

MEMORANDUM

Texas Department of Human Services * Long Term Care/Policy

TO: LTC-R Regional Directors
Section/Unit Managers

FROM: Marc Gold
Section Manager
Long Term Care-Policy
State Office MC: W-519

SUBJECT: Regional Survey & Certification Letter #99-23

DATE: September 22, 1999

The attached RS&C Letter is being provided to you for information purposes and should be shared with all professional staff.

- RS&C Letter No. 99-23 -- Certification of a Hospital-Based Skilled Nursing Facility With Two or More Remote Locations; Call Elva Longoria, Professional Services, at (512) 438-2345.

If you have any questions, please direct inquiries to the individuals or sections listed above.

~Original Signature on File~

Marc Gold

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Region VI
1301 Young Street, Room 833
Dallas, Texas 75202

June 2, 1999

REGIONAL SURVEY AND CERTIFICATION LETTER NO: 99-23

To: All State Survey Agencies (Action)
All Title XIX Single State Agencies (Information)

Subject: Certification of a Hospital-Based Skilled Nursing Facility With Two or More Remote Locations

The purpose of this memorandum is to provide the current policy on the certification of a Hospital-Based Skilled Nursing Facility (SNF) with two or more remote locations.

The term or designation "provider-based" is an outgrowth of the Medicare cost reimbursement system. The main purpose of the provider or facility-based designation is to accommodate the appropriate accounting and allocation of costs where there is more than one type of provider activity taking place within the same facility/organization. This cost allocation and cost reimbursement more often than not results in Medicare program payments that exceed what would have been paid for if the same services were rendered by a free-standing entity.

With the growth of integrated delivery systems, the Health Care Financing Administration (HCFA) has received numerous requests from entities requesting provider-based status. These requests, if approved, increase the portion of the facility's general and administrative costs that are supported by the Medicare program with no commensurate benefit to Medicare and its beneficiaries. Therefore, it is critical that HCFA designate only those entities that are unquestionably qualified as provider-based.

It should be noted that it is the intent of existing Statutory and Regulatory criteria for Medicare to operate as a prudent purchaser of services that enhance the care of beneficiaries. Medicare must comply with Congressional intent as reflected in §1861(v)(1)(A) of the Social Security Act to pay only for those costs that are necessary for the efficient delivery of needed health services. This Statute also provides general and specific criteria for developing payment rules to carry out the basis intent of the law as well as provisions when aggregate reimbursement produced by existing methodologies proves to be inadequate or excessive.

After reviewing the existing regulations and the State Operations Manual (SOM), we have concluded that there is no authority to say that a hospital-based SNF would have to be restricted to one location. Since Section 2024 of the SOM allows for geographically separate components of a hospital to be certified as one facility, then we would allow a hospital-based SNF to have remote locations.

The remote site would have to be in close proximity to the parent facility and be certified under the parent's Medicare provider number. The SA would certify the facilities as a single component if all the following requirements apply for payment purposes:

1. The entity is physically located in close proximity of the provider where it is based, and all facilities serve the same patient population (e.g., from the same service, or catchment area);
2. The entity is an integral and subordinate part of the provider where it is based, and as such, is operated with other departments of that provider under common licensure (except in situations where the State separately licenses the provider-based entity);
3. The entity is included under the accreditation of the provider where it is based (if the provider is accredited by a national accrediting body), and the accrediting body recognizes the entity as part of the provider;
4. The entity is operated under common ownership and control (i.e., common governance) by the provider where it is based, as evidenced by the following:
 - a. The entity is subject to common bylaws and operating decisions of the governing body of the provider where it is based;
 - b. The provider has final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the provider-based entity; and
 - c. The entity functions as a department of the provider where it is based with significant common resource usage of buildings, equipment and service personnel on a daily basis.
5. The entity director is under the direct day-to-day supervision of the provider where it is located, as evidenced by the following:
 - . The entity director or individual responsible for day-to-day operations at the entity maintains a daily reporting relationship and is accountable to the Chief Executive Officer of the provider and reports through that individual to the governing body of the provider where the entity is based; and
 - a. Administrative functions of the entity, e.g., records, billing, laundry, housekeeping and purchasing, are integrated with those of the provider where the entity is based.
 6. Clinical services of the entity and the provider where it is located are integrated as evidenced by the following:
 - a. Professional staff of the provider-based entity have clinical privileges in the provider where it is based;
 - b. The medical director of the entity (if the entity has a medical director) maintains a day-to-day reporting relationship to the Chief Medical Officer or other similar official of the provider where it is based;
 - c. All medical staff committees or other professional committees at the provider where the entity is based are responsible for all medical activities in the provider-based entity;
 - d. Medical records for patients treated in the provider-based entity are integrated into the unified records system of the provider where the entity is based;
 - e. Patients treated at the provider-based entity are considered patients of the provider and have full access to all provider services; and
 - f. Patient services provided in the entity are integrated into corresponding inpatient and/or outpatient services, as appropriate, by the provider where it is based.

7. The entity is held out to the public as part of the provider where it is based (e.g., patients know they are entering the provider and will be billed accordingly);
8. The entity and the provider where it is based are financially integrated as evidenced by the following:
 - a. The entity and provider where it is based have an agreement for the sharing of income and expenses; and
 - b. The entity reports its cost in the cost report of the provider where it is based using the same accounting system for the same cost reporting period as the provider where it is based.

Determinations concerning whether an entity is provider-based will be made by the Regional Office (RO) with the assistance of the RO's Division of Financial Management and Program Initiatives' Medicare Financial Management Branch, the State agency and the provider's fiscal intermediary. The State agency will continue to make their independent evaluation of an entity's provider-based status and forward the determination to the RO for review.

If you have any questions concerning this letter, please contact Wanda Eskue at (214) 767-4428. Thank you for your time and attention to this matter.

Sincerely,

~Signature on File~

Calvin G. Cline, Chief
Survey and Certification Operations Branch