Weekly Checkup

Medicare's Quiet Shift in Hospital Oversight

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On July 7, the Centers for Medicare and Medicaid Services (CMS) published its calendar year 2027 proposed rule for the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. While the proposed rule's 340B program drug reimbursement reductions and expansion of site-neutral payments for certain imaging services provided in off-campus hospital outpatient departments (HOPDs) have understandably attracted attention, CMS' less covered proposal to implement a statutory provision enacted in the Consolidated Appropriations Act, 2026 (CAA) may prove just as consequential.

Under the proposal, hospitals would be *required* to periodically attest that each of their off-campus provider-based departments (PBDs) continues to satisfy Medicare's "provider-based" requirements. The proposed attestation requirements would strengthen federal oversight of one of Medicare's most valuable regulatory designations, and signal that the designation is no longer a one-time compliance determination, but rather a temporary status subject to ongoing verification.

Why is provider-based status for off-campus HOPDs so valuable for hospitals? CMS offers its own explanation in the proposed rule, stating **"compared to being treated as a freestanding facility," PBDs may receive several advantages, "including, most notably, increased payments from Medicare."** This statement refers to the current Medicare payment framework, under which qualifying PBDs may receive reimbursement under the OPPS rather than the Physician Fee Schedule, generally resulting in higher payments for comparable services furnished in freestanding settings. Additionally, provider-based status can also expand access to discounted drugs through the 340B program, as certain PBDs of eligible hospitals may be registered as covered outpatient sites, extending participation in discounted drug purchasing. **These combined financial advantages**

stemming from provider-based status have widely been viewed as major factors encouraging hospitals' acquisitions of freestanding physician practices.

Congress and CMS have long sought to address the unintended incentives arising from provider-based status. In response to growing concerns over health care consolidation and inaccurate Medicare payments, federal lawmakers enacted a law in 2015, which generally eliminated higher OPPS service reimbursement in newly acquired off-campus HOPDs. At the same time, CMS has consistently maintained that accurately distinguishing PBDs from freestanding facilities is essential to protecting appropriate Medicare spending, as failure to do so "can result in provider overpayments." Notably, **prior to the CAA, hospitals were not required to submit recurring attestations demonstrating each PBD continued to meet Medicare's provider-based requirements**. Hospitals voluntarily submitted attestations only when seeking a preliminary CMS determination, and OPPS payment was not conditioned on periodic validation. **The CAA changes this system by directing CMS to establish a process for recurring hospital attestations, leading to the new requirements in the recently proposed rule**.

The CMS proposal does not fundamentally change the underlying provider-based regulations. Instead, the rule aims to implement a new verification process under which OPPS payments would depend on hospitals demonstrating continued compliance with provider-based requirements. As directed by the CAA, **beginning in 2028, applicable off-campus HOPDs would be required to main a unique National Provider Identifier (NPI), have the parent hospital submit an initial attestation within two years before the provider submits claims to Medicare under that specific NPI, and have the parent hospital submit subsequent attestations confirming the facility continues to satisfy Medicare's provider-based requirements within the mandated timeframe**. Initial attestations from hospitals with existing PBDs would be required before the 2028 deadline, with subsequent attestations required at intervals not exceeding five years.

To streamline implementation, the proposed rule would also establish a new standardized provider-based status attestation form replacing all current Medicare Administrative Contractor- (MAC) specific forms. Aligned with an agency-wide commitment to modernize workflows, hospitals would submit the standardized form through a new centralized electronic submission system. The proposed rule would also modify the attestation process by **authorizing MACs and other contractors to conduct review and validation activities in support of provider-based determinations, rather than forwarding recommendations to CMS for a separate decision**. Determinations for all initial attestations would be supported through standardized processes, including

"automated validation activities, data analysis, risk-based screening methodologies, targeted documented review, and other program integrity activities." Although hospitals are not expected to submit all mandatory documentation at the time of initial attestation submission, they would be required to maintain records demonstrating compliance – including documentation pertaining to ownership, public awareness, and clinical integration – in the event that CMS or its contractors requested it during targeted reviews, audits, or site visits. Through CAA, CMS was instructed to contemplate penalties for hospital noncompliance, which may include the full recovery of OPPS payments or removal from the Medicare program. **CMS espouses that these changes may collectively reduce administrative burden and promote a more efficient and consistent review process for all parties involved**.

The calendar year 2027 OPPS and ASC proposed rule is the most recent federal effort to address the Medicare spending problem and the incentives created by provider-based status. The message is clear: Policymakers are demanding greater accountability from the providers benefiting from federal programs such as OPPS and 340B. **By making Medicare payments contingent on new recurring hospital attestations, Congress and CMS are changing provider-based status from a one-time designation into an ongoing compliance obligation subject to continued oversight**.