

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**HCFA Management of Provider-Based  
Reimbursement to Hospitals**



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# EXECUTIVE SUMMARY

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## PURPOSE

To describe Health Care Financing Administration management of provider-based status for hospital owned entities.

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## BACKGROUND

Hospitals often purchase entities such as physician practices and nursing facilities. Under Medicare, such hospitals can account for their entities as free-standing or as part of the hospital. The latter arrangement is called “provider-based” status. In its program guidance, HCFA stated that provider-based status for hospital owned entities would increase costs for Medicare and its beneficiaries with no commensurate benefits. Therefore, the guidance stated that it is critical to designate only unquestionably qualified entities for provider-based status.

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## FINDINGS

### **Regional offices do not consistently follow HCFA processes for review and approval of provider-based status**

The HCFA regions use different processes and standards, and require varying levels of documentation for approving provider-based status for hospital owned entities. For example, some regions accept hospital self-attestation that their entities meet HCFA criteria for provider-based status. Others, however, do a detailed review to ascertain qualifications for the status. Some regions obtain assistance from HCFA intermediaries and State licensure agencies, as required, and others do not. The inconsistencies occur both within and among regional offices.

### **HCFA data systems are inadequate for managing hospital use of provider-based status**

Neither HCFA headquarters nor regional offices could furnish reliable data showing hospital requests or approvals for provider-based status. More importantly, HCFA could not determine, from existing data systems, which hospitals were improperly claiming the status and billing Medicare under the higher cost provider-based rules. Such basic data is essential for assuring that only qualified hospital owned entities are approved, and for identifying unqualified hospitals that bill Medicare under the provider-based rules.

## **Hospitals often bill for reimbursement under the provider-based rules without HCFA approval**

Hospitals often simply assume provider-based status for their off-site entities and bill Medicare without getting HCFA approval. Such practices are improper, but they often go undetected for several years. Further, when detected, HCFA policy guidance is widely interpreted as allowing only prospective payment corrections. Finally, no penalties are levied on hospitals who engage in the improper practice.

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## **CONCLUSION AND RECOMMENDATIONS**

**HCFA management of its provider-based determination process provides little or no assurance that only qualified hospital owned entities are approved.** Qualified hospitals benefit from provider-based designations for their off-site entities because they can shift overhead costs to them and receive higher Medicare reimbursement. HCFA recognized that provider-based designations for qualified hospital owned entities would increase costs for Medicare and its beneficiaries, with no commensurate benefits -- as compared to free-standing arrangements. However, the costs are unnecessarily further increased when unqualified hospital owned entities bill Medicare under the financially advantageous provider-based rules.

However, to assure that only qualified hospital entities receive provider-based status would likely require considerable resources by HCFA, its intermediaries, and State licensure agencies. This possibility, combined with the increased cost of qualified and unqualified hospitals, and no commensurate benefits for Medicare and its beneficiaries, raises serious questions about the merits of continuing the provider-based option for hospital owned entities.

Therefore, as recommended in our prior OIG report on physician practices, we recommend that HCFA **eliminate provider-based status as an accounting option for all types of hospital owned entities.**

If HCFA chooses to continue the use of provider-based status, it should

- ▶ **Impose severe and substantial penalties, as recommended in our prior report, when hospitals bill Medicare for unqualified medical entities they own.**
- ▶ **Revise and clarify its program policy and procedures.**
- ▶ **Develop reliable data systems for program management.**
- ▶ **Require that all hospitals claiming provider-based status reapply for that status.**

## AGENCY COMMENTS

The Health Care Financing Administration commented on our draft report. The full text of those comments are shown in appendix C.

In brief, HCFA did not agree with the recommendation to eliminate the provider-based program. Instead, HCFA supported our alternative recommendation to establish reliable systems to improve its management of the provider-based program. To that end, HCFA has initiated various actions, including revising regulations and procedures, implementing management data and control systems, and providing training for staff responsible for program administration and control.

The HCFA expressed concern about the administrative burden of full implementation of our recommendation to require all hospitals claiming provider-based status to reapply so that HCFA could assure they qualified for the benefit. Instead, HCFA plans a less burdensome, alternative approach to resolving that problem. Specifically, HCFA plans to assure that all new applicants qualify for the benefit. Further, when a complaint or other evidence indicates that an existing provider-based arrangement does not meet requirements, HCFA plans to reassess the hospital's qualifications for the benefit at that time.

While we believe that HCFA's planned corrective action will significantly strengthen their future management of the Medicare provider-based reimbursement provision, we are concerned that some problems described in our report will continue. Specifically, existing non-qualified hospitals will continue to bill Medicare under the cost advantageous provider-based rules until they are caught.

Therefore, we continue to believe that it is appropriate to require all hospitals to reapply. We recognized that there would be administrative costs associated with this requirement. However, we believe that such costs would be more than off-set by savings accruing from termination of inappropriate billings to the program.

# INTRODUCTION

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## PURPOSE

To describe Health Care Financing Administration management of provider-based status for hospital owned entities.

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## BACKGROUND

### Provider-based status for hospital reimbursement

Hospitals often purchase a variety of other medical entities such as physician practices, nursing facilities and home health agencies. Under Medicare, hospitals can account for medical entities they own as either free-standing or as part of the hospital. If a hospital accounts for an entity as part of the hospital, it is referred to as a “provider-based” arrangement. This is a cost accounting and allocation mechanism which requires Health Care Financing Administration (HCFA) approval.

### Benefits of provider-based status for the Medicare program and its beneficiaries

Prior to 2000, HCFA has recognized that provider-based status for hospitals has no benefit for Medicare or its beneficiaries. According to HCFA program guidance<sup>1</sup>, provider-based status actually increases the portion of a hospital’s general and administrative costs that are supported by Medicare, with no commensurate benefit to Medicare or its beneficiaries. The guidance further showed that Medicare payments for services in provider-based entities exceed what Medicare would have paid under free-standing status.

Medicare payments are higher largely because of the increased general and administrative costs supported by Medicare under provider-based rules. Hospitals can include such costs as reimbursable in their Medicare cost reports. Medicare reimburses such hospitals on an interim basis and reconciles the cost reports at the end of the reporting period. That reimbursement is under Part A of the program. Hospitals may also receive other reimbursement under Part B, such as clinical laboratory services.

Hospitals must exclude from their Medicare cost reports any overhead and administrative costs associated with services at their free-standing entities. Such costs associated with its free-standing entities must be shown as non-reimbursable on hospital cost reports to Medicare.

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<sup>1</sup>Program Memoranda A-96-7 dated August 1, 1996; A-98-15 dated May 1, 1998; and A-99-24 dated May 1, 1999 (see Appendix A)

Likewise, as documented in our September 1999 OIG report<sup>2</sup>, provider-based status often increases coinsurance costs for Medicare beneficiaries.

### **Prevalence of provider-based status**

Our September 1999 OIG report showed that HCFA and its Medicare contractors have little specific knowledge on the extent that provider-based designations have been requested and approved. The report showed, however, that hospitals are acquiring physician practices in significant numbers. While HCFA program guidance issued in 1996, 1998, and 1999 did not specify the prevalence, it showed that HCFA receives numerous requests from hospitals for provider-based status for their off-site entities.

### **Approval of provider-based status**

Considering the increased costs and absence of any recognized benefit to Medicare and its beneficiaries, HCFA declared in its program guidance that it is critical to designate only entities that are unquestionably qualified for provider-based status.

To this end, hospitals must request provider-based status from HCFA for entities they own. Only after receiving HCFA approval may a hospital legitimately claim provider-based status and bill Medicare for services provided in their off-site entities. The review and determination process calls for a written request, which specifies that an entity meets eight criteria published by HCFA in program policy guidance (see Appendix A).

HCFA's program guidance does not provide specific and detailed instructions or formats for requesting, approving, and disapproving provider-based status. It requires regional offices to make provider-based determinations with assistance from intermediaries and State licensure agencies. Typically, hospitals should submit requests to their intermediary, which remands the requests to HCFA for a determination. The program guidance does not specify the level of information needed from hospitals, types of assistance needed from intermediaries, or the depth of analysis.

On April 7, 2000, HCFA issued final regulations<sup>3</sup> which could affect the process for granting provider-based status for hospital owned entities. The regulations, prompted by an upcoming prospective payment system for hospital outpatient services, emphasize the fiscal impact of provider-based status on Medicare. They also present regulatory definitions for provider-based status, provider-based entities, and other terms. Further, the new regulations require a hospital to report its acquisitions to HCFA if the hospital wishes to obtain provider-based status for them. Finally, the April regulations revise the wording on whether or not Medicare and its beneficiaries benefit from provider-based designations. However, our review of the revised wording showed it makes no substantive changes that indicate an intended benefit to Medicare and its beneficiaries. The regulations appear, however, to enhance HCFA's control over which hospital owned entities receive approval to bill Medicare under the provider-based cost rules.

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<sup>2</sup>*Hospital Ownership of Physician Practices* (OEI-05-98-00110)

<sup>3</sup>The regulations were published with a 60-day comment period. They are to be effective July 1, 2000. However, the specific provisions on provider-based status are not effective until October 10, 2000.



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## METHODOLOGY

This report describes HCFA's management and oversight process<sup>4</sup> for assuring that only qualified hospital owned entities are approved for provider-based status as intended.

Our scope included HCFA headquarters, all HCFA regional offices, all fiscal intermediaries, and all State licensure agencies. We collected and analyzed data from February 1998 through January 1999. Where needed, we verified data through September 1999. At each location we reviewed policies, procedures, and practices for provider-based determinations, including HCFA's eight criteria. (See Appendix A.)

Our data collection methods included a combination of written surveys, personal interviews, and document searches. We used standardized survey questionnaires for collecting information on policies, procedures, and practices. We provided our questionnaires to HCFA regional offices and intermediaries by electronic mail, and to the State agencies by traditional mail. Table 1 shows the response rates to our questionnaire.

**Table 1**  
**Agency Response**

<b>Agency Type</b>	<b>Responses — Percent of Universe</b>
HCFA regional offices	10 of 10 (100%)
State licensure survey agencies (50 States, District of Columbia, and Puerto Rico)	44 of 52 (85%)
Medicare fiscal intermediaries	39 of 39 (100%)

In addition to the mail questionnaire, we made on-site inspections at three selected regional offices, three State agencies, and five intermediaries. Using our standardized questionnaire, we interviewed staff and officials at each site to determine what policies, procedures, guidance, and practices were actually followed in approving and disapproving provider-based status. At each location, we also reviewed and analyzed documentation on criteria, guidance, procedures, and practices for approving provider-based entities. Appendix B shows the specific locations of our on-site inspections.

Further, we analyzed 85 sample case files showing HCFA decisions on provider-based status for hospital owned entities. We obtained 70 files from intermediaries and 15 from HCFA regional offices. We reviewed the case files to identify what procedures were actually used and what resulted from reviewing, approving, and disapproving requests.

Our selection of the 85 case files was based almost entirely on availability of records. To illustrate, we requested 5 sample case files from each of the 39 Medicare intermediaries.

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<sup>4</sup>This report frequently refers to HCFA's provider-based process. That term encompasses HCFA's policy, instructions, protocol, practices, and procedures for reviewing, approving, disapproving, and tracking provider-based status for hospital owned entities.

To avoid anomalies, we requested files that documented typical determinations of provider-based or free-standing status. If each intermediary had provided our requested five cases, we would have reviewed a total of 195 cases. However, only 15 intermediaries could provide cases for our review. They provided a total of 70 cases. Twelve of those intermediaries provided at least the 5 case files we requested.

We also requested one case file from each HCFA regional office. In response, we received 15 cases -- 1 case each from 6 regions, 2 cases from 1 region, 3 cases from 1 region, and 4 cases from 1 region. One region provided no case files.

We integrated and compared information and data from HCFA, its intermediaries, States, and our case file review. The information and data, however, was scarce, incomplete, and often inconsistent. Accordingly, because of our concerns about data reliability we did not project the results of our survey and case file analysis. We used dBASE, excel, and manual worksheets as tools to help aggregate and analyze the data obtained.

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We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# FINDINGS

## Regional offices do not consistently follow HCFA processes for approving provider-based status

According to HCFA program guidance, its regional offices have responsibility for determining whether or not hospital owned entities qualify for provider-based status. In approving entities for provider-based status, HCFA regional offices are required to obtain assistance from Medicare intermediaries and State licensure agencies.

In practice, however, HCFA regions do not consistently carry out their responsibilities for approving provider-based status for hospital owned medical entities. The regions were inconsistent in applying criteria for provider-based status, using fiscal intermediary and State assistance, and documenting decisions. The inconsistencies occurred not only among regions, but within the same region.

The most common reason HCFA regional, intermediary, and State staffs gave for inconsistent application of the review process was that it is not clear. They said their respective roles and HCFAs eight criteria are not clear.

## The level and extent of review varies considerably within and among HCFA regions

Overall, our survey responses, interviews, documents searches, and case analysis showed that some HCFA regions perform a detailed, documented analysis in approving provider-based status for hospital owned entities. Others perform only a minimal review and do not document the basis for their decision.

**Variation within the same region:** In 1997, one HCFA region approved a hospital request for provider-based status for one of its entities. The approval was given only after a thorough review of the request and supporting documentation from the hospital. HCFA regional staff reviewed both the operations of the hospital and its entity. The regional office required the hospital to submit a detailed request along with supporting documentation addressing each of the eight HCFA criteria. For each of the eight criteria, the intermediary indicated compliance or noncompliance for provider-based status. Further, the hospital's request for provider-based status was signed by its Certified Public Accountant.

In 1998, this same region approved another hospital request for provider-based status for one of its entities. However, in this instance the approval was given after only minimal review. The hospital's request consisted of a simple one and one-third page, unsigned memorandum. Generally, the support was an assertion by the hospital that its entity met HCFA criteria. For four of the eight criteria, the hospital's assertion consisted of a single sentence statement. No additional support was furnished by the hospital, or requested by HCFA regional office staff.

**Variation among regions:** In 1998, another HCFA region approved a hospital request for provider-based status for seven off-site entities. In this example, the HCFA region gave approval after an extensive review of supporting documentation. The hospital submitted over 1,000 pages of supporting documentation before obtaining approval. Further, the case files show that HCFA and intermediary staff made considerable inquiries into the qualifications of the seven entities. To illustrate, the distance of each entity from the acquiring hospital was checked thoroughly and plotted on a map to assure compliance with HCFA criteria on proximity. Further, HCFA regional staff even required documentary evidence that each of the entities was accredited as claimed by the hospital.

Conversely, another region advised us that there is no requirement for establishing specific provider adherence to the provider-based approval process. This region relies mainly on self-attestation statements from hospitals as evidence that their entities qualify for provider-based status.

Similarly, an intermediary in another region described the process as primarily the hospital's self-attestation that their entities qualify for the status.

### **HCFA regions do not always use fiscal intermediaries and State licensure agencies in approving provider-based status**

The extent to which HCFA regional offices use assistance from Medicare intermediaries and State licensure agencies varied. Use of those important sources by HCFA in approving or disapproving provider-based status ranges from consistent involvement to total exclusion.

**HCFA fiscal intermediaries:** As HCFA contractors for Medicare reimbursement, the intermediaries are well positioned to contribute important information to HCFA regional offices for determining whether hospital owned entities are unquestionably qualified for provider-based status. They have routine interaction with hospitals on a wide range of Medicare issues that provide a sound understanding of hospital operations, including those of off-site entities. This knowledge is frequently reinforced and enhanced as a result of reviewing hospital cost reports and conducting routine audits.

At the time of our inspection, HCFA used 39 fiscal intermediaries to pay Medicare claims for Part A medical services. Despite HCFA program memoranda requiring their assistance in approving provider-based status for hospital owned entities, 16 intermediaries reported not being involved in the approval process.

Additionally, 13 of the remaining 23 intermediaries that did have a role in the approval process said that their role was not clear and inconsistently carried out.

Staff at one intermediary specifically described three different practices by three HCFA regions for using the intermediaries to help determine if hospital owned entities qualified for provider-based status. The intermediary serves medical providers in each of the three different HCFA regions.

- The first HCFA regional office typically approved newly licensed entities as free-standing, and instructed the owning hospital to request provider-based status from the intermediary.
- The second regional office approved hospital owned entities for provider-based status contingent on the intermediary review and finding.
- The third regional office approved hospital owned entities for provider-based status without any consideration of the intermediary.

**State licensure agencies:** State licensure agencies routinely review hospitals and various other types of medical facilities for licensing and Medicare certification purposes. These functions frequently involve on-site inspections of hospitals and entities they own. Therefore, State agencies are well positioned to assist HCFA in making provider-based determinations.

However, HCFA regional offices frequently do not use the assistance of States. For example, only 20 of the 44 State agencies that responded to our questions said they make on-site reviews of hospital owned entities in support of HCFA determinations. Of those agencies, 16 said they made recommendations to HCFA or its intermediaries for approval or disapproval for provider-based status. Staff in 3 State agencies that do not make site visits also said they make a recommendation, but it is based on their general knowledge of the hospitals. One of the 19 States that make recommendations told us they recently discontinued their involvement in the approval process because HCFA told them to do so.

Of the 44 State agencies, 15 said their responsibilities in the approval process is unclear. Many of the remaining 29 States did not provide clear information on their role.

### **Provider-based decisions are not always documented**

The HCFA regions and intermediaries often do not document their decisions for or against provider-based status, and the basis for those decisions. At least one region had issued guidance to intermediaries requiring them to document provider-based decisions. That region required intermediaries to document, at a minimum, that they had applied each of HCFAs eight criteria in determining provider-based status for hospital owned entities. The region allowed flexibility to do so in a checklist, summary, or other method. However, many of the files we reviewed contained no such documentation.

To illustrate, our analysis showed that of the 85 case files we reviewed, HCFA regions determined that 55 entities (65 percent) were qualified for provider-based status, and 20 (23 percent) were free-standing. Files for five cases contained inadequate documentation to determine if HCFA had approved or disapproved the application. The remaining five cases were incorrectly provided to us. They were for provider enrollment and change of ownership rather than determinations of provider-based status, as we had requested.

Of the 75 case files that showed the approval or disapproval decision, 26 contained clear documentation for the basis of the decisions. About half of the 26 decisions were for provider-based status and half were for free-standing status. The files for 15 of the 75

determinations contained only minimal documentation, but we could ascertain that a decision had been made. On the other hand, the files for the remaining 34 determinations did not contain supporting documentation for the decision. Documentation was either missing altogether from the case files, or insufficient to determine how the decisions were reached. HCFA regional offices, however, had approved a clear majority (28) of those 34 cases for provider-based status.

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## **HCFA data systems are inadequate for managing the provider-based review process**

Neither HCFA headquarters nor regional offices could furnish reliable data on provider-based determinations. For example, from the data HCFA provided, we could not ascertain the number of

- hospitals requesting provider-based status,
- hospitals that had been approved for provider-based status,
- hospitals that had been rejected or disapproved for provider-based status, and
- hospitals that simply billed Medicare under the provider-based rules without notifying HCFA.

Timely availability of such basic data is essential for sound program management. Without it, HCFA is unable to provide needed program oversight to assure appropriate costs and impacts for the Medicare Trust Funds and beneficiaries. Further, without basic data showing approvals of hospitals for provider-based status, HCFA's fiscal intermediaries can not assure that off-site entities are properly accounted for in hospital cost reports. Finally, without such basic management data, HCFA is highly vulnerable to improper Medicare Trust Fund reimbursements.

### **HCFA can not identify hospitals that have requested and been approved for provider-based status**

HCFA program guidance does not fix responsibility on which organization (HCFA central office, its regions, its fiscal intermediaries, or State licensure agencies) should maintain records on provider-based determinations. Our inspection showed that none of the organizations maintained complete and accurate records. Therefore, HCFA does not have such basic data as which hospitals have requested and been approved for provider-based status.

First, HCFA headquarters does not maintain a data base or other record-keeping system showing which hospitals have properly applied for and received approval for provider-based status for entities they own.

Second, data bases at HCFA regional offices either do not exist, or they are clearly incomplete. For example, of the 10 HCFA regional offices, only 2 had data bases that

listed hospitals which had requested provider-based status for off-site entities. Another regional office could only manually retrieve copies of some of their provider-based determination notices. The staff in this region told us they were unable to identify all provider-based determinations.

Third, such data is not consistently maintained by HCFA fiscal intermediaries. Only 11 of the 39 intermediaries told us that they have a data base or other record-keeping system from which provider-based entities can be identified. Typically, the other intermediaries relied on manual searches of their files, or less reliable methods such as the knowledge or recollections of various staff persons. For example, we requested 5 case files for CY 1997 from each of the 39 intermediaries. Out of a possible 195 files, we received 70 from 15 intermediaries. Generally, the missing cases were not maintained or were not accounted for by intermediaries. For example, eight intermediaries could furnish no case files, although they told us that they had assisted HCFA with 16 determinations. Another 5 intermediaries furnished 11 files, but said they actually assisted HCFA in 13 decisions.

Finally, State licensure agencies do not maintain data on hospitals that have requested or obtained provider-based status for their off-site entities. Of the 44 State agencies that responded to our survey, only 4 told us they have a data base from which they can retrieve information on provider-based status. Of those four agencies, none could provide us with case-specific data. For example, we could not always determine, from the State provided data, if hospital owned entities had been approved for provider-based status. In instances where approval was clear, we could not ascertain when it occurred.

### **HCFA efforts to identify hospitals that bill for provider-based reimbursement for off-site entities have generally been unsuccessful**

Staff in 7 of the 10 HCFA regional offices said they had tried several ways to identify hospitals that bill for provider-based entities. Four of the seven had specifically directed intermediaries to identify hospitals that are billing for provider-based reimbursements for off-site entities. They said that they had been generally unsuccessful.

Staff in 3 of the 10 regions gave various reasons for not attempting to identify hospitals that were billing for provider-based reimbursement for their entities. For example, two regions said HCFA had not mandated or funded initiatives for this purpose and another said they had no consistent way of collecting such information.

Likewise, HCFA intermediaries have been generally unsuccessful in identifying hospitals that are claiming provider-based status for their entities. Of the 39 intermediaries, only 18 said they had taken specific action to determine which hospitals are claiming provider-based status for their off-site entities rather than free-standing status. However, they reported generally unsuccessful results. For example, some of the intermediaries had surveyed hospitals in their jurisdiction, but only a few responded. Of those that responded, their responses were often nonspecific. Some intermediaries sent inspection teams to the hospitals. However, even these intermediaries could not provide a complete listing of hospitals in their jurisdictions that were claiming provider-based reimbursement for their off-site entities.

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## Hospitals often bill for provider-based Medicare reimbursement without approval

Overall, the system for approving provider-based arrangements for hospital owned entities does not work very well. As a result, Medicare incurs excessive costs. Because data systems were incomplete or nonexistent, we were unable to quantify the excessive costs. However, data from certain regions and intermediaries suggest that those costs could be substantial.

Hospitals are required to obtain HCFA approval before billing for Medicare reimbursement under the provider-based accounting rules. However, in practice, many HCFA and intermediary staff stated that hospitals do not obtain approval from HCFA. They said hospitals simply assume provider-based status for their entities and bill Medicare accordingly. Such billing is inappropriate. In some instances, HCFA intermediaries do not detect that the hospitals are billing Medicare under the higher cost provider-based rules until after several years have elapsed. Further, when improper payments are made under the provider-based rules, intermediaries reported to us that they typically make only prospective corrections.

### **The number of improperly designated medical entities is unknown, but may be substantial**

Numerous intermediary staff told us that hospitals frequently bill Medicare under the provider-based rules without HCFA approval. Intermediary staff also said that, in many such instances, the hospital owned entities do not meet HCFA criteria. Neither HCFA nor its intermediaries had data or information showing the extent of this practice nationally. However, the examples below indicate that the practice may be extensive.

Data at one intermediary showed that 213 hospital owned entities claimed provider-based status during 1997 and early 1998. The hospitals had properly requested provider-based status for only 5 of those. The hospitals had, without HCFA approval, assumed provider-based status for the remaining 208 entities and billed Medicare under the provider-based rules.

After learning about the 208 designations through its hospital audits, the intermediary and HCFA staff reviewed and approved 185 of them for provider-based status. The HCFA regional office disapproved the remaining 28. Therefore, 14 percent of the entities for which hospitals had improperly assumed provider-based status were unqualified for Medicare reimbursement under the provider-based rules.

Likewise, data provided by another intermediary showed that 58 entities claimed provider-based status during 1997 and early 1998. Only 2 of the 58 had been properly requested in advance. The remaining 56 were assumed by hospitals without approval. Subsequently, HCFA disapproved 45 of the 56 entities for which hospitals had improperly assumed provider-based status. Therefore, 80 percent of the entities for which hospitals merely assumed provider-based status in this State were unqualified for reimbursement under the provider-based rules.



Additionally, after learning of these improperly assumed designations, the intermediary referred 6 of the 56 entities for Medicare program integrity investigations. The referrals were based on failure to meet an essential Medicare program requirement for off-site entities. As of September 1999, the intermediary was in the process of determining overpayments made in connection with those cases.

In another HCFA region, a fiscal intermediary initiated a comprehensive effort to identify hospital owned entities that billed Medicare under the provider-based rules. According to intermediary staff, this review disclosed numerous hospitals that were reimbursed under the provider-based rules, but should have been reimbursed under the less costly free-standing rules. The intermediary could not furnish specific numbers.

A fiscal intermediary in another region conducted a similar review of provider-based entities owned by 23 hospitals in one State. That intermediary found one entity that was receiving Medicare reimbursement under the provider-based rules, but should have been receiving it under the free-standing rules.

### **Improperly designated medical entities and the resulting incorrect Medicare payments may go undetected for years**

When a hospital improperly assumes provider-based status for an unqualified entity, it may collect improper Medicare payments until the intermediary learns of, and corrects the improper designation. The intermediary typically learns of such improperly designated entities after the fact through its audit process.

In some instances, the audit process may not disclose improperly designated provider-based status and improper billings for hospital owned entities for years. For example, our review of case files for 50 hospital owned entities from one intermediary showed that at least 4 had been improperly billing Medicare under the financially advantageous provider-based rules for between 4 and 6 years.

### **The cost of improperly designated provider-based entities is unknown, but could be substantial**

Because of the absence of complete, reliable records, we did not determine the extent of improper payments for unqualified entities. HCFA, its intermediaries, and States had no reliable data for comparing the costs of operating hospital owned entities under provider-based rules versus operating them under the rules for free-standing entities.

However, one HCFA region provided an estimate by one hospital that gives an indication of the financially advantageous reimbursement under the provider-based rules as compared to free-standing rules.

In this example, HCFA determined that a hospital owned medical entity was actually a free-standing entity rather than a provider-based entity. Therefore, the hospital was not allowed to claim Medicare reimbursement under the provider-based rules. Instead, it had to claim reimbursement under the free-standing rules. The hospital appealed HCFA's decision. In its appeal, the hospital estimated that HCFA's denial had cost it \$440,000 over an 8-month period. That estimate was the difference between Medicare Part B

reimbursement to the entity as a free-standing entity and what Medicare would have reimbursed had the entity been classified under the provider-based accounting rules.

To the extent that the estimate by that hospital is reliable, the excessive cost for numerous unqualified hospital owned entities billing under the provider-based rules would be considerable. As shown above, hospitals often improperly bill Medicare for provider-based status, and incorrect payments may be undetected for years.

### **Retroactive adjustments of improper payments for provider-based status are typically not made**

Staff at all HCFA regional offices, most intermediaries, and most State licensure agencies told us that controls are needed to prevent hospitals from improperly billing Medicare for entities that do not qualify for provider-based status. As shown earlier, hospitals often improperly assume provider-based status for their entities and bill Medicare under the more costly provider-based rules. HCFA does not have authority to impose penalties on such hospitals. Further, when HCFA learns of such improper payments, it typically does not retroactively adjust Medicare reimbursements. As a result, hospitals have little or no incentive to assure that their entities are unquestionably qualified for the financially advantageous reimbursements under provider-based status.

The majority of Medicare intermediaries typically do not make retroactive adjustments of Medicare payments when they find that a hospital has been improperly reimbursed under the provider-based rules. Those improper payments occur because the hospital should have been reimbursed under the less costly free-standing rules. We asked the 39 intermediaries if they make retroactive adjustments when they discover through audits or other means that a hospital had been improperly reimbursed. Of the 39 intermediaries, 30 answered our question. Of those 30 intermediaries, 21 said they do not make retroactive adjustments, and only 9 said they make such adjustments.

Data on provider-based status was incomplete and our attempts to ascertain the impact of not retroactively adjusting for improper Medicare payments was unsuccessful. However, the impact could be significant based on anecdotal examples provided by a few of the 21 intermediaries that clearly stated they do not retroactively adjustment payments. To illustrate, 3 of the 21 intermediaries told us they did not retroactively adjust Medicare payments to numerous hospitals for 68 hospital owned entities. Through the audit process, the intermediaries learned that the hospitals had billed under the provider-based rules for the 68 entities, but should have billed under the free-standing rules.

Partly, this problem stems from a lack of consistent understanding among HCFA regions and intermediaries on what HCFA program guidance is relative to retroactive adjustments. The following examples illustrate the widely divergent views on HCFA program guidance relative to retroactive adjustments of payments for hospital owned entities. Three intermediaries interpreted HCFA guidance to mean no adjustment even though the hospitals had billed Medicare under the provider-based rules without HCFA approval. Similarly, one HCFA regional office staff said they were not familiar with authority to make a retroactive adjustment.

Conversely, another HCFA regional office interpreted the guidance to allow a retroactive adjustment unless HCFA had previously made an incorrect determination of provider-based status. If HCFA had made the improper determination, the region felt it could not make a retroactive adjustment. This interpretation precludes retroactive adjusted payments when a hospital improperly assumes provider-based status. As shown earlier in this report, hospitals often do not ask HCFA for a determination. They simply assume provider-based status and bill Medicare accordingly.

In its new regulations which could revise the provider-based rules, HCFA has included language on retroactive adjustments or recovery of overpayments. However, staff at several intermediaries said that reclassifying costs and correcting cost reports, as a means of adjusting for improper payments, was an over-simplification of the problem. Those intermediaries and many others stated that the more significant problems are inadequate controls for assuring consistent, accurate determinations of provider-based status, and inadequate safeguards to prevent hospitals from improperly billing Medicare for unqualified off-site entities.

## CONCLUSION AND RECOMMENDATIONS

**HCFA management of the process for granting provider-based status gives little or no assurance that only qualified hospital owned entities are approved.** The process often results in hospitals improperly billing Medicare for off-site entities that are not qualified for reimbursement under the higher cost provider-based rules. Further, when HCFA identifies improper Medicare reimbursements for unqualified hospital owned entities, it typically does not make retroactive adjustments. The extent of improperly designated provider-based entities and the resulting improper Medicare reimbursements is not readily determinable because of inadequate data systems. However, opinions from HCFA, fiscal intermediary, and State staffs, plus the limited data they could provide suggested that improper Medicare reimbursements are substantial.

In establishing procedures for granting provider-based status, HCFA recognized that the costs to both Medicare and its beneficiaries would be greater, with no commensurate benefits. However, hospitals benefit from the provider-based arrangement because they are allowed to shift overhead costs to their provider-based entities and receive higher Medicare reimbursement. For these reasons, in establishing procedures for granting provider-based status, HCFA stressed the importance of assuring that only unquestionably qualified hospital entities are approved.

Implementing needed systems for properly managing the provider-based provision would likely require considerable resource investments by HCFA, its fiscal intermediaries, and States. Considering this possibility, the recognized increased costs of the provider-based status for qualified and unqualified hospitals, and the absence of any commensurate benefit for Medicare and its beneficiaries, we question the merits of any additional expenditures on provider-based status for hospital owned entities.

Because of such concerns, we recommended in our September 1999 OIG report<sup>5</sup> that HCFA eliminate provider-based status as an option for physician practices. Our current inspection showed that the same concerns are applicable for all types of hospital owned entities, including physician practices, home health agencies, nursing homes, and others. Therefore, expanding on our prior recommendation,

**we recommend that HCFA eliminate provider-based status as an accounting option for all types of hospital owned entities.**

If HCFA chooses to continue use of the provider-based option for hospital owned entities, it should

- ▶ **Impose severe and substantial penalties, as recommended in our prior report, when hospitals bill Medicare for unqualified medical entities they own.** Penalties should provide an incentive for hospitals to request HCFA approval, as

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<sup>5</sup>*Hospital Ownership of Physician Practices* (OEI-05-98-00110)

required, before billing Medicare under provider-based rules. Penalties would reduce the incentive for hospitals to bill Medicare for unqualified entities.

- ▶ **Revise and clarify its program policy and procedures.** HCFA guidance should better define processes for requesting, approving, tracking, and evaluating provider-based status. Procedural guidance is needed to assure that HCFA regions, fiscal intermediaries, States, and hospitals understand eligibility criteria for provider-based status, and their respective roles in the approval process. Further, such clarification is needed to assure consistent application of eligibility criteria by HCFA regions, fiscal intermediaries, and States. The need for a consistent process related to recovery or non-recovery of reimbursement improperly claimed by hospitals is yet another reason clarification of policy and procedures would be beneficial.
- ▶ **Develop reliable data systems for program management.** At a minimum, data systems should identify hospitals that request provider-based status, hospitals that are approved, and those that simply assume the status without approval and bill Medicare inappropriately. Further, HCFA needs such basic data to evaluate the cost of provider-based arrangements versus the cost for free-standing medical entities.
- ▶ **Require that all hospitals claiming provider-based status reapply for that status.** Reapplication could be done on a one-time or periodic basis. It would give HCFA valuable information on which hospitals are being reimbursed under the financially advantageous provider-based rules. It would also allow HCFA an opportunity to assure that only unquestionably qualified hospitals are approved. Further, if HCFA establishes serious intent to control approval based on its eight criteria, some unqualified hospitals might not reapply. Finally, this option would give HCFA an opportunity to establish reliable baseline data for program management.

## AGENCY COMMENTS

The Health Care Financing Administration commented on our draft report. The full text of those comments are shown in appendix C.

In brief, HCFA did not agree with the recommendation to eliminate the provider-based program. Instead, HCFA supported our alternative recommendation to establish reliable systems to improve its management of the provider-based program. To that end, HCFA has initiated various actions, including revising regulations and procedures, implementing management data and control systems, and providing training for staff responsible for program administration and control.

The HCFA expressed concern about the administrative burden of full implementation of our recommendation to require all hospitals claiming provider-based status to reapply so that HCFA could assure they qualified for the benefit. Instead, HCFA plans a less burdensome, alternative approach to resolving that problem. Specifically, HCFA plans to assure that all new applicants qualify for the benefit. Further, when a complaint or other evidence indicates that an existing

provider-based arrangement does not meet requirements, HCFA plans to reassess the hospital's qualifications for the benefit at that time.

While we believe that HCFA's planned corrective action will significantly strengthen their future management of the Medicare provider-based reimbursement provision, we are concerned that some problems described in our report will continue. Specifically, existing non-qualified hospitals will continue to bill Medicare under the cost advantageous provider-based rules until they are caught.

Therefore, we continue to believe that it is appropriate to require all hospitals to reapply. We recognized that there would be administrative costs associated with this requirement. However, we believe that such costs would be more than off-set by savings accruing from termination of inappropriate billings to the program.

## Provider-Based Criteria

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**Program Memorandum (Intermediaries), HCFA Pub. 60A, Transmittal No. A-99-24  
May 1999**

**This Program Memorandum re-issues Program Memorandum A-98-15, dated May 1998. The only change is the discard date and contact person; all other material remains the same.**

**This Program Memorandum re-issues Program Memorandum A-96-7.**

SUBJECT: Policy Clarification: Provider-Based Designation

### PURPOSE:

The purpose of this program memorandum (PM) is to consolidate and clarify the Health Care Financing Administration's (HCFA's) policy regarding provider-based and free-standing designation decisions. The various elements of this policy have been issued previously in regulations, program manuals, and letters to HCFA regional offices (ROs) or providers. This policy applies to all such designation decisions regarding any provider of services under Medicare, including physician's practices or clinics that state they are part of a provider.

### BACKGROUND:

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, e.g., a hospital-based skilled nursing facility. 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, 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.

For example, some hospitals are purchasing physicians' clinics and multiple clinics in areas far from the licensed hospital and designating the clinics as "outpatient departments" of the hospital. If Medicare were to approve such designation as an "outpatient department" the hospital would then be allowed to increase Medicare payments by shifting overhead costs to the "outpatient department" and by increasing payments for indirect medical education. In addition to the

## Provider-Based Criteria

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payment impact, the Medicare coverage of “incident-to” services would also be affected if a physician’s office is redesignated as a hospital outpatient department.

Medicare beneficiaries are also subject to an increased financial liability. In the example above of a hospital acquired physician practice, the beneficiary pays the usual deductible and co-insurance for physician services which are capped by the physician fee schedule. He is also responsible for a second deductible and co-insurance for a “clinic visit” or “facility fee” to the hospital.

These charges are not subject to the Medicare allowable charge or limiting charge restrictions of a physician’s office.

Moreover, 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. The statute at §1861(v)(1)(A) also provides general and specific criteria for developing payment rules to carry out the basic intent of the law as well as provisions when aggregate reimbursement produced by existing methodologies proves to be inadequate or excessive.

### POLICY STATEMENT:

It is HCFA’s policy that the following applicable requirements must be met before an entity can be designated as part of a provider for payment purposes:

1. The entity is physically located in close proximity of the provider where it is based, and both 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:
  - The entity is subject to common bylaws and operating decisions of the governing body of the provider where it is based;



## Provider-Based Criteria

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- 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
  - 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
  - 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:
- Professional staff of the provider-based entity have clinical privileges in the provider where it is based;
  - 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;
  - 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;
  - 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;
  - Patients treated at the provider-based entity are considered patients of the provider and have full access to all provider services; and
  - Patient services provided in the entity are integrated into corresponding inpatient and/or outpatient services, as appropriate, by the provider where it is based.

## Provider-Based Criteria

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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:

- The entity and the provider where it is based have an agreement for the sharing of income and expenses; and
- 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:

Determinations concerning whether an entity is provider-based (e.g., common licensure, governance, professional supervision criteria, reimbursement and accounting information) will be made by the appropriate HCFA RO components, i.e., the RO Division of Health Standards and Quality and the RO Division of Medicare with the assistance of the State survey agencies and the fiscal intermediary.

Please note that the issuance of this clarifying instruction may result in identification of previous provider-based decisions that would not be in accordance with the criteria described in this PM. In those instances, the ROs are not precluded from taking a corrective action on such erroneous designation/determinations. However, any corrective action is to be applied prospectively.

**This Program Memorandum may be discarded May 31, 2000.**

**For further information, please contact George Morey at (410) 786-4653.**

## Locations of On-Site Inspections

We surveyed all HCFA regional offices, State agencies, and intermediaries. We also selected a limited sample for on-site inspections. We selected sites on the basis of accessibility. The table below identifies those selected.

### On-Site Inspections

Site	HCFA Region	Location
HCFA Regional Office	IV	Atlanta, Georgia
HCFA Regional Office	VII	Kansas City, Missouri
HCFA Regional Office	X	Seattle, Washington
Medicare Intermediary	III	Baltimore, Maryland
Medicare Intermediary	III	Richmond, Virginia
Medicare Intermediary	IV	Birmingham, Alabama
Medicare Intermediary	IV	Columbus, Georgia
Medicare Intermediary	IV	Durham, North Carolina
State Licensure Agency	III	Baltimore, Maryland
State Licensure Agency	III	Richmond, Virginia
State Licensure Agency	IV	Raleigh, North Carolina

## Agency Comments

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RECEIVED

The Administrator  
Washington, D.C. 20201

DATE: JUL 19 2000

2000 JUL 20 AM 11:01

TO: June Gibbs Brown  
Inspector General

OFFICE OF INSPECTOR  
GENERAL

FROM: Nancy-Ann Min DeParle  
Administrator

*Nancy-Ann DeParle*

SUBJECT: Office of the Inspector General (OIG) Draft Report: "HCFA Management of  
Provider-Based Reimbursement to Hospitals" (OEI-04-97-00090)

Thank you for the opportunity to review and comment on the above-referenced report. The purpose of OIG's inspection was to analyze and describe the Health Care Financing Administration's (HCFA) management of provider-based status for hospital-owned entities.

The provider-based program is a critical part of HCFA's program that does increase beneficiary protections and improve access to care. In fact, many provider-based entities provide services that are enhanced relative to free-standing entities and that are virtually identical to those provided in the main portion of hospitals. Also, under new regulations, we also clarify the obligations that provider-based entities must fulfill (including compliance with the Emergency Medical Treatment and Active Labor Act at the provider-based entity).

We agree HCFA should take steps to improve the management of the provider-based determinations. In fact, as you can see in the attached response, we have already begun this process. Our detailed comments on the OIG's recommendations are attached.

We appreciate the effort that went into this report. Again, thank you for the opportunity to review and comment.

Attachment

IG	_____
E/IG	_____
PDIG	_____
DIG-AS	_____
DIG-EI	_____
DIG-OI	_____
DIG-MP	_____
OCIG	_____
ExecSec	_____
Date Sent	<i>7/20/00</i>

Comments of the Health Care Financing Administration on the OIG Draft Report: "HCFA  
Management of Provider-Based Reimbursement to Hospitals"  
(OEI-04-97-00090)

OIG Recommendation

HCFA should eliminate provider-based status as an accounting option for all types of hospital-owned entities. Alternatively, if HCFA continues with provider-based status, the agency should take steps to improve the management of the program.

HCFA Response

We agree that HCFA should continue to protect our beneficiaries and the Medicare Trust Fund by taking steps to improve the management of the provider-based program. The provider-based program is a critical part of HCFA's program that does increase beneficiary protections. We also believe that provider-based entities can improve access to care. In fact, many provider-based entities provide services that are enhanced relative to free-standing entities and that are virtually identical to those provided in the main portion of hospitals.

In order to accommodate for the financial and clinical integration of the main provider and a subordinate entity, HCFA has permitted certain subordinate entities to be considered provider-based. The determination of provider-based status allows the main provider to achieve certain economies of scale. To the extent that overhead costs (such as housekeeping) of the main provider are shared by the subordinate entity those costs are appropriately allowed to flow through the cost allocation process in the hospital cost report to the subordinate entity. Therefore, where there is a true provider-based relationship as defined in the regulations, and not just that the entity is owned by the main provider, it is appropriate for Medicare to adjust payments to the provider-based entity to account for those costs.

We have already taken significant steps to strengthen administration of this provision and we will continue to take additional actions.

For example, in the Outpatient Prospective Payment System (PPS) final rule published April 7 in the Federal Register (68 FR 18504 - 18524), HCFA provided clear rules for defining provider-based entities. Specifically, this final rule served to consolidate HCFA's policy outlined in previously published documents regarding provider-based status (Program Memorandum A-96-7, A-98-15 and A-99-24; section 2446 of the Provider Reimbursement Manual, Part I; and section 2004 of the State Operations Manual) in order to generate a unified general set of regulatory criteria for the designation of provider-based status for virtually all facilities or organizations. Also, under the new regulations, we also clarify the obligations that provider-based entities bears (including compliance with the Emergency Medical Treatment and Active Labor Act at the provider-based entity), and to accord payment at appropriate levels where the qualifications and obligations are met.

In addition to setting forth clear rules, we will continue to train HCFA, state survey agency, and intermediary staff on the new provisions of the regulation to ensure that there is a consistent application of the policy. Also, we will also work to educate the provider community through educational materials, training sessions, and technical assistance.

We believe that our concrete actions of issuing new criteria through regulation and training the public and our staff on the new policy will greatly improve the provider-based process. We will achieve our goal of helping beneficiaries by preserving their access to care and ensuring that no unnecessary increases in beneficiary liability for deductibles or coinsurance occur, while securing the Medicare Trust Fund.

OIG Recommendation

If HCFA continues with provider-based status, the agency should take a series of steps to improve the management of the program. HCFA should:

1. Impose severe and substantial penalties when hospitals bill Medicare for unqualified medical entities they own;
2. Revise and clarify its program policy and procedures;
3. Develop reliable data systems for program management; and,
4. Require that all hospitals claiming provider-based status reapply for that status.

HCFA Response

Overall, we concur. As discussed earlier, we believe that where a valid provider-based determination has been made, it is appropriate for Medicare to provide for additional payments to the provider-based entity. We believe the concrete steps we have already taken will greatly improve the management of the provider-based program. We will carefully monitor the effect of the improved criteria and implementation strategy regarding provider-based status to ensure Medicare's integrity. We will continue to work hard to resolve any issues and develop improved policies and approaches as needed. Specific responses to each recommendation follow.

1. *HCFA should impose severe and substantial penalties when hospitals bill Medicare for unqualified medical entities they own.*

We concur. Improper billing undermines the integrity of the Medicare program, and HCFA, with the help of OIG, has established a solid record of combating fraud and abuse. HCFA has outlined policy and procedures for the treatment of providers that improperly bill Medicare for an entity as provider-based under the new regulations at 42 CFR section 413.65(i), (j), and (k). Specifically, if we find that a facility or organization is improperly being treated as provider-based, we will adjust future payments to avoid overpayments, and review and recover previous payments (if necessary). Any recovery efforts for those cost-reporting periods subject to reopening will be performed in accordance with applicable law and regulations on overpayment recovery.

We will review the status of specific facilities or organizations in response to complaints or any other credible information that indicates that provider-based status requirements are not being met. Any improper reimbursement made by HCFA as a result of the main provider billing for an unqualified provider-based entity will be reconsidered and adjusted in accordance with applicable law and regulations on overpayment recovery under 42 CFR section 413.65. In addition, effective under our new regulations on October 10, HCFA will require that providers receive an affirmative provider-based status determination prior to the billing of any facility or organization as provider-based.

It should be noted that we do not believe that HCFA has any other authority to penalize the provider-based entity. However, if HCFA finds evidence of intentional wrong doing, we will certainly refer those findings to appropriate law enforcement agencies, including OIG.

*2. HCFA should revise and clarify its program policy and procedures.*

We concur. As explained above, we have already revised and clarified our program policy and procedures regarding provider-based entities. The criteria for provider-based status determination is outlined in the April 7, 2000 Outpatient PPS final rule (68 FR 18504 - 18524) and the addition of 42 CFR section 413.65 provides assurance that only qualified hospital-owned entities are approved. A facility or organization will not be treated as provider-based simply because it or the main provider believes it to be provider-based. Effective October 10, main providers and provider-based facilities or organizations will be required by regulation to meet the requirements set forth in section 413.65. Many of the criteria and requirements outlined in section 413.65(e) and (d), such as the reporting requirements of the main provider, are designed to be a signal that there may need to be a review of the facility's or organization's provider-based status.

The responsibility for consistent administration of provider-based determinations will fall primarily on the HCFA regional offices (ROs), based on the policy outlined in the April 7 final rule. Involvement by other entities, such as fiscal intermediaries (FIs) or state agencies, will be needed for assistance with the gathering of information regarding provider-based status. We plan to ensure that all HCFA staff and intermediaries involved in provider-based determination activities receive the necessary training and expertise required to carry out the policy set forth under section 413.65.

*3. HCFA should develop reliable data systems for program management.*

We concur. HCFA is developing a clear approval process that the ROs will utilize for provider-based status determination. The ROs will rely on the assistance from FIs and state agencies where needed. The information furnished in accordance with the provider-based determination requirements outlined in section 413.65(d) will serve as the data needed to evaluate provider-based arrangements versus freestanding medical entities.



*4. HCFA should require that all hospitals claiming provider-based status reapply for that status.*

We agree that it is critical to assure that only qualified entities receive provider-based status. That is why we have made some changes to the regulations. First, effective October 10, a main provider or a facility or organization that was not previously determined to be provider-based, must contact HCFA for a provider-based determination before the main provider bills for services of the facility or organization as if it was provider-based or before it includes costs of those services on its cost report.

Also, HCFA will review past determinations in response to complaints or any other credible information that indicates that provider-based status requirements are not being met. Provider-based status will become applicable as of the earliest date on which a request for provider-based status has been made and all requirements for provider-based status are shown to have been met. Providers denied provider-based status are encouraged to reapply once corrections to provider-based status eligibility requirements and criteria can be demonstrated. Additionally, providers seeking provider-based status for a facility or organization are afforded appeal rights. We will carefully consider and take other steps to protect program integrity as necessary. However, we are very concerned that requiring all hospitals to reapply for provider-based status would pose a significant administrative burden.