



DEPARTMENT: Legal	POLICY DESCRIPTION: Provider-Based Program Development, Operations and Compliance
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EFFECTIVE DATE: June 1, 2009	REFERENCE NUMBER: LL.019
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: Hospitals, Critical Access Hospitals and Medical Centers affiliated with the Company (“Providers”) and all Corporate Departments, Groups, Divisions, and Markets involved in the development, operation and compliance of any patient care service furnished directly by the hospital that functions as and/or stated as being part of the Hospital and for which separate payment could be claimed under Medicare or Medicaid (“Provider-Based Programs”).

PURPOSE:

1. To establish guidelines relevant to the development of, and compliance with, requirements for Provider-Based Programs.
2. To establish guidelines relevant to service agreements where Providers purchase/lease certain components of patient care services (e.g., management expertise, equipment, technical staff, supplies) for the Provider-Based Programs from third party entities (“Contractors”).
3. To establish additional requirements specific to certain Provider-Based Programs that fall under the scope of the provider-based regulations in 42 C.F.R. section 413.65.

POLICY:

1. Development, Operations and Compliance. Provider-Based Programs must be developed and operated to meet legitimate community need and business purposes, in accordance with feasibility studies, capital acquisition requirements, legal review and approval, The Joint Commission (TJC) standards, Medicare Conditions of Participation, the Requirements for a Determination that a Facility or an Organization has Provider-Based Status at 42 C.F.R. section 413.65 (“Provider-Based Regulations”), state and federal regulatory agency requirements, the agency of local authority building codes and this Policy, as applicable.
2. Services Agreements. Providers may purchase/lease/contract certain components of patient care services (e.g., management expertise, equipment, technical staff, supplies) for the Provider-Based Programs from third party entities (“Contractors”). Contractors and any employees of Contractors considered or used to develop and/or operate any Provider-Based Programs must be evaluated closely on a case-by-case basis. Such Contractors must comply with applicable laws, regulations, standards, Conditions of Participation and reimbursement provisions in accordance with Corporate Policies and Procedures.
3. Additional Requirements Specific to Provider-Based Programs That Fall Under the Scope of the Provider-Based Regulations. Certain Provider-Based Programs must also be compliant with the procedures set forth in section 3 of this policy.

DEFINITIONS:

Furnished Directly by the Hospital: Services provided to registered patients of the hospital **in hospital space by hospital staff** are considered to be furnished directly by the hospital. Staff is either employed, leased or contracted by the hospital and all space, equipment and supplies are

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owned or leased by the hospital. The hospital-based services are held out to the public as part of the hospital and are provided exclusively to registered patients of the hospital.

Hospital Space: Hospital space is defined as space, real estate, or property where the hospital either directly owns or directly holds the lease of such space.

PROCEDURE:

1. Development, Operations and Compliance
 - a. A Provider must consider only legitimate community need and business reasons in developing a Provider-Based Program; a Provider must not develop a Provider-Based Program to obtain, reward, or retain referrals or generate other business between the Provider and a physician or other referral source.
 - b. A Provider must prepare feasibility studies or *pro formae* prior to initiating a Provider Based Program. The Division Manager, Reimbursement, will assist with studies and help the Provider to determine the viability of the proposed Provider-Based Program.
 - c. A Provider must obtain capital items such as real estate, tenant improvement and high-cost equipment for the development of a Provider-Based Program through the capital asset management review and approval process. The same review and approval process is also required where a capital item is purchased from a Contractor, including purchases through funds borrowed or otherwise advanced from the Contractor.
 - d. A Provider must use appropriate/relevant standard form agreements prepared or reviewed and approved by the Legal Department. Operations Counsel must review and approve any forms supplied by Contractors.
 - e. A Provider-Based Program must use all of the space and other resources in the physically defined area of the Program solely for the business and operation of the Program. Provider-Based Programs must not commingle, time-share or block lease such provider space or other resources with any third party such as a physician's private office or ambulatory surgery center. Concurrent use or block leasing of Provider space or any other resources to any third party is not permitted even in the event that expenses would be split.
 - f. It is preferable for all clinical and non-clinical staff to be engaged pursuant to an employment or independent contractual arrangement directly with the Provider. The Provider should not share staff with private physician offices or practices in a Provider Based Department.

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- g. A Provider may contract with or employ physicians and non-physician practitioners. Employment is preferable under applicable federal law unless contrary to applicable state law. Any payments for professional services may only be based upon the services personally performed (including “incident to” services) and may not include payments related to orders or referrals.
 - h. A Provider must pay fair market value for any administrative oversight or support (e.g., medical directorship). Ordinarily, the Provider will make these payments on an hourly basis pursuant to adequate time records submitted on at least a monthly basis, for specified services, and with maximum monthly and annual amounts.
 - i. Any ancillary services should be within the Provider’s capability and be performed by the Provider. Any referral by physicians employed or contracted by Provider to third parties who are competitors for these services is inappropriate. The Provider must evaluate the conduct of any physician employed or contracted by Provider who insists on directing or referring patients to a private practice for ancillary services that can be performed at the Provider. The Provider must take corrective action if the referral is based upon reasons that are not in the best interest of quality patient care and may be abusive to any government program from which payment will be sought.
2. Service Agreements
- a. There are no preferred Contractors at this time. Any questions or issues such as compensation, services, or performance concerning Contractors should be directed to assigned Operations Counsel, who may consult with Regulatory Compliance Support (Regs).
 - b. If a Contractor is selected to provide components of patient care services (e.g., management expertise, select equipment, certain staff, supplies), the Provider and the Contractor must enter into a written agreement that requires the Contractor to comply with applicable law, regulations, standards, Conditions of Participation and reimbursement provisions.
 - c. Any services agreement must allow for any necessary and appropriate changes so that the Provider-Based Program can remain viable after any regulatory changes occur or after clarification of program guidance.
 - d. The Provider shall assure the monitoring and evaluation of the quality and appropriateness of Contractor services or those directed by the Contractor, with reporting of results for review, action and approval by the Board of Trustees.
 - e. The services to be provided must be specific in the agreement and not exceed what are reasonable and necessary to develop and operate the Provider-Based Program.

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- f. The term of any services agreement must be at least one year and preferably no more than two years and should not automatically renew.
 - g. The Provider should not be bound by a restrictive covenant not to compete with respect to the operation of a Provider-Based Program following the termination of the services agreement.
 - h. Payment terms for management services purchased for the Provider-Based Program must be set in advance as a fixed monthly fee at fair market value, unless Operations Counsel approves the use of some other method of calculating a fair market value fee such as a variable-tiered fixed fee based upon volume ranges that forces risks on both sides. The Company does not authorize percentage, contingency-based, “per click” (e.g., a fixed rate is paid per procedure, per patient or per encounter) or time-based compensation fees for management services. The fee must be in accordance with prudent buyer guidelines. It must not be determined in a way that takes into account the volume or value of any referrals (subject to any influence, including any promotion, marketing or advertising), or business otherwise generated between the parties. It must be adjusted no more than on an annual basis.
 - i. If the services agreement includes expenses such as implementation fees, leasing/contracting of clinical/technical staff that provides patient care, leasing of equipment, and/or licensing of software, these expenses must be separately identifiable and not included in the compensation fee to manage the Provider-Based Program. The fixed monthly compensation fee for management services for the Provider-Based Program should only include such expenses as management oversight and administrative staff that do not provide any direct patient care.
 - j. A Provider must avoid proposals, letters of intent, or management agreements that limit the Provider’s choices after the Contractor has been engaged (e.g., non-compete provisions with expensive buy-outs, minimum “development” fees, or a ban on the use of data provided unless the Contractor is engaged as the developer/manager).
 - k. A Provider must not pay or reimburse a Contractor for any capital costs such as real estate, tenant improvement and high-cost equipment through the management fee. Only the Provider may bear capital costs.
3. Requirements Specific Only to Provider-Based Programs that fall within the scope of the Provider-Based Regulations.
- Note:** Section 3 of this Policy is not applicable to the following Provider-Based Programs since they do not fall under the scope of the Provider-Based Regulations: Ambulatory Surgery Centers (ASCs) paid by the ASC prospective payment system (PPS), Comprehensive Outpatient Rehabilitation Facilities, Home Health Agencies, Skilled

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<p>Nursing Facilities, Hospices, Inpatient Rehabilitation Units that are excluded from the Inpatient PPS for acute hospital services, Independent Diagnostic Testing Facilities, Ambulances or Rural Health Clinics affiliated with hospitals having 50 or more beds.</p> <p>a. Provider administration is responsible for identifying all Provider-Based Programs that fall under the scope of the Provider-Based Regulations and assessing compliance of the Provider-Based program's structure and operations in relation to the provide-based criteria.</p> <p>b. Structures of Provider-Based Programs that clearly would not be compliant with the Provider-Based Regulations must be avoided.</p> <p>c. Provider-Based Programs that were either 1) in existence on October 1, 2000 and the Provider was billing and being paid as provider-based or had a written determination from CMS that it was provider-based or 2) received from CMS, formal provider-based status on or after October 1, 2000 and before October 1, 2002; must be compliant with all applicable provider-based designation criteria, TJC standards, Medicare conditions of participation, state and federal regulatory requirements, the agency of local authority building codes and this Policy.</p> <p>d. Provider-Based Programs created or acquired on or after October 1, 2002 must</p> <p>i. Be compliant with all applicable provider-based requirements and obligations at 42 C.F.R. section 413.65, TJC standards, Medicare Conditions of Participation, state and federal regulatory agency requirements, the agency of local authority building codes and this Policy, prior to billing the program as a hospital service.</p> <p>ii. Complete the provider-based designation attestation statement ("Attestation") required by the Hospital's Medicare Contractor. If the Medicare Contractor does not require a specific attestation, obtain permission to use the attestation available on the Company's Intranet under the Government Programs/Regulatory Compliance Support/Provider-Based Tools folder.</p> <p>iii. Forward the attestation and all supporting documentation to the Division Manager, Reimbursement for review and final approval.</p> <p>iv. Submit the final attestation and supporting documentation for all locations (i.e., on campus or off campus) to the Medicare Contractor and forward copies to the CMS Regional Office. For all newly created or acquired Provider-Based Programs, the final attestation and supporting documentation must be sent within 14 days after the date the Provider begins to bill the services of the Provider-Based Program as provider-based.</p>

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- v. Provider-Based Programs that are created or acquired on or after October 1, 2002 may be billed as a hospital service prior to receiving formal provider-based status determination from CMS as long as the provider-based program is compliant with all applicable provider-based requirements and obligations. **Exception:** A service not located on the campus of a hospital and used as a site where physician services of the kind ordinarily furnished in physician offices are furnished, must be determined by CMS to have provider-based status before it begins billing its services as provider-based.
- e. Provider administration must report to the CMS RO and Medicare Contractor any material change in the relationship between it and any Provider-Based Program, such as a change in ownership status, entry into a new or different management contract, change in licensure status, or change in location that would affect the provider-based status of the Provider-Based Program.
- f. Provider Administration and Division Manager, Reimbursement are responsible for continued compliance with all applicable provider-based criteria.
- 4. If the Provider operates a Provider-Based Program that is not in full compliance with this Policy, Provider administration should consult with the Division Manager, Reimbursement, and assigned Operations Counsel for assistance to analyze the structure of the Provider-Based program, request a policy exception, implement any changes, and/or negotiate revised contractual arrangements.

REFERENCES:

42 U.S.C. §1320a-7b; 42 C.F.R. §1001.952(a)(v)

Social Security Act, §1887(b), Payments of Provider-Based Physicians and Payment Under Certain Percentage Arrangements

HCFA Program Memorandum A-99-24 (May 1999)

42 C.F.R. §413.65, Requirements for a Determination that a Facility or an Organization has Provider-Based Status, as may be amended from time to time

CMS Program Memorandum A-03-030 (April 18, 2003) with Sample Attestation Form

“Medicare Provider Cost Reports: Evaluating the Reasonableness of the Fee in Management Contract Arrangements,” *Administrative Bulletin* 1401,80.02 (September 3, 1980), and *Administrative Bulletin* 1401 (December 13, 1979)



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Provider Reimbursement Manual 2723, Responsibility of Intermediaries

Provider Reimbursement Manual 289 (guidance on section 109)

Provider Reimbursement Manual 2135, Purchased Management and Administrative Support Services