record retrieval from both the main provider and the provider-based entity.
- Inpatient and outpatient services of the provider-based entity and the Hospital are integrated, and patients treated at the provider-based entity who require further care have full access to all services of the Hospital and are referred where appropriate to the corresponding inpatient or outpatient department or service of the Hospital. Documentation may include information on how inpatient and outpatient services of the remote location and the main provider are integrated and examples of integration of services,
including data on the frequency of referrals from inpatient to outpatient facilities of the provider or vice versa.  

(c) Financial Integration

The financial operations of the provider-based entity are fully integrated within the financial system of the main provider (the Hospital), as demonstrated by the following:

- Shared income and expenses between the provider-based entity and the Hospital
- The costs of the provider-based entity are reported in the appropriate cost center or cost centers of the Hospital
- The financial status of the provider-based entity is incorporated and readily identified in the Hospital’s trial balance

Documentation may include a copy of the appropriate section of the main provider’s chart of accounts or trial balance that would show the location of the facility’s revenues and expenses.  

(d) Public Awareness

The provider-based entity is held out to the public and payers as part of the Hospital. When patients enter the provider-based entity, they are aware they are entering the Hospital and are billed accordingly.

(e) Obligations of Hospital Outpatient Departments and Hospital-Based Entities

If the provider-based entity is a hospital outpatient department or a hospital based entity, the provider-based entity must comply with additional obligations of hospital outpatient departments and hospital based entities. These additional requirements are as follows:

- **EMTALA**: On-campus departments and off-campus departments that are dedicated emergency departments of the Hospital must comply with EMTALA.
- **Hospital Provider Agreement**: Hospital outpatient departments must comply with all of the terms of the hospital’s provider agreement.
- **Treat Patients as Hospital Outpatients**: Hospital outpatient departments must treat all Medicare patients, for billing purposes, as hospital outpatients. The department may not treat some

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3 42 C.F.R. §413.65(d)(2).
4 42 C.F.R. §413.65(d)(3).
5 42 C.F.R. §413.65(d)(4).
Medicare patients as hospital outpatients and others as physician office patients.

- **Health and Safety**: Hospital outpatient departments must meet applicable hospital health and safety rules for Medicare-participating hospitals in 42 CFR Part 482.
- **3 Day DRG Window Compliance**: If a patient is admitted to the hospital as an inpatient after receiving treatment in hospital outpatient department or the hospital based entity, payment for such services in the hospital outpatient department or hospital-based entity, payment for services in the hospital outpatient department or hospital based entity are subject to the payment window provisions applicable to prospective payment system ("PPS") and to hospitals and units excluded from PPS.
- **Co-insurance notices**: When a Medicare beneficiary is treated in a hospital outpatient department that is not located on the main provider’s campus, the treatment is not required to be provided by the antidumping rules (EMTALA) at 42 CFR §489.24, and the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician services, the following requirements must be met:
  - The hospital must provide written notice to the beneficiary before the delivery of services, of (a) the amount of the beneficiary’s potential financial liability; or (b) if the exact type and extent of care needed are not known, an explanation that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based, an estimate based on typical or average charges for visits to the facility, and a statement that the patient’s actual liability will depend upon the actual services furnished by the hospital;
  - The notice must be one that the beneficiary can read and understand;
  - If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary’s authorized representative; and
  - In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules (EMTALA) of 42 CFR § 489.24, the notice must be given as soon as possible after the existence of an emergency has been ruled out or the emergency condition has been stabilized.
III. Provider Based Requirements – Specific Requirements for Off-Campus Locations

In addition to the requirements set forth above that all entities must meet in order to qualify as a provider-based entity, those entities that are located off-campus who seek to obtain provider-based status must meet additional requirements.

(a) Operation under the Ownership and Control of the Main Provider

The remote location must be operated under the ownership and control of the main provider (the Hospital) as evidenced by complying with all of the following:

- The business enterprise that constitutes the remote location is 100% owned by the Hospital
- The Hospital and the remote location have the same governing body
- The remote location is operated under the same organizational documents as the Hospital. For example, the remote location must be subject to common bylaws and operating decisions of the governing body of the Hospital
- The Hospital has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct) and final approval for medical staff appointments at the remote location.  

(b) Administration and Supervision

The reporting relationship between the remote location and the main provider Hospital must have the same frequency, intensity, and level of accountability that exists in the relationship between the Hospital and one of its existing departments, as evidenced by complying with all of the following:

- The remote location is under the direct supervision of the Hospital
- The remote location is operated under the same monitoring and oversight by the Hospital as any other department of the Hospital and is operated just as any other department of the Hospital with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the remote location:
  (i) maintains a reporting relationship with a manager at the Hospital that has the same frequency, intensity, and level of

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6 42 C.F.R. §413.65(e)(1).
accountability that exists in the relationship between the Hospital and its existing departments
(ii) is accountable to the governing body of the Hospital in the same manner as any department head of the Hospital

The following administrative functions of the remote location are integrated with those of the Hospital: billing services, records, human resources, payroll, employee benefit package, salary structure and purchasing structure. Either the same employees or group of employees handle these administrative functions for the remote location and the Hospital or the administrative functions for both locations are:
(i) contracted out under the same agreement; or
(ii) handled under different contract agreements, with the contract of the remote location being managed by the Hospital

(c) Location

The remote location is within a 35-mile radius of the Hospital campus. In addition, the remote location and the Hospital must be located in the same state or adjacent state, when permitted by state law.

IV. Attestations

Since October 2002, the mandatory requirement for provider-based determinations has been replaced with a voluntary attestation process. Providers are no longer required to apply for and receive a provider-based determination for their facilities prior to billing for services in those facilities as provider-based. However, a provider may choose to obtain a determination of provider-based status by submitting an attestation stating that the facility meets the relevant provider-based requirements. Entities can seek determinations as to the provider-based status of their facilities by submitting a provider-based attestation to CMS. Although attestations are voluntary, there may be certain benefits to seeking a provider-based determination.

First, the CMS regulations state that “[a] facility that is not located on the campus of a hospital and that is used as a site where physician services of the kind ordinarily furnished in physician offices are furnished is presumed as a free-standing facility, unless CMS determines the facility has provider-based status.” Thus, if the provider based entity provides outpatient physician services of the type normally rendered in physician offices, CMS could presume in the absence of a provider-based attestation that the entity seeking provider-based status (or at least that aspect of its operations) is freestanding.

7 42 C.F.R. §413.65(e)(2).
8 42 C.F.R. §413.65(e)(3).
9 42 C.F.R. §413.65(b)(3).
Second, if a hospital submits an attestation but CMS subsequently determines that the facility does not, in fact, satisfy the applicable provider-based requirements, it appears that under these facts CMS would recover only the difference between the amount of payment that actually was made since the date the hospital submitted a complete attestation for a provider-based determination and the amount that CMS estimates should have been made in the absence of compliance with requirements during such time period.

Further, when a main provider attests and receives a positive provider-based determination, and subsequently a material change occurs in the relationship between the main provider and the provider-based facility, and the main provider properly reports the change to CMS, then treatment of the facility as provider-based would cease only with the date that CMS determines that the facility no longer qualifies for provider-based status. By contrast, a provider that does not submit a provider-based attestation, or obtains an affirmative determination but fails to report the subsequent material change, could face a recovery of the difference between provider-based and freestanding payment for all cost reporting period subject to reopening.

CMS included a sample form of attestation in a Program Memorandum issued to fiscal intermediaries on April 18, 2003 (Transmittal A-03-030). This attestation form is attached as Exhibit A.

V. Recent Developments – OIG 2013 Work Plan

In the Department of Health and Human Services’ Office of the Inspector General (OIG) 2013 work plan the OIG announced a new review of hospital-owned physician practices billing Medicare as provider-based physician practices. The OIG plans to review the extent to which practices using the provider-based status are satisfying CMS billing requirements. In the 2013 Work Plan the OIG addressed the 2011 review by Medicare Payment Advisory Commission (MedPAC) of provider-based billing practices. In the study MedPac expressed concern regarding the financial incentives presented by provider-based status and identified an increase in physician office visits performed in provider-based outpatient departments from 2004 to 2010. The OIG’s proposed review of provider-based rules and practices in 2013 emphasizes the need for providers to ensure they are in compliance with the relevant provider-based rules.

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Exhibit A
Sample Provider-Based Attestation Form

SAMPLE ATTESTATION FORMAT

The following is an example of an acceptable format for an attestation of provider-based compliance.

Please note that provider-based determinations in relation to hospitals are not made for the following facilities: ambulatory surgical centers (ASCs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), skilled nursing facilities (SNFs), hospices, inpatient rehabilitation units that are excluded from the inpatient prospective payment system for acute hospital services, independent diagnostic testing facilities furnishing only services paid under a fee schedule (subject to §413.65(a)(1)(ii)(G)), facilities other than those operating as parts of CAHs that furnish only physical, occupational, or speech therapy to ambulatory patients (subject to §413.65(a)(1)(ii)(H)), IRFs, and facilities, departments of providers that perform functions necessary for the successful operation of the providers but do not furnish services of a type for which separate payment could be claimed under Medicare or Medicaid (for example, laundry or medical records departments, ambulances).

(Note: As of the date of release of this Program Memorandum, legislation has not been enacted to further extend the moratorium on applying the $1,500 annual cap on physical therapy, occupational therapy, and speech therapy services of providers and suppliers other than hospitals.)

Provider-Based Status Attestation Statement

Main provider’s Medicare Provider Number: ________________________________
Main provider’s name: ___________________________________________________
Main provider’s address: _________________________________________________
Application Contact name and Phone Number ______________________________

Facility/Organization’s name: ___________________________________________
Facility/Organization’s exact address: ______________________________________
Facility/Organization’s Medicare Provider Number, if there is one: ____________

Is the facility/organization part of a multi-campus hospital?: ________________
Is the facility a Federally Qualified Health Center (FQHC)? If so, and if the FQHC meets the criteria at section 413.65(n), it need not attest to its provider-based status. The provider-based rules do not apply to other FQHCs that do not meet the criteria at section 413.65(n), and an attestation should not be submitted.

The facility/organization became provider-based with the main provider on the following date: ________________________________

(Please indicate if this attestation is adding deleting, or changing previous information—if yes, please make certain to include the effective date.)

Indicate whether the facility/organization is "on campus" or "off campus" (per § 413.65(a)(2)) with the main provider:

1. _____ On campus of the main provider (located within 250 yards from the main provider building)

   OR

2. _____ Off campus of the main provider (located 250 yards or greater from the main provider building, but subject to § 413.65(a)(3))
I certify that I have carefully read the attached sections of the Federal provider-based regulations, before signing this attestation, and that the facility/organization complies with the following requirements to be provider-based to the main provider (initial ONE selection only):

1. ______ The facility/organization is 'on campus' per 42 C.F.R. §413.65(a)(2) and is in compliance with the following provider-based requirements (shown in the following attached pages) in §413.65(d) and §413.65(g), other than those in §413.65(g)(7). If the facility/organization is operated as a joint venture, I certify that the requirements under §413.65(f) have been met. I am aware of and will comply with the requirement to maintain documentation of the basis for these attestations (for each regulatory requirement) and to make that documentation available to the Centers for Medicare & Medicaid Services (CMS) and to CMS contractors upon request.

OR

2. ______ The facility/organization is 'off campus' per 42 C.F.R. §413.65(a)(2) and is in compliance with the following provider-based requirements (shown in the following attached pages) in §413.65(d) and §413.65(e) and §413.65(g). If the facility/organization is operated under a management contract/arrangement, I certify that the requirements of §413.65(h) have been met. Furthermore, I am submitting along with this attestation to the Centers for Medicare & Medicaid Services (CMS), the documentation showing the basis for these attestations (for each regulatory requirement).

Please complete the following for on campus AND off campus facilities and organizations:

I attest that the facility/organization complies with the following requirements to be provider-based to the main provider (please indicate Yes or No for each requirement):

1. ______ The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license. If the provider and facility/organization are located in a state having a health facilities cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers, the commission or agency has not found that the facility/organization is not part of the provider.

2. ______ The clinical services of the facility or organization seeking provider-based status and the main provider are integrated.

2a. ______ Professional staff of the facility or organization have clinical privileges at the main provider.

2b. ______ The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

2c. ______ The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.
2d. Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

2e. Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

2f. Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

3. The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance.

4. The facility or organization seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

5. In the case of a hospital outpatient department or a hospital-based entity (if the facility is not a hospital outpatient department or a hospital-based entity, please record "NA" for "not applicable" and skip to requirements under number 6), the facility or organization fulfills the obligation of:

5a. Hospital outpatient departments located either on or off the campus of the hospital that is the main provider comply with the anti-dumping rules in §§489.20(i), (m), (q), and (r) and §489.24 of chapter IV of Title 42.

5b. Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) are billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined under the rules of Part 414 of chapter IV of Title 42.

5c. Hospital outpatient departments comply with all the terms of the hospital's provider agreement.

5d. Physicians who work in hospital outpatient departments or hospital-based entities comply with the non-discrimination provisions in §489.10(b) of chapter IV of Title 42.

5e. Hospital outpatient departments (other than RHCs) treat all Medicare patients, for billing purposes, as hospital outpatients. The departments do not treat some Medicare patients as hospital outpatients and others as physician office patients.
5f. In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at §412.2(c)(5) of chapter IV of Title 42 and at § 413.40(c)(2) of chapter IV of Title 42, respectively. (Note: If the potential main provider is a CAH, enter “NA” for this item).

5g. (Note: This requirement only applies to off campus facilities). When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider’s campus, and the treatment is not required to be provided by the antidumping rules in §489.24 of chapter IV of Title 42, the hospital provides written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary’s potential financial liability (that is, that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability).

(1) The notice is on that the beneficiary can read and understand.

(2) If the exact type and extent of care needed is not known, the hospital furnishes a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based.

(3) The hospital furnishes an estimate based on typical or average charges for visits to the facility, but states that the patient’s actual liability will depend upon the actual services furnished by the hospital.

(4) If the beneficiary is unconscious, under great duress, or for any other reason is unable to read a written notice and understand and act on his or her own rights, the notice is provided before the delivery of services, to the beneficiary’s authorized representative.

(5) In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules at § 489.24 of chapter IV of Title 42, the notice is given as soon as possible after the existence of an emergency condition has been ruled out or the emergency condition has been stabilized.

5h. Hospital outpatient departments meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

For off campus facilities, please complete the following:

In addition to the above requirements (numbers 1-5h), I attest that the facility/organization complies with the following requirements to be provider-based to the main provider as an off campus facility (please indicate Yes or No for each requirement):

6. The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

6a. The business enterprise that constitutes the facility or organization is 100 percent owned by the provider.
8b. The main provider and the facility or organization seeking status as a department of the provider, a remote location of a hospital, or a satellite facility have the same governing body.

6c. The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status is subject to common bylaws and operating decisions of the governing body of the provider where it is based.

6d. The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the facility or organization.

7. The reporting relationship between the facility or organization seeking provider-based status and the main provider has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:

7a. The facility or organization is under the direct supervision of the main provider.

7b. The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity—

(1) Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its existing departments; and

(2) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

7c. The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based:

billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are (1) contracted out under the same contract agreement; or (2) handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

8. The facility or organization is located within a 35-mile radius of the campus of the potential main provider, except when the requirements in paragraph 8a of this section are met (please check below in the appropriate location if you qualify for the exemption):

8a. The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under §412.106 of chapter IV of Title 42) greater than 11.75 percent or is described in §412.106(c)(2) of chapter IV of Title 42 implementing section 1866(e)(5)(F)(i)(II) of the Act and is:

(1) Owned or operated by a unit of State or local government;
(2) ____ A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(3) ____ A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

8b. ____ The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the attestation for provider-based status is filed with CMS; and for each subsequent 12-month period:

(1) ____ At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(2) ____ At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from the main provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(3) ____ If the facility or organization is unable to meet the criteria in (1) or (2) directly above because it was not in operation during all of the 12-month period described paragraph 8b, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in paragraph 8b, accounted for at least 75 percent of the patients served by the main provider.

8c. ____ If the facility or organization is attempting to qualify for provider-based status under this section, then the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.

Note: An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area as defined in §412.62(f)(1)(iii) of chapter IV of Title 42, and has fewer than 50 beds as determined under §412.105(b) of chapter IV of Title 42, is not subject to the criteria in 8a and 8b above.

9. ____ The facility or organization that is not located on the campus of the potential main provider and otherwise meets the requirements of 1-8 above, but is operated under management contract, meets all of the following criteria (please respond to 9a - 9d if the facility is operated under a management contract; otherwise record "NA" for "not applicable"): 9a. ____ The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at Part 414 of chapter IV of Title 42. Other than staff that may be paid under such a Medicare fee schedule, the main provider does not utilize the services of "leased"
employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.

9b. The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph 7c above.

9c. The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph 7b above.

9d. The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

For facilities/organizations operated as joint ventures requesting provider-based determinations: In addition to the above requirements (numbers 1-5h for on campus facilities), I attest that the facility/organization complies with the following requirements to be provider-based to the main provider:

10. The facility or organization being attested to as provider-based is a joint venture that fulfills the following requirements:

10a. The facility is partially owned by at least one provider;

10b. The facility is located on the main campus of a provider who is a partial owner;

10c. The facility is provider-based to that one provider whose campus on which the facility organization is located; and

10d. The facility or organization meets all the requirements applicable to all provider-based facilities and organizations in paragraphs 1-5 of this attestation.
I certify that the responses in this attestation and information in the documents are accurate, complete, and current as of this date. I acknowledge that the regulations must be continually adhered to. Any material change in the relationship between the facility/organization and the main provider, such as a change of ownership or entry into a new or different management contract, may be reported to CMS. (NOTE: ORIGINAL ink signature must be submitted)

Signed: ___________________________
(Signature of Officer or Administrator or authorized person)

(PRINT Name of signature)

Title : ____________________________
(Title of authorized person acting on behalf of the provider)

(Direct telephone number)

Date : _____________________________

* Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years or both. (18 U.S.C. § 1001).
Overview of Viability of Affiliated PC Model under State Law

The Prohibition Against the Corporate Practice of Medicine

Virtually all hospital/physician integration models raise federal regulatory issues that affect how the arrangement can be structured, the compensation terms, reimbursement and operations. Once an arrangement has successfully negotiated the federal law minefield, however, it can still be blown up by state law restrictions or requirements. One of the key state law issues to be considered in this context is the prohibition against the corporate practice of medicine (CPOM).

CPOMs are usually traceable to one of two sources: common law or physician licensing statutes. The archetype for the first source is the California Supreme Court’s opinion in *Painless Parker v. Board of Dental Examiners*, 216 Cal. 285, 14 P.2d 67 (1932). To its fans, the California rule is a bulwark against the inevitability of K-Mart or Sears hiring physicians to provide branded physician services. To its critics, the California rule is an anachronistic impediment to improving the health care delivery system.

The second source is the statutory prohibition against unlicensed persons practicing medicine or holding themselves out as having the requisite skill and training. That prohibition is almost universal, which introduces some level of ambiguity in transactions between hospitals and physicians in even the most laissez faire states. Until the relevant state Supreme Court has rejected the argument, there is always the possibility that one party will assert that its obligations in the transaction are unenforceable because the underlying structure violates the CPOM.

Against that background, one common approach to structuring a hospital-physician joint venture is the use of a “friendly” or “captive” professional corporation (sometimes called a professional service corporation.) PCs are creatures of state statutes that were created, at least in part, to allow physicians to set up deferred compensation or pension programs that would otherwise be unavailable to the physicians under laws in the 1960s.

Initially, the rules on PCs were fairly uniform and stringent: only licensed persons could be shareholders in, or officers or directors of, the corporation. Over time, the rules were somewhat relaxed to recognize situations such as the death of the licensed physician/shareholder/director/officer and the desirability of allowing someone trained in finance to serve as the treasurer of the corporation.

One iteration of the captive PC involves a hospital or other lay entity forming a professional corporation with the assistance of a physician shareholder who is bound by various restrictions in the corporate organization documents and additional contractual obligations. Under a captive PC model the hospital maintains control of the corporation
through various contractual rights including the right to replace the physician shareholder with another physician.

Internal Revenue Service (IRS) training materials published in 2000 provide a checklist of restrictions on the power of the physician shareholder to act in ways inimical to the sponsoring hospital's interest. The training materials address a scenario where a hospital in a state with a robust CPOM seeks to engage physicians to provide professional services in a hospital’s offsite outpatient clinic. Although the training materials do not indicate official IRS policy, the IRS materials are still remarkable in that they admit of the possibility that a for-profit professional corporation can obtain 501(c)(3) status. The safeguards that the IRS required can be used as a checklist of issues a hospital involved in a captive PC model should consider. Those safeguards may include:

- A shareholder control or trust agreement. The agreement seeks to transfer structural and financial control over the PC to the hospital, and the physician/shareholder agrees to hold the stock for the benefit of the Parent.
- The articles of incorporation and bylaws
  - Organization must be organized and operated exclusively for exempt purposes.
  - The corporation’s purposes are exclusively tax exempt purpose.
  - Upon dissolution, the corporation’s assets will be dedicated to tax exempt purpose.
  - The hospital should have
    - the right to amend, alter, or repeal the certificate of incorporation and bylaws.
    - the right to approve significant actions including:
      - annual operating and capital budgets
      - the sale, lease, mortgage or other transfer or encumbrance of the corporation’s property,
      - the merger, acquisition, consolidation, liquidation, or dissolution of the corporation
      - electing directors, appointing directors, changing the number of directors and removing directors, with or without cause,
      - settling lawsuits, and
      - Selecting auditors.
- An employment agreement with the PC that requires the physician to discharge duties defined by the hospital.

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11 A copy of the IRS training materials is attached.
A management agreement whereby the hospital (or, more likely, an affiliate) provides administrative services to the PC, and thus is involved in the day-to-day operations.

In seeking 501(c)(3) status, the hospital must commit to exercising its legal and equitable authority to avoid “diversion or wasting” of the PC’s charitable assets.

The enforceability of the contractual restrictions incorporated into a captive PC model may not be known until the hospital wants to enforce them and the physician wants to avoid them. It may be apparent that the structure was designed to avoid the application of the state’s restrictions on professional corporations. Although that motivation may be helpful to highlight in the context of explaining how the hospital endeavored to ensure that the PC furthers its charitable purposes, it does open the door to an argument that the court should decline to enforce the restrictions because they promote a purpose inconsistent with the public policy underlying the physician licensing statutes.

The IRS training materials restrict the possibility of the for profit tax exempt PC to states with a restrictive CPOM. In 2000, that list included California, Texas, Ohio, Colorado, Iowa, Illinois, New York and New Jersey. Thus, it will be a greater challenge to convince the IRS to approve a tax exempt captive professional corporation in other states. If the PC cannot be tax exempt, a taxable captive could be created. When dealing with a taxable entity, however, an exempt hospital would need to exercise caution in structuring its funding of the PC and other financial relationships. Surmounting the funding challenges often requires additional creativity. One source of inspiration may come from the various new types of business organizations that have been authorized.

In addition to authorizing the use of professional corporations, most states have enacted statutes that allow one or more of the following

- limited liability companies,
- limited liability partnerships
- non-profit, non-stock corporations

To varying degrees, states have allowed various classes of licensed professionals to use one or more of those forms. By utilizing a number of these entities, the hospital may be able to define a structure that satisfies the literal requirements of the statutes as well as the business objectives of the parties.

For the purpose of illustration only, consider the following hypothetical:

Harry Hospital and Sally Specialist are in State W. Sally is organized as a professional limited liability corporation (PLLC). Harry is nonprofit corporation that is exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code.
Given the general economy and the state of health care reform, Sally is under some financial stress. Harry thinks that affiliating with Sally is in its long-term interest. That may require a capital infusion, and Harry is acutely aware of its duties as a tax exempt entity. With no slight intended, Harry thinks that it may be able to help Sally in navigating the stormy waters to come, and therefore seeks a “seat at the table” in making important business decisions.

After scouring the state’s statutes, Harry’s lawyers find the following:

Professionals may organize a nonprofit nonstock corporation to provide professional services.

A professional corporation may be a member of a PLLC if its shareholders, directors, and its officers other than the secretary and the treasurer, are licensed or otherwise legally authorized to render the same specific professional services as the professional limited liability company.

Using those provisions as a base, Harry’s lawyers create nonprofit, nonstock professional corporation. Harry is the sole member of the nonprofit PC. Physicians who are employed at the hospital are the corporation’s directors and officers.

The nonprofit PC purchases a majority interest in the PLLC, and the PLLC’s organization documents are amended to a) reserve certain powers for either a super-majority approval or the approval of the nonprofit PC, and b) explicitly identify the purpose of the organization as tax exempt. The capital infusion is accomplished through the purchase, the “seat at the table” is accomplished through both the majority status and the reserved powers, and Harry’s tax exempt status is not threatened by being aligned too closely a for profit entity consisting of highly compensated physicians.