



STRATEGIC

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Provider-Based Status, Site Neutrality, and Upcoming Changes

April 20, 2026



Learning Objectives

- Define the term provider-based and other related terms
- Differentiate between provider-based requirements
- Understand the financial implications of site neutrality payment rules
- Identify planning tips for January 2028 regulatory deadline



Provider-Based Definitions

What does it mean for a facility to be provider-based?

“Provider-based” defined [42 CFR 413.65(a)(2)]:

- A provider of health care services that is either created by, or acquired by, a main provider
- “Facility or organization is clearly and unequivocally . . . integral and subordinate . . .”
- “Provider-based entity” refers to the physical facility, as well as personnel & equipment
- The status of provider-based describes the relationship between a main provider and a provider-based entity or department, remote location, or satellite facility

Free-standing: All other entities that are not integrated within any other entity

- A site is either provider-based or it’s not
- There is no qualification for free-standing status



Provider-Based Definitions

What are examples of provider-based entities?

Provider-based entities may be:

- Hospital outpatient departments (HOPDs)
- Clinics (including HBOCs and Rural Health Clinics)
- Sub-units (e.g., IPFs, IRFs, SNFs, NFs, OLTCs, OPTs, CORFs, CMHCs, HHAs, Hospices)

Department of a provider

- For the purpose of furnishing health care services of the same type as the main provider
- Under the ownership and administrative and financial control of the main provider
- May not, by itself, be qualified to participate in Medicare as a separate provider



Provider-Based Definitions

Main Campus (or On-Campus)

- 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
- Any other areas determined by CMS Regional Office on a case-by-case basis
- See original OPPS Final Rule (65 FR 68, 4/7/2000) for definition of "on-campus"
 - In central city areas, a campus may not necessarily be contiguous and may be crossed by public streets





Provider-Based Definitions

Questions About Main Campus

- What is considered the main buildings? Typically, where inpatient services occur.
 - Is a building connected by a tunnel/bridge/walkway part of the main buildings?
- How do you measure “within 250 yards”? From anywhere at the building?
 - Prior Interpretations: From main entrance or from ED entrance
 - CMS clarified that the measurement may be from any point of the main campus to any point of the provider-based entity with a straight-line measurement (81 FR 79703, 11/14/2016)
 - What about the end of a parking ramp up to the entrance?
 - States have different rules, which makes standardization difficult





Provider-Based Definitions

Remote Location (or Off-Campus)

- Any facility/unit that first meets the basic definition for a provider-based facility/department
- Not considered “on-campus” of the main provider
- Typically applies to inpatient units, such as off-site DPUs or multi-campus hospitals
- Must be within 35-mile radius of the main campus, with a few exceptions





Provider-Based Definitions



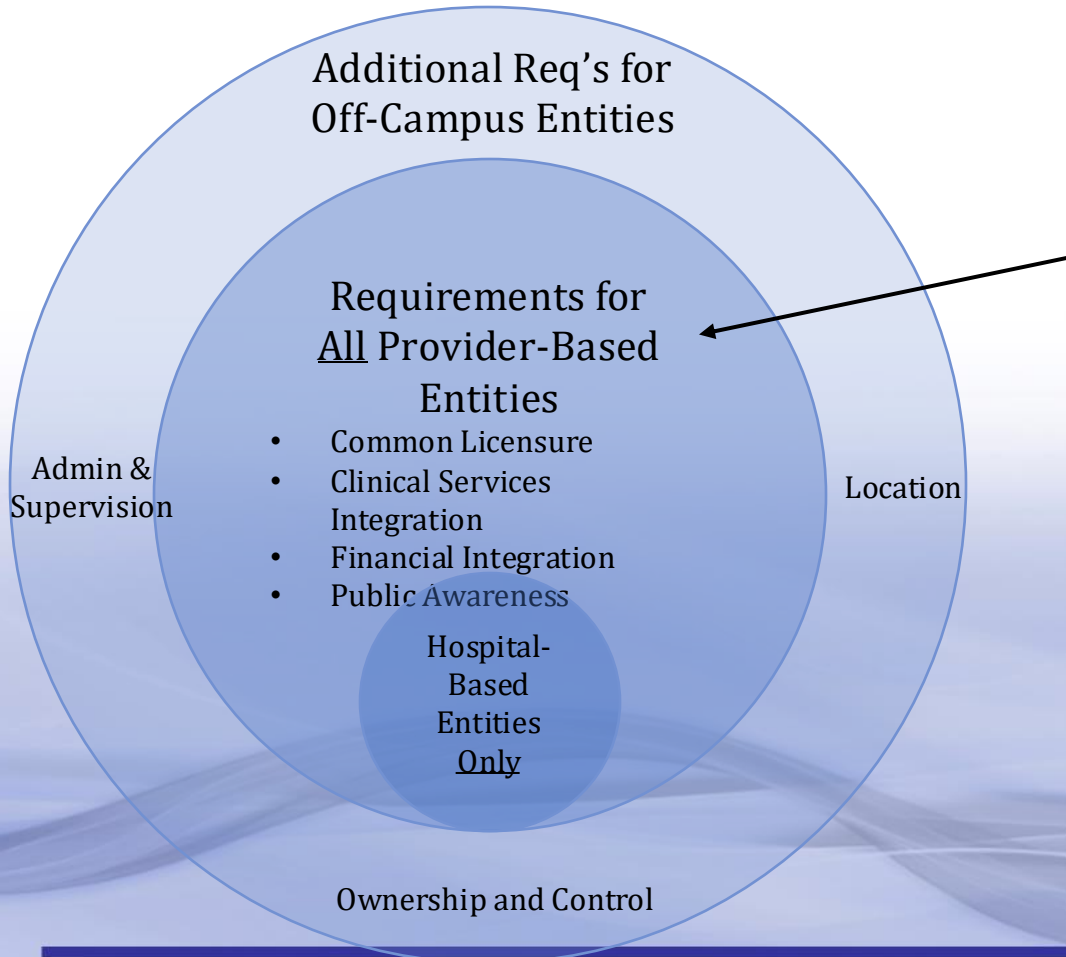
Mercy Hospital – St. Louis
615 South New Ballas Rd.
Creve Coeur, MO

Key Areas:

- Main Hospital & Main Entrance
- ED Entrance
- Patient Parking
- Behavioral Health (IPF subunit)
- New Building Location



Provider-Based Status Requirements

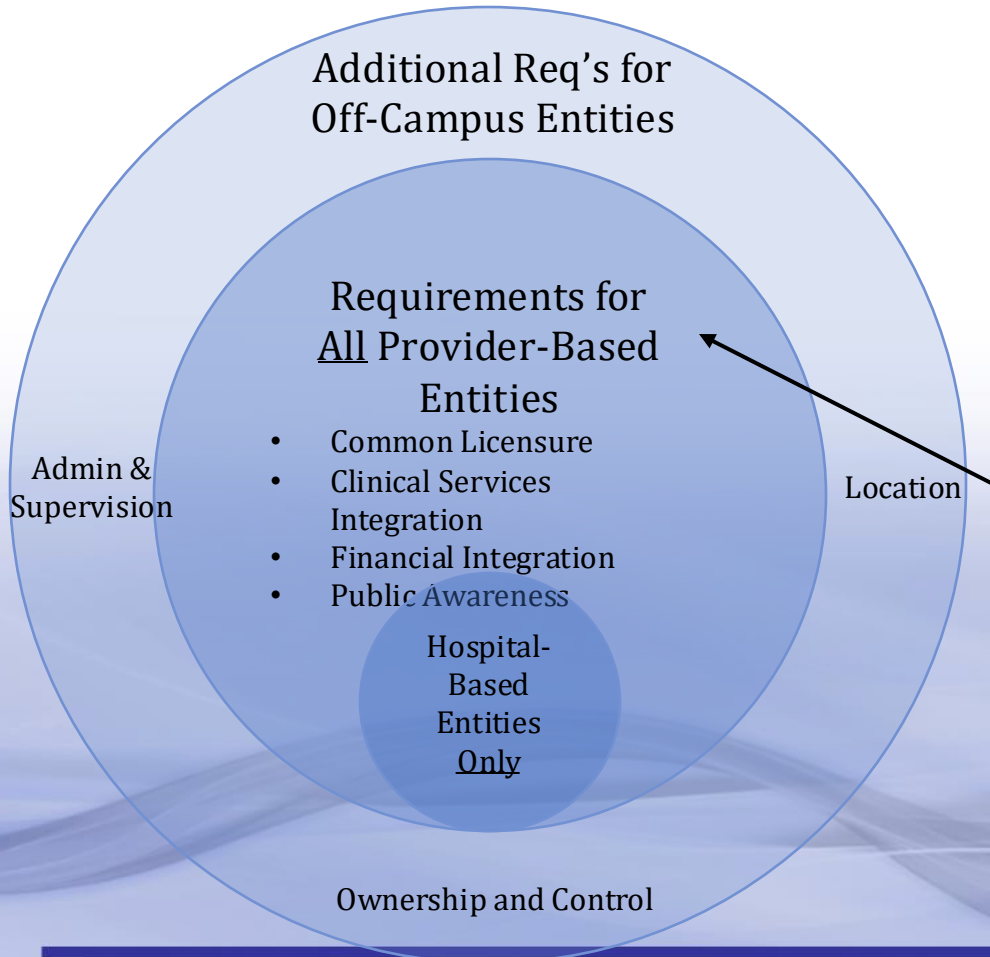


All Provider-Based Entities

- **Licensure**
 - Operated under same license as main provider
 - Exception: When State requires a separate license, in which case CMS will make the determination
- Clinical Services Integration
- Financial Integration
- Public Awareness



Provider-Based Status Requirements

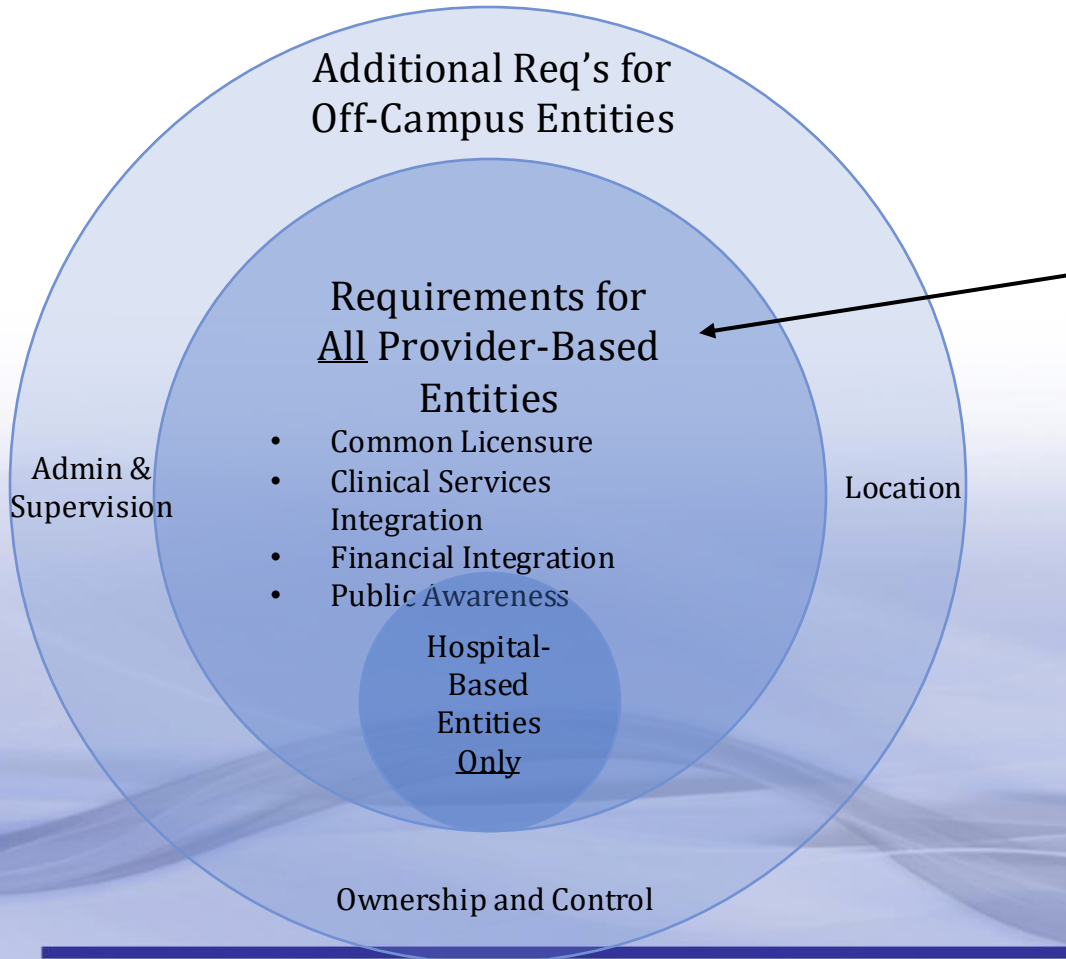


All Provider-Based Entities

- Licensure
- **Clinical Services Integration**
 - Professional staff have clinical privileges at main provider
 - Main provider maintains oversight of entity, as it does for any other department
 - Med director of entity maintains reporting relationship with CMO or other similar official of main provider
 - Med staff committees at main provider are responsible for medical activities at entity, including quality assurance, utilization review, and coordination of clinical services
 - Medical records are integrated into a unified retrieval system of the main provider
 - Inpatient and outpatient services are integrated, and patients treated at the entity who require further care have full access to services at main provider
- Financial Integration
- Public Awareness



Provider-Based Status Requirements

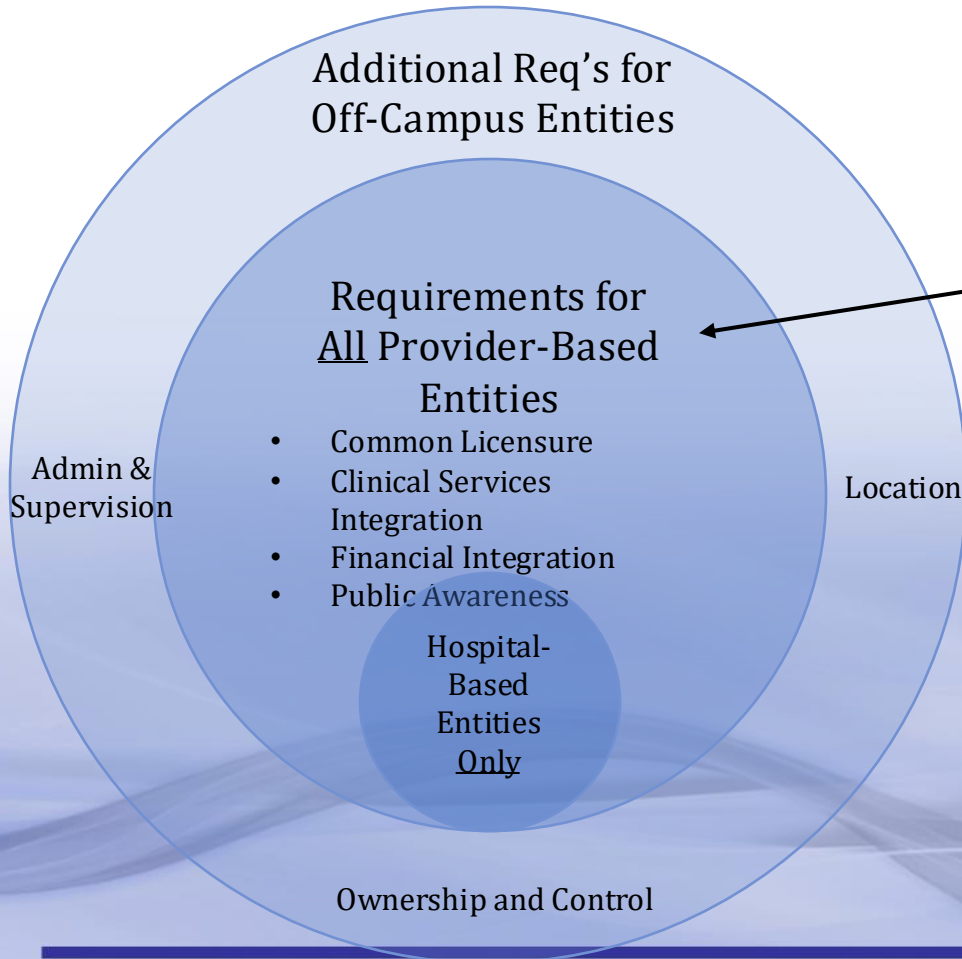


All Provider-Based Entities

- Licensure
- Clinical Services Integration
- **Financial Integration**
 - Shared income and expenses reported in a cost center of main provider
 - Financial status of entity is incorporated and identified in main provider's trial balance
- Public Awareness



Provider-Based Status Requirements

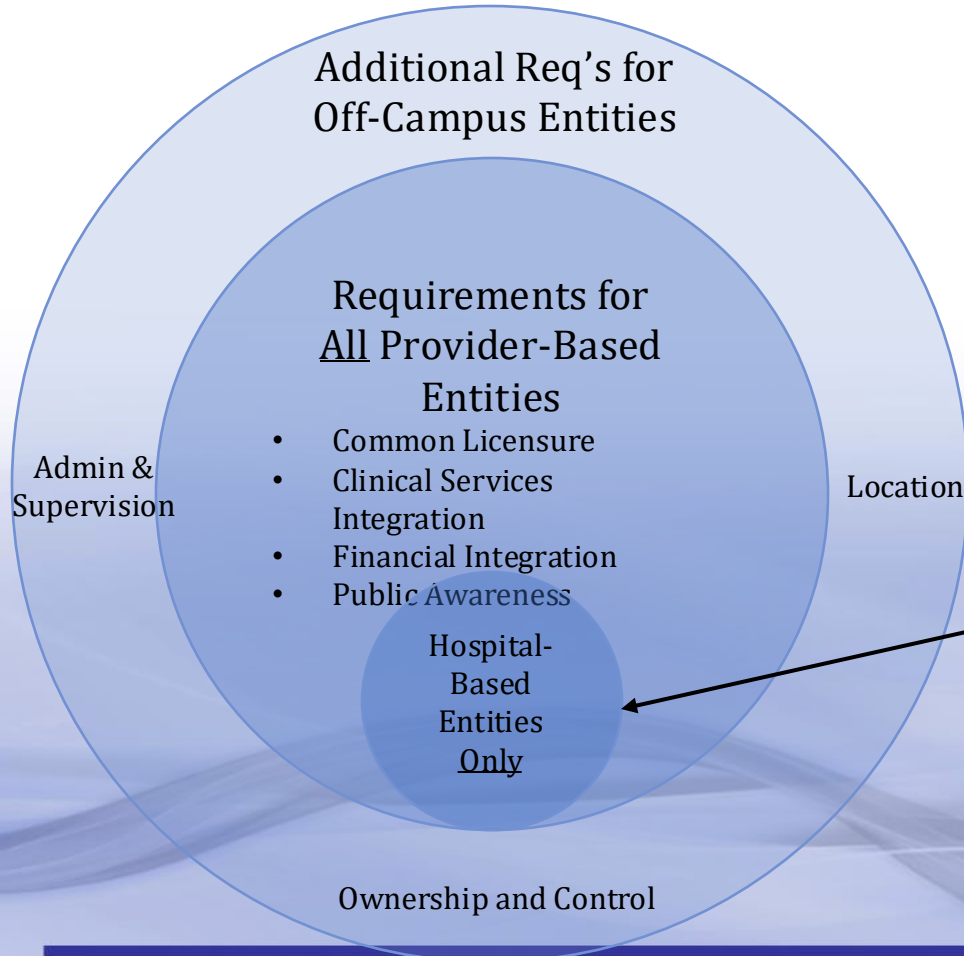


All Provider-Based Entities

- Licensure
- Clinical Services Integration
- Financial Integration
- **Public Awareness**
 - Entity is held out to the public and other payers as part of main provider
 - When patients enter the provider-based facility, they are aware that they are entering the main provider and are billed accordingly



Provider-Based Status Requirements



All Provider-Based Entities

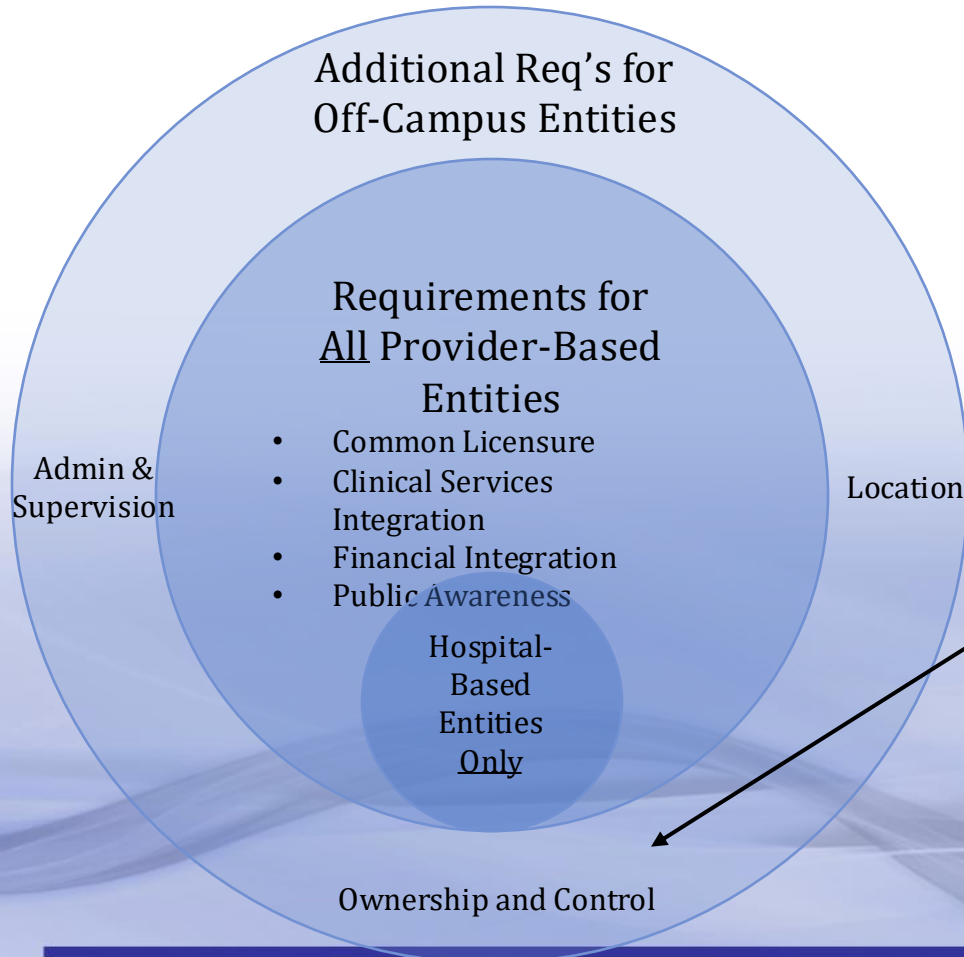
- Licensure
- Clinical Services Integration
- Financial Integration
- Public Awareness

Obligations of Hospital-Based Entities Only

- Comply with anti-dumping rules, if on main campus or an ED located off campus
- Physician services must be billed with correct site-of-service code (11 vs. 19, 22, or 23)
- Comply with terms of the hospital's agreement
- Comply with non-discrimination provisions of 42 CFR 489.10(b)
- Must bill all Medicare patients as hospital outpatients, except RHCs
- Patient admitted as inpatients subject to 3-day payment window
- Must provide written notice to beneficiaries of financial liability, before services are rendered
- Must comply with all health and safety rules at 42 CFR 482 (EMTALA)



Provider-Based Status Requirements



All Provider-Based Entities

- Licensure
- Clinical Services Integration
- Financial Integration
- Public Awareness

Obligations of Hospital-Based Entities Only

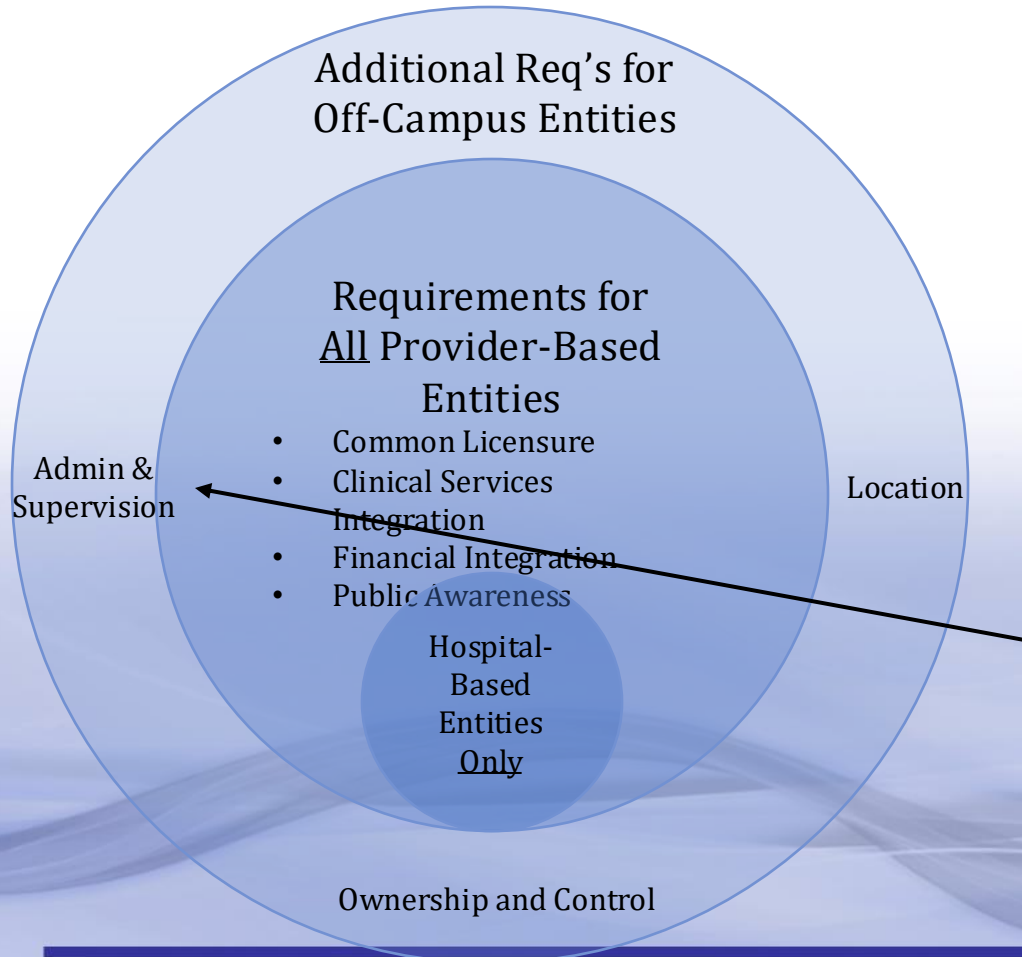
Off-Campus Entities Only

• **Ownership and Control**

- 100% owned by main provider
 - Same governing body
 - Operated under same organizational documents (e.g., bylaws)
 - Main provider has final responsibility for administrative decisions, approval of contracts, approval of personnel actions and policies, and approval of medical staff appointments
- Administration and Supervision
 - Location



Provider-Based Status Requirements



All Provider-Based Entities

- Licensure
- Clinical Services Integration
- Financial Integration
- Public Awareness

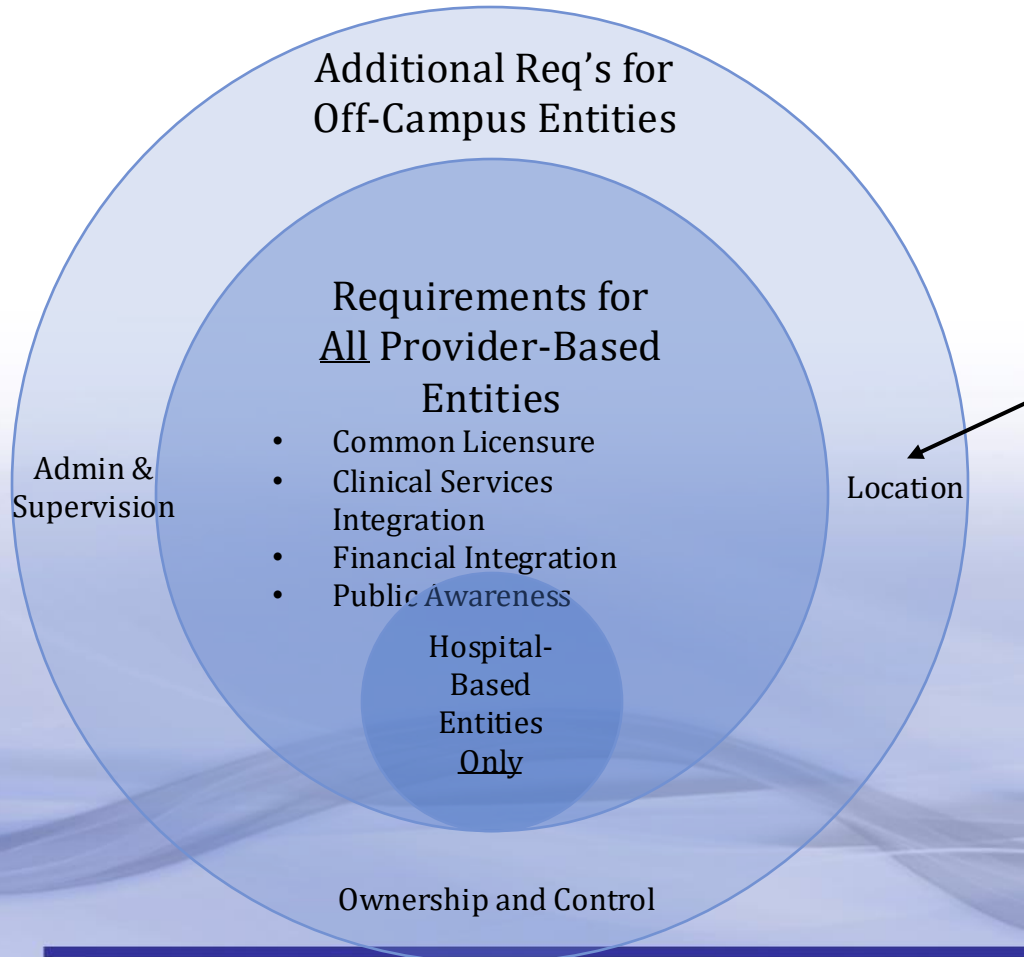
Obligations of Hospital-Based Entities Only

Off-Campus Entities Only

- Ownership and Control
- **Administration and Supervision**
 - Relationship must have same frequency, intensity, and level of accountability that exists with any other department
 - Under direct supervision of main provider
 - Same monitoring and oversight (i.e., reporting relationship with manager at main provider AND accountable to the governing body of main provider, same as other depts)
 - Admin functions are integrated (i.e., billing, HR, payroll, emp ben package, salary, etc.)
 - Same employees OR contracted under same agreement



Provider-Based Status Requirements

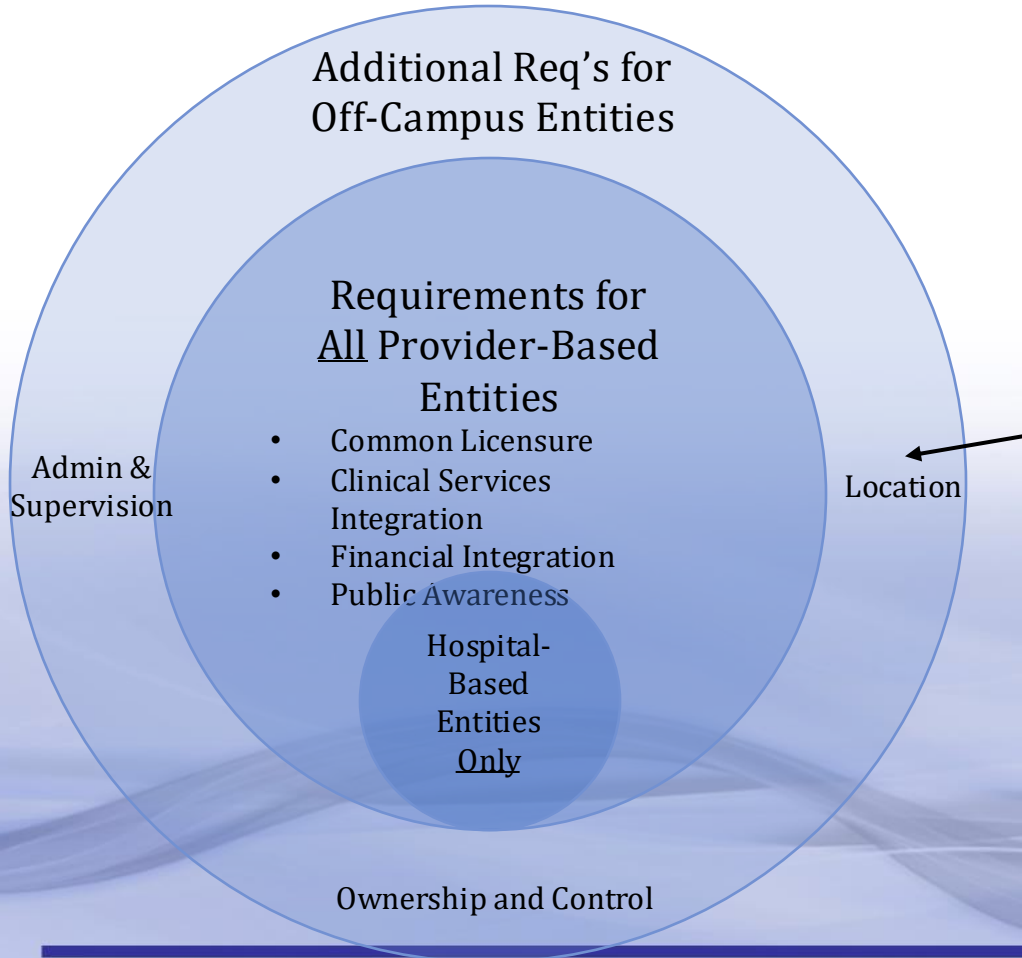


Off-Campus Entities Only

- Ownership and Control
- Administration and Supervision
- **Location** (Must meet one of the following 6 criteria, as well as the 7th)
 1. **Located within 35-mile radius of main campus (IPPS vs. CAH rules)**
 2. Owned and operated by hospital with DSH > 11.75%, et al.
 3. Demonstrates high level of integration with main provider
 4. Alternate method for demonstrating high level of integration
 5. Meets all of several criteria related to children's hospitals
 6. RHC attached to rural hospital <50 beds
 7. Must be located in same state or adjacent state (if allowed)



Provider-Based Status Requirements

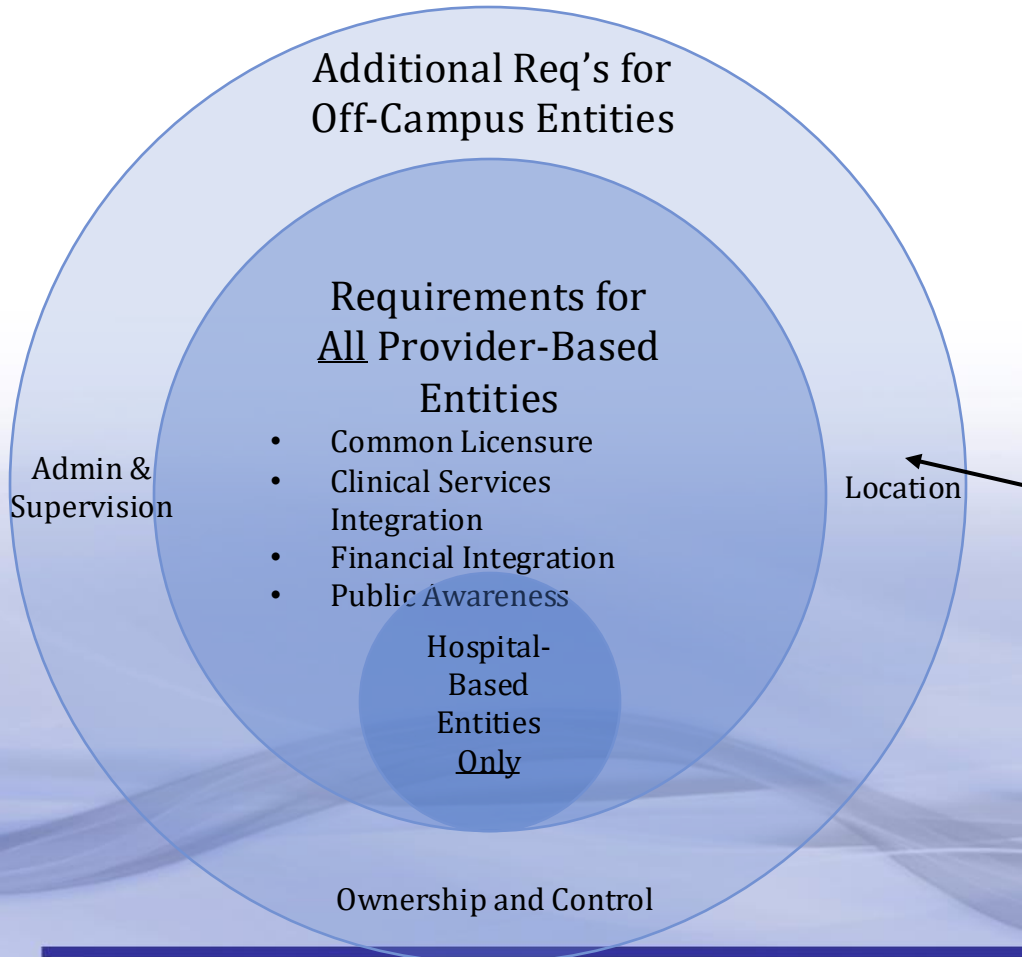


Off-Campus Entities Only

- Ownership and Control
- Administration and Supervision
- **Location** (Must meet one of the following 6 criteria, as well as the 7th)
 1. Located within 35-mile radius of main campus
 2. **Owned and operated by hospital with DSH > 11.75%, and is:**
 - a. Owned or operated by a unit of State or Local government; **OR**
 - b. Public or nonprofit corp that is formally granted governmental powers by a unit of State or Local government; **OR**
 - c. Private hospital that has a contract with a State or Local government that includes the operation of clinics located off campus in well-defined service areas to provide services to low-income individuals not entitled to Medicare/Medicaid (**Enrollment in 340B Drug Discount Program is not enough!**)



Provider-Based Status Requirements

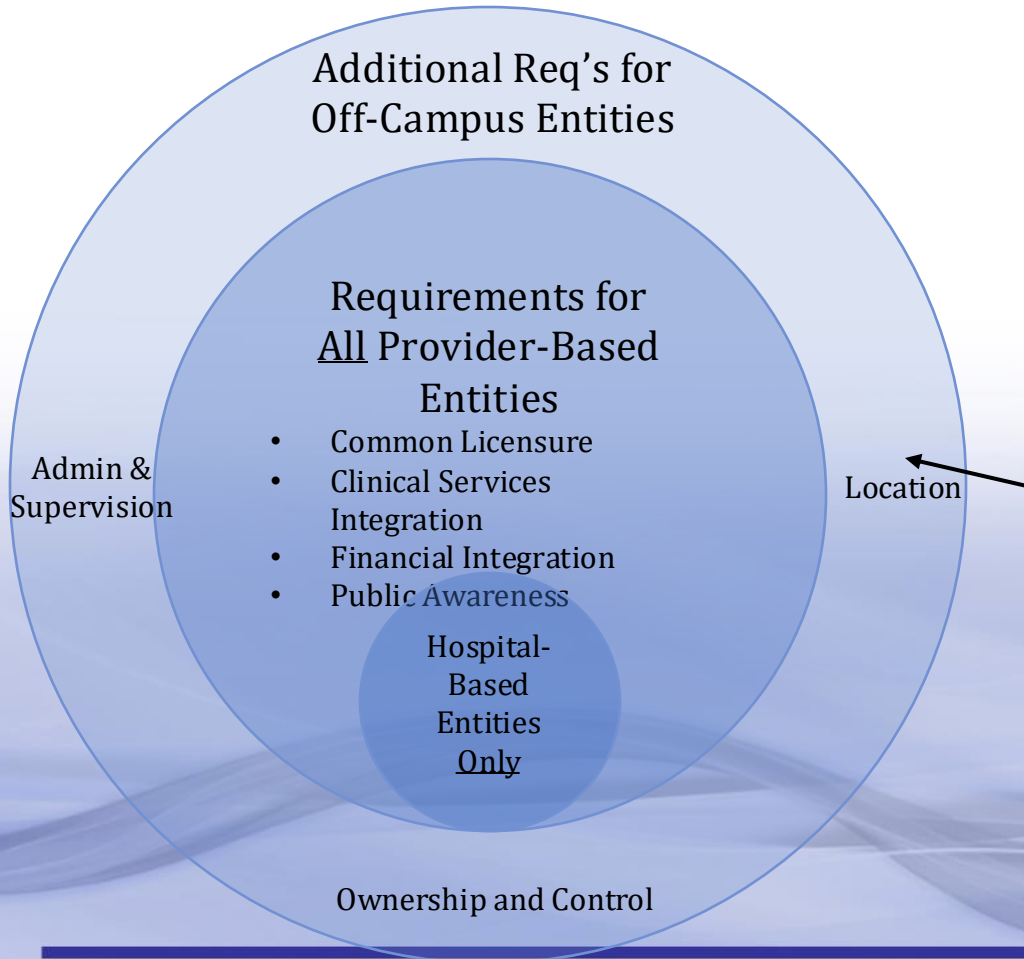


Off-Campus Entities Only

- Ownership and Control
- Administration and Supervision
- **Location** (Must meet one of the following 6 criteria, as well as the 7th)
 1. Located within 35-mile radius of main campus
 2. Owned and operated by hospital with DSH > 11.75%, et al.
 3. **Demonstrates high level of integration with main provider**
 - a. At least 75% of patients reside in same zip code as 75% of patients served by main provider; **OR**
 - b. At least 75% of patients who required type of care furnished at main provider received care there
 4. Alternate method for demonstrating high level of integration
 5. Meets all of several criteria related to children's hospitals
 6. RHC attached to rural hospital <50 beds
 7. Must be located in same state or adjacent state (if allowed)



Provider-Based Status Requirements

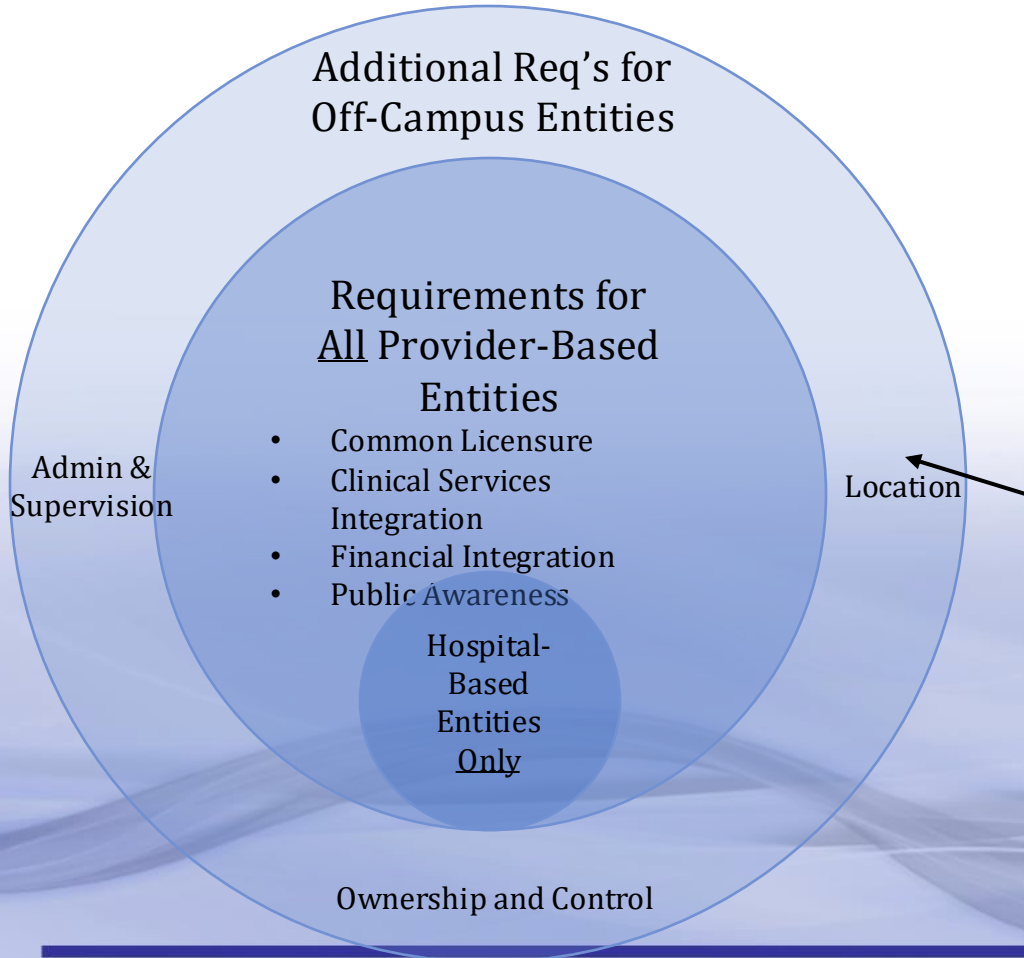


Off-Campus Entities Only

- Ownership and Control
- Administration and Supervision
- Location (Must meet one of the following 6 criteria, as well as the 7th)
 1. Located within 35-mile radius of main campus
 2. Owned and operated by hospital with DSH > 11.75%, et al.
 3. Demonstrates high level of integration with main provider
 4. **Alternate method for demonstrating high level of integration**
 - a. If the facility is unable to meet the third criteria noted above because it was not in operation for a full 12-month period, then the facility must be located in a zip code that accounted for at least 75% of the patients served by the main provider
 5. Meets all of several criteria related to children's hospitals
 6. RHC attached to rural hospital <50 beds
 7. Must be located in same state or adjacent state (if allowed)



Provider-Based Status Requirements

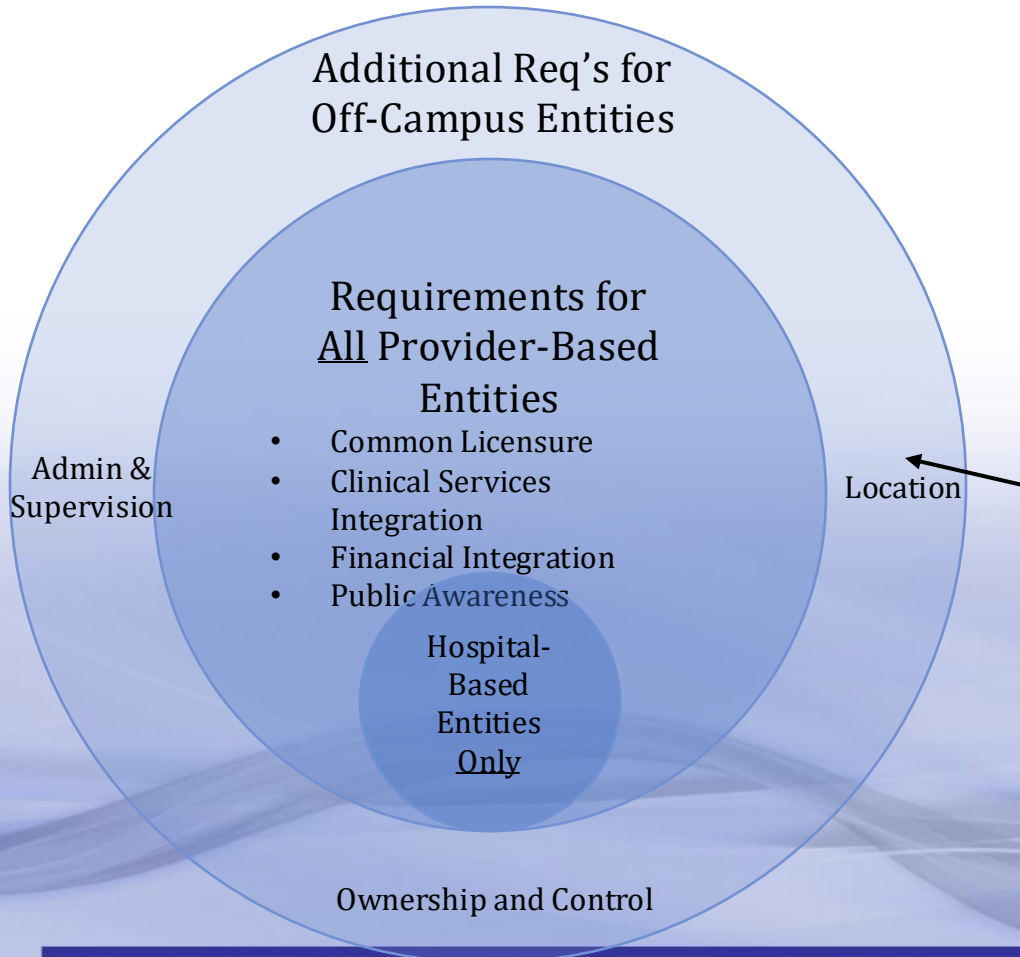


Off-Campus Entities Only

- Ownership and Control
- Administration and Supervision
- **Location** (Must meet one of the following 6 criteria, as well as the 7th)
 1. Located within 35-mile radius of main campus
 2. Owned and operated by hospital with DSH > 11.75%, et al.
 3. High level of integration with main provider
 4. Alt method for demonstrating integration
 5. **Meets all of several criteria related to children's hospitals**
 - a. Meets the criteria under 42 CFR 412.23(d) as a children's hospital
 - b. Has specific ICUs under cost reimbursement at 42 CFR 415.53(d)
 - c. Accepts only newborn infants who require ICU care on an IP basis
 - d. Physically located in a rural area per 42 CFR 412.64(b)(1)(ii)(C)
 - e. Located within a 100-mile radius of the children's hospital that is main provider
 - f. Located at least 35 mi from nearest NICU
 - g. Meets all other requirements for provy-based



Provider-Based Status Requirements

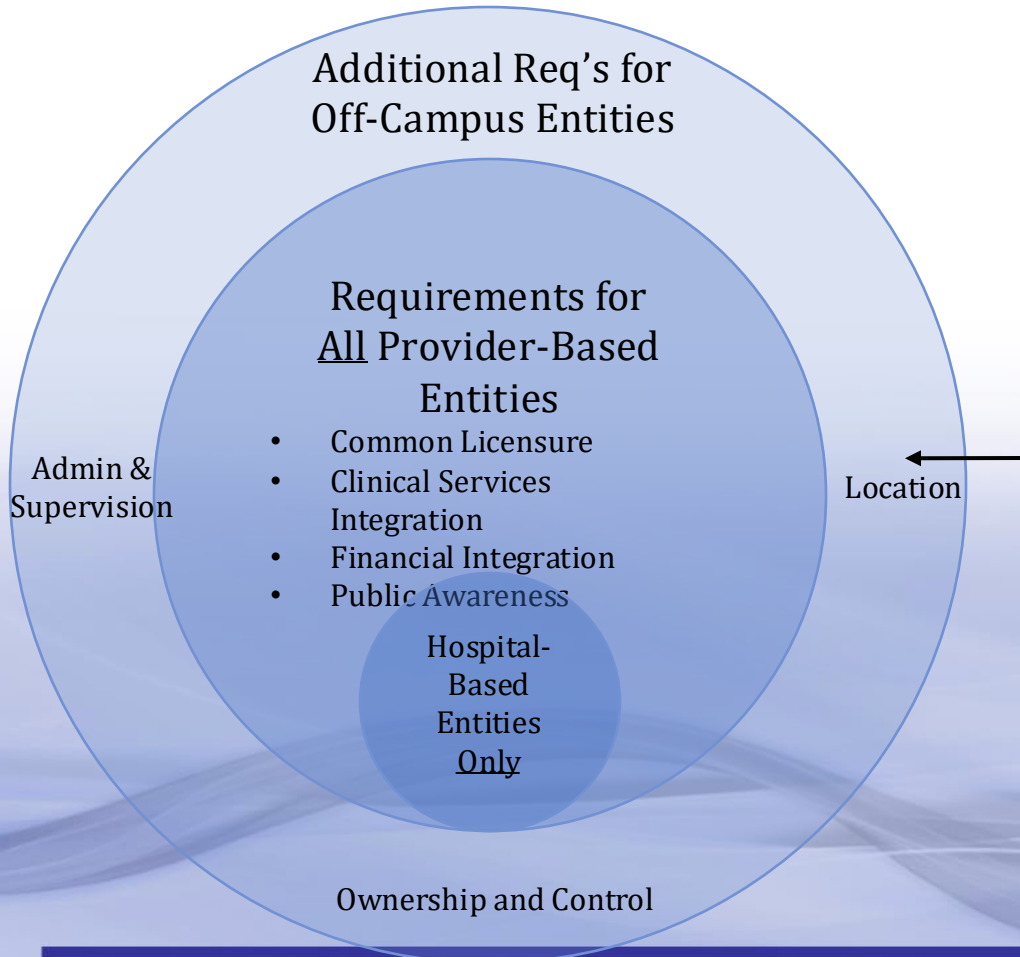


Off-Campus Entities Only

- Ownership and Control
- Administration and Supervision
- **Location** (Must meet one of the following 6 criteria, as well as the 7th)
 1. Located within 35-mile radius of main campus
 2. Owned and operated by hospital with DSH > 11.75%, et al.
 3. Demonstrates high level of integration with main provider
 4. Alternate method for demonstrating high level of integration
 5. Meets all of several criteria related to children's hospitals
 6. **RHC attached to rural hospital < 50 beds**
 - a. Facility is an RHC that is otherwise qualified as a provider-based entity of a hospital that has fewer than 50 beds; **AND**
 - b. Main hospital is located in a rural area as defined in 42 CFR 412.64(b)(1)(ii)(C)
 7. Must be located in same state or adjacent state (if allowed)



Provider-Based Status Requirements



Off-Campus Entities Only

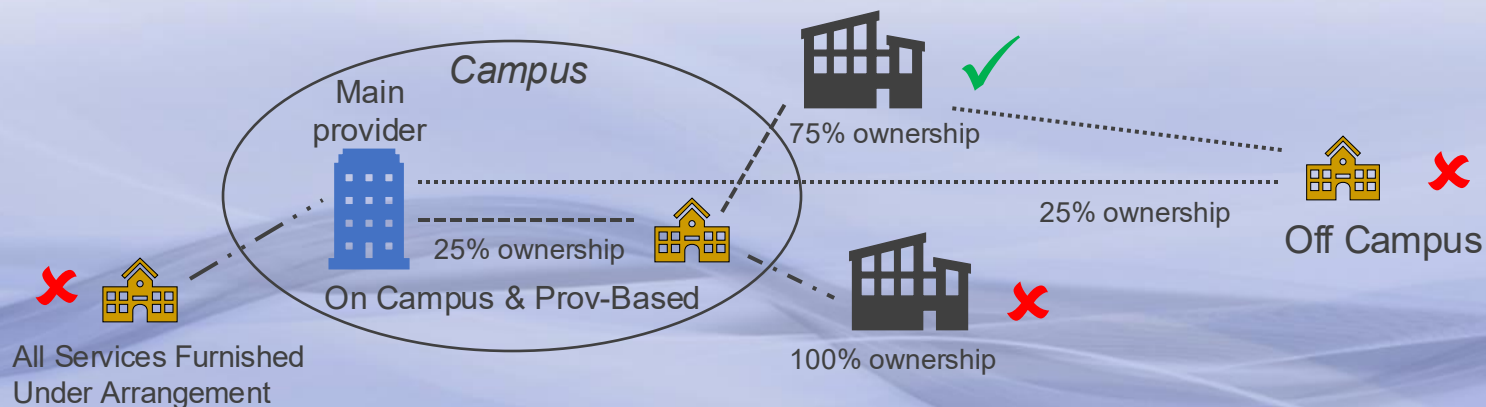
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- **Location** (Must meet one of the following 6 criteria, as well as the 7th)
 1. Located within 35-mile radius of main campus
 2. Owned and operated by hospital with DSH > 11.75%, et al.
 3. Demonstrates high level of integration with main provider
 4. Alternate method for demonstrating high level of integration
 5. Meets all of several criteria related to children's hospitals
 6. RHC attached to rural hospital < 50 beds
 7. **Must be located in same state or adjacent state (if allowed)**
 - a. Provider-based facility and the main provider must be located in the same state, or when consistent with the laws of both states, in adjacent states



Provider-Based Status Requirements

Joint Ventures

- Partially owned by at least one main provider;
- Located on main campus of a provider who is a partial owner;
- Provider-based to that one provider on whose campus the facility is located; **AND**
- Meets all requirements applicable to on-campus entities





Provider-Based Checklist

PROVIDER-BASED DESIGNATION CHECKLIST W/P # _____

MAC		CMS	
MAC:		Regional Office:	
Completed By:		Completed By:	
Completion Date:		Completion Date:	
Reviewed By:		Reviewed By:	
Reviewed Date:		Reviewed Date:	
MAC Control No.		CMS -MIS Control No.	

Main Provider Name: _____
 Provider No. _____ NPI No. _____

Main Provider Address: _____

Application Contact Name (please print): _____

Application Contact Phone Number: _____

Application Contact Email Address: _____

Main Provider Type: Acute Care CAH SCH _____ Other: _____

Name of Provider Based Entity: _____

Provider-Based No. _____ Provider-Based NPI No. _____

Provider Based Entity Address: _____

Date provider based entity acquired (if applicable) _____ Date PB conditions met (if applicable) _____

Date request received: _____ Date review initiated: _____

Provider-Based Status: On-Campus Off-Campus

Type of Facility	Select	Type of Services
Department	<input type="checkbox"/>	
Remote Location	<input type="checkbox"/>	
Department <=250 Yards of Remote	<input type="checkbox"/>	
Satellite Facility	<input type="checkbox"/>	
Rural Health Clinic (RHC)	<input type="checkbox"/>	
Other: Specify	<input type="checkbox"/>	

Is the facility/organization part of a multi-campus hospital? Yes No

Did the contractor send an acknowledgment letter? Yes No

Did the contractor comply with CMS's processing time-frames when reviewing the provider-based facility request?
 Yes No

Contractor's recommendation: Approve Deny No recommendation

If denial recommendation, contractor's reason: _____

CMS Notes/Comments/Next Steps: _____

<https://med.noridianmedicare.com/documents/10538/4310092/Provider-Based+Designation+Checklist.pdf>



CMS Determination Process

- Entities are **not simply entitled** to be treated as provider-based simply because they believe to be
- Applicable **criteria must be met, and documentation must be gathered** in order to prove this status
- Both **new facilities and older facilities** that have been in existence for many years must be able to show that they continue to meet the criteria
- **Verifying Compliance**
 - Self-attestation (most common)
 - Voluntary request for determination from CMS; prior approval is not a requirement to bill as provider-based
 - Audit by CMS/MAC to determine compliance
- **Best Practice:** Maintain documentation and periodically self-verify
- Off-campus facilities where **physician services** are furnished and billed as such are **presumed to be free-standing** unless CMS determines otherwise



CMS Determination Process

What happens when something changes or the location is no longer in compliance?

- **Material Changes**
 - Determination or disclosures should be made when any changes in ownership or management contracts occur
- **Non-Compliance**
 - If CMS learns that a provider's entity does not meet the provider-based requirements, the provider has treated the entity as provider-based, and the provider did not request a determination from CMS, CMS will:
 - Adjust the amount of future payments
 - Recover the difference between actual and corrected payments for all open cost reports; AND
 - Ask if the provider intends to seek a determination from CMS
- **Effective Date**
 - Provider-based status is effective on the earliest date that all requirements have been met
 - Any funds received prior to the date that compliance can be proven may be in jeopardy



Financial and Other Impacts

Why Does Provider-Based Status Matter?



Impact to hospital OPPS payments (APC vs. MPFS) and cost-to-charge ratios



340B Child Site eligibility



Ability to claim account for Medicare Bad Debt and UC DSH



Additional DSH & IME for patient populations at IP remote locations



Impact to other payer contracts



Financial and Other Impacts

Why Concerns Exist with Provider-Based Status?



Dual co-payments for patients (i.e., hospital and physician bills)



- Consumer-driven patients are more price-sensitive; new price transparency rules



Physician dissatisfaction

- Driven mostly by patient dissatisfaction
- Billing/Payment issues



Shifting regulatory landscape

- Gray areas create uncertainty in reimbursement due to unclear guidance and “case-by-case” reviews
- Enforcement can mean claw back of funds to date of determination/compliance – too much risk → For example, what is happening now



Financial and Other Impacts

Provider-Based Status does not impact reimbursement for the following:

- Ambulatory surgical centers (ASCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Home health agencies (HHAs)
- Hospices
- Skilled nursing facilities (SNFs)
- Inpatient rehabilitation facilities (IRFs) and inpatient psychiatric facilities (IPFs) excluded from IPPS
- Independent diagnostic testing facilities (IDTFs)
- End stage renal disease (ESRD) facilities
- Ambulances
- Rural health clinics (RHCs) affiliated with hospitals having 50+ beds



Financial and Other Impacts

Provider-Based vs Free-Standing

Period: CY2023
Location: Modesto, CA

CPT/HCPCS	Description	Prof Global Fee PFS (Non-Facility)	vs.	Prof Comp Only PFS (Facility)	OPPS (Excepted)	Total Payment
99213	Office o/p est low 20-29 min	93.74		67.05	-	67.05
G0463	Hospital outpt clinic visit	-		-	147.24	147.24
73020	X-ray exam of shoulder	23.13		7.58	105.84	113.42
	Total	116.87		74.63	253.08	327.71

Physician office reimbursement: Prof + Tech (Staff/Facility) →

Physician reimbursement: Professional Component Only →

Facility reimbursement: Technical Component (Excepted) +

As of 1/1/2019:

CPT/HCPCS	Description	Prof Global Fee PFS (Non-Facility)	vs.	Prof Comp Only PFS (Facility)	OPPS (Non-Excepted)	Total Payment
99213	Office o/p est low 20-29 min	93.74		67.05	-	67.05
G0463	Hospital outpt clinic visit	-		-	58.90	58.90
73020	X-ray exam of shoulder	23.13		7.58	42.34	49.92
	Total	116.87		74.63	101.23	175.86

Facility reimbursement: Technical Component (Non-Excepted) →

Receive either Excepted or Non-Excepted Payment
(40% of APC Rate)



Site Neutrality Payments

Bipartisan Budget Act of 2015, Section 603

- **Site Neutrality Principle:** CMS should pay same amount for services, regardless of location/status of site
- **Effective Date:** As of **1/1/2017**, no “off-campus” outpatient department (HOPD) may bill under standard OPPS unless it is:
 - Grandfathered (also known as “Excepted”); **OR**
 - Dedicated emergency department (DED)
- Reduction in payment is 60% off of standard APC rate (i.e., **only 40% of standard APC rate paid**)
- “On-campus” departments are not subject to the site neutrality payment rule; **only applies to “off-campus”**
- **CMS is concerned about payment parity** with physician offices



Site Neutrality Payments

What Does It Mean to be An “Excepted Site”?

- **Basic Rules**
 - If site was billing under OPPS on or before 11/1/2015, then the site is protected/grandfathered
 - Site may continue to bill as a hospital location and be reimbursed under standard APC rate
 - Site must use billing modifier PO to indicate HOPD; otherwise use PN for MPFS payment or lower APC
- **Restrictions**
 - No relocation allowed; site must remain fixed
 - Must remain at address listed on CMS 855A (and as noted in PECOS)
 - Complete address is considered, all the way down to the suite number, which can not change
 - Use of “Road” vs. “Rd” or “Street” may even cause a rejection
 - Understanding how PECOS works and how to navigate the system is important! (e.g., CHOI resetting timing)
 - Only relocation allowed is back to main provider campus or a provider-based remote location
 - “Extraordinary circumstance” application may be submitted to CMS within 30 days of event
 - Natural disaster or riot will likely qualify, if building needs to be completely gutted after the event
 - Being evicted by landlord or lease not being renewed does not qualify



Site Neutrality Payments

What Does It Mean to be An “Excepted Site”?

- More Rules and Restrictions
 - Expansion of services are okay, as long as site’s **address or provider number does not change**
 - **Recycling** of provider-based services in that space is **okay** (e.g., swap one service with another)
 - **CMS** makes the **final determinations** as to status of the site
 - No administrative or judicial review allowed
 - May still be able to appeal whether a site qualifies as provider-based
- Mid-Build Exception
 - If a hospital **was in the process of starting an HOPD** and had not yet billed Medicare **by 11/1/2015**, then the provider may seek an exception from CMS
 - Deadline of 2/13/2017 to file certification and attestation for exception
 - If approved, site may be considered “excepted” (or grandfathered)



Site Neutrality Payments

Payment Adjustments for “Non-Excepted” Sites (and New Adjustments for “Excepted” Sites)

- Continue to bill on CMS 1450 (UB-04), receive lower APC, and request two copays
- Clinical visits
 - As of 1/1/2019, CMS expanded reduced APC payment for HCPCS G0463 (hospital outpatient clinic visits) to excepted sites, even if site met requirements to be grandfathered (\$760M annual impact)
- Reduced 340B drug discount
 - As of 1/1/2018, non-excepted site discount was reduced from ASP + 6% to ASP – 22.5%
 - As of 1/1/2019, CMS also made this same change for excepted sites
 - In the OPPI CY2023 Final Rule, CMS changed the formula back to ASP + 6% for CY2018-2022 in order to comply with the outcome of *American Hospital Association v. Becerra* (142 S. Ct. 1896, 6/15/2022)
- Drug Admin – In 2025, CMS expanded site neutrality (90 FR 53821, 11/25/2025)



Site Neutrality Payments

The Bottom Line:

- Section 603 Does Not Apply To:
 - On-campus HOPDs (whether old or new)
 - Grandfathered HOPDs that were billing as hospital HOPDs on or before 11/1/2015
 - Dedicated emergency departments (DEDs)
 - Inpatient remote locations of a hospital
 - Separately certified provider-based HHAs, Hospices, CAHs, RHCs, or FQHCs
- How Are Provider-Based Facilities Impacted?
 - If Section 603 does not apply to the HOPD, then site receives the “Excepted APC” (Full Rate) + MPFS
 - If Section 603 does apply to the HOPD, then site receives the lower “Non-excepted APC” (40% of Full Rate) + MPFS professional fee



Changes Put In Motion

- Consolidated Appropriations Act (CAA) of 2026 (P. Law 119-75)
- Enacted February 3, 2026
- Section 6225
 - Requires a separate NPI and a provider-based attestation for each off-campus outpatient department of a provider
 - Must comply with both requirements by January 1, 2028
 - Items and services must be billed under a unique NPI, separate from the parent provider's NPI
 - Provider-based attestation applicable to items and services furnished during the 2-year period ending on the date of submission



More Detail About Those Changes

- Watch for notice and comment rulemaking from CMS to establish a process for initial and subsequent attestations, site visits, and remote audits
 - More details forthcoming from CMS
 - Possible periodic new attestations (every 2 years?)
 - Likely to be released in OPPS Prop Rule (late July 2026)
- Off-Campus is not
 - On campus (as currently defined)
 - Within allowable distance of a remote location of a hospital facility
- HHS OIG report is due to DHHS Secretary by 1/1/2030



What's Next?

- What is the ultimate outcome of this new regulation?
What is CMS trying to accomplish?
 - A reporting mechanism by which to gather data for future site neutrality payment adjustments
 - A compliance requirement by which to remove non-compliant hospital off-campus outpatient departments from receiving full APC payments
 - With only \$20M to implement this new process, CMS will be stretched thin to establish and continue operating this new procedure (e.g., PECOS system changes, updates to forms/procedures, ongoing audits)



Outstanding Questions

- What is the process for obtaining an NPI?
 - Apply online at <https://nppes.cms.hhs.gov>
- What should you do if you find that a department didn't previously comply with provider-based requirements?
 - Coordinate with Legal Counsel and Compliance Team
- What happens if the NPI or provider-based status is in the process of being approved on 1/1/2028?
 - Likely okay, if ultimately approved
- If an NPI is not obtained or provider-based status application is not approved, what happens on 1/1/2028?
 - No payment? Or 40% of OPPS payment for technical component?



What Can You Do To Prepare?

- Pull together a multi-disciplinary team to plan/implement
 - Legal, Compliance, Prov Enrollment, Govt Reimbursement, Rev Cycle, and Ambulatory Clinical Operations
 - Put together a project plan to address as soon as possible for all payers
- Prioritize HOPDs to be reviewed/verified in logical order
 - Identify all impacted “departments” (department ≠ location/facility)
 - Determine which departments you wish to remain provider-based
- Address non-compliant departments
- Decision: Submit now or wait until Rule is published?
 - New procedures may be more or less strict
 - If you disagree, may be able to submit after PR (late July) but before FR



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Questions/Comments

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