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Contents

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Attestation May Send Some PBDs Packing; 'They May Find Things Have Eroded Over Time'

Some off-campus provider-based departments (PBDs) may be in jeopardy because of the new attestation requirements in the 2026 Consolidated Appropriations Act (CAA).[1] After the regulatory soul-searching that will come from completing an attestation, some hospitals may conclude that their PBDs are out of compliance with the provider-based regulation and that closing the gaps would be overwhelming, attorneys say. Whatever the fate of the PBDs, the sooner hospitals get to work on the attestation, the better, because there's more to it than meets the eye.

The CAA requires hospitals to submit attestations that their PBDs comply with Medicare requirements. Unless the hospital submits an attestation between Jan. 1, 2026, and Dec. 31, 2027, Medicare will stop paying for services provided at the off-campus PBD. The CAA also requires hospitals to get a National Provider Identifier (NPI) for every off-campus PBD.

'They Will Have to Make Changes'

"You have to be able to attest to compliance with provider-based rules and it's very likely many hospitals will have locations that don't currently meet the requirements and may not ever be able to," said attorney Emily Cook, with McDermott Will & Shulte. "They will have to make changes." Even if PBDs had checked off the boxes of PBD requirements years ago, "they may find things have eroded over time," said Valerie Rinkle, president of Valorize Consulting (see box, pages 3-4).[2]

For example, some hospitals need new signage for their PBDs. Off-campus PBDs are required to have a sign bearing the name of the hospital they're associated with, said attorney Sandra DiVarco, with McDermott Will & Shulte. Using the name of the health system isn't good enough. And the main hospital must provide monitoring and oversight of its PBDs, DiVarco explained. For example, nurses have to ultimately report to the chief nursing officer at the hospital. "The farther away a location is, the harder it is to really say logically there is that same level of supervision," she noted.

Patient notices are another area where PBD compliance goes awry, Rinkle said. The regulation requires PBDs to provide written notice to Medicare beneficiaries that ballparks their financial liability or, if it's unknown, explain they will owe coinsurance to the hospital that they wouldn't owe if the entity weren't provider-based (e.g., it was a freestanding clinic). "A lot of places get caught because they're no longer doing the notification," Rinkle said. PBDs might have given the notices for a while, "but systems get updated and things change. That would be a problem."

If PBDs are out of compliance, hospitals may have to return overpayments for the period of noncompliance and could face false claims liability, DiVarco and Cook said. And if hospital outpatient departments lose their provider-based status altogether, they will be forced to convert PBDs to freestanding clinics, Cook and DiVarco said.

'A Significant Resource Drain'

Even though Congress left it to CMS to spell out the attestation and NPI

the 2015 Balanced Budget Act. Medicare pays PBDs a physician fee schedule (PFS)-equivalent rate for clinic visits, which is about 40% of the OPPS rate.

There's more. The 2026 Medicare Physician Fee Schedule rule extended site neutrality to drug administration. The reason for the change is the surge of drug administration in PBDs, where it's far more expensive.

What's curious about the NPI requirement is CMS already has data on off-campus PBDs through use of the PO and PN modifiers, Rinkle said. Hospitals report the PO modifier with codes for items and services provided in an off-campus PBD for excepted items and services. That means they're paid the full outpatient prospective payment system (OPPS) rate because the PBD was grandfathered into Sec. 603, which bars full OPPS payment for new PBDs after Nov. 2, 2015. Hospitals report the PN modifier with codes for items and services that aren't excepted. They are paid 40% of the OPPS rate. "Hospitals use the modifiers for outpatient claim lines in different PBDs," she explained.

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Endnotes

1 Consolidated Appropriations Act, 2026, H.R. ____, 119th Cong. (2d Sess. 2026), https://bit.ly/3YUGCII.

2 Nina Youngstrom, "Checklist of Provider-Based Department Requirements," *Report on Medicare Compliance* 35, no. 8 (March 2, 2026).

3 42 C.F.R. § 413.65, Requirements for a determination that a facility or an organization has provider-based status, https://bit.ly/4ilCgT3.

In Fraud 'Crackdown,' CMS Bans DME Suppliers, Promises Revocation List

CMS has shut Medicare's door to new durable medical equipment (DME) suppliers for six months nationally as part of the Trump administration's "major crackdown on health care fraud" announced Feb. 26.[1] The enrollment moratorium gives CMS time to find additional safeguards "to further mitigate longstanding

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Checklist of Provider-Based Department Requirements

This checklist, which is based on provider-based requirements in 42 C.F.R. § 413.65, was developed by Valerie Rinkle, president of Valorize Consulting. Most hospitals are now required to submit an attestation of their compliance with the regulation (see story, p. 1).[1] Contact her at valerie@valorizeconsulting.com.

Disclaimer: This is provided as a summary resource and does not substitute for qualified healthcare legal counsel review of appropriateness of provider-based status of each location.

Checklist for Provider-Based Departments

Provider-Based Department Info & CMS Criteria from 42CFR413.65		Comments
Department Name		
Physical Address		
Type of Services		
Location listed in 855A enrollment		
Modifiers used on services (PN, PO, ER)		
Expense GL #		
Revenue GL #		
Off-Campus Y or N		
Location listed on Hospital License Y or N		
Remote Location of Hospital Y or N		
Satellite Facility Y or N		
Is it a mobile unit and not a physical address?		
Date of last Accreditation Review & by what entity?		
100% Ownership by Hospital		
Is PBD address on hospital license from the State (if the state requires it)		

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instances of fraud, waste, and abuse perpetrated" by certain DME, prosthetics and orthotics suppliers.

The grab bag of initiatives in the new crackdown is part of the administration's war on fraud, waste and abuse in Medicare and Medicaid. This time around, however, Vice President J.D. Vance will be running the show, sending a message that "crushing fraud" is a major value proposition.

HHS—led by President Trump, HHS Sec. Robert F. Kennedy Jr., and CMS Administrator Mehmet Oz—is also withholding federal funds from Minnesota Medicaid and has released a request for information (RFI) on ways to cut fraud, waste and abuse.[2] For example, CMS is soliciting feedback on reducing the one-year timely claim filing deadline for high-risk items and services on the grounds it will "reduce the ability of providers to back-bill for fraudulent claims."

'Too Much Hassle' May Affect Access

The crackdown added to the anti-fraud ecosystem that has emerged across agencies in Trump 2.0. For example, the White House on Jan. 8 said it's establishing the U.S. Department of Justice Division for National Fraud Enforcement to enforce federal criminal and civil laws against fraud affecting federal government programs and benefits, businesses, nonprofits and private citizens.

All this shows "the level of engagement and messaging that has been consistent from this administration" and "underlines and puts in bold" the importance of an effective compliance program for health care organizations doing business with the government, said Gregory Demske, former chief counsel to the HHS Inspector General.

But the flurry of measures raises questions about the impact on access to care.

"Everybody hates real fraud, but people can differ as to the definition of what is considered fraud," said attorney Judy Waltz, with Foley & Lardner LLP. "An aggressive definition of fraud and aggressive enforcement have to be balanced against the possibility that the approach may limit access to reasonable and necessary care. In other words, too much hassle in fraud oversight can have the unintended consequence of driving legitimate providers out of the field or a decision to opt out of serving Medicare patients."

CMS: Long-Awaited Screening Tool Is Coming

Health care organizations also will get a hand with identifying potentially bad actors based on their status with original Medicare and Medicare Advantage (MA). Echoing the HHS Office of Inspector General's exclusion list, CMS said it will publish information on providers and suppliers whose billing privileges have been revoked and the reason why, along with their National Provider Identifier. The same goes for providers and suppliers on the Preclusion List (i.e., providers and prescribers who are barred from payment under MA or Part D organizations because their Medicare billing privileges have been revoked, among other reasons). Waltz noted that currently, there's no public list of people and entities whose billing privileges have been revoked. They're reported to the National Practitioner Data Bank, MA organizations, Part D sponsors and state Medicaid programs, but the list isn't available to the public, she noted.

"This is a huge step forward," Waltz said. Health care organizations will be able to look at the revocation and preclusion lists and make an assessment about a person they're hiring "before it's too late." That means weeding certain people out long before payers deny a claim stemming from their services, she explained.

Benefits of Moratorium May Be Overstated

On the DME supplier moratorium, CMS said it "applies to all applications for initial enrollment and changes in majority ownership for medical supply companies." But Waltz has "real doubts moratoria work." California has had some longstanding moratoria in the past, but "what happened was licenses became really valuable assets," she noted. "You aren't necessarily keeping less desirable operators out. It may be incentivizing those who have a pot of money and can pay a lot because they want to transfer a license as opposed to starting up their own business. And the approach may wind up with an unintended consequence of limiting patient access to necessary services."

The DME moratorium will hit potential new suppliers hard because it's nationwide, said Demske, with Goodwin Procter. CMS limited earlier moratoria to geographic areas that are hotbeds of fraud, such as Texas and South Florida, for specific provider types (e.g., home health and hospice), he noted.

CMS also said it will withhold $259.5 million of federal matching funds from Minnesota Medicaid because of its program integrity shortcomings, including "expenditures of $243.8 million for unsupported or potentially fraudulent Medicaid claims and $15.4 million related to claims involving individuals lacking a satisfactory immigration status." CMS cited very high spending for certain services, such as personal care services and home and community-based services. If Medicaid doesn't clean up its act, CMS may defer more than $1 billion in federal funds during the coming year.

Lots of Questions for Providers

CMS also released an RFI about "Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)"—a variation on its theme of crushing fraud. "This request for information (RFI) solicits stakeholder feedback on potential regulatory changes that might be included in a potential upcoming CRUSH proposed rule, as well as other programmatic changes that could be implemented to make CMS more effective in crushing fraud to protect taxpayer dollars and the Americans we serve," according to the notice in the Feb. 27 *Federal Register*.

CMS is asking for feedback on certain topics all over the program-integrity map. "There's a lot being thrown at providers," said Claire Ernst, director of government relations and public policy at Hooper, Lundy & Bookman. "This RFI is potentially a sign of things to come."

Here's a sampling of questions that CMS hopes to answer:

On program integrity:

- "Are there ways to modify provider enrollment (including revocation), medical review, investigation, audit, payment suspension, and other program integrity oversight policies to provide CMS with increased authority and flexibility to expeditiously prevent bad actors from engaging in fraud, waste, and abuse?
- "Are there existing requirements or policies, including those issued through regulations, memoranda, administrative orders, subregulatory guidance documents, or policy statements that could be altered to increase CMS' ability to promote payment accuracy and efficiency to protect the integrity of Medicare, Medicaid, CHIP, and the Health Insurance Marketplace?
- "What types of analytics, methodologies, or data-driven approaches would be most effective in identifying indicators of potential fraud, waste, or abuse?
- Should CMS establish regulatory requirements that allow MA organizations and Part D sponsors to implement payment suspensions under circumstances similar to the payment suspension authority that exists for Traditional Medicare?"

There are also questions in the RFI about discrete risk areas, including MA and lab testing (i.e., genetic tests and molecular diagnostic tests and DME suppliers); the use of AI in MA coding oversight and hospital billing; and beneficiary issues (e.g., communication).

"As CMS pushes out more fraud-related initiatives and asks the community stakeholders for their input," it should supercharge its education, Ernst said. "We should be trying to empower providers as well as make sure they are following all the requirements and that's making sure there's enough educational material out there."

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Endnotes

1 Centers for Medicare & Medicaid Services, "Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud," news release, February 25, 2026, https://go.cms.gov/4aYNiv2.

2 Centers for Medicare & Medicaid Services, Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH) 91 Fed. Reg. 9,803 (Feb. 27, 2026), https://bit.ly/4tPePHM.

CMS Sees No Problem With New MA Plan Admission Payment Policies

CMS doesn't have a problem with new admission policies from Medicare Advantage (MA) plans that flip the script on hospital inpatient claims. Two MA plans have essentially turned a coverage decision into a payment calculation, experts say. Aetna implemented a policy along those lines Jan. 1[1] and Independence Blue Cross will do the same March 5.[2] Although some hospitals consider this an end-run around the Two-Midnight Rule—which MA plans are required to follow—CMS doesn't agree.

"In general, policies that operate as payment structures rather than a limitation on coverage do not violate a Medicare Advantage (MA) plan's obligation to furnish basic benefits under 42 C.F.R. § 422.101," a CMS spokesperson told *RMC*. "For contracted providers, MA organizations are not required to adhere to Original Medicare billing codes or claims processing procedures. Instead, they may establish their own billing and payment processes, including processes for Medicare-covered services. These procedures are typically governed by the terms of the contract between the provider and the MA organization."

In fact, CMS is prohibited from requiring MA plans to adopt a particular policy or contract with certain providers (under the non-interference clause), the spokesperson said. "As a result, CMS generally does not get involved in pricing or contractual negotiations or disputes between MA organizations and their contracted providers. For providers who do not have a contract with an MA organization, the organization is generally required to reimburse the providers at no less than the Original Medicare rate for Medicare-covered services [42 C.F.R. § 422.100(b)(2)]."