

Supporting Statement – Part A

Prospective Payments for Hospital Outpatient Services and Supporting Regulations in 42 CFR 413.65 (CMS-R-240; OMB 0938-0798)

Background

This is a revision of the information collection request previously approved under OMB control number 0938-0798. CMS is making revisions to this collection as a result of the NPRM (CMS-1850-P), which include proposals to implement section 6225 of the Consolidated Appropriations Act, 2026 (CAA 2026), Pub. L. 119-75. The estimated burden and number of responses has increased due to the section 6225 of the CAA requirement for main providers to submit attestations for off-campus provider-based departments.

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the cost-based payment methodology with a prospective payment system (PPS).

On April 7, 2000, CMS published a final rule with comment period (65 FR 18434) that addressed the provisions of the PPS for hospital outpatient services. Under this system, Medicare payment for hospital outpatient services included in the PPS is made at a predetermined, specific rate. The April 7, 2000 final rule with comment period also established requirements for provider departments and provider-based entities and prohibited Medicare payment for non-physician services furnished to a hospital outpatient by a provider or supplier other than a hospital unless the services are furnished under arrangement. The provider-based rules are necessary so that CMS can distinguish facilities or organizations that function as department of hospitals from those that are freestanding, so that CMS can determine which services should be paid under the outpatient prospective payment system (OPPS), the clinical laboratory fee schedule, or other payment provisions applicable to services furnished to hospital outpatients. Medicare payment and beneficiary coinsurance may be different when services are provided in a hospital outpatient department compared to a freestanding facility making these rules necessary. CMS implemented the OPPS on August 1, 2000.

The following history summarizes regulatory action related to the provider-based rules:

On August 3, 2000, CMS published an interim final rule with comment period (65 FR 47670) that corrected and clarified certain provider-based provisions included in the April 7, 2000 rule.

- On August 1, 2002 (67 FR 49982), CMS finalized a rule which revised the criteria used for determinations of provider-based status, and replaced, the prior, mandatory application requirement with a voluntary attestation provision. For facilities or organizations treated as provider-based on October 1, 2000, these changes are effective for provider cost reporting periods beginning on or after July 1, 2003. For other facilities or organizations, these changes were effective on October 1, 2002.
- CMS made further clarification of the criteria used for determinations of provider-based status and the obligations of provider-based facilities in proposed and final regulation published on: May 4, 2005 (70 FR 23443), August 12, 2005 (70 FR 47457), May 22, 2009 (74 FR 24204), and August 27, 2009 (74 FR 43940).
- The May 22, 2009 proposed rule (74 FR 24204) and August 27, 2009 final rule (74 FR 43940) made a clinical diagnostic laboratory that is part of a critical access hospital (CAH) subject to the provider-based rules. The change was made because clinical diagnostic laboratory tests furnished by CAHS are paid under reasonable costs and not under the clinical laboratory fee schedule. As there is a payment difference depending upon whether a clinical diagnostic laboratory service is furnished to a CAH outpatient or in any other setting, a clinical diagnostic laboratory that is part of a CAH must meet the provider-based rules for the CAH to be paid on the basis of reasonable costs for clinical diagnostic laboratory tests.
- The July 7, 2026 proposed rule (91 FR 41734) included proposals to implement section 6225 of the Consolidated Appropriations Act, 2026 (CAA 2026), Pub. L. 119-75. Section 6225 of the CAA requires, as a condition of receiving payment under the OPPS as of January 1, 2028, that an off-campus department of a provider obtain and bill under a separate National Provider Identifier (NPI) and that the main provider must submit a provider-based status attestation that the off-campus outpatient department is compliant with the requirements at §413.65 for such departments. Section 6225 further requires the Secretary, through notice and comment rulemaking, to establish a process for each provider with an off-campus outpatient department to submit an initial and subsequent attestation, for the review of each such attestation and for the determination whether each off-campus outpatient department is compliant with the provider-based requirements. Specifically, under proposed § 413.65(b)(6), as of January 1, 2028, in order to receive payment, a main provider must submit an initial attestation of provider-based status for each of its off-campus outpatient departments within 2 years prior to furnishing services, and subsequent attestation(s) within a period not to exceed 5 years thereafter.

A. Justification

1. Need and Legal Basis

Section 1833(t) of the Act, as added by section 4523 of the Balanced Budget Act of 1997 (the BBA) requires the Secretary to establish a prospective payment system (PPS) for hospital

outpatient services. Successful implementation of an outpatient PPS requires that CMS distinguish facilities or organizations that function as departments of hospitals from those that are freestanding, so that CMS can determine which services should be paid under the OPPTS, the clinical laboratory fee schedule, or other payment provisions applicable to services furnished to hospital outpatients. Information from the reports required under sections 413.65(b)(3) and (c) is needed to make these determinations. In addition, section 1866(b)(2) of the Act authorizes hospitals and other providers to impose deductible and coinsurance charges for facility services, but does not allow such charges by facilities or organizations which are not provider-based. Implementation of this provision requires that CMS have information from the required reports, so it can determine which facilities are provider-based. Section 6225 of the CAA requires that, as a condition of receiving payment under the OPPTS as of January 1, 2028, an off-campus department of a provider obtain and bill under a separate NPI and that the main provider must submit a provider-based status attestation that the off-campus outpatient department is compliant with the requirements for such departments.

2. Information Users

For sections 413.65(b)(3) and (c), CMS will use the information to determine whether a facility or organization acquired by a main provider should be treated as provider-based for Medicare certification, coverage, and payment purposes or whether a main provider has had a material change in its relationship to a provider-based facility or organization that affects the provider-based status of the facility or organization.

3. Use of Information Technology

Under the proposed policy, for the attestations under sections 413.65(b)(6), providers will submit responses through a centralized electronic system using a standardized form to minimize administrative burden for providers and a more efficient review process for Medicare Administrative Contractors (MACs) and CMS. Standardization and centralized submission processes will reduce unnecessary duplicative documentation burden while continuing to support appropriate compliance review and program integrity oversight.

4. Duplication of Efforts

These ICRs do not duplicate similar information.

5. Small Businesses

These requirements affect only small businesses and CMS has kept the requirements to the minimum necessary to implement the statute.

6. Less Frequent Collection

If this information is collected less frequently, the respondents would be out of compliance with the law.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

The FY 2027 OPPTS/ASC (CMS-1850-P) Notice of Proposed Rulemaking (NPRM) was published in the Federal Register (91 FR 41734) on July 7, 2026.

The 30-day Federal Register notice **TBD**.

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents. If a facility or organization does not provide the requisite notification to beneficiaries, they cannot qualify for provider based status. If a facility or organization is not provider based, it will not be reimbursed by Medicare as part of a provider. If a facility or organization does not submit an attestation and CMS determines that the facility or organization does not qualify for provider based status, CMS will recoup any overpayments back to the date the facility or organization opened. However if a facility or organization does submit an attestation and CMS later determines the facility or organization does not qualify for provider based status, CMS will only recoup overpayments back to the date of attestation.

10. Confidentiality

Data from this collection will be handled in accordance with established standards under the Freedom of Information and Right to Privacy Acts as set forth in 42 CFR 401 Subpart B.

11. Sensitive Questions

There are no sensitive questions.

12. Burden Estimates (Hours & Wages)

SECTION 413.65 REQUIREMENTS FOR A DETERMINATION THAT A FACILITY OR AN ORGANIZATION IS A DEPARTMENT OF A PROVIDER OR A PROVIDER-BASED ENTITY.

Section 413.65(b)(3) states that a provider which is seeking a determination of provider-based status for a facility not located on the provider's campus must submit an attestation of compliance with applicable provider-based requirements and must supply documentation supporting its attestation at the time the attestation is made. Section 413.65(a)(1)(ii) establishes a listing of specific facilities for which determinations for provider-based status for payment purposes are not made. As CMS removed certain CAH-based facilities from this list, such facilities must comply with provider-based rules to be paid as a CAH for outpatient services on a reasonable cost basis. To implement the requirements of section 6225 of the CAA, section 413.65(b)(6) would state that, as of January 1, 2028, a main provider must submit an initial attestation of provider-based status for each of its off-campus outpatient departments within the 2-year period prior to furnishing services, and subsequent attestation(s) within a period not to exceed 5 years thereafter.

The burden associated with this requirement is the time for the main provider to report the facility's status to CMS and furnish all information needed for a determination. We believe this is reasonable as the information submitted by the applicant is typically information that the applicant already has with regard to their business. It is estimated that 1,832 main providers will take 5 hours per attestation and will submit 9 attestations for existing provider based departments. Because there is a two year period during which the attestations for existing facilities, for the purposes of estimation, we expect half of the attestations to be submitted in the first year and half in the second. Additionally, we estimate that 250 main providers will submit an attestation for new departments annually. Therefore, we estimate that for each year for the first two years, 8,244 attestations (1,832 main providers x 9 attestations per main provider) for existing facilities will be submitted in addition to 250 attestations for new facilities for a total of 8,494 attestations annually. Therefore we have calculated the burden as follows: 8,494 responses x 5 hours per response = 42,470 burden hours (annual). For the third year, we estimate that only 250 attestations for new departments will be submitted. Therefore, we estimate that, for the third year of this collection, we have calculated the burden as follows: 250 responses x 5 hours per response = 1,250 burden hours (annual). The time estimate for preparation of an attestation is based upon the professional judgment of staff members at the Centers for Medicare and Medicaid Services.

We believe that an executive officer will be making the attestation because an executive officer is in the best position to have access to the business information required to make the attestation. Based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2025) at [http://www.bls.gov/oes/current/oes_nat.htm#](http://www.bls.gov/oes/current/oes_nat.htm#11-0000) for Category 11-0000 for the position of Top Executives, the mean hourly wage for a top executive is \$68.33. We have added 100 percent for fringe and overhead benefits, which calculates to \$136.66 per hour. We estimate the total annual cost for each of the first two years of this collection is \$5,803,950 (42,470 hours x \$136.66 per hour). We estimate that the total cost for the third year of this collection is \$170,825 (1,250 hours x 136.66 per hour). The total estimated cost for all 3 years is \$11,778,725 (\$5,803,950 x 2 + \$170,825).

As described previously, to implement the requirements of section 6225 of the CAA, section 413.65(b)(6) would specify that in addition to an initial attestation, subsequent attestation(s) must be submitted within a period not to exceed 5 years thereafter (that is, a maximum 5-year timeframe). We assume these subsequent attestation(s) will be submitted on a rolling basis for the estimated annual 8,494 attestations beginning in the fifth year. Therefore, we estimate main providers will submit 1,699 subsequent attestations annually (8,494 annual initial attestations divided by 5 years). In general, significantly less information is expected to be required for subsequent attestations for provider departments that received an affirmative determination of provider-based status and remain in compliance. We believe the subsequent attestations, on average, will take 1 hour per attestation. Therefore we have calculated the burden as follows: 1,699 responses x 1 hours per response = 1,699 burden hours (annual). Using the same assumption that an executive officer will be making the attestation, we estimate the total annual cost of this collection for subsequent attestations is \$232,158 (1,699 hours x \$136.66 per hour).

Section 413.65(d)(2)(v) states that medical records for patients treated in a facility or organization must be integrated and maintained into a unified retrieval system (or cross reference) of the main provider. The burden associated with this requirement is the time required for the main provider to maintain medical records in a unified retrieval system. While this requirement is subject to the PRA, CMS believes this requirement is a usual and customary business activity and the burden associated with this requirement is exempt from the PRA, as stipulated under 5 CFR 1320.3(b)(2) and (b)(3).

Section 413.65(e)(3) requires that if a determination of provider-based status is sought for a facility or organization that is not located within a 35-mile radius of the potential main provider, the facility or organization must demonstrate compliance with the location requirement in one of two other ways. The first option for meeting the location requirement is to show that the facility or organization is owned or operated by a hospital or CAH that has a disproportionate share adjustment (as determined under 42 CFR 412.106) greater than 11.75 percent or is described in 42 CFR 412.106(c)(2) implementing section 1886(e)(5)(F)(i)(II) of the Social Security Act and is either owned or operated by a unit of State or local government, is a public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government, or is a private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services to low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan). The other option for meeting the location requirement is for the facility to demonstrate a high level of integration with the main provider by showing that it meets all of the other provider-based criteria, and demonstrate that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period meet the requirements of paragraphs (e)(iii)(A), (B), or (C). While the information collection requirements listed below are subject to the PRA, the burden associated with these requirements is captured under §§413.65(b)(3) and (c).

Section 413.65(g)(7) states that when a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity, the hospital has a duty to notify the beneficiary, prior to the delivery of services, of the beneficiary's potential financial liability (that is, a coinsurance liability for a facility visit as well as for the physician service). The burden associated with this requirement is the time for the provider to disseminate information to each beneficiary of the beneficiary's potential financial liability (that is, a coinsurance liability for a facility visit as well as for the physician service). It is estimated that 1,832 providers will make on average 7,450 disclosures on an annual basis, at 3 minutes per disclosure (i.e. 0.05 hours). Therefore we have calculated the burden as follows: 13,648,400 responses x 0.05 hours per response = 682,420 burden hours (annual). The time estimate for preparation of a beneficiary notification is based upon the professional judgment of staff members at the Centers for Medicare and Medicaid Services. We believe this is reasonable as the information can be disseminated by providing the patient with a pre-printed written statement and we believe that most providers will provide the information to beneficiaries at the time of check-in through their receptionists. Based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2025) at

http://www.bls.gov/oes/current/oes_nat.htm# for Category 43-4171 for the position of Receptionist and Information Clerks, the mean hourly wage for a receptionist and information clerk is \$18.97. We have added 100 percent for fringe and overhead benefits, which calculates to \$37.94 per hour. We estimate the total annual cost is \$25,891,015 (682,420 hours x \$37.94 per hour).

Section 413.65(j)(5) requires that upon notice of denial of provider-based status sent to the provider by CMS, the notice will ask the provider to notify CMS in writing, within 30 days of the date the notice is issued, of whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services in a free-standing facility. This requirement is exempt from the PRA as stipulated under 5 CFR 1320.4(a)(2).

Years 1 and 2						
Main Provider Attestation Estimated Responses	Time Per Attestation		Annual Burden Hours			
8,494	5 Hours		42,470			
Occupational Title	Occupation Code	Median Hourly Wage (\$/hour)	Fringe Benefit (\$/hour)	Adjusted Hourly Wage (\$/hour)	Annual Burden Hours	Total Annual Cost
Top Executive	11-000	68.33	68.33	136.66	42,470	25,803,950

Year 3						
Main Provider Attestation Estimated Responses	Time Per Attestation		Annual Burden Hours			
250	5 Hours		1,250			
Occupational Title	Occupation Code	Median Hourly Wage (\$/hour)	Fringe Benefit (\$/hour)	Adjusted Hourly Wage (\$/hour)	Annual Burden Hours	Total Annual Cost
Top Executive	11-000	68.33	68.33	136.66	1,250	\$170,825
Estimated Number of Providers	Estimated Number of Annual Disclosures	Total Number of Disclosures	Time Per Attestation			Annual Burden Hours
1,832	7,450	13,648,400	0.05 Hours (3 Minutes)			682,420
Occupational Title	Occupation Code	Median Hourly Wage (\$/hour)	Fringe Benefit (\$/hour)	Adjusted Hourly Wage (\$/hour)	Annual Burden Hours	Total Annual Cost
Receptionist and Information Clerks	43-4171	18.97	18.97	37.94	682,420	\$25,891,015

Further, if the provider indicates that the facility or organization, or its practitioners, will be seeking to meet enrollment and other requirements for billing for services in a free-standing facility, the facility or organization must submit a complete enrollment application and provide all other required information within 90 days after the date of notice; and the facility or organization, or its practitioners, furnish all other information needed by CMS to process the enrollment application and verify that other billing requirements are met.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

CMS, through the MACs, will receive and review provider attestations. For sections 413.65(b) (3) and (c), the Federal cost is based on the efforts expended by CMS to review the data submitted by the respondents. CMS estimates that cost to be \$4,854,397. We arrived at this estimate by multiplying our estimated 16,488 responses per year times 3 hours per response times the estimated hourly rate of the reviewer, which we believe will be equivalent to a GS-12, step 1, salary for the Locality Pay Area of Washington-Baltimore-Arlington, DC-MD-VA-WV-PA of \$49.07 per hour, adding 100 percent for fringe and overhead benefits, which calculates to \$98.14 per hour. We have chosen to use the Washington-Baltimore-Arlington pay area for our estimate because, while the attestations are reviewed by each hospital's applicable MAC, there is a good deal of fluctuation in the number of attestations reviewed by the various MACs such that we cannot accurately estimate how many each would review in a particular year.

15. Changes to Burden

Wage data has been updated to reflect Bureau of Labor and Statistics data from 2025. For beneficiary notification, we do not estimate any changes in the hour burden compared to the previous submission. We estimate an increase in the cost burden due to the updated BLS data used in this submission. For provider attestations, the estimated number of responses has increased due to the section 6225 of the CAA requirement for main providers to submit attestations for off-campus provider-based departments. As such, the number of attestations has increased from 250 to 16,488 annually. However, due to the electronic standardized submission format being developed for the attestations, we estimate a decrease in the number of hours per response from 10 to 5. Overall, we estimate an increase in the total burden for provider attestation, primarily due to the increased number of responses. Hourly burden (775,545) and Number of responses (15,510,900) previously approved were incorrectly calculated and are being corrected during this PRA process. Burden (682,420) should have remained the same for the 2024 submission and are being increased for this PRA process.

16. Publication/Tabulation Dates

CMS has no plans to publish, tabulate, or manipulate individual providers' reports received in compliance with sections 413.65(c)(1) and (c)(2). However, it may be necessary to use data from these reports in completing studies or reviews of provider-based activity. Such studies or reviews could be needed for internal CMS use, required by the Office of the Inspector General (OIG) or the U.S. General Accounting Office (GAO) investigators, or mandated by Congress. In any case, data from the reports would be handled in accordance with established standards under the Freedom of Information and Right to Privacy Acts as set forth in 42 CFR 401 Subpart B.

17. Expiration Date

CMS will display the expiration date on the first page of the data collection instrument forms, in the upper right-hand corner.

18. Certification Statement

There are no exceptions to the certification statement.