Hospital-Owned Physician Practices Face Tougher Scrutiny

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Practice Area: Provider Groups and Clinics

In 1998, the Office of the Inspector General (OIG) conducted a study to determine how pervasive hospital ownership of physician practices was and whether fiscal intermediaries and carriers were aware of the hospital ownership. The OIG sought this data to determine how the reimbursement methodologies for hospital-owned physician practices affected the Medicare program.

In a summary of results published last fall, the OIG concluded that hospital ownership of physician practices is prevalent, although the fiscal intermediaries are often unaware of whether a hospital owns a physician practice. It further concluded that this lack of awareness coupled with the current methods of reimbursing hospital-owned physician practices could lead to unnecessary and excessive payments by the Medicare program.

In response to perceived increased costs to the Medicare program and Medicare beneficiaries, the OIG recommended that the Secretary of Health and Human Services end the Health Care Financing Administration's (HCFA) provider-based designation for hospital-owned physician practices. At the same time, the OIG recommended that HCFA require hospitals to report all purchases of physician practices and clinics and that HCFA pursue legislation to sanction hospitals for failing to make required reports.

Background

Increasingly, hospitals have purchased physician practices and clinics in an attempt to establish physician networks that will attract third party payors. Under the current regulations, a hospital may treat the physician practices as free-standing or provider-based. The designation determines the method by which the hospital will be reimbursed for the physician services as well as the rate of reimbursement. A provider-based designation, however, results in higher reimbursement. In order to receive provider-based designation, a hospital must submit an application requesting provider-based status.

If a hospital receives provider-based designation for a physician practice, the costs of operating the provider-based practice, including overhead and operating costs are reported on the hospital's cost report. In addition, the hospital submits a separate claim to the Medicare carrier for the physician's professional services using the physician fee schedule.

If a hospital-owned physician practice is treated as free-standing, the hospital may submit only claims for professional services to the Medicare carrier, which will pay the claims according to the physician fee schedule. If the hospital provides any services to the free-standing practice, the hospital must establish a non-allowable cost center on its cost report to allow Medicare to capture any costs associated with operating the physician practice, such as administration and medical records. Medicare does not reimburse these nonallowable costs because the Medicare carrier has already paid the hospital using the physician fee schedule.

Perceived Problems Associated with Current Payment Methodologies

Essentially, there are two Medicare reimbursement mechanisms related to purchased physician practices. One reimbursement mechanism is for services provided by a provider-based physician facility. Under this reimbursement mechanism, hospitals are allowed to include the operating costs of the provider-based physician practice on their cost reports. In addition, the hospitals can submit a separate claim to the Medicare carrier for the physician's professional services, which are reimbursed pursuant to the physician fee schedule as adjusted for the operating and overhead costs reimbursed by the fiscal intermediary.

The other reimbursement mechanism is for services provided by a free-standing physician facility. Under this reimbursement mechanism, reimbursement is made by the Medicare carrier pursuant to the physician fee schedule, including reimbursement for operating and overhead costs.

If a hospital's physician practice is provider-based, the hospital receives a higher level of reimbursement because it receives payment for the physician's professional services under the physician fee schedule and it receives payment for its overhead and operating costs, which are included on the hospital's cost report. If a hospital fails to report its provider-based designation when it submits claims to the carrier for physician services, however, it will be paid overhead costs twice since the physician fee schedule already accounts for the operating and over-head costs of a physician practice.

Also, provider-based physician facilities generate higher costs for Medicare beneficiaries because the beneficiaries must pay the copayment for both the physician charges as well as for the hospital charges. In contrast, Medicare beneficiaries who receive services at a free-standing physician facility only have to pay the copayment for the physician charges.

Failure to establish a non-allowable cost center on a hospital's cost report for a free-standing physician practice can also result in overpayment to the hospital. The overpayments arise because the outpatient costs claimed on the hospital's cost report are not reduced by the hospital's overhead costs associated with operating the freestanding physician practice, which have already been paid for under the physician fee schedule.

OIG's Recommendations

Because fiscal intermediaries are only aware of hospital ownership approximately 50% of the time, and because fiscal intermediaries lack the resources to conduct full-scale audits to determine hospital ownership, the OIG is recommending that hospitals be required to report all past and present acquisitions of physician practices. The OIG proposes a number of ways to gather this information. For example, it recommends that HCFA clarify its "Provider Cost Reimbursement Questionnaire," to require hospitals to report the purchase of physician practices as well as those purchased by subsidiaries. Alternatively, or in addition, the OIG suggested that HCFA include language in proposed regulations requiring hospitals to report past purchases of physician practices and indicate whether the practices are treated as free-standing or provider-based. Other OIG suggestions include surveying hospitals using Medicare Integrity Program funds or having fiscal intermediaries conduct focused audits of hospitals identified as owning physician practices through the OIG's 1998 survey.

To provide a hammer to compel compliance with reporting requirements, the OIG is also recommending that HCFA seek legislation sanctioning hospitals that fail to report the ownership or purchase of physician practices. Because of the significant potential for overpayments under either payment methodology, the OIG stated that the penalty should accrue regardless of how the service was reimbursed.

The OIG also recommended that HCFA eliminate the provider-based designation for physician practices entirely, asserting that provider-based status increases beneficiary coinsurance costs without providing any added benefits to Medicare or the beneficiary. In an example, the OIG stated that a patient diagnosed with diabetes and leg ulcers would have to pay $47.16 more in coinsurance for services at a provider-based facility than that patient would have to pay in a freestanding facility. The difference in costs are attributable to the coinsurance that patients must pay for the hospital charges associated with a provider-based facility. The OIG asserted that the patient would receive the same quality of services in a free-standing facility and questioned why two payment methodologies are allowed for the same services. Although the OIG noted that regulations are proposed to change the manner of calculating a beneficiary's coinsurance for outpatient services which would eventually alleviate these differences, the OIG felt that this remedy was inadequate since Medicare beneficiaries still have to pay excessive coinsurance amounts during the transition period.

HCFA's Response

HCFA concurred with two of the OIG's recommendations but rejected the third. Specifically, HCFA agreed that regulations requiring hospitals to report all hospital purchases of physician practices was advisable. It noted that modifications would be necessary to the proposed regulations for the outpatient prospective payment system (PPS). Although the proposed regulations require reporting of physician practices a hospital wishes to claim as provider-based, the proposed regulations do not currently require reporting of freestanding practices. HCFA indicated that it would take as many of the actions recommended by the OIG to help mandate reporting as it could, given HCFA's budgetary and legal constraints. HCFA also concurred with the OIG's recommendation for sanctions. It noted that currently, it could only recoup overpayments for bills improperly submitted as provider-based and indicated that it desired a more powerful tool to discourage inappropriate claims.

HCFA, however, rejected the OIG's recommendation to eliminate the provider-based designation for hospital-owned physician practices. HCFA asserted that its policy was to encourage integrated delivery systems and stated that provider-based entities help achieve this goal. It further noted that it had established criteria requiring substantial clinical and managerial integration that a provider must meet to become provider-based and stated that a hospital would have to make changes in the operations of an acquired physician practice in order to meet the provider-based requirements. HCFA asserted that if a hospital met those requirements, it would be difficult to differentiate the provider-based physician practice from any other hospital outpatient department. Therefore, HCFA declined to eliminate the provider-based designation stating that 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."

Future OIG Actions

Although the direction HCFA will take with respect to hospital ownership of physician practices and the provider-based designation has been clarified by HCFA's response to the OIG's recommendation, hospitals can expect further efforts by the OIG to manage the Medicare costs associated with hospital-owned physician practices. First, the OIG has indicated that it intends to review the process that HCFA uses to determine whether a physician practice qualifies for provider-based designation. Second, the OIG also intends to review whether services rendered in provider-based facilities are properly billed to Medicare. Finally, the OIG intends to conduct a comparison of the payment rates under the proposed outpatient PPS to determine whether provider-based or free-standing rates are higher. Based upon the results of these studies, it is likely that hospital-owned physician practices will receive greater scrutiny from HCFA.

Conclusion

Hospitals should, as part of their compliance program, confirm that all outpatient facilities being treated as provider-based meet HCFA's eight factor test. If necessary, hospitals should undertake operational changes to meet the criteria. Hospitals that operate free-standing clinics should verify that operating and overhead costs are not being reported on the hospital's cost reports.

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