

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CMS IS TAKING STEPS TO
IMPROVE OVERSIGHT OF
PROVIDER-BASED FACILITIES,
BUT VULNERABILITIES REMAIN**



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EXECUTIVE SUMMARY

WHY WE DID THIS STUDY

We reviewed the Centers for Medicare & Medicaid Services' (CMS) oversight of provider-based billing to ensure that only facilities that met provider-based requirements were receiving higher payments allowed by the provider-based designation. Under Medicare, payments for services performed in provider-based facilities are often more than 50 percent higher than payments for the same services performed in a freestanding facility. This increased cost is borne by both Medicare and its beneficiaries. "Provider based" is a Medicare payment designation established by the Social Security Act that allows facilities owned by and integrated with a hospital to bill Medicare as a hospital outpatient department, resulting in these facilities generally receiving higher payments than freestanding facilities. Provider-based facilities, which may be on or off the main hospital campus, must meet certain requirements (e.g., the facility generally must operate under the same license as the hospital). In addition, under current policy, hospitals may, but are not required to, attest to CMS that their provider-based facilities meet requirements to bill as a hospital outpatient department.

Dating back to 1999, the Office of Inspector General (OIG) has identified vulnerabilities associated with the provider-based status designation. These include oversight challenges and increased costs to Medicare and its beneficiaries, with no documented benefits. On the basis of these findings, OIG has recommended eliminating the provider-based designation. Further, the Medicare Payment Advisory Commission has recommended equalizing payment for selected services provided in hospital outpatient departments and physician offices. The Bipartisan Budget Act of 2015 partially accomplished this by eliminating higher payment for new off-campus provider-based facilities. However, it permits existing off-campus, as well as existing and new on-campus, facilities to continue to receive higher payment.

HOW WE DID THIS STUDY

We surveyed a projectable random sample of 333 hospitals to determine the number of provider-based facilities they owned. Next, we collected and analyzed supporting documentation from a purposive sample of 50 hospitals that reported owning off-campus provider-based facilities but had not voluntarily attested that the facilities met requirements. We limited our review to off-campus facilities because CMS requires that owning hospitals submit supporting documentation when attesting that off-campus – but not on-campus – provider-based facilities meet requirements. Further, off-campus facilities may have more difficulty meeting integration requirements because of their distance from the main hospital. We determined the extent to which these 50 hospitals and their off-campus facilities met provider-based requirements. We also collected information from CMS to determine the extent to which CMS has systems and procedures to oversee provider-based billing and had conducted analysis to determine the benefits of the provider-based designation. Finally, we collected information from CMS about its attestation reviews and challenges associated with its review process.

WHAT WE FOUND

Half of hospitals owned at least one provider-based facility. However, CMS does not determine whether all provider-based facilities meet requirements for receiving higher provider-based payment. Moreover, because the attestation process is voluntary, not all hospitals attest for all of their facilities. CMS is taking steps to improve its monitoring of provider-based billing; however, vulnerabilities associated with provider-based billing remain. For example, CMS cannot identify all on- and off-campus provider-based billing in its aggregate claims data, a capability that is critical to ensuring appropriate payments. Further, CMS may have difficulty implementing recent legislative changes because of its inability to segregate all provider-based billing from other claims data.

Whether or not hospitals voluntarily attest, provider-based facilities must meet specific requirements to receive higher provider-based payment. However, more than three-quarters of the 50 hospitals we reviewed that had not voluntarily attested for all of their off-campus provider-based facilities owned off-campus facilities that did not meet at least one requirement. Examples of requirements not met include demonstrating that an off-campus facility was operating under the control of the main provider and that beneficiaries were notified of potential cost increases for services at the provider-based facility. These facilities may be billing Medicare improperly and may be receiving overpayments. Further, beneficiaries may be overpaying for services in these facilities. CMS's efforts to gather information on the volume of the services provided by off-campus provider-based facilities are positive steps to improve oversight. However, CMS has no independent way to determine the amount of overpayments for on-campus provider-based facilities or multiple off-campus facilities owned by the same hospital in one building or campus, when the physician claim does not specify the exact location of the service. Further, CMS reported that it often has difficulty obtaining the hospital documentation needed to support its attestation reviews.

WHAT WE RECOMMEND

CMS is taking steps to improve its oversight of provider-based facilities; however, vulnerabilities identified in this review continue to limit its ability to ensure that all provider-based facilities bill appropriately. CMS also has not provided OIG with evidence that services in provider-based facilities deliver benefits that justify the additional costs to Medicare and its beneficiaries. Therefore, we continue to support previous OIG and MedPAC recommendations to either eliminate the provider-based designation or equalize payment for the same physician services provided in different settings – actions that go beyond those required by the Bipartisan Budget Act of 2015. If CMS elects not to seek authority to implement these measures, we recommend that it (1) implement systems and methods to monitor billing by all provider-based facilities, (2) require hospitals to submit attestations for all their provider-based facilities, (3) ensure that regional offices and MACs apply provider-based requirements appropriately when conducting attestation reviews, and (4) take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements. CMS partially concurred with our first new recommendation, did not concur with the second, and concurred with the third and fourth.

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OBJECTIVES

To determine the extent to which:

1. hospitals owned provider-based facilities,
2. Centers for Medicare & Medicaid Services (CMS) has procedures to oversee provider-based billing,
3. hospitals and their off-campus provider-based facilities met provider-based requirements, and
4. CMS and its contractors identified challenges associated with the attestation review process.

BACKGROUND

Medicare Part B pays for medically necessary physician services, such as office visits and surgical procedures. Medicare payments for physician services vary depending on whether they were rendered at a freestanding facility¹ or provider-based facility.² According to MedPAC, from 2012 to 2013, the use of Medicare services provided in a hospital outpatient setting, which includes provider-based facilities, increased by nearly 4 percent, and over the past seven years, the cumulative increase was 33 percent.³ This increase was due, in part, to hospitals purchasing freestanding facilities and converting them to provider-based facilities.⁴ The increase in volume of Medicare services provided in a hospital outpatient setting has been accompanied by a shift in Medicare billing to

¹ A freestanding facility is an entity that furnishes health care services that is not integrated with or part of a hospital. Freestanding facilities include independent physician practices. 42 CFR § 413.65(a) (2).

² In this report, the term, provider-based facility, refers to an on-or off-campus outpatient facility that (1) operates under the same name, ownership, and financial and administrative control of a main provider; and (2) furnishes the same types of services as the main provider. These are outpatient departments with provider-based status. 42 CFR § 413.65(a)(2). In contrast, provider-based entities are providers with provider-based status that (1) are under the ownership and administrative and financial control of the main provider; and (2) furnish services of a different type than those of the main provider. 42 CFR § 413.65(a)(2). Certain regulatory requirements set forth in 42 CFR § 413.65(g) are applicable only to provider-based facilities (i.e., hospital outpatient departments), and others are applicable to both provider-based facilities and provider-based entities. Provider-based entities are outside the scope of this report; consequently, this report addresses only those statutory and regulatory requirements applicable to provider-based facilities.

³ Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, March 2015.

⁴ Ibid. A freestanding facility may be owned by a hospital without being integrated with it (i.e., the facility does not operate under the hospital's administrative and financial control).

provider-based facilities for services that previously were performed in either a freestanding facility or an inpatient hospital setting.⁵

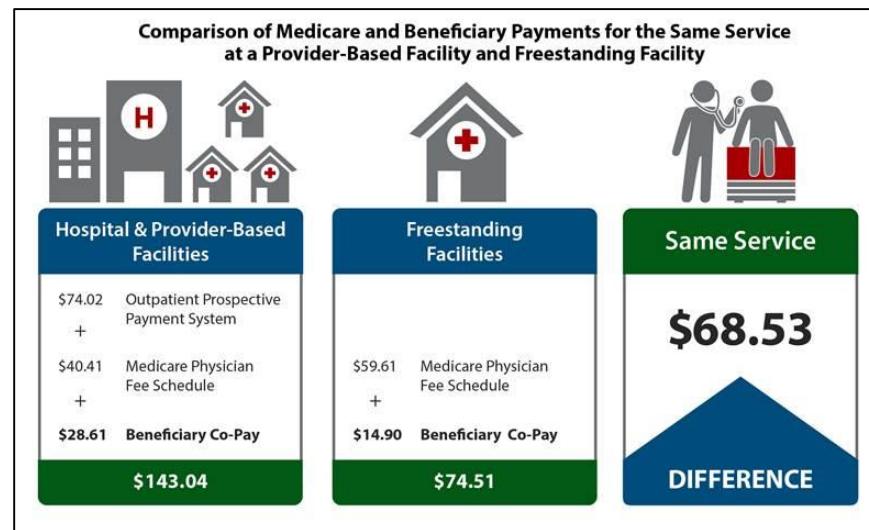
Medicare Provider-Based Status

Provider-based status is a Medicare payment designation established by the Social Security Act. It allows health care facilities with this designation to bill Medicare as a hospital outpatient department and thereby receive higher payments. CMS has asserted that provider-based facilities offer important potential benefits, such as increased beneficiary access and integration of care, which may improve quality of care. However, CMS has not provided the Office of Inspector General (OIG) with any documentary support for this assertion.

Medicare often pays over 50 percent more for services performed in provider-based facilities than for the same services performed in a non-hospital based facility (i.e., a freestanding facility).⁶ Further, Medicare beneficiaries are responsible for copayments of 20 percent of the Medicare-approved amount for Part B services in both freestanding and provider-based facilities. Therefore, beneficiaries generally are responsible for higher copayments for most services in provider-based facilities than in freestanding facilities.

The example below illustrates the differences in Medicare and beneficiary costs for the same service in provider-based and freestanding facilities.

Comparison of Medicare and Beneficiary Costs for the Same Service at a Provider-Based and Freestanding Facility



Source: OIG analysis of average 2014 Medicare Physician Fee Schedule and Outpatient Prospective Payment System payments for Healthcare Common Procedure Coding System code 99202 for an office or other outpatient visit for the evaluation and management of a new Medicare patient.

⁵ Ibid.

⁶ MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2011, p.44.

A freestanding facility, such as a physician's office, furnishes services to Medicare beneficiaries but is not integrated with a hospital.⁷ Physicians who provide services in freestanding facilities are required to bill Medicare using a place-of-service code on the Medicare claim, indicating where the services were furnished.⁸

Medicare pays for physician services provided in freestanding facilities using the Medicare Physician Fee Schedule (MPFS). Under MPFS, CMS sets payment rates for individual services.⁹ The MPFS payment reimburses the provider for the cost of the physician service (i.e., the professional component) and the operational expense for the facility, such as the cost of equipment and overhead (i.e., the facility component).¹⁰

In contrast, a provider-based facility, which operates under the ownership, administrative, and financial control of a hospital, bills as an outpatient department of the hospital.¹¹ Provider-based facilities may be on campus (within 250 yards of the main buildings of the main provider) or off campus (more than 250 yards but less than or equal to 35 miles from the main buildings of the main provider).

Because provider-based facilities bill as outpatient departments of the hospital, two claims are submitted for services rendered in these facilities. The hospital submits one claim for the component of the service related to the facility's operating costs. Medicare pays this claim through the Outpatient Prospective Payment System (OPPS).¹² This payment covers the operational expenses of the owning hospital. However, OPPS does not

⁷ 42 CFR § 413.65(a)(2).

⁸ CMS defines "office" as a location other than a hospital, skilled nursing facility, military treatment facility, community health center, State or public local health clinic, or intermediate care facility, where the physician routinely provides health examinations, diagnoses, and treatment of illnesses or injuries on an ambulatory basis. CMS, *Medicare Claims Processing Manual*, ch. 26, § 10.5.

⁹ These services are identified by Current Procedural Terminology (CPT) codes included in the Healthcare Common Procedure Coding System (HCPCS). **The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2011 by the American Medical Association (AMA).** CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

¹⁰ 77 Fed. Reg. 68891, 68897 (Nov. 16, 2012). See also, CMS, *Payment System Fact Sheet Series: Medicare Physician Fee Schedule*, December 2011. Accessed at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedcrephysFeeSchedfctsht.pdf> on May 9, 2014.

¹¹ 42 CFR § 413.65(a)(2). The hospital that owns and controls the provider-based facility is known as the *main provider* in this relationship.

¹² Under OPPS, each code is grouped into an ambulatory payment classification, which CMS translates into a dollar amount.

cover the costs of the professional component of the patient's medical care.¹³

The physician submits a separate claim for the professional component of the same service. The claim contains a place-of-service code to indicate the setting in which the service was performed (e.g., off-campus or on-campus provider-based facility).¹⁴ For services in provider-based facilities, the physician typically uses place-of-service code 22 on the claim and includes the address of the facility where the physician provided the service.

Since January 1, 2016, CMS has required physicians to use different place-of-service codes on claims to distinguish between services performed in on- or off-campus provider-based facilities. Physicians use place-of-service code 22 for services in on-campus provider-based facilities and place-of-service code 19 for services in off-campus provider-based facilities.¹⁵

Physician claims for the professional component of the services are billed under the attending physician's national provider identifier number. Medicare pays the claim using a reduced MPFS (i.e., non-facility) rate because it does not include the facility component cost.¹⁶ For services in provider-based facilities, the combination of OPPS and MPFS payments generally results in higher payments than if the services were provided in a freestanding facility.¹⁷

On November 2, 2015, the President signed into law the Bipartisan Budget Act of 2015.¹⁸ This law mandates that, effective January 1, 2017, only off-campus outpatient departments billing the OPPS for services before November 2, 2015, (grandfathered provider-based facilities) may continue to receive payment from the OPPS. This will allow the grandfathered facilities to continue to generally receive higher payments (i.e., payments from both the OPPS and MPFS) for services than if the same services were provided in a freestanding facility (i.e., receiving payment only from

¹³ CMS, *Medicare Claims Processing Manual*, ch. 6, § 20.1.1.2; CMS, *Medicare Benefit Policy Manual*, Ch. 15, § 30.1.

¹⁴ CMS, *Medicare Claims Processing Manual*, ch. 26, § 10.5.

¹⁵ CMS, *New and Revised Place of Service Codes (POS) for Outpatient Hospital*, Transmittal 3315 (Change Request 9231; August 6, 2015).

¹⁶ CMS, *Medicare Claims Processing Manual*, ch. 12, § 20.4.2. All Medicare providers are assigned a unique 6-digit identification number. All claims from Medicare providers must contain this number.

¹⁷ According to CMS, for a small number of services, the payment is less when the service is furnished in an outpatient department or provider-based facility of the hospital than in a freestanding facility.

¹⁸ Bipartisan Budget Act of 2015, P.L. 114-74, Title VI, § 603.

the MPFS). Off-campus provider-based facilities that are not grandfathered would be paid under another applicable payment system, beginning January 1, 2017, resulting in lower overall payment. Table 1 provides the effective dates and descriptions of important changes to provider-based billing.

Table 1: Dates and Descriptions of Important Changes to Provider-Based Billing

Date	Description
November 1, 2015	Off-campus provider-based facilities that began billing for provider-based services after this date may continue to receive higher provider-based payment only until December 31, 2016.
January 1, 2016	Date after which physicians must use place-of-service code 19 on professional claims for services in off-campus provider-based facilities and code 22 for services in on-campus provider-based facilities. Hospital claims must contain a modifier for services in an off-campus outpatient facility.*
January 1, 2017	Only those off-campus provider-based facilities that billed for provider-based services before November 2, 2015, may continue to receive the higher provider-based payment after this date.**

*CMS, *April 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)*, Transmittal 3238 (Change Request 9097; April 22, 2015); CMS, *New and Revised Place of Service Codes (POS) for Outpatient Hospital*, Transmittal 3315 (Change Request 9231; August 6, 2015).

**All off-campus provider-based facilities that are dedicated emergency departments defined by regulations will continue to receive the higher provider-based payment after December 31, 2016. On-campus provider-based facilities, as well as on- and off-campus provider-based entities, may continue to receive higher payments regardless of when they began billing for provider-based services.

Source: OIG analysis of Federal regulations and Bipartisan Budget Act of 2015, 2015.

Provider-Based Requirements and Attestations

Hospitals and their provider-based facilities have to meet specific requirements described in 42 CFR § 413.65 and CMS Transmittal A-03-030 to appropriately bill Medicare as a provider-based facility.¹⁹ Provider-based requirements apply to hospitals and their provider-based facilities, and additional requirements apply to off-campus facilities. These include practice licensure, integration of clinical services and financial operations, and compliance with nondiscrimination and health and safety rules.

Additional requirements, such as administration and supervision and location, apply to off-campus provider-based facilities. See Appendix A for a detailed list of provider-based requirements.

Although not required, hospitals may submit an attestation to CMS that a facility meets provider-based requirements. If a hospital chooses to submit an attestation, it is required to maintain supporting documentation indicating that its on- and off-campus provider-based facilities for which it

¹⁹ CMS Transmittal A-03-030 does not contain requirements other than those listed in 42 CFR § 413.65; however, it notifies providers of actions they must take to implement the regulations.

is attesting comply with all provider-based requirements.²⁰ Hospitals that attest for on-campus facilities do not have to submit documentation with the attestation. In contrast, hospitals that attest for off-campus facilities must submit documentation demonstrating that the requirements are being met.

A hospital that voluntarily attests must first submit the attestation form and, if applicable, supporting documentation, to Medicare Administrative Contractors (MACs).²¹ MACs review these documents to determine whether they comply with all provider-based requirements and recommend approval or denial of provider-based status to the appropriate CMS regional office.

Next, CMS regional offices conduct reviews and make decisions regarding the approval or denial of provider-based status on the basis of the attestations and MAC reviews. These reviews and decisions are tracked in CMS's Management Information System database. Regional offices and MACs also may return an attestation to a hospital if the attestation is incomplete or does not include sufficient documentation, giving the hospital additional time to gather and submit necessary documentation.

If a regional office denies an attestation, CMS may recoup the overpayments to the facility related to its provider-based billing. The overpayment amount is the difference between the OPPS and MPFS (provider-based) and the MPFS (freestanding) payments.²² However, to calculate these overpayments, CMS must rely on hospitals to self-report the claims billed for services in the provider-based facility.

CMS provides incentives for hospitals to voluntarily submit provider-based attestations by reducing the amount of overpayments it seeks if the hospital and facility do not meet provider-based requirements.²³ Specifically, if a hospital submits an attestation that is denied, CMS will seek to recover overpayments made only after the date the attestation was submitted, rather than seeking to recover all overpayments made since the

²⁰ The attestation must also include general information such as the identity of the hospital and the facility(ies) seeking provider-based status, an enumeration of each facility and a statement of its exact location (i.e., street address and whether it is on- or off-campus), the date on which the facility became provider-based to the main provider, and contact information should the regional office have further questions.

²¹ CMS contracts with MACs primarily to process medical claims for Medicare beneficiaries and to serve as the primary operational contact between the Medicare Fee-For-Service program and enrolled health care providers.

²² This applies to all cost reporting periods subject to reopening.
42 CFR § 413.65(j) (1) (ii).

²³ CMS may use several methods to find that a hospital and facility do not meet provider-based requirements. These include attestation reviews, provider self-disclosure, or audits.

hospital and facility began billing as provider-based. For example, if a hospital and facility began billing as provider-based on January 1, 2014, and submitted an attestation on June 1, 2015, that CMS denied, CMS would seek to recover overpayments made only after June 1, 2015. However, had the hospital not submitted an attestation and CMS determined the hospital and facility did not meet provider-based requirements, it would seek to recover overpayments going back an additional year and a half, to January 1, 2014.

Related Work

In 1999, OIG reported that hospitals were purchasing physician practices (i.e., freestanding facilities) in significant numbers.²⁴ OIG also found that CMS was unaware both of the extent of hospital ownership of these facilities and that provider-based status increased costs to Medicare and its beneficiaries, with no apparent benefit. OIG recommended that CMS eliminate the use of the provider-based status designation and require hospitals to report purchases of freestanding facilities. CMS did not concur with the recommendation to eliminate provider-based status and stated that provider-based billing encouraged integrated health care delivery systems. Instead, CMS produced a set of standards (i.e., 42 CFR § 413.65) for provider-based facilities and entities designed to guard against abuse of the payment system.²⁵ To date, CMS has not provided OIG with any evidence that provider-based facilities produce specific benefits, such as integrated or improved quality of care, that justify the higher costs compared to freestanding facilities.

In 2000, OIG found that CMS regional offices do not follow consistent processes for the review and approval of voluntary provider-based attestations and that CMS's data systems were inadequate for managing provider-based status.²⁶ Specifically, CMS could not identify (1) the number of hospitals denied provider-based status or (2) hospitals billing as provider-based. OIG again recommended that CMS discontinue its use of the provider-based status designation, and, if CMS did not do so, that it develop reliable data systems for program management. Again, CMS did not concur with OIG's recommendation. CMS maintained that increased payments were appropriate to accommodate higher costs resulting from

²⁴ OIG, *Hospital Ownership of Physician Practices* (OEI-05-98-00110), September 1999, pp. 5-6. Recommendations were made to the Health Care Financing Administration, which is now CMS.

²⁵ Ibid., pp. 23-24.

²⁶ OIG, *Health Care Financing Administration Management of Provider-Based Reimbursement to Hospitals* (OEI-04-97-00090), August 2000, pp. 1-2. Recommendations were made to the Health Care Financing Administration, which is now CMS.

financial and clinical integration. However, CMS concurred with the recommendation to develop reliable data systems for program management.²⁷ Since then, CMS has developed a management information system that contains the results of provider-based reviews and enables CMS to monitor review status.

In 2011, OIG found that physicians in provider-based facilities (i.e., hospital outpatient departments) did not always use correct place-of-service codes. For example, they used code 11 for a freestanding physician's office instead of code 22 for a hospital outpatient department on Part B claims submitted to and paid by Medicare contractors.²⁸ OIG estimated that as a result of these errors, Medicare contractors overpaid physicians \$9.5 million during 2009. OIG recommended that CMS recover overpayments for the sampled physician services, educate physicians about the importance of correctly reporting the place of service, and encourage physicians to implement internal control systems to prevent such incorrect billings. CMS concurred with these recommendations and stated that it was developing detailed guidance on the proper use of place-of-service codes.

Finally, in a 2012 report, the Medicare Payment Advisory Commission (MedPAC) recommended to Congress that it equalize payment for evaluation and management office visits, one type of physician service provided in hospital outpatient departments, provider-based facilities, and physician offices. MedPAC stated that this change could decrease Medicare spending by more than \$10 billion in over 5 years.

METHODOLOGY

To determine the number of facilities that were billing as provider-based, we selected a random stratified statistical sample of 333 hospitals.²⁹ Of these, 272 responded to our request, a weighted response rate of 84 percent. Next, we collected information from CMS regional offices and MACs regarding the extent to which CMS had procedures to oversee provider-based billing. We asked CMS whether it has conducted analyses to determine the benefits of the provider-based designation. We collected and analyzed supporting documentation from a purposive sample of 50 of the 272 hospitals that reported owning off-campus provider-based

²⁷ Ibid, p. 18.

²⁸ OIG, *Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2009* (A-01-10-00516), September 2011, pg. 4.

²⁹ Hereafter, unless otherwise noted we refer to facilities billing as provider based as "provider-based facilities," regardless of whether CMS approved an attestation for the facility.

facilities but had not voluntarily attested that all of their facilities met requirements. We determined the extent to which these hospitals and one of their selected off-campus facilities met provider-based requirements. Finally, we collected information from CMS and MACs about attestation reviews in 2012 as this was the most current and complete data available at the time of our review. We also asked CMS whether there were any challenges associated with the review process.

See Appendix B for a more detailed description of our methodology. See Appendix C for the sample size, point estimates, and 95-percent confidence intervals for statistics in our report for hospitals that reported owning provider-based facilities. Additionally, all references to hospitals and their off-campus provider-based facilities for which they had not voluntarily attested apply only to our sample of 50 and are not projected to the population.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

CMS is taking steps to improve its monitoring of provider-based billing; however, vulnerabilities remain. For example, CMS does not determine whether all provider-based facilities meet requirements to bill at the higher provider-based rate. This is, in part, because the attestation process is voluntary and not all hospitals attest for all facilities. Further, CMS cannot segregate billing by provider-based facilities, which is critical to ensuring appropriate payments and implementation of the Bipartisan Budget Act of 2015. In addition, some facilities may be improperly billing at the higher provider-based rate, as we identified hospitals with a provider-based facility that did not meet at least one requirement. Finally, CMS reported challenges with the provider-based attestation review process because of difficulties obtaining supporting documentation.

Half of hospitals owned at least one provider-based facility, but CMS does not determine whether all meet provider-based billing requirements

As of May 2013, half of hospitals owned at least one on- or off-campus provider-based facility.³⁰ The average number of provider-based facilities that each hospital owned was 6, and the number of provider-based facilities owned by hospitals in our review ranged from 1 to 84.

CMS does not determine whether all facilities meet the requirements for receiving the higher provider-based rate because the attestation process is voluntary and not all hospitals attest for all of their facilities. Nearly two-thirds (61 percent) of hospitals that owned provider-based facilities had not attested for at least one of those facilities.³¹ The remaining hospitals (39 percent) that owned provider-based facilities had attested for all of them. Table 2 shows the percentage of hospitals that attested for none, some, or all of their provider-based facilities that hospitals owned.

³⁰ See Appendix C for the sample size, point estimates, and 95-percent confidence intervals for statistics in this report. For purposes of this report, we define provider-based facilities as those that are owned by and integrated with a hospital to bill Medicare as a hospital outpatient department.

³¹ Ibid.

Table 2: Percentage of Hospitals That Attested for None, Some, or All of Their Provider-Based Facilities, 2013

Portion of Hospitals' Provider-Based Facilities for Which They Voluntarily Attested	Percentage of Hospitals With Provider-Based Facilities
No Facilities	43%
Some Facilities	18%
All Facilities	39%
Total	100%

Source: OIG analysis of 2013 hospital respondent data, 2015.

CMS is taking steps to improve its oversight of provider-based billing; however, vulnerabilities remain

CMS initiatives in early 2016 to improve its oversight of provider-based facilities include implementing new place-of-service codes and modifiers on claims. However, CMS may not be able to identify all provider-based billing and potential overpayments based on claims data, even with the new place-of-service codes. Moreover, the vulnerabilities in CMS's oversight make it difficult to implement the Bipartisan Budget Act of 2015.

New and revised claim processing procedures will allow CMS to identify off-campus provider-based facility billing

As of January 2016, CMS has made two changes that will help it identify off-campus provider-based-facility billing. First, CMS requires physicians to use a new place-of-service code (code 19) to distinguish between services provided in an off-campus outpatient hospital setting and those provided in an on-campus hospital outpatient setting.³² The latter will continue to use code 22, whether the service is provided in a hospital outpatient department or on-campus provider-based facility. Second, CMS requires that all facility (i.e., hospital) claims contain a specific two-digit modifier for services in an off-campus provider-based facility.³³

These are positive steps designed to support CMS's efforts to determine the frequency, type, and cost of services furnished in off-campus provider-based facilities. Further, these changes will support CMS's ability to

³² CMS, *New and Revised Place of Service Codes (POS) for Outpatient Hospital*, Transmittal 3315 (Change Request 9231; August 6, 2015).

³³ *Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Report Programs; Physician-Owned Hospitals; Data sources for Expansion Exception; Physician Certification of Inpatient Hospital Services; Medicare Advantage Organizations and Part D Sponsors; CMS-identified Overpayments Associated with Submitted Payment Data* (79 Fed. Reg. 66769, 66910-66914 (Nov. 10, 2014)). This modifier must contain the label “PO”.

match the facility and professional components of a claim from claims data.

CMS cannot identify billing for all provider-based services from claims data

CMS's implementation of new place-of-service codes to distinguish between claims for services in off-campus and on-campus provider-based facilities should significantly enhance the agency's ability to segregate provider-based services within claims data. However, despite the implementation of new codes, vulnerabilities remain. For example, although payment amounts are identical for the same service, CMS may not be able to distinguish between billing for services in on-campus provider-based facilities and outpatient hospital departments because professional claims for services in both types of locations will continue to use the same place-of-service code (22). Further, MAC staff in one region stated that they use beneficiary numbers and dates of service on claims to match facility and professional claims, which can lead to false positives (i.e., matching claims that appear to be for the same service, but are not) when the patient receives multiple services performed on the same day.

The inability to identify all facilities billing as provider-based limits CMS in calculating and recouping potential overpayments to facilities that do not meet provider-based requirements. For instance, an on-campus provider-based facility is subject to provider-based requirements that do not apply to a hospital outpatient department. If CMS determines that an on-campus provider-based facility does not meet requirements, but the professional claims for services in this facility do not specify the facility's address (e.g., suite or building number) from the hospital's address, CMS would not be able to determine the payment amounts for claims billed for provider-based services in this facility. This vulnerability also applies to off-campus provider-based facilities if a hospital owns multiple off-campus facilities in one building or campus, and the physician claim does not specify the exact location of the service.

Further, CMS's inability to identify all facilities billing as provider-based limits its full enforcement of the Bipartisan Budget Act of 2015, which mandates that, effective January 1, 2017, off-campus outpatient facilities cannot be paid the higher payment rate under the OPPS unless they had been billing for services under that system as of November 1, 2015.

Before January 2016, CMS could not distinguish billing from on- and off-campus provider-based facilities owned by the same hospital, or among multiple off-campus provider-based facilities. Therefore, CMS cannot create a population of off-campus provider-based facilities that should be grandfathered (i.e., exempt) from new legislation.

CMS also does not match the facility component of a claim to the associated professional component of a claim. Therefore, CMS still has no means of ensuring that claims for the professional component of provider-based services use the correct place-of-service code, resulting in the appropriate lower payment for this component of the claim. For example, a hospital might bill Medicare for the facility component of a provider-based service, and the physician might use place of service code 11 instead of 19 or 22 on the claim, which would result in additional payment for the operational expense for the facility.³⁴ This would result in an overpayment that CMS could not identify from the claims data.

More than three-quarters of the 50 hospitals we reviewed that had not voluntarily attested for all of their provider-based facilities owned off-campus facilities that did not meet at least one requirement

We found that 39 of the 50 hospitals in our purposive sample that had not voluntarily attested for all of their provider-based facilities owned off-campus facilities that did not meet at least one provider-based requirement (see Table 3). However, the remaining 11 of 50 hospitals and the facilities they owned met all requirements.

Because the Medicare attestation process for provider-based status is voluntary, facilities may bill Medicare at the higher provider-based rate without demonstrating to CMS that they meet provider-based requirements. Thus, these hospital facilities may be improperly billing Medicare at the higher provider-based facility amount and may be receiving overpayments.

The 39 hospitals owned off-campus facilities that did not meet at least one provider-based requirement because the hospital (1) provided information (e.g., documentation or responses) that did not support compliance with provider-based requirements, or (2) stated that they did not have the required documentation to support compliance. See Table 3 for the number of hospitals that owned provider-based facilities that did not meet each provider-based requirement. See Appendix D for a description and number of the hospitals that owned off-campus provider-based facilities that did not meet at least one provider-based requirement. See Appendix A for a description of the provider-based requirements and examples of documents hospitals could have submitted to demonstrate compliance with these requirements.

³⁴ Code 11 is for freestanding physician offices and codes 19 and 22 are for hospital off- and on-campus provider-based facilities, respectively.

Table 3: Number of Hospitals That Owned Off-Campus Provider-Based Facilities That Did Not Meet At Least One Provider-Based Requirement

Category of Requirements	Number of Hospitals That Owned Provider-Based Facilities That Did Not Meet Requirements		
	Provided Information That Did Not Support Meeting Requirements	Stated That They Did Not Have Required Documentation to Support Meeting Requirements	Total Number of Hospitals
Administration and Supervision	21	4	25
Operation Under the Control of the Hospital	24	3	24
Clinical Services Integration	18	9	23
Beneficiary Awareness	10	0	10
Compliance With Hospital Rules	2	0	2
Licensure	0	5	5
Financial Integration	0	1	1
Public Awareness	0	1	1
Location	0	1	1
Total	37	19	39*

*The sum of certain columns exceeds their total because some hospitals owned facilities that did not meet more than one requirement. The sum of certain rows also exceeds their total because some hospitals owned facilities that did not meet requirements for both methods we used to determine compliance.

Source: OIG analysis of hospitals' supporting documentation for off-campus provider-based facilities, 2015.

CMS reported challenges with the provider-based review process primarily because of difficulties obtaining documentation

Eight of 10 CMS regional offices and six of 14 MACs reported challenges with the provider-based review process primarily because they experienced difficulties obtaining documentation from hospitals. CMS regional offices and MACs also reported challenges associated with unclear CMS guidance regarding documentation necessary to support compliance with provider-based requirements.

Four CMS regional offices reported receiving incomplete provider documentation from MACs or hospitals. As a result, CMS regional offices had to request additional information from MACs. This increased the workload for CMS regional offices and may further contribute to delays in attestation approvals and denials.

Two CMS regional offices reported challenges related to the lack of CMS guidance regarding specific documents hospitals must submit with attestations for off-campus provider-based facilities to demonstrate compliance with provider-based requirements.³⁵ Of the two remaining

³⁵ CMS Transmittal A-03-030 provides background on the provider-based regulations at 42 CFR § 413.65, and includes provider-based requirements and instructions to providers for submitting provider-based attestations.

regional offices, one reported challenges related to working with a new MAC and another reported inconsistencies between requirements in the regulation and the CMS transmittal.

In addition, of the six MACs reporting challenges with the provider-based review process, five reported challenges obtaining the required documentation from hospitals. These challenges may delay the attestation review process if MACs must review attestation multiple times because they received multiple rounds of documentation. The remaining MAC reporting challenges indicated that different CMS regional offices in the same MAC jurisdiction look for varying types of supporting documentation from providers for the same requirement.

The lack of specific guidance on the documentation needed to support compliance with provider-based requirements may contribute to inconsistencies in the attestation approval process across CMS regional offices, as well as delays and review burden. Separate offices may apply different thresholds for the documentation needed to support the same requirement. These differences may account for the range of attestation approval rates found across CMS regional offices. For instance, in 2012, the percentage of attestations that regional offices approved ranged from 21 to 98 percent. This may indicate that some CMS regional offices have different approval thresholds (e.g., lower documentation thresholds may contribute to a greater approval rate). See Appendix E for the number and percentage of attestations that CMS regional offices approved for on- and off-campus provider-based status in 2012.

CONCLUSION AND RECOMMENDATIONS

Dating back to 1999, OIG has identified vulnerabilities associated with the provider-based status designation. These include oversight challenges confronting CMS and increased costs to Medicare and its beneficiaries, with no documented benefits. Based on these findings, OIG has recommended eliminating the provider-based designation. MedPAC has recommended equalizing payment for certain services in hospital outpatient departments and physician offices. The Bipartisan Budget Act of 2015 eliminates higher payment for new off-campus provider-based facilities. However, it permits existing off-campus, as well as existing and new on-campus, facilities to continue to receive higher payment.

CMS is taking steps to improve its monitoring of provider-based billing; however, vulnerabilities remain. Changes, effective January 2016, in the way CMS distinguishes off-campus provider-based services on Medicare claims should improve oversight of provider-based billing. Specifically, CMS now requires claims for services provided in off-campus provider-based facilities to be billed using a new place-of-service code. In addition, CMS now requires a modifier on hospital outpatient claims identifying when a service has been provided in an off-campus provider-based facility. These are positive steps designed to support CMS's efforts to determine the frequency, type, and cost of services furnished in off-campus provider-based facilities. Further, these changes should support CMS's ability to match the facility and professional components of a claim from claims data. However, CMS has not taken similar actions for on-campus provider-based facilities, which have also been of concern to OIG. Further, the new modifier and place-of-service code do not allow CMS to distinguish when services are furnished in different off-campus provider-based facilities owned by the same hospital.

In addition, not all hospitals voluntarily attest to CMS that all of their provider-based facilities meet requirements, and for those that do, CMS may have challenges obtaining supporting documentation from hospitals. Some hospitals' off-campus facilities with a provider-based designation do not meet all requirements and may be billing Medicare improperly, resulting in overpayments by Medicare and its beneficiaries for services in these facilities. CMS's efforts to gather information on the volume of costs associated with off-campus provider-based facilities are positive steps to improve oversight. However, CMS has no independent way of determining the amount of overpayments to on-campus provider-based facilities or hospitals with multiple off-campus facilities.

Finally, CMS has not provided OIG with evidence to support its contention that the provider-based billing designation delivers benefits that

justify the additional costs. Therefore, we continue to support previous OIG and MedPAC recommendations to either eliminate the provider-based designation or equalize payment for the same physician services provided in different settings – actions that go beyond those required by the Bipartisan Budget Act of 2015. If CMS elects not to seek authority to implement these changes, we recommend that it do the following:

Implement systems and methods to monitor billing by all provider-based facilities

CMS should implement systems and methods to monitor on- and off-campus billing by provider-based facilities to help it implement the Bipartisan Budget Act of 2015 and better monitor billing by individual facilities. To implement the Bipartisan Budget Act of 2015, CMS should develop methods for monitoring off-campus outpatient facilities that did not bill under the OPPS before November 2, 2015, and ensuring that these facilities do not receive payment from the OPPS on or after January 1, 2017.

CMS also issued new requirements for provider-based facilities to include new modifiers or codes effective 2016; however, CMS will still be unable to fully match all facility and professional claims to specific provider-based facilities or determine which services are furnished in on-campus provider-based facilities. To address this issue, CMS could require all provider-based facilities to have a unique identification number on their claims.

Require hospitals to submit attestations for all their provider-based facilities

To ensure that hospitals and their facilities meet provider-based requirements, CMS should require hospitals to submit attestations for all of their provider-based facilities, both on and off campus. CMS also should require hospitals to submit documentation for on-campus facilities, so regional office and MAC staff may review it for compliance with provider-based requirements. Further, CMS should establish a deadline after which it would deny claims for services in provider-based facilities that do not have an attestation on file with CMS. Finally, CMS should determine how to address the issue of grandfathered facilities that do not meet regulatory requirements after January 1, 2017, and determine whether they may continue billing as provider-based facilities if they later come into compliance.

Ensure that regional offices and MACs apply provider-based requirements appropriately when conducting attestation reviews

CMS should ensure that its regional offices and MACs apply provider-based requirements appropriately when reviewing documentation during their attestations reviews. Specifically, CMS should further specify and provide guidance to its regional offices, MACs, and hospitals regarding the documentation necessary to demonstrate compliance with provider-based requirements. Such actions could reduce delays, burden, and inconsistencies that CMS regional offices and MACs reported in the attestation review process. In addition, the CMS central office could review a sample of attestations for selected provider-based facilities to ensure that its regional offices and MACs are applying the requirements consistently and accurately and that the facilities are submitting acceptable documentation and meeting requirements.

Take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements

In a separate memorandum, we will refer to CMS for appropriate action the hospitals and their off-campus facilities that did not meet provider-based requirements. At a minimum, CMS should determine whether additional followup is necessary to ensure that these hospitals meet provider-based requirements. Moreover, if CMS determines that hospitals and facilities were improperly billing as provider-based, it should seek to recover overpayments and take action to ensure they do not receive higher provider-based payment in the future until non-compliance is corrected.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Of the four new recommendations in our report, CMS partially concurred with one recommendation, did not concur with one recommendation, and concurred with our remaining two recommendations.

CMS partially concurred with our first recommendation to implement systems and methods to monitor billing by all provider-based facilities. CMS's view is that the primary policy concerns regarding this issue apply to off-campus provider-based facilities (i.e., those that are more than 250 yards but less than or equal to 35 miles from the main buildings of the main provider), and CMS does not have the same concerns for on-campus provider-based facilities (i.e., those within 250 yards of the main buildings of the main provider). Therefore, CMS does not believe it is prudent to focus its resources on distinguishing among services provided in on-campus provider-based facilities and those on the main campus of the hospital. However, OIG continues to believe that monitoring appropriate billing is important for both off-campus and on-campus provider-based facilities.

CMS did not concur with our second recommendation to require hospitals to submit attestations for all of their provider-based facilities. CMS stated that it shares OIG's concerns about vulnerabilities in provider-based billing and described steps it has taken to address this issue. These include implementing a new modifier and place-of-service codes for claims furnished in an off-campus provider-based facility. Although these are positive steps, we do not believe they fully address vulnerabilities. We continue to recommend that CMS require hospitals to submit attestations for all provider-based facilities, to ensure that CMS is aware of all provider-based facilities and that they meet provider-based requirements.

CMS concurred with our third recommendation to ensure that regional offices and MACs apply provider-based requirements appropriately when conducting attestation reviews, and it described actions it has taken toward this end.

Finally, CMS concurred with our fourth recommendation to take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements and indicated that it will work with the MACs to recover any overpayments and revise the provider's prospective payment to those for freestanding units found to be out of compliance.

For the full text of CMS's comments, see Appendix F.

APPENDIX A

42 CFR § 413.65(d) and Transmittal A-03-030 describe the following requirements that are applicable to both hospitals and on- and off-campus provider-based facilities, as well as additional requirements applicable only to off-campus facilities.

Provider-Based Requirements

(1) Licensure: A provider-based facility and the main provider must be operated under the same license, unless State laws prohibit this or require separate licenses. Documentation may include a copy of the State license or documentation that the State in which the facility is located requires a separate license.

(2) Clinical Services Integration: A provider-based facility and main provider must have integrated clinical services as evidenced by the following:

- professional staff of the provider-based facility have clinical privileges at the main provider;
- the main provider maintains the same monitoring and oversight of the facility as it does for any other hospital department;
- the medical director of the provider-based facility maintains a reporting relationship with the main provider's chief medical officer or other similar official who has the same frequency, intensity, and level of accountability as the relationship between this official and other medical directors within the main provider;
- medical staff committees or other professional committees at the main provider are responsible for medical activities in the provider-based facility, including quality assurance, utilization review, and the coordination and integration of services, to extent practicable, between the provider-based facility and the main provider;
- the main provider and facility seeking provider-based status have a unified retrieval system for medical records; and
- inpatient and outpatient services of the main provider and provider-based facility are integrated and patients have full access to all services of the main provider.

Documentation may include information about whether professional staff of the provider-based facility have clinical privileges at the main provider, a copy of the record retrieval policy of the main provider and provider-based facility, and examples of inpatient and outpatient service integration.

(3) Financial Integration: The main provider and a provider-based facility must have fully integrated financial operations. The costs of a provider-based facility must be reported in the appropriate cost center on the main provider's cost center and the financial status of any provider-based facility must also be incorporated and readily identified in the main provider's trial balance. Documentation may include the appropriate section of a main provider's cost report or trial balance that show the provider-based facility's revenues and expenses.

(4) Public Awareness: The provider-based facility is held out to the public and other payers as part of the main provider. Documentation may include letterhead with a shared name, websites, and other examples to show that the facility is part of the main provider.

(5) Compliance with Hospital Rules: Hospital-based entities and on- and off-campus provider-based facilities (i.e., hospital outpatient departments) must comply with applicable hospital anti-dumping, nondiscrimination, and health and safety rules.³⁶ Provider-based facilities are also subject to the main provider's agreement with Medicare and must also meet Medicare payment rules. Documentation may include copies of anti-dumping and nondiscrimination policies.

Additional Provider-Based Requirements for Off-Campus Facilities

(1) Operation Under the Ownership and Control of the Main Provider: An off-campus provider-based facility must operate under the ownership and control of the main provider. The main provider must own 100-percent of the provider-based facility and have final responsibility and approval for administrative and personnel decisions. A provider-based facility and main provider must also have the same governing body and operate under the same organizational documents. Documentation may include bylaws for the main provider and provider-based facility.

(2) Administration and Supervision: The reporting relationship between an off-campus provider-based facility and main provider must have the same frequency, intensity, and level of accountability that exists between the main provider and one of its existing facilities. This criterion includes additional requirements concerning direct supervision, monitoring, and oversight of the provider-based facility and the integration of administrative functions (e.g., billing services, payroll). Documentation

³⁶ 42 CFR § 413.65(g) sets forth requirements applicable only to provider-based facilities (i.e., hospital outpatient departments), as well as requirements applicable to both provider-based facilities and hospital-based entities. For hospital antidumping rules, see 42 CFR §§ 489.20(1), (m), (q), and (r) and § 489.24. For hospital nondiscrimination rules, see 42 CFR § 489.10(b). For hospital health and safety rules, see 42 CFR part 482.

may include an organizational chart that reflects reporting relationships and a list of the integrated administrative functions.

(3) Location: A provider-based facility must be located within a 35-mile radius of the main provider's campus. There are several exceptions to this criterion, including facilities that are owned by the main provider with a disproportionate share adjustment, facilities that demonstrate high levels of integration with the main provider, and rural health centers that meet the other provider-based requirements.³⁷ Documentation may include maps indicating the location of each facility.

(4) Obligation to Deliver Written Notice to Beneficiaries: When providing treatment to a Medicare beneficiary that is not required by anti-dumping rules, off-campus provider-based facilities (i.e., hospital outpatient departments) must give beneficiaries written notice of potential co-insurance liabilities before delivering the service.³⁸ This notice must indicate the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital, as well as for the physician's service and an estimate of the amount of that additional liability. Documentation may include a copy of the form given to patients and a copy of policies regarding distribution of the form.³⁹

³⁷ Disproportionate share adjustments (i.e., increased payments) are available to certain hospitals that serve a disproportionate share of low-income patients. 42 CFR § 412.106.

³⁸ If a provider-based facility provides examination or treatment that is required to be provided by the antidumping rules of 42 CFR § 489.24, notice must be given as soon as possible after the existence of an emergency has been ruled out or the emergency condition has been stabilized.

³⁹ Notices are not required if the facility furnishes services for which the beneficiary will not be charged coinsurance. However, an Advance Beneficiary Notice (ABN) does not meet this requirement. An ABN must be issued when a provider believes that Medicare may not pay for an item or service that it usually covers because the item or service is not considered medically reasonable and necessary. In these cases, the beneficiary must pay the provider directly for any noncovered services.

APPENDIX B

Detailed Methodology

To determine the number of provider-based facilities that hospitals owned, we selected a random stratified statistical sample of hospitals from the population of hospitals participating in Medicare nationwide. We sent an information request to each hospital selected. We collected information from CMS regional offices and MACs to determine the extent to which CMS has procedures to oversee provider-based billing. We also asked CMS whether it has conducted analyses to determine the benefits of the provider-based designation.

We collected and analyzed supporting documentation from a purposive sample of 50 hospitals that reported owning off-campus provider-based facilities but had not voluntarily attested that these facilities met all provider-based requirements. We determined the extent to which these hospitals and their off-campus provider-based facilities met all provider-based requirements.⁴⁰ Finally, we collected and analyzed data to determine the number of attestations that CMS reviewed in 2012 and the results of these reviews, as well as whether there were challenges associated with this review process.

Data Collection and Analysis

Determining the Number of Hospitals That Owned Provider-Based Facilities. We sent an information request to 333 sampled hospitals. To select our sample, we used CMS's Certification and Survey Provider Enhanced Reporting database to identify the population of 5,119 hospitals that participated in Medicare and received OPPS payments in 2012. We organized these hospitals into three strata based on the number of beds in the hospital.

We randomly selected hospitals from each strata, resulting in a total of 333 hospitals. Of these 333 hospitals, 272 responded to our request, a weighted response rate of 84 percent. Table B-1 shows the number of hospitals in each stratum, the number of sampled hospitals in each stratum, the number of hospital respondents, and response rate for each stratum.

⁴⁰ We collected and analyzed supporting documentation from off-campus provider-based facilities because the hospitals that own them must maintain supporting documentation for these facilities even if they do not submit a voluntary attestation. Hospitals that own on-campus provider-based facilities and choose to submit a voluntary attestation have to attest only that these facilities meet requirements but are not required to submit supporting accompanying documentation.

Table B-1: Hospital Response Rate by Stratum, 2013

Stratum	Number of Hospitals in Stratum	Number of Hospitals in Sample	Number of Hospital Respondents	Response Rate
0–300 Beds	4,232	150	127	85%
301–1,000 Beds	854	150	123	82%
Greater Than 1,000 Beds	33	33	22	67%
Total	5,119	333	272	84%*

Source: OIG analysis of CMS's Certification and Survey Provider Enhanced Reporting database and 2013 hospital respondent data, 2015.

*Total response weight is weighted by each stratum.

The estimates in this report were derived from measures obtained from the 272 responding hospitals in our sample of 333 hospitals.

We sent an information request to hospitals in May 2013 to obtain information about the provider-based facilities the hospitals' owned. The information request asked hospitals to report the following information:

- the number of provider-based facilities the hospital owned and the number that were on and off campus,
- the number of provider-based facilities for which the hospital had attested,
- the distance in miles between the provider-based facility and the owning hospital for all provider-based facilities owned by the hospital, and
- ownership type (e.g., part of a health system).⁴¹

We analyzed the responses to determine the extent to which hospitals owned provider-based facilities and to identify the locations of these facilities.

Assessing CMS Oversight of Provider-Based Billing. We sent a separate information request to all 10 CMS regional offices and 14 MAC

⁴¹ For purposes of this report, we define provider-based facilities as those that are owned by and integrated with a hospital and billing Medicare as a hospital outpatient department. Additionally, according to the American Hospital Association, a system is either a multihospital or a diversified single hospital system. A multihospital system is two or more hospitals owned, leased, sponsored, or contract managed by a central organization. Single, freestanding hospitals may be categorized as a system by bringing into membership three or more, and at least 25 percent, of their owned or leased non-hospital preacute or postacute health care organizations. American Hospital Association, Fast Facts on US Hospitals. Accessed at www.aha.org/research/rc/stat-studies/fast-facts.shtml on February 26, 2016.

jurisdictions that were operational in 2012.⁴² We asked them to document the procedures they used to ensure appropriate provider-based billing, such as how CMS identified facilities that were improperly billing as provider-based (i.e., hospitals and provider-based facilities billing Medicare but not meeting these requirements), and whether resulting overpayments were recouped from these facilities and owning hospitals.

We also asked CMS and MAC staff how CMS calculates overpayment amounts to facilities improperly billing as provider-based.

We received responses from all 10 CMS regional offices and 14 MAC jurisdictions. We reviewed responses and supporting documentation.

We also spoke with CMS staff to determine whether they have conducted analyses to determine the benefits of the provider-based designation.

Determining the Extent to Which Hospitals and Off-Campus Facilities That They Owned Met Provider-Based Requirements. Of the 272 hospitals that responded to our request, 84 hospitals reported a total 694 off-campus provider-based facilities for which they had not voluntarily attested. To ensure that we selected facilities from different types of hospitals we organized these 84 hospitals into three strata based on the number of off-campus provider-based facilities that the hospitals owned. We purposively selected a total of 50 hospitals and facilities from these three strata based on location of the provider-based facility to the hospital and size (i.e., number of beds) of the hospital. We applied this criteria to ensure variability in facility distance from the hospital (i.e., over 250 yards to no more than 35 miles) and hospital size.

See Table B-2 for selection of hospitals in our purposive sample, as well as the number of hospitals in each stratum, the number of hospitals selected from each stratum, and the percentage of hospitals selected out of those in each stratum.

⁴² We defined operational MAC jurisdictions as those that reviewed provider-based attestations in 2012.

Table B-2: Selection of Hospitals in Our Purposive Sample, 2013

Stratum	Number of Hospitals Selected in Stratum	Number of Hospitals in Sample	Percentage of Hospitals Selected Out of Stratum
Owes 0-5 Provider-Based Facilities	30	17	57%
Owes 6-10 Provider-Based Facilities	27	17	63%
Owes Greater Than 10 Provider-Based Facilities	27	16	59%
Total	84	50	60%*

Source: OIG analysis of 2013 hospital respondent data, 2015.

*Total is weighted by each stratum.

We sent an information request to the 50 hospitals in our sample and asked whether the hospital and the selected off-campus provider-based facilities that they owned met requirements in 42 CFR § 413.65. We requested supporting documentation for these responses. We received responses and documentation from all 50 hospitals and determined whether hospitals and facilities met all provider-based requirements. If the hospital indicated they met a requirement, we asked it to provide supporting documentation. For instance, if a hospital stated that it owned 100-percent of a provider-based facility (one of the requirements for an off-campus facility), we asked for documentation supporting this response. While CMS Transmittal A-03-030 contains examples of documents that indicate compliance with provider-based requirements, CMS has not developed a list of specific documents that must be submitted with attestations to support compliance with these requirements. Therefore, we were conservative in our analysis and if the documentation submitted was not among the types of acceptable example documents listed in CMS Transmittal A-03-030, we reviewed the content of the documentation to determine whether it met requirements.

We determined that hospitals and their provider-based facilities did not meet requirements if the hospitals provided documentation that did not meet requirements (e.g., stating that the hospital and provider-based facility were integrated but providing documentation that did not support this response) or if the hospital reported that it did not have documentation that it met requirements. Additionally, if hospitals and their provider-based facilities did not meet one element of a requirement, we determined that they did not meet the requirement.

Determining the Number of Attestations CMS Reviewed in 2012 and the Results of These Reviews. To determine the number of provider-based attestations that CMS reviewed in 2012, we reviewed CMS's management

information system data that contained the number of attestations received in 2012 and the results of CMS's reviews of these attestations (e.g., approvals and denials). At that time, the database contained observations for 942 attestations; however, CMS had entered decisions (e.g., approval, denial) for only 715 of these 942 attestations. Therefore, we did not include the remaining 227 attestations in our analysis. Of these 715 attestations, we determined the number and percentage that were approved for provider-based status, and whether they were on or off campus. We also calculated the number of attestations that regional offices returned because the attestations lacked documentation or were incomplete in other ways, as well as those the hospital withdrew or cancelled submitting it.

In addition, we collected information from CMS and MACs about the provider-based review process, such as whether CMS or MACs had experienced any challenges during its reviews, and the reason for these challenges. We received responses from all 10 CMS regional offices and 14 MAC jurisdictions.

APPENDIX C

Sample Sizes, Point Estimates, and 95-Percent Confidence Intervals

Estimate Description	Sample Size	Point Estimate	Confidence Interval
Percentage of hospitals that owned at least one on- or off-campus provider-based facility	272	49.7%	42.4%–57.0%
Average number of provider-based facilities that hospitals owned	168	6.0	4.8–7.2
Percentage of hospitals that own provider-based facilities that have not attested for at least one (i.e., some or none) of these facilities	168	60.9%	51.2%–70.6%
Percentage of hospitals that own provider-based facilities that have not attested for any (i.e., none) of their facilities	168	43.1%	33.2%–53.1%
Percentage of hospitals that own provider-based facilities that have attested for some of their facilities	168	18.3%	10.5%–26.1%
Percentage of hospitals that own provider-based facilities that have attested for all of their facilities	168	38.6%	28.6%–48.5%

Source: OIG analysis of 2013 hospital respondent data, 2015

APPENDIX D

Description and Number of Hospitals That Owned Facilities That Did Not Meet Provider-Based Requirements

Thirty-seven of the 50 hospitals in our sample provided information for their off-campus facilities that did not support compliance with at least one provider-based requirement. Twenty-four hospitals that owned off-campus provider-based facilities did not meet requirements to operate their provider-based facility under the control of the hospital. Of these, 14 hospitals owned provider-based facilities that did not meet the requirement that the main provider have final approval or responsibility over the facility for decisions, such as personnel actions and medical staff appointments. The remaining 10 hospitals owned facilities that did not meet other requirements, such as showing that the provider-based facility and main provider operated under the same organizational documents or that these providers were governed by the same body.

Twenty-one hospitals owned off-campus facilities that did not meet requirements related to the administration and supervision of the provider-based facility. All of these hospitals owned facilities that did not meet the requirement that administrative functions (e.g., human resources, billing services) be integrated with those of the main provider.

Eighteen hospitals in our sample owned off-campus facilities that did not meet the clinical services integration requirements, despite this being one potential benefit of provider-based billing. Of these, seven hospitals submitted documentation that indicated beneficiaries treated at the provider-based facility who required further care did not have full access to services at the main provider. The remaining 11 hospitals owned facilities that did not meet other requirements, such as integrating the medical records of the provider-based facility and the main provider or ensuring that professional committees at the main provider were responsible for quality assurance activities and integration of services in the provider-based facility.

Ten hospitals owned off-campus facilities that did not meet requirements to make beneficiaries aware that the facility was a part of the hospital. This noncompliance could lead to beneficiaries being unaware of the additional co-insurance liability incurred when receiving services at these facilities.

Additionally, two hospitals owned off-campus facilities that did not meet requirements to comply with hospital rules. These hospitals owned facilities that did not report compliance related to billing correct place-of-service codes. For instance, one of the hospitals reported that physicians

in the facility billed place-of-service code 11 for provider-based services, while these facilities should have used code 22. Code 11 should be used by facilities that are not under the control of an owning hospital. Using the incorrect service code could result in potential overpayments.⁴³

Nineteen of the 50 hospitals in our sample reported that they did not have documentation to support that the off-campus facilities that they owned met provider-based requirements. These 19 hospitals in our sample reported that they owned off-campus facilities that met provider-based requirements but stated that they did not have supporting documentation. Specifically, nine hospitals in our sample did not have documentation supporting that clinical services at the provider-based facility were integrated with those of the main provider. Of these, six hospitals did not have documentation to support that medical records from the provider-based facility were integrated with those of the main hospital. The remaining three hospitals did not have documentation to support other requirements, such as the requirement that medical committees at the main provider are responsible for medical activities in the provider-based facility.

Five hospitals stated that they did not have documentation of a hospital license or regulations stating that off-campus provider-based facilities that they owned do not need to be included on the hospital's license.

Four hospitals in our sample stated that they did not have supporting documentation showing that the off-campus facilities they owned met requirements related to the administration and supervision of the provider-based facility. Nor did these hospitals have documentation showing that the hospital was responsible for certain administration functions, such as human resource and purchasing services, which were integrated with the main provider.

Three hospitals stated that they did not have supporting documentation showing that the off-campus provider-based facilities they owned operated under the control of the main provider. For instance, hospitals did not have documentation showing that the provider-based facility operated under the same organizational documents (e.g., bylaws) as the main provider.

⁴³ If a provider-based facility uses the incorrect place of service code when billing for physician services, Medicare and beneficiaries pay for the hospital's facility component of the service under OPPS and for the physician component of the service under the MPFS (i.e., non-facility) rate. This results in an overpayment because the Medicare reimbursement equals the non-facility MPFS rate plus the OPPS rate, rather than the reduced (i.e., facility) MPFS rate plus the OPPS rate.

For the remaining three requirements, hospitals stated that they did not have supporting documentation showing that the facilities they owned met requirements related to financial integration, public awareness, and location of the provider-based facility relative to the main provider. For instance, one hospital did not have documentation showing the provider-based facility's financial status was readily incorporated into the main provider's trial balance. Another hospital stated that it did not have documentation to make beneficiaries aware that the provider-based facility it owned is part of the hospital, which would cause beneficiaries to incur higher copayments. Specifically, this hospital did not have documentation of written notices informing beneficiaries that the facility is provider-based and that a visit to the facility would result in an additional copayment. Finally, one hospital stated that it did not have documentation to support that the provider-based facility it owned was clearly identified as part of the main provider and another hospital did not have documentation to support that its provider-based facility was less than 35 miles from the main provider.

APPENDIX E

Number and Percentage of Attestations that CMS Regional Offices Approved for Provider-Based Status, 2012

Regional Office	Number of Attestations Approved	Number of On-Campus Attestations Approved	Number of Off-Campus Attestations Approved	Number of Attestations for Which Regional Offices Made Decisions	Percentage of Attestations Approved
1 – Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	77	23	54	79	97%
2 – New Jersey, New York, Puerto Rico, Virgin Islands	6	1	5	10	60%
3 – Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	6	5	1	29	21%
4 – Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	255	66	189	267	96%
5 – Illinois, Indiana, Ohio, Michigan, Minnesota, Wisconsin	89	28	61	102	87%
6 – Arkansas, Louisiana, New Mexico, Oklahoma, Texas	61	10	51	64	95%
7 – Kansas, Iowa, Missouri, Nebraska	17	5	12	25	68%
8 – Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	53	22	31	55	96%
9 – American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Mariana Islands	25	7	18	26	96%
10 – Alaska, Idaho, Oregon, Washington	57	18	39	58	98%
Total	646	181	461	715	90%

Source: OIG analysis of CMS management information system database, 2015.

APPENDIX F

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

FEB 29 2016

To: Daniel R. Levinson
Inspector General
Office of Inspector General

From: Andrew M. Slavitt /S/
Acting Administrator
Centers for Medicare & Medicaid Services

Subject: CMS is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain (OEI-04-12-00380)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to protecting taxpayer dollars by ensuring proper billing by provider-based facilities.

Medicare payments for physicians' services vary depending on whether they are furnished at a freestanding facility or provider-based facility. A provider-based facility operates under a hospital's ownership and meets the requirements in our regulations while a freestanding facility furnishes services to Medicare beneficiaries but is not integrated with a hospital. Under our regulations, provider-based facilities can either be on-campus (within 250 yards from the main provider) or off-campus (greater than 250 yards). Total Medicare payment for services furnished in provider-based facilities is generally higher than Medicare payment for the same services furnished in freestanding facilities because those services are also paid under the Hospital Outpatient Prospective Payment System (OPPS).

As OIG noted in its report, CMS has taken positive steps to address vulnerabilities in provider-based billing. In 2015, the President's FY 2016 HHS budget included a proposal to equalize payments for services furnished in all off-campus provider-based and freestanding facilities. The amendments made by section 603 of the Bipartisan Budget Act of 2015 partially enacted this proposal by requiring certain off-campus provider-based facilities to be paid under the applicable payment systems other than the OPPS beginning on January 1, 2017. CMS is working to implement this provision.

In addition, CMS continues to seek a better understanding of the growing trend toward hospital acquisition of physicians' offices and the impact on beneficiary cost-sharing. In order to better track these trends, on January 1, 2016, CMS began requiring facilities to use a modifier on hospital outpatient claims identifying when a service has been furnished in an off-campus provider-based department. Similarly, CMS requires physicians to use a new place-of-service

code that distinguishes whether a service was furnished in an off-campus facility or an on-campus facility. CMS is using the data from this new modifier and place-of-service code to analyze the frequency, type, and payment for services furnished in off-campus provider-based hospital departments.

OIG Recommendation

OIG recommends that CMS implement systems and methods to monitor billing by all provider-based facilities.

CMS Response

CMS partially concurs with this recommendation. In the CY 2015 OPPS Final Rule, CMS created a Healthcare Common Procedure Coding System (HCPCS) modifier “PO” for hospital claims that is to be reported for items and services furnished in an off-campus provider-based department of a hospital. In addition, physician and practitioner claims furnished in off-campus provider-based departments are required to use new place-of-service codes. Reporting of this new modifier and place of service codes became mandatory on January 1, 2016, and will allow CMS to better monitor billing by off-campus provider-based facilities. We believe the major policy concerns regarding this issue are with hospitals acquiring physicians’ offices that are off-the-campus of the hospital, making such offices into provider-based departments, and billing Medicare under the OPPS for the services furnished in such departments even though nothing has changed about the services being furnished. We do not believe there are the same concerns with on-campus provider-based departments. Further, we note that the distinction between the parts of the main campus of the provider that are part of that provider and those parts of the main campus that are provider-based is much more difficult to parse than the location distinction for off-campus provider-based departments. Finally, we note that concerns regarding patient understanding of whether they are in a provider-based department or a freestanding clinical setting are most acute in off-campus settings. For all of these reasons, we do not believe it is prudent to focus our resources on distinguishing among services provided on the main campus of the hospital.

OIG Recommendation

OIG recommends that CMS require hospitals to submit attestations for all provider-based facilities.

CMS Response

CMS non-concurs with this recommendation. CMS shares the OIG’s concerns about possible vulnerabilities in provider-based billing. CMS has taken several steps to address this issue, including implementing a new modifier and place-of-service codes for claims furnished in an off-campus provider-based facility. The amendments made by section 603 of the Bipartisan Budget Act of 2015 also requires certain off-campus provider-based entities to be paid under the applicable payment systems other than the OPPS rate beginning on January 1, 2017, which may

limit the vulnerability identified by the OIG in provider-based billing. After implementing such amendments, CMS will consider whether additional activities are needed to ensure that only those facilities that qualify as provider-based departments are being paid at the OPPS rate.

OIG Recommendation

OIG recommends that CMS clarify the documentation that hospitals must submit to demonstrate that their off-campus provider-based facilities meet requirements.

CMS Response

CMS concurs with this recommendation. CMS has worked with the Medicare Administrative Contractors (MACs) to streamline the attestation review process including developing tools to make sure provider-based facilities meet all requirements. CMS also hosted a training session for CMS staff and MACs to review the provider-based status regulations and the attestation process.

OIG Recommendation

OIG recommends that CMS take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements.

CMS Response

CMS concurs with this recommendation. CMS will work with the MACs to determine if the providers referred by the OIG are out of compliance with the provider-based requirements. If a provider is found to be out of compliance, CMS will work with the MACs to recover any overpayments and revise the provider's prospective payment rates to those for free-standing units.

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Jaime Stewart, Deputy Regional Inspector General.

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