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healthcare financial management association

Achieving and Maintaining Provider-Based Status for Outpatient Services

You'll Learn:

- How to apply the Medicare provider-based status rules both to new outpatient facilities and to existing clinics and outpatient departments.
- The different procedures and substantive rules for on-campus units and for existing and proposed off-campus units.
- For planned facilities, an approach to determining the financial impact of being provider-based versus freestanding.
- How to review existing operations with regard to compliance with the existing provider-based status rules.
- The process of developing attestation letters to the Centers for Medicare and Medicaid Services and the compilation of supporting documentation.
- The possible sanctions of failing to apply correctly the provider-based rules.

Who Should Attend:

Hospital and Clinic executives including: chief operating officers, chief financial officers, directors of ambulatory services, other operations executives, reimbursement managers, patient accounting managers, strategic planners, and compliance officers.



Schedule:

This seminar runs for one day.

Seminar Outline:

Achieving Medicare provider-based status can mean very significant financial benefits to hospital outpatient departments and clinics. Through a mixture of lecture and facility-specific dialogue, this course reviews the regulatory requirements so that hospitals may insure that current units are in compliance and determine whether future units should or should not seek provider-based status.

I. Overview of the Provider-Based Status Issue: The Much-Modified Regulations.

- a. Prior application of provider-based status and the regulatory changes.
- b. The need to assess current and proposed outpatient departments and clinics under the new rules and the submission of attestations to CMS.

II. The Seven Elements of Provider-Based Status.

- a. Key definitions of the regulations and their importance to outpatient units.
- b. A review of the seven elements of the provider-based status regulations.
- c. CMS interpretations and open issues; also: joint ventures, management agreements.
- d. The different rules for on-campus and off-campus outpatient units.

III. Financial Benefit Analysis.

- a. The financial implications of being provider-based versus freestanding.
- b. The approach to determining the financial benefits and costs of being provider-based versus freestanding.



For more information,
contact Dawna White
at 800-252-4362 x338
or
via e-mail at
dwhite@hfma.org

IV. A Practical Guide to the Review of Existing and Planned Outpatient Operations.

- a. Assembling the appropriate team to review the organization's provider-based status issues.
- b. Identification of particular issues that may affect compliance possibilities.
- c. Determining whether to achieve (or maintain) provider-based status.

V. Specific Review of Operations and Modifications to Meet the Requirements.

- a. Detailed review of operations and supporting documentation.
- b. Identification of needed changes to operational, financial, public awareness, and other items.
- c. Handling the changes necessary to achieve compliance.

VI. Drafting Attestations to CMS and Requests for Determination of the Status.

- a. Review of on-campus and off-campus attestation requirements.
- b. Developing the documents to support the attestations.
- c. Submission to the Regional Office and contacts with CMS.

VII. Special Problem Areas and Specialty Services.

- a. The special rules concerning management contracts and joint ventures.
- b. Complex corporate structures, parent entity issues, and licensure issues.
- c. Specialty clinics and services and the relevance of provider-based status.

VIII Case Studies – Hypothetical and Concrete Issues.

- a. Examples of specific problems and commonly occurring issues.
- b. Opportunity for the facility to present issues for discussion.

