Davis Wright Tremaine LLP

Prove It or Lose It:

Provider-Based Compliance After Section 6225

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Agenda

BACKGROUND	Refresher on provider-based status for off-campus hospital outpatient departments
SECTION 6225	Review of new requirements for off-campus hospital outpatient departments under Section 6225 of the Consolidated Appropriations Act, 2026
CONSEQUENCES	Discussion of payment impacts associated with failing to meet Section 6225 requirements
CHALLENGES	Discussion of tricky compliance challenges for off-campus hospital outpatient departments
GUIDANCE	Suggestions for actions in 2026 and 2027 to meet Section 6225 requirements
BEST PRACTICES	Tips for addressing imperfections discovered during work associated with Section 6225

Provider-Based Status: The Basics

- Hospital outpatient departments (HOPDs) are considered to be part of the hospital even if located in a building that does not have any inpatient services
- Operated under the name, ownership, and financial and administrative control of the hospital
- May be located “on-campus” or “off-campus”
- Various legal authorities in play:
  - State hospital licensing laws
  - Social Security Act § 1833 (Medicare reimbursement)
  - Provider-Based Rule – 42 CFR § 413.65

Benefits

- Different (hopefully higher!) Medicare and Medicaid payment amounts than if services were offered in a “freestanding” setting
- Covered by the hospital’s payor contracts, though reimbursement may be different
- 340B drug discount program eligibility
- Bad debt payments
- Main provider disproportionate share hospital and indirect medical education payments
- Residents count for IME/GME payments

HOPD Billing & Reimbursement

- Two Medicare claims for each HOPD encounter
- Physician/APP claim for professional services
  - Billed on CMS-1500 claim form or electronic equivalent
  - Must use appropriate Place of Service code
  - Paid the facility rate under the Medicare Physician Fee Schedule – reduces the “practice expense” component
- Hospital claim for facility services
  - Billed on CMS-1450/UB-04 claim form or electronic equivalent
  - Paid under the Outpatient Prospective Payment System
  - Excludes reimbursement for physician/NPP professional services
  - Must include a modifier to indicate whether services were provided on campus or off campus
- Total payment under PFS and OPPS is generally greater than payment when same service is furnished at a “freestanding” facility and paid the nonfacility PFS rate

Provider-Based Status — Location Matters First

On-Campus Hospital Outpatient Department

- Located on the main hospital campus
- Includes areas immediately adjacent to main buildings
- Includes locations within **250 yards** of main buildings
- Subject to **core integration requirements**

Off-Campus Hospital Outpatient Department

- Located **more than 250 yards** from:
  - Main campus and
  - Any approved remote location
- Subject to **additional regulatory requirements**
- Heightened CMS scrutiny

Bottom line: location determines the requirements that apply.

Provider-Based Status for Off-Campus Departments

- Hospitals often operate outpatient departments located **more than 250 yards from the hospital's main campus**, known as off-campus hospital outpatient departments (HOPDs)
- These locations may qualify for **provider-based status**
- Provider-based status historically allowed billing under the **Medicare Outpatient Prospective Payment System (OPPS)**
- Payment differences between **HOPDs and physician offices** have drawn increasing scrutiny
- Congress and CMS have implemented policies aimed at **site-neutral reimbursement** that have diminished the value of provider-based status

Provider-based Status: Core Requirements
(Apply to all provider-based departments)

Licensure
Operates under the hospital's license *(unless state law requires separate licensure)*

Clinical Integration
Services integrated with hospital clinical operations and processes

Financial Integration
Department costs and revenues reported through the hospital

Public Awareness
Held out to the public as part of the hospital *(signage, branding, patient notices)*

Hospital Obligations
Compliance with Medicare requirements applicable to hospitals *(e.g., EMTALA, supervision, billing rules)*

Physician Services
Physicians must bill using correct site of service

Uniform Billing
Treat all Medicare patients as hospital outpatients

Off-Campus HOPDs: Additional Requirements

Location + Hospital Control Requirements

An off-campus HOPD must:

- Be located within 35-miles of the hospital campus or meet one of the alternative tests focusing on the population served by the hospital
- Be owned and controlled by the hospital
- Be administratively and operationally integrated with hospital management
- Be subject to direct oversight by the hospital governing body
- Report directly to hospital leadership

📌 *This is where CMS evaluates whether the site is truly a hospital department — not a freestanding clinic in disguise.*

Off-Campus HOPDs: Additional Requirements

Beneficiary Notice Requirement

An off-campus HOPD must:

- Provide written notice to Medicare beneficiaries:
  - With the amount of potential financial liability, or
  - If not known, an explanation that coinsurance may apply that would not apply if the facility was not provider-based and an estimate based on typical charges for visits at the facility
- Notice must generally be provided before services are furnished

Site-Neutral Payments and Congressional Concerns about HOPDs

- Site-neutral payment policies aim to align payments across care settings
  - Payors pay the same rate for the same service, regardless of whether it is provided in a hospital outpatient department, ambulatory surgery center, or physician office
- Hospitals tend to have sicker / more complex patients and higher overhead so view PBD as necessary
- Lawmakers cite several concerns about provider-based billing:
  - Increased Medicare spending
  - Higher patient cost-sharing due to facility fees
  - Limited transparency regarding hospital-owned clinics

Section 603 and Site-Neutral Payment Policy

- The **Bipartisan Budget Act of 2015 (Section 603)** introduced major changes for off-campus HOPDs
- Off-campus HOPDs billing under the OPPS **before Nov. 2, 2015** are considered **"excepted"**
- Non-excepted off-campus HOPDs generally **cannot bill under OPPS**
- Non-excepted off-campus HOPDs must bill under an **"applicable payment system"**
- CMS designated the **Medicare Physician Fee Schedule (MPFS)** as the applicable payment system
- **Cancer hospitals** are subject to unique rules under Section 603 and can develop new off-campus HOPDs that receive full reimbursement if attestations are submitted timely

Current Payment Framework

- Non-excepted off-campus HOPDs are reimbursed under the **MPFS**
- MPFS payment rates are approximately **40%** of the OPPS rates
- CMS requires **claim modifiers** identifying whether an HOPD is excepted
- CMS has expanded **reimbursement cuts** for certain services, including **clinic visits** and **drug administration services,** to **excepted HOPDs**
- Site-neutral payment policy continues to influence **Medicare outpatient hospital reimbursement**

New Requirements for Off-Campus HOPDs

Section 6225 of the **Consolidated Appropriations Act, 2026** introduces new statutory requirements to maintain provider-based status for off-campus HOPDs

Applies to **all off-campus HOPDs**, including those excepted from Section 603

Establishes two new conditions for Medicare payment:

- **Provider-based attestation**
- **Separate National Provider Identifier (NPI)**

Requirements become effective **January 1, 2028**

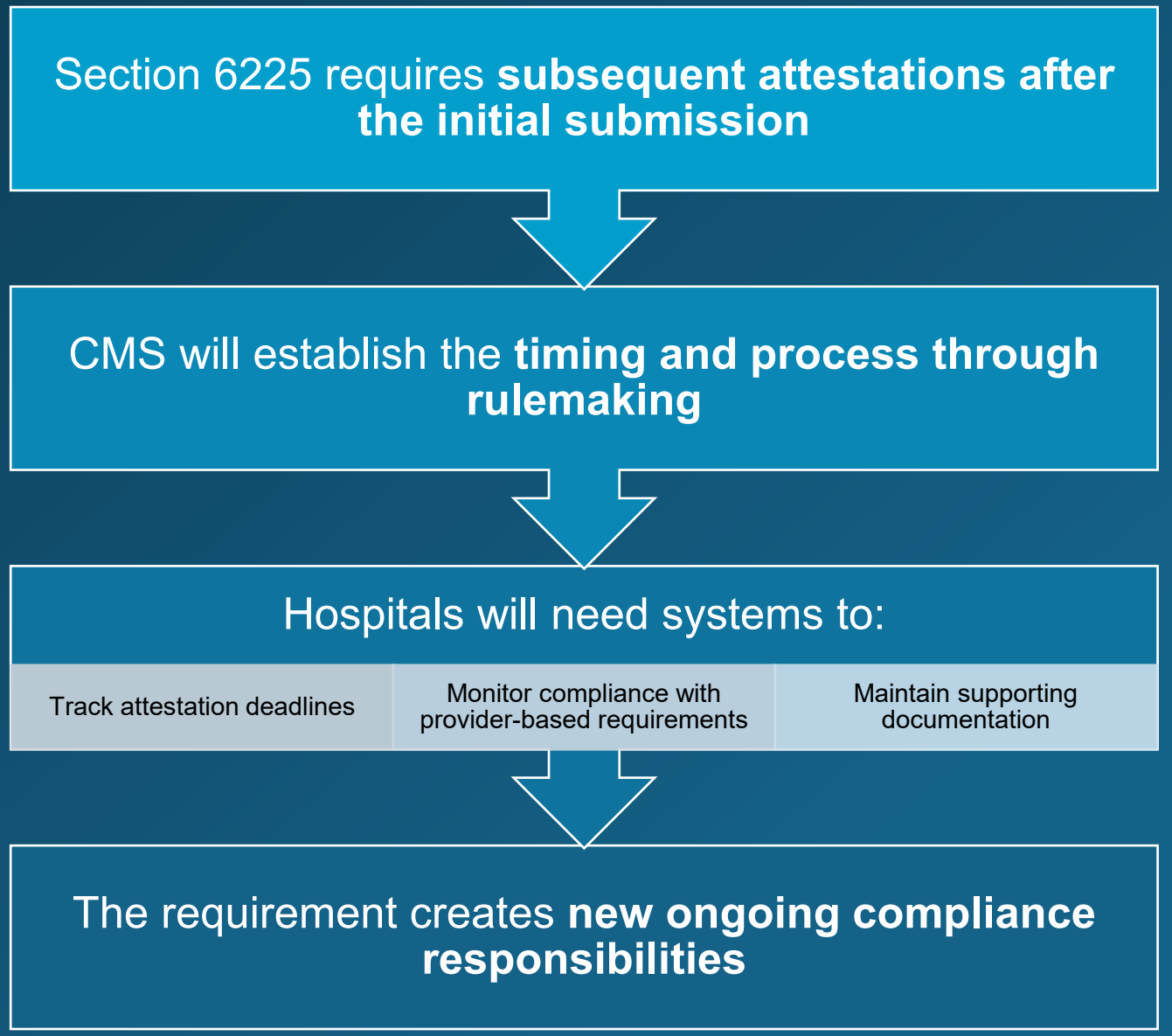
Mandatory Provider-Based Attestations

- Hospitals must submit a **provider-based attestation** for each off-campus HOPD
- The attestation certifies compliance with **42 C.F.R. § 413.65**
- Initial attestations must be submitted **between January 1, 2026** and **December 31, 2027**
- Applies to **all off-campus HOPDs**, including those that existed **prior to Nov. 2, 2015**
- Without a submitted attestation, **Medicare payment will cease beginning January 1, 2028**

Separate NPI Requirement

- Each off-campus HOPD must obtain a **separate National Provider Identifier**
- Services must be billed using the **department-specific NPI**
- Hospitals may need to update:
  - Medicare enrollment records
  - Medicaid and commercial payor enrollment
  - Billing systems and internal workflows
- Implementation will require coordination across **compliance, revenue cycle, and IT**

Re-Attestation Requirement



Why does this matter?

- **Loss of Medicare payment beginning January 1, 2028**
- Billing failures tied to missing or incorrect NPIs
- Increased audit and enforcement risk around provider-based status
- Revenue cycle disruption and operational instability
- Little room for correction once CMS payment stops

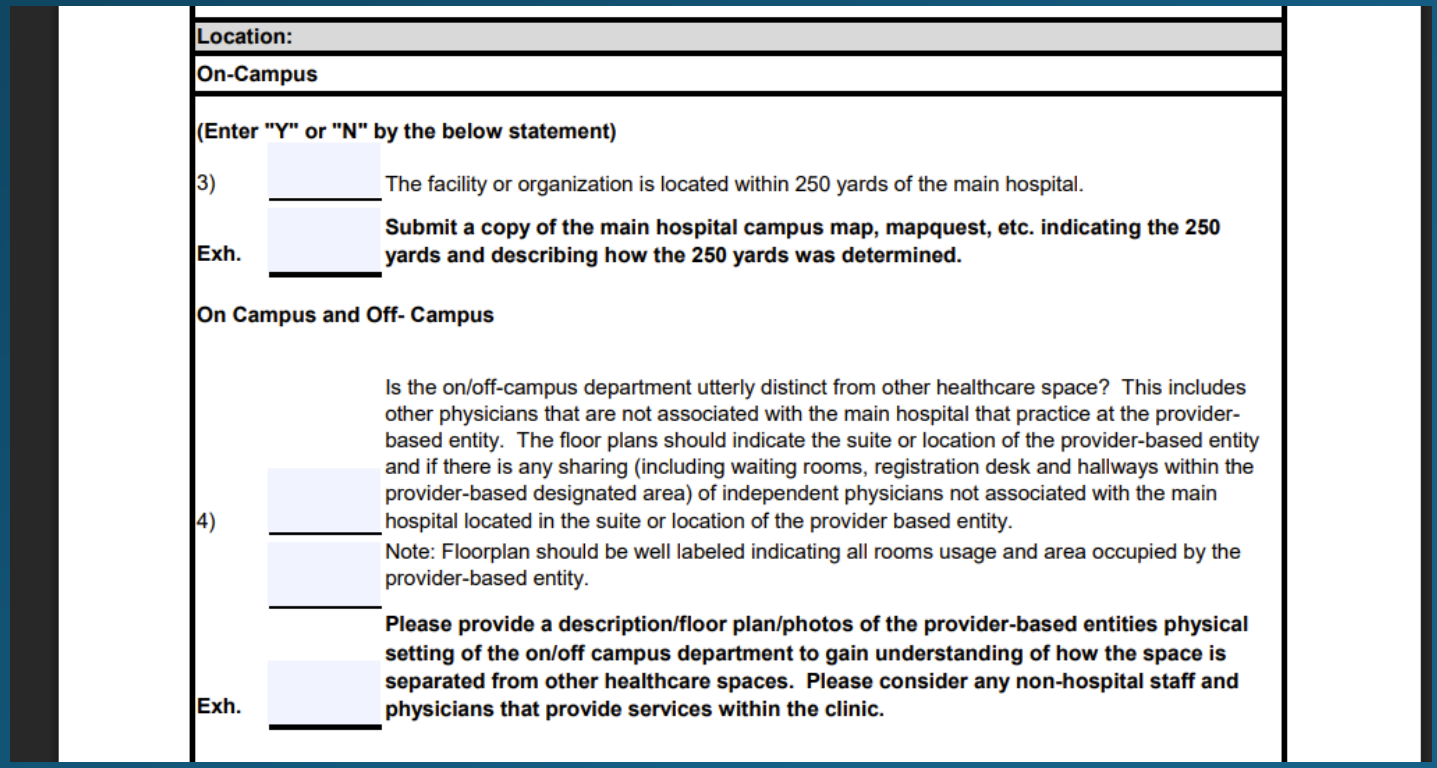
Provider-based attestations are no longer a technical exercise — they are a payment condition.

Attestations

- Currently attestations are voluntary for most hospitals
- Medicare Administrative Contractors process attestations in coordination with the CMS Regional Office
- Each MAC has their own format requirements
- Most still refer to Program Memo A-03-030
- Attestations are very detailed
- Important to submit thorough, easy to understand information
- Appeal rights for the outcome of the attestation, but not Section 6225 itself

Current Attestation Example

- WPS has a required form: https://www.wpsgha.com/uploads/08_23_24_Provider_Based_Attestation_Tagged_Reader_Extended_kl_a3bef3116d.pdf



Location:

On-Campus

(Enter "Y" or "N" by the below statement)

3) _____ The facility or organization is located within 250 yards of the main hospital.

Exh. _____ **Submit a copy of the main hospital campus map, mapquest, etc. indicating the 250 yards and describing how the 250 yards was determined.**

On Campus and Off- Campus

4) _____ Is the on/off-campus department utterly distinct from other healthcare space? This includes other physicians that are not associated with the main hospital that practice at the provider-based entity. The floor plans should indicate the suite or location of the provider-based entity and if there is any sharing (including waiting rooms, registration desk and hallways within the provider-based designated area) of independent physicians not associated with the main hospital located in the suite or location of the provider based entity.

_____ Note: Floorplan should be well labeled indicating all rooms usage and area occupied by the provider-based entity.

Exh. _____ **Please provide a description/floor plan/photos of the provider-based entities physical setting of the on/off campus department to gain understanding of how the space is separated from other healthcare spaces. Please consider any non-hospital staff and physicians that provide services within the clinic.**

Tackling Section 6225

2026 Action Items

- Monitor CMS rulemaking implementing Section 6225
- Create an inventory of all off-campus HOPDs
- Conduct thoughtful provider-based compliance reviews for off-campus HOPDs
- Obtain separate NPIs for each off-campus HOPD
- Prepare for billing system, EHR, and revenue cycle updates to implement site-specific NPIs

2027 Action Items

- Prepare and submit required provider-based attestations
- Add NPIs to 855A enrollment records
- Implement separate NPIs for each off-campus HOPD
- Build systems to track periodic re-attestations and supporting documentation

2028 and Beyond

- Monitor CMS rulemaking and Congressional actions
- Conduct re-attestations as required

Common Compliance Pitfalls

Hospitals often encounter challenges demonstrating full compliance with the provider-based rule:

- **Public awareness issues**, including signage and naming conventions
- Maintaining required **clinical oversight and reporting structures**
- Difficulty demonstrating **financial integration** with main campus

Failure to Meet Public Awareness Requirements

CMS requires patients to be aware when they are receiving care in a **hospital outpatient department.**

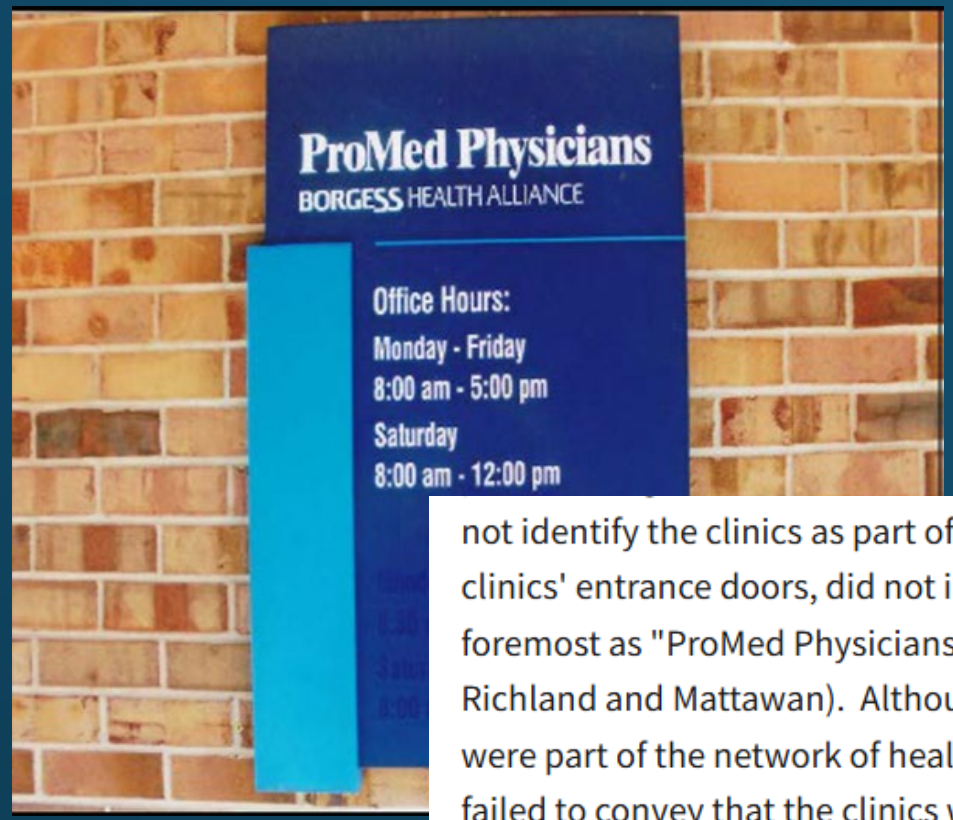
CMS Auditors may request:

- Patient registration materials
- Facility signage
- Website and marketing materials
- Notices regarding hospital outpatient billing and facility fees

Common compliance issues include:

- Incorrect signage
- Registration materials that **do not identify the department as part of the hospital**
- Missing **patient notices about potential facility fees**
- Website and marketing materials that describe the location as an **independent clinic**

Name Issues



not identify the clinics as part of Borgess Medical Center. As CMS's photographs reflect, the signs, which appeared near the clinics' entrance doors, did not include the main provider's name. In each instance, the sign identified the clinic first and foremost as "ProMed Physicians." CMS Ex. 3, at 1; CMS Ex. 4; CMS Ex. 5, at 1-3; *see also* CMS Ex. 8, at 1-2 (Google street views of Richland and Mattawan). Although the signs indicated, in smaller type below the ProMed Physicians name, that the clinics were part of the network of healthcare facilities known as "Borgess Health" or "Borgess Health Alliance," that information failed to convey that the clinics were parts of Borgess Medical Center because the Borgess Health network encompassed multiple types of healthcare facilities, including physician practices, not merely Borgess Medical Center.[10] CMS Ex. 12.

Misunderstanding Clinical Integration

Departments must be **clinically integrated with the hospital.**

Auditors may request documentation showing:

- Hospital governance oversight
- Integration with hospital policies and procedures
- Medical staff credentialing through the hospital

Common problems include:

- Independent clinic policies rather than hospital policies
- Separate medical staff credentialing processes
- Lack of hospital oversight of quality assurance programs
- Differing medical director relationships and accountability

Misunderstanding Financial Integration

Department must be financially integrated with the hospital.

CMS auditors may examine whether the department:

- Uses hospital accounting systems
- Is included in the hospital's cost report
- Is financially controlled by the hospital

Common problems include:

- Separate or partially separate accounting systems
- Incomplete cost report integration
- Lease or management arrangements that look too independent (hospital cannot demonstrate direct financial control and integration)
- Department not included in hospital budgeting and financial statements
- Legacy structures from acquisitions (e.g., retained physician practice entities or leftover financial workflows)

Managing Compliance Imperfections

- Likely to discover imperfections in provider-based compliance during this work
- Consider whether the work can be done under attorney-client privilege
- Not all mistakes should be considered material
- Better to fix imperfections before submitting an attestation than submit an attestation with concerning features
- Creative disclosure strategies may be helpful

Key Takeaways

- Section 6225 significantly increases **CMS oversight of provider-based billing**
- Off-campus departments must obtain **separate NPIs**
- Hospitals must submit **provider-based attestations**
- Hospitals should set up systems to prepare for **subsequent** attestations
- **Rulemaking** will be critical
- CMS enforcement begins **January 1, 2028**
- Hospitals should begin **systemwide compliance planning now**

Questions? Please reach out!

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