Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HOSPITAL OWNERSHIP OF PHYSICIAN PRACTICES

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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To examine the potential impact on the Medicare program and beneficiaries and the inherent fiscal vulnerabilities that exist from hospital ownership of physician practices.

BACKGROUND

As part of the changing healthcare market, hospitals as well as other entities have been purchasing physician practices. An outcome of these purchases is the ability of hospitals to obtain reimbursement for services provided in these practices. While hospitals have historically operated outpatient clinics on their campuses, many of the newly acquired practices are located in different cities or States and not on the hospital grounds. The location and operation of these clinics raise questions regarding the payment mechanism Medicare should use for the services provided by these purchased practices.

Hospitals have two options regarding how to account for their purchased physician practices. They can treat them as free-standing or as part of the hospital, referred to as provider-based. If a hospital treats the physician practice as part of the hospital, then the hospital can include the operating costs of the practice in the hospital's cost report. Medicare reimburses hospitals using interim payments which are reconciled with the hospital's actual costs at the end of the cost reporting period. The payments for these provider-based services are typically higher than the payment for services provided in a free-standing physician office.

If the hospital elects to treat the physician practice as free-standing, payments are made by the Medicare carrier using the Physician Fee Schedule. If the hospital provides any type of service to the practice, the hospital should establish a nonreimbursable cost center in its cost report to capture and exclude the costs associated with the practice.

Medicare needs to be aware of hospital purchases of physician practices and how these hospitals are accounting for and treating them in their cost reports. This information is needed to ensure that appropriate payments have been made.

FINDINGS

Hospitals are purchasing and operating physician practices in significant numbers

Based on our review, we estimate that 62 percent of for-profit and not-for-profit general, short-term hospitals purchased or owned a physician practice.

Fiscal intermediaries are frequently unaware of hospital ownership of physician practices

Of the hospitals we identified as owning physician practices, fiscal intermediaries (FIs) knew about the ownership 50 percent of the time. This lack of knowledge could lead to the inability of the FIs to ensure that physician practices are properly accounted for in hospital cost reports.

Lack of knowledge of hospital ownership of physician practices presents a fiscal vulnerability to the Medicare program

If a hospital chooses to handle a practice as provider-based and the practice meets the criteria for provider-based status, then Medicare requires the hospital to report the costs and charges of the practice as reimbursable services in the cost report. However, if a hospital fails to seek provider-based status for their practice, but claims the costs for the practice in the cost report, Medicare could be paying excessive amounts for services provided in the practice.

If the hospital elects to treat the physician practice as free-standing, the hospital excludes the costs of operating the practice from Medicare reimbursement through the cost report. Medicare requires the hospital to report the costs of operating the practices but must indicate that they are nonallowable costs. If a hospital fails to do so and the FI fails to detect the error, a substantial amount of Medicare reimbursement could be in question.

Most likely the FI would never discover these situations unless the FI conducted a full scale audit. Few hospitals are subject to full scale audits. The net result is that potentially overhead and operating costs for these purchased practices are paid twice or hospitals are receiving reimbursement for practices that do not meet the provider-based criteria.

Current HCFA efforts begin to address this issue, but may not go far enough

The Health Care Financing Administration (HCFA) has taken some steps to gather information about hospital purchase of physician practices although the steps are limited. Effective June 1998, hospitals were required to report to the FI's any current purchase of physician practices. They are not required to report past purchases.

Also, in December 1997, HCFA published proposed regulations changing the conditions of participation for hospitals. As part of the proposed regulations, HCFA would require that hospitals report purchases of physician practices if a hospital plans on seeking provider-based status for the practice. However, the regulations do not require that a hospital report a purchase of a physician practice if it elects to treat the practice as free-standing.

Provider-based status increases beneficiary coinsurance with questionable benefit to Medicare and its beneficiaries

The provider-based designation allows hospitals to shift costs to facilities subject to cost-based reimbursement. A provider-based designation results in increased Medicare payment with no apparent benefit for Medicare or the beneficiary. In addition, a beneficiary's coinsurance is higher for services furnished in provider-based physician practices than for services provided in free-standing physician practices.

If a hospital elects to treat a practice as provider-based, then a beneficiary is responsible for 20 percent of the hospital charges as well as 20 percent of the reduced Physician Fee Schedule for the physician's services. These payments are often two to three times greater than the coinsurance for services provided by a free-standing practice. If beneficiaries are being treated in facilities that do not meet the provider-based criteria, but hospitals are billing as if they did, then beneficiaries are paying excessive coinsurance amounts. Proposed regulations will change the methodology used to compute a beneficiary's coinsurance. However, for some outpatient services, this process may be lengthy and beneficiaries will be subject to artificially high coinsurance rates for the duration.

RECOMMENDATIONS

Provider-based status for hospital owned physician practices has a significant impact on both Medicare and its beneficiaries. At issue is whether the site, or ownership of the site, where the service is rendered should dictate a higher payment amount by the Medicare program and the beneficiary.

We recommend that HCFA change its policy and eliminate the provider-based designation for hospital owned physician practices.

The HCFA should require that hospitals treat all purchased physician practices and those they currently own, as free-standing entities. The HCFA could make exceptions for long-standing clinics located on contiguous hospital campuses. Monitoring of hospital compliance will be necessary. Procedures will need to be developed to ensure that hospitals are not billing for services provided by these entities and receiving payments other than under the Physician Fee Schedule.

Under the proposed outpatient prospective payment system, hospitals may continue to have an incentive to treat acquired physician practices as provider-based, since some rates may result in higher payment for services performed in provider-based facilities versus payment for those same services performed in free-standing facilities.

We recommend that HCFA require hospitals to report all purchases of physician practices or clinics and declare how the costs associated with the operation of these entities are handled in hospital cost reports.

Regardless of whether HCFA eliminates provider-based status, it will continue to be important that fiscal intermediaries be aware of current and past purchases of physician practices.

We offer solutions on how HCFA can implement this recommendation. We believe hospital purchases of physician practices are wide spread. Currently, neither HCFA nor its fiscal intermediaries have a good handle on whether hospitals are handling the operating costs associated with these purchases correctly in the cost reports.

We recommend that HCFA seek legislation to sanction hospitals for failure to report the ownership of physician practices.

Hospitals failing to inform HCFA or its fiscal intermediaries of the ownership and purchase of physician office practices, regardless of whether these physician offices are provider-based, free-standing or were past purchases, should be sanctioned.

AGENCY COMMENTS

We requested and received comments from the Health Care Financing Administration. Their comments are included in Appendix B. The HCFA concurred with two of our three recommendations. They did not concur with our recommendation to change its policy and eliminate provider-based designation for hospital owned physician practices.

The HCFA recognizes that the current system may result in abuse of Medicare's payment system in some cases. They state that it would be difficult to construct rules that differentiate physician practices from outpatient clinics to include one and exclude the other from designation as provider-based. In the long run, HCFA believes the most effective alternative to avoid abuse of the payment system is to move further toward the elimination of the differences in payments across sites that make advantageous the designation of physician practices as provider-based.

We appreciate HCFA's positive response to our report. We agree with their long-term plans of eliminating differences in payments for similar services across sites. However, we are uncertain whether the current set of provider-based standards, as well as the proposed set of regulations, can adequately safeguard Medicare's payment system. We are currently examining the process of designating facilities as provider-based. We hope that the results of this additional work will be helpful in resolving the problems that remain with the current system.

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INTRODUCTION

PURPOSE

To examine the potential impact on the Medicare program and beneficiaries and the inherent fiscal vulnerabilities that exist from hospital ownership of physician practices.

BACKGROUND

As part of the changing healthcare market, hospitals, as well as, other entities have been purchasing physician practices. For hospitals, one of the major reasons to purchase physician practices is to establish physician networks to compete with managed care products being offered by insurance companies. An outcome of these purchases is the ability for hospitals to obtain reimbursement for services provided in these practices.

While hospitals have historically operated outpatient clinics located on their campuses, many of the newly acquired practices are not located on the hospital grounds. Some of these newly acquired practices are located in different cities or States. The location and operation of these clinics raise questions regarding the payment methods Medicare should use for the services provided by these purchased practices.

Medicare Reimbursement Options

It is the Health Care Financing Administration's (HCFA's) policy that a hospital may treat an acquired physician practice as either provider-based or free-standing. The hospital's decision on how to treat the practice will affect the amount of payment received by the hospital for physician services rendered in the practice.

Option one is to treat the facility as provider-based. In essence, the hospital treats the purchased physician practice as if it were a hospital outpatient department. If the hospital wishes to treat the practice as provider-based, the hospital must submit an application to HCFA requesting provider-based status. The HCFA has established eight criteria that a physician practice must meet before HCFA grants provider-based status.[1] These criteria deal with such issues as: the physical location of the entity, the patient population served, and the type of control and governance exhibited by the hospital over the practice. (See Appendix A for the list of criteria.)

Once HCFA grants provider-based status, the hospital may receive reimbursement for services provided in the purchased facility using the reasonable cost reimbursement method. This is the same payment method used for services provided in hospital outpatient departments. Reimbursement for services in a provider-based practice, as well

[1] The Office of Inspector General is currently working on a report that examines how HCFA approves provider-based status.

as in a hospital outpatient department, generally include both a facility payment and a payment for the service or procedure performed. Under the reasonable cost reimbursement method, Medicare reimburses hospitals for either the costs or charges for services[2] provided by hospital outpatient departments or provider-based physician practices, whichever is lower. Medicare reimburses hospitals using interim payments which are reconciled with the hospital's actual costs at the end of the cost reporting period. To determine the costs of providing services, Medicare requires hospitals to file an annual cost report. Included in this cost report are all the overhead and operating costs associated with operating the hospital as well as any physician practices the hospital owns.

In addition, the hospital can also submit a separate claim to the Medicare carrier for the physician's professional services. Medicare pays for these services using the Physician Fee Schedule.[3] If the hospital properly codes the claim as provider-based, the Medicare carrier adjusts the amount paid for the practice's operating and overhead costs which have already been paid by the fiscal intermediary (FI) through the cost report. If the hospital does not properly code these claims, Medicare will erroneously pay overhead costs twice. The combined payments for these provider-based services are typically higher than the payment for services provided in a free-standing physician office.

Option two is to treat the facility as free-standing. If the hospital treats the purchased practice as a free-standing practice, then it does not have to meet any of HCFA's criteria for provider-based status. The hospital submits claims for services provided in the free-standing practice to the Medicare carrier which pays these claims under the Physician Fee Schedule.

The Physician Fee Schedule payment includes portions for both the physician's professional service as well as for the costs incurred in operating a physician's office. If a hospital provides any services to the free-standing practice, the hospital must establish a nonallowable cost center on their cost report that captures any costs [4] associated with operating the purchased physician practice.

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[2] The Congress has legislated a number of different payment methods for specific types of hospital outpatient services. The methods include a fee schedules for clinic laboratory services and payments based on blends of hospital costs and the rates paid in other ambulatory settings. Nevertheless, payment for services performed in a hospital outpatient setting remains largely cost-based.

[3] The Physician Fee Schedule consists of three main components, the physician's work, the practice expense and the malpractice insurance expenses. Physicians are paid under this fee schedule regardless of setting. The physician work and malpractice expense components are constants, irrespective of the setting in which the service is performed. However, for some services, the practice expense component is reduced by 50 percent when these services are provided outside the physician office setting. This is done because it is assumed that the practice expense component reflects the operating costs of the physician's office. When these services are performed in a hospital outpatient department or provider-based physician office, the physician office operating costs are subsumed in the facility payment.

[4] Examples of costs that hospitals should include in the nonreimbursable cost center are administrative services, medical records and maintenance.

These nonallowable costs are not reimbursable by Medicare because the Medicare carrier has already paid the hospital using the Physician Fee Schedule. The overall effect of nonallowable cost centers on a hospital cost report is to lower the outpatient costs claimed by the hospital. However, if the hospital does not identify the costs associated with operating a physician's practice as nonallowable then Medicare will reimburse the hospital twice.

METHODOLOGY

To examine the potential impact of hospital purchases of physician practices on the Medicare program, we selected a stratified random sample of 100 for-profit and 100 not-for-profit general, short-term hospitals.[5] We did not contact the sampled hospitals directly to question them regarding their purchase of physician practices. Rather, we identified whether the hospitals purchased practices through other means.

For our sampled hospitals, we used the following methods to determine whether there appeared to be an affiliation between our sampled hospitals and physician practices:

- An Internet search for any sites that discussed or showed the appearance of physician practices purchased or operated by our sampled hospitals.
- A phone book search of listings looking for physician practices that are advertising using logos, symbols or the names of our sampled hospitals.
- A request to the fiscal intermediaries for any information regarding the purchase or ownership of a physician practice by our sampled hospitals.
- A request to the HCFA regional office for any information they may have concerning the purchase or ownership of a physician practice by our sampled hospitals.
- A search of the American Hospital Association's (AHA's) data regarding hospital ownership of physician practices.

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

[5] We obtained a list of hospitals from HCFA's Online Survey and Certification Reporting System. The list contained 6,164 hospitals. We selected only general, short-term hospitals leaving us with a list of 5,093 hospitals. After further discussion, we decided to limit our analysis to not-for-profit and for-profit hospitals, excluding government owned hospitals. We selected our sample from this list of 3,610 hospitals.

FINDINGS

Hospitals are purchasing and operating physician practices in significant numbers

Based on our review of the Internet, phone book listings and information from the fiscal intermediaries, we estimate that 62 percent[6] of for-profit and not-for-profit general, short-term hospitals purchased or owned a physician practice. Using only AHA data gathered in 1996, our estimate decreases to 51 percent.[7]

Other information also indicates that ownership of physician practices by hospitals is significant. According to the Health Care Advisory Board, a group that serves chief executives and senior administrators of more than 1,400 hospitals and health systems, the number of physician practices owned or managed by a hospital rose from 4,126 practices in 1993 to 11,234 practices in 1995, an increase of 172 percent. In another study, the Center for Healthcare Industry Performance Studies surveyed hospitals, insurance companies, physician management companies and others about recent purchases of physician practices. Based on the results of their survey, hospitals were responsible for 83 percent of the purchased practices they reviewed.

Fiscal intermediaries are frequently unaware of hospital ownership of physician practices

Of the hospitals we identified as owning physician practices, the FIs knew about the ownership about 50 percent of the time. This lack of knowledge could lead to the inability of the FIs to ensure that hospitals are accounting for physician practices properly in hospital cost reports, resulting in excessive Medicare reimbursement. This vulnerability is discussed in our next finding.

At the time we were conducting our study, there was no requirement for hospitals to report to HCFA or the FIs the purchase of physician practices unless the hospital was requesting provider-based status for these practices.

In 1998, HCFA reports that few hospitals requested provider-based status. These situations are known to the FIs. Other ways fiscal intermediaries became aware of hospital owned physician practices were through a review of hospital marketing materials, newspaper articles or by word of mouth. In other cases, the FIs became aware of the ownership of a physician practice(s) while auditing the hospital cost report for other reasons or through beneficiary complaints.

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[6] ±6.48 at a 90 percent confidence level

[7] ±6.71 at a 90 percent confidence level

Lack of knowledge of hospital ownership of physician practices presents a fiscal vulnerability to the Medicare program

Fiscal intermediaries are often unaware of hospital owned physician practices and this handicaps their ability to ensure that hospitals have appropriately handled the costs associated with these practices in hospital cost reports. While we could not estimate the extent of inappropriate Medicare reimbursement caused by FIs being unaware of the purchase and ownership of physician practices, the potential amounts paid inappropriately could be substantial. Medicare losses can occur whenever hospitals, intentionally or not, inappropriately claim Medicare reimbursement for the operating costs of provider-based practices when their physician practices are, in reality, free-standing.

Provider-based cost report vulnerabilities

If a hospital chooses to handle a practice as provider-based and the practice meets the criteria for provider-based status, then Medicare requires the hospital to report the costs and charges of the practice as reimbursable services in the cost report to receive Medicare payment. However, if a hospital fails to seek provider-based status for their practice but claims the costs for the practice in the cost report, Medicare could be paying excessive amounts for services provided in the practice.

For example, Medicare reimbursed hospitals approximately $548 million for outpatient clinic services in Fiscal Year 1996. In some cases, hospitals may have included operating costs for physician practices that they purchased even though these practices do not meet the eight criteria for provider-based status. In these cases, some portion of the $548 million could have been reimbursed inappropriately. We do not mean to infer that the services provided in these situations were inappropriate, only that the method used to reimburse the hospital may have caused Medicare to pay more than it should.

Free-standing cost report vulnerabilities

If the hospital elects to treat the physician practice as free-standing, the hospital excludes the costs of operating the practice from Medicare reimbursement through the cost report. Medicare requires the hospital to report the costs of operating the practices but must indicate that they are nonallowable costs. If a hospital fails to do so and the FI fails to catch the mistake, a substantial amount of Medicare reimbursement could be in question.

For example, one hospital in our sample reported $903,658 in nonallowable costs for physician practices it owns. Using this amount for all hospitals that we believed owned physician practices but were unknown to the FIs, the potential amount that hospitals should have excluded from their reimbursable costs was $726 million.

If the $726 million was not excluded from total costs, Medicare would have reimbursed $86.4 million[8] inappropriately. This is not an estimate of program losses, but rather an example of the potential extent of the problem that could exist if FIs are unaware of hospital purchase and ownership of physician practices.

Difficulty in discovering these vulnerabilities

Most likely the FI would never discover these situations unless the FI conducted a full scale audit. Few hospitals are subject to full scale audits, possibly because the funding to conduct such audits may be prohibitive. The net result is that potentially overhead and operating costs for these purchased practices are paid twice or hospitals are receiving reimbursement for practices that do not meet the provider-based criteria.

The possibility exists that Medicare carriers may also be making excess payments for physician office services they believe are being provided in a free-standing facility, when in fact these services are being performed in a provider-based facility. Medicare carriers may be reimbursing physicians for office operating costs that have already been paid by the FI through interim payments.

In the future, HCFA is changing Medicare's payment method for outpatient services to that of a prospective payment system (similar to the way Medicare pays for hospital inpatient services). However, this does not remove the need for the fiscal intermediaries to be aware of hospital owned physician practices. The implementation of this new payment method would highlight the different payment rates between settings. As a result, decisions about where to provide services may become more dependent on which setting is more profitable, rather than which setting is most clinically appropriate. Thus, hospitals may continue to have an incentive to acquire and treat physician practices as provider-based.

Current HCFA efforts begin to address this issue, but may not go far enough

The HCFA is committed to gathering information about hospital purchase of physician practices. Through four separate actions, HCFA is beginning to collect information that may assist the fiscal intermediaries in determining whether hospitals are accounting for physician practices appropriately in their cost reports. Unfortunately, these efforts may fall short as they will not ensure that FIs are aware of hospitals' past and present purchases of physician practices or how hospitals are treating the operating costs of these practices in their cost reports.

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[8] Using Sudaan, a statistical package that accounts for stratified samples, we estimated that $726 million would represent the amount of money that should have been excluded from those hospital cost reports where the FI appeared to be unaware of the ownership of physician practices. We then estimated, using Fiscal Year (FY) 1996's Hospital Minimum Data Set, the percent of Medicare costs to Medicare charges for outpatient clinics. According to our calculations, this amounted to 11.9 percent. We then multiplied the $726 million by 11.9 percent to arrive at $86.4 million.

In May 1998, HCFA issued a program memorandum requiring hospitals, as part of the "Provider Cost Report Reimbursement Questionnaire" submitted with the annual cost report, to answer questions about whether the facility purchased a physician's practice. This was effective for cost reporting periods ending on or after June 30, 1998. The questions specifically target purchases for the cost reporting year being filed. It does not ask about practices that the hospital may have purchased in years prior to the current cost report year.

Entities, such as hospitals and physician practices, applying for a Medicare provider number must complete a provider enrollment application (HCFA 855). This form also solicits ownership information and providers may use this form, or some other means, to inform HCFA and its contractors of a change in ownership. Again, this document does not request information about past purchases.

In December 1997, HCFA published proposed regulations changing the conditions of participation for hospitals. As part of the proposed regulations, HCFA would require that hospitals report purchases of physician practices if they plan on seeking provider-based status for these practices.

Currently, HCFA uses eight criteria to determine whether a practice can be considered provider-based. These criteria are contained in a program memorandum published in August 1996 and again in May 1998. (See Appendix A for a list of the criteria.) As part of the proposed regulations for Outpatient Prospective Payment, HCFA proposes to set in regulation the criteria that facilities must meet to be considered part of the hospital for cost reporting purposes. Again, it will only require hospitals to notify HCFA if the hospital plans on seeking provider-based status for the physician practices.

The proposed regulations for Outpatient Prospective Payment also do not require a hospital to report the purchase of a physician practice if it elects to treat the practice as free-standing. The HCFA has acknowledged the vulnerability free-standing entities can present in its proposed regulations. To address this vulnerability, providers will be required "...to develop detailed work papers showing the exact cost of the services, including overhead, provided to or by the free-standing entity and show those carved out costs as non-reimbursable cost centers in the provider's trial balance." This should help alert FIs to hospitals' ownership and purchase of physician practices as long as the scope of the FI audit includes a review of this information.

Many, but not all, of the vulnerabilities mentioned in this report will be alleviated with passaged of the proposed outpatient prospective payment system regulations and if HCFA is able to enforce its provider-based policies, with respect to hospital purchased physician practices. Such will not be the case, however, if hospitals fail to: (1) report their physician practice purchases to the fiscal intermediaries, and (2) inappropriately claim overhead expenses for free-standing facilities in their cost report.

Provider-based status increases beneficiary coinsurance with questionable benefit to Medicare and its beneficiaries

The current system that provides for provider-based entities came about as a policy decision by HCFA to accommodate the integration of the financial operations of merging health care delivery systems, such as hospitals and clinics. Prior to the inpatient prospective payment system, hospitals could achieve greater economies of scale in overhead costs, thus provider-based designation was beneficial to both the Medicare program and hospitals. However, as hospitals looked for ways to increase Medicare revenues, they established provider-based facilities that were one of the few remaining methods hospitals could use to receive cost-based reimbursement. These cost-based facilities, such as outpatient clinics and physician practices, shifted costs to "increase Medicare payments with no commensurate benefit to the Medicare program or its beneficiaries."[9]

The coinsurance paid by Medicare beneficiaries for services provided by provider-based physician practices are higher than for services provided in free-standing physician practices. A beneficiary's coinsurance can vary substantially depending on how hospitals handle the physician practices they own. If a hospital treats a practice as free-standing, then a beneficiary is responsible for 20 percent of the full Physician Fee Schedule. However, if a hospital elects to treat a practice as provider-based then a beneficiary is responsible for 20 percent of the hospital charges as well as 20 percent of the reduced Physician Fee Schedule for the physician's services. The example in Table 1 demonstrates the impact on the beneficiary if a hospital elects to treat a practice as provider-based.

Table 1

Example Of Impact To Beneficiary Coinsurance By Type Of Facility

Patient Diagnosis and Procedure Performed: Male, age 70, is diagnosed with diabetes and leg ulcers. Procedure performed is debridement of ulcer.

Billing Provider	Service Description	Beneficiary Coinsurance	
		Provider-Based Facility	Free-Standing Facility
Hospital	Clinic & Treatment Room	$ 52.05	NONE
Physician	Office Visit	$ 8.83	$ 10.99
	Debridement	$ 10.93	$ 13.66
TOTAL BENEFICIARY PAYMENT		$ 71.81	$ 24.65

[9] Federal Register, Vol. 63, No 173, September 8, 1998, pg. 47,588.

In the example in Table 1, the beneficiary would incur a $71.81 coinsurance payment if the procedure is performed in a physician's office with provider-based status, as opposed to a $24.65 coinsurance payment if the same procedure is performed in a free-standing physician's office. The beneficiary in this example would have paid $47.16 more because the procedure was performed in a provider-based physician practice. It is likely that these same services could have been provided to the beneficiary in a free-standing physician's office with no adverse effects to the beneficiary. This situation also raises questions on why different payment methods should apply to the same services.

Medicare has recognized the unfair financial burden placed on beneficiaries when services are provided in a provider-based facility versus one that is free-standing. Proposed regulations for the outpatient prospective payment system, published in September 1998, changes the methodology for computing beneficiary coinsurance for hospital outpatient services. Currently, for some outpatient services, the beneficiary coinsurance equals 50 percent or more of the total Medicare payments to hospitals.[10] These proposed regulations will eventually transition the current beneficiary coinsurance to 20 percent of the prospective payment rate, rather than 20 percent of charges. However, for some outpatient services, this process may be lengthy and beneficiaries will be subject to artificially high coinsurance rates for the duration.

[10] Medicare payments to provider-based facilities are affected by the amount of coinsurance they collect from beneficiaries. The greater the provider-based facility charge to the patient the greater the patient coinsurance and the lower the Medicare payment.

RECOMMENDATIONS

Provider-based status for hospital owned physician practices has a significant impact on both Medicare and its beneficiaries. At issue is whether the site, or ownership of the site, where the service is rendered should dictate a higher payment amount by the Medicare program and the beneficiary.

Prospective payment for outpatient services will highlight for hospitals the different payment rates between service settings. Outpatient prospective payment rates may result in higher aggregate payments for some services performed in provider-based facilities versus payment for those same services performed in free-standing facilities.

We recommend that HCFA change its policy and eliminate the provider-based designation for hospital owned physician practices.

The HCFA should require that hospitals treat all purchased physician practices and those they currently own, as free-standing entities. This would financially benefit Medicare beneficiaries by eliminating the coinsurance inequities they are currently experiencing when they receive services in provider-based, rather than free-standing, facilities.

The Medicare Payment Advisory Commission in a March 1998 report expressed its concerns about the effects of inappropriate payment levels that, if too low, would restrict beneficiary access to care or prompt shifts of the site of services for financial rather than clinical reasons. On the other hand, they also expressed concern that if the rates are too high this would result in an increase in the volume of outpatient services that is unrelated to patient needs. They were also concerned regarding the impact on service delivery when Medicare pays different amounts based on the site of service. They believe that HCFA should move to a payment method that pays the same for the service provided regardless of the setting in which the service is performed.

The HCFA could make exceptions to their policy, but only if the hospital is able to demonstrate to the FI that the purchased physician practice is part of the hospital campus. The physician practice site is part of the hospital campus if it is located at contiguous buildings on the same campus and under common direction. The burden of proof to this fact should be born by the hospital.

We recognize that enforcement may be difficult. Because FIs perform a very limited number of hospital cost report audits on an annual basis, they must rely on the hospital, or happenstance, for information about hospital ownership of physician office practices. Therefore, monitoring of hospital compliance will be necessary. Even under prospective payment, procedures will need to be developed to ensure that hospitals are not billing for services provided by these entities and receiving payments other than under the Physician Fee Schedule.

We recommend that HCFA require hospitals to report all purchases of physician practices or clinics and declare how the costs associated with the operation of these entities are handled in hospital cost reports.

Regardless of whether HCFA eliminates provider-based status, it will continue to be important that fiscal intermediaries be aware of current and past purchases of physician practices.

We offer the following solutions to implement this recommendation:

1. Clarify the language on the "Provider Cost Report Reimbursement Questionnaire" to require hospitals to report the purchase of physician practices, including past purchases and those purchased by hospital subsidiaries.

2. Include in any proposed regulations requiring the reporting of hospital ownership of physician practices the reporting of past purchases and a declaration of whether these practices have been treated as provider-based or free-standing in the hospital's cost reports.

3. Conduct hospital surveys, using Medicare Integrity Program funds from the Health Insurance Portability and Accountability Act, to determine whether physician practices owned by hospitals are handled correctly in the cost report.

4. Direct the fiscal intermediaries to conduct focused audits of the hospitals we identified as having an ownership interest in physician practices of which the FIs were unaware.

5. Include the issue of hospital ownership of physician practices in the Quality Audit Program, the oversight program HCFA implemented to ensure that FIs are appropriately reviewing cost reports and correctly reimbursing hospitals.

This recommendation offers options on how to identify and ensure that hospitals are correctly handling the costs associated with the operation of physician practices. We recognize that HCFA is proposing regulations that will require hospitals to keep detailed work papers identifying the free-standing entities as non-reimbursable cost centers. This should help FIs identify cost associated with hospital purchased physician practices.

We recommend that HCFA seek legislation to be able to sanction hospitals for failure to report the ownership of physician practices.

Hospitals failing to inform HCFA or its fiscal intermediaries of the ownership or purchase of physician office practices, regardless of whether or not these physician offices are provider-based or free-standing, or were purchased in the past, should be sanctioned.

Continuing work

Equally as important as ensuring that FIs handle correctly the costs from the operation of these physician practices and reimburse appropriately, is the process that HCFA uses to determine if a physician practice meets the provider-based criteria. This issue is currently under review by the Office of Inspector General.

An additional area we plan to review includes whether physician services provided in provider-based facilities are appropriately billed to Medicare. We also plan to compare the payment for services performed in provider-based settings with those performed in free-standing settings. We will compare these payment rates to those proposed in the outpatient prospective payment regulations to determine which payment rates are higher.

AGENCY COMMENTS

We requested and received comments from the Health Care Financing Administration. Their comments are included in Appendix B. The HCFA concurred with two of our three recommendations. They did not concur with our recommendation to change its policy and eliminate provider-based designation for hospital owned physician practices.

The HCFA recognizes that the current system may result in abuse of Medicare's payment system in some cases. They state that it would be difficult to construct rules that differentiate physician practices from outpatient clinics to include one and exclude the other from designation as provider-based. In the long run, HCFA believes the most effective alternative to avoid abuse of the payment system is to move further toward the elimination of the differences in payments across sites that make advantageous the designation of physician practices as provider-based.

We appreciate HCFA's positive response to our report. We agree with their long-term plans of eliminating differences in payments for similar services across sites. However, we are uncertain whether the current set of provider-based standards, as well as the proposed set of regulations, can adequately safeguard Medicare's payment system. We are currently examining the process of designating facilities as provider-based. We hope that the results of this additional work will be helpful in resolving the problems that remain with the current system.

Provider-Based Criteria

Program Memorandum (Intermediaries), HCFA Pub. 60A, Transmittal No. A-96-7 August 1, 1996

Reissued as Transmittal N. A-98-15, (May 1, 1998)

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 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;

- 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.

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 PM may be discarded after JULY 31, 1997.

For further information, please contact David Goldberg at (410) 786-4512.

Deputy Admir
Washington, [

DATE: JUL 2 8 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Hospital Ownership of Physician Practices," (OEI-05-98-00110)

We appreciate the opportunity to review the above-subject draft report that focuses on some of the problems associated with hospital ownership of physician practices. The report found that hospitals are purchasing and operating physician practices in significant numbers and that fiscal intermediaries (FIs) are frequently unaware of these purchases. As a result, this lack of knowledge makes FIs unable to ensure that physician practices are properly accounted for in hospital cost reports.

Our detailed comments on the report recommendations follow.

OIG Recommendation
HCFA should change its policy and eliminate the provider-based designation for hospital owned physician practices.

HCFA Response
We do not concur. In general, we believe that encouraging integration of delivery systems is desirable, and development of provider-based entities can help serve this end in many instances. We are, nevertheless, cognizant that abuse of Medicare's payment system may result in some circumstances. To safeguard against such abuse, we have accordingly articulated a set of detailed standards that must be met for an entity to qualify as provider based. The standards require a substantial degree of clinical and managerial integration of the provider and the provider-based entity. We would not expect that a physician practice purchased by a hospital would qualify as provider-based in the absence of further changes to achieve such integration.

If the standards are met, it is not obvious how to distinguish physician practices from outpatie departments on functional grounds. Physicians practice in both settings, and the mix of services delivered in physician offices and outpatient departments is in many instances

quite similar. It would be difficult to construct rules that differentiate physician practices from outpatient clinics in order to include one and exclude the other from designation as provider-based.

The standards noted above are already in place in program memoranda. We proposed a revision, which will clarify and somewhat strengthen these standards, in the Notice of Proposed Rule Making for the hospital outpatient prospective payment system. The comment period on that notice has recently been extended to July 30, 1999. We will take the OIG's views into consideration as we review comments in preparing the final rule. We expect to finalize these provisions by early next year.

Over the long run, we continue to believe the most effective alternative to avoid abuse of the payment system is to move further toward elimination of the differences in payments across sites that make advantageous the designation of physician practices as hospital outpatient departments.

OIG Recommendation
HCFA should require hospitals to report all purchases of physician practices or clinics and declare how the costs associated with the operation of these entities are handled in hospital cost reports.

HCFA Response
We concur. The provider-based rules included in the outpatient prospective payment system proposed regulations would require all providers to report acquisition of all facilities or organizations they wish to claim as provider-based. Complementary requirements would be necessary to insure that hospitals report physician practices they own that are not provider-based. We will also review the options presented by the OIG in this report and will undertake as many of them as are feasible, given budgetary and legal constraints.

OIG Recommendation
HCFA should seek legislation to be able to sanction hospitals for failure to report the ownership of physician practices.

HCFA Response
We concur. Under current law, when a facility or entity improperly bills as provider-based, our only recourse is to recover the resulting overpayment. The provider does not have strong incentives to insure billings are appropriate. Authority to impose sanctions would help balance the incentives and discourage inappropriate claims.