Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE AND BENEFICIARIES PAID SUBSTANTIALLY MORE TO PROVIDER-BASED FACILITIES IN EIGHT SELECTED STATES IN CALENDAR YEARS 2010 THROUGH 2017 THAN THEY PAID TO FREESTANDING FACILITIES IN THE SAME STATES FOR THE SAME TYPE OF SERVICES

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Office of Inspector General

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Report in Brief
Date: June 2022
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare and Beneficiaries Paid Substantially More to Provider-Based Facilities in Eight Selected States in Calendar Years 2010 Through 2017 Than They Paid to Freestanding Facilities in the Same States for the Same Type of Services

Why OIG Did This Audit

Three Medicare Payment Advisory Commission reports to Congress and a previous OIG report found that hospitals were increasingly purchasing physician practices and operating them as provider-based facilities because of their higher payment rates, and that Medicare payments and beneficiary coinsurance payments were substantially higher for services in provider-based facilities than they were for the same services in freestanding facilities.

Our objective was to identify the potential cost savings to both the Medicare program and its beneficiaries by comparing their payments made for certain evaluation and management (E&M) services performed at provider-based facilities in calendar years 2010 through 2017 in eight selected States with what Medicare and beneficiaries would have paid for the same type of services performed at freestanding facilities in the same eight States.

How OIG Did This Audit

Our audit covered $3.95 billion that Medicare and beneficiaries paid for E&M services they received at provider-based facilities in the selected States. We developed a database of payments made to physicians and provider-based facilities based on outpatient and Physician Fee Schedule (PFS) claims for E&M services performed in these facilities. We then compared those payments to what would have been paid at freestanding facilities.

What OIG Found

Both the Medicare program and its beneficiaries could have realized significant savings for E&M services if those services had been paid as if provided at freestanding facilities. If the physicians in the selected States had been paid at the freestanding PFS nonfacility rate and hospitals paid nothing under the Outpatient Prospective Payment System for our audit period, the Medicare program could have realized cost savings of $1.3 billion and its beneficiaries could have realized cost savings of $334 million, for combined savings totaling over $1.6 billion. In addition, beneficiaries would have been required to make only one coinsurance payment rather than two (as they are currently required to do) and the cost-sharing would generally be lower because it would be based only on the freestanding facility rate.

The Centers for Medicare & Medicaid Services (CMS) has taken some steps intended to equalize payments. If these changes had been in effect during the period covered by our audit, the potential cost savings of these changes for E&M services in the selected States for our audit period could have been a combined $1.4 billion for the Medicare program and its beneficiaries. However, the combined $1.4 billion in potential cost savings would still have been less than the $1.6 billion in potential cost savings if E&M services had been paid at the freestanding PFS nonfacility rate.

What OIG Recommends and CMS Comments

We recommend that CMS pursue legislative or regulatory changes to lower costs for both the Medicare program and beneficiaries, by equalizing payments as appropriate between provider-based facilities and freestanding facilities for E&M services.

CMS did not directly agree or disagree with our recommendation; it referred to regulatory action it had taken and added that any changes to further implement our recommendation "may require legislative action." We commend CMS for the regulatory action it has taken and note that its comments are closely aligned with our findings and recommendation. We continue to recommend that CMS pursue legislative or regulatory changes to lower costs by equalizing payments between the two types of facilities.

The full report can be found at https://oig.hhs.gov/oas/reports/region7/71802815.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

Historically, hospitals that purchased physician practices could treat them as either part of the hospital and integrated into the hospital for financial purposes ("provider-based") or as separate from it ("freestanding facilities").[1] Three Medicare Payment Advisory Commission (MedPAC) reports to Congress and a previous Office of Inspector General (OIG) report found that hospitals were increasingly purchasing physician practices and operating them as provider-based facilities because of their higher payment rates.[2, 3]

These reports also found that total Medicare payments and beneficiary insurance copayments were substantially higher for services in provider-based facilities than they were for the same services in freestanding facilities. In particular, MedPAC reported that the difference in payment methodologies (payment differences) between the two types of facilities resulted not only in higher Medicare payments to provider-based facilities, but also in beneficiaries making two coinsurance payments for one office visit to those facilities. MedPAC further stated that the increased payments to provider-based facilities did not result in clear benefits, such as improved quality of care, for beneficiaries.

To address these payment differences, Congress has enacted legislation and CMS has promulgated rules and regulations, including a payment adjuster (discussed later in this report), the intent of which was to bring Medicare payments to provider-based facilities into closer alignment with Medicare payments to freestanding facilities.[4] Despite these actions, payment

[1] More precisely, Medicare-participating hospitals can classify physician practices they own as provider-based (specifically hospital outpatient departments (HOPDs)) if the physician practice operates under the name, ownership, and financial and administrative control of the hospital (42 CFR §§ 413.65(a)(2) and (d)). There are additional requirements if the physician practice is located off-campus from the hospital (42 CFR § 413.65(e)). Alternatively, hospitals can classify physician practices they own as freestanding facilities by not integrating them with the hospital (42 CFR § 413.65(a)(2)).

[2] MedPAC, *Report to the Congress: Medicare Payment Policy*, Mar. 15, 2012, chapter 3, "Hospital inpatient and outpatient services"; MedPAC, *Report to the Congress: Medicare Payment Policy*, Mar. 14, 2014, chapter 3, "Hospital inpatient and outpatient services"; and MedPAC, *Report to the Congress: Medicare Payment Policy*, Mar. 15, 2017, chapter 3, "Hospital inpatient and outpatient services." The March 2014 and March 2017 reports had a similar focus to that of the March 2012 report and broadened the scope of the earlier report's recommendations.

[3] *Hospital Ownership of Physician Practices* (OEI-05-98-00110), Sept. 13, 1999.

[4] The terms "rule(s)" and "regulation(s)" are used interchangeably to describe documents issued by Federal agencies under proper authority that have general applicability and legal effect. In this report, we use the term "regulations" to distinguish those rules that are or will be codified in the Code of Federal Regulations (CFR) after appearance in the Federal Register from those rules that do not get codified in the CFR. Examples of the latter include large portions of the annual Inpatient Prospective Payment System and Outpatient Prospective Payment System (OPPS) final rules that contain changes to Medicare payment policies and rates, as well as new and modified codes.

differences still exist between provider-based facilities and freestanding facilities. The intent of our audit was to quantify the payment differences between provider-based and freestanding facilities. In addition, we reviewed the legislation, rules, and regulations that have been implemented to address those payment differences as well as the costs paid by beneficiaries; we did so to identify potential cost savings to the Medicare program and its beneficiaries.

OBJECTIVE

Our objective was to identify the potential cost savings to both the Medicare program and its beneficiaries by comparing their payments made for certain evaluation and management (E&M) services performed at provider-based facilities in calendar years (CYs) 2010 through 2017 in eight selected States with what Medicare and beneficiaries would have paid for the same type of services performed at freestanding facilities in the same eight States.[5]

BACKGROUND

Medicare Program

Under Title XVIII of the Social Security Act (the Act), Medicare provides health insurance for people aged 65 years and older, people with disabilities, and people with permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Medicare Part B covers doctors' services and outpatient care, as well as some other medical services that Part A does not cover, including certain physical and occupational therapy services and some home health care. As more fully explained below, provider-based facilities receive payments for designated hospital outpatient services rendered to Medicare beneficiaries through both the Medicare Part B Physician Fee Schedule (PFS) and the Outpatient Prospective Payment System (OPPS). Physicians receive payment for services rendered to Medicare beneficiaries at freestanding facilities through the PFS.

Evaluation and Management Services

For this audit, we analyzed Medicare and beneficiary payments made for E&M services provided at provider-based facilities under both the OPPS and PFS and compared them with what the payments would have been if those same services were provided at freestanding facilities under only the PFS. E&M services are professional face-to-face services rendered by a physician or nonphysician practitioner to assess and manage a patient's health. On Medicare Part B claims, physicians must use Current Procedural Terminology (CPT) codes that represent

[5] The eight selected States were California, Colorado, Florida, Louisiana, Michigan, Missouri, New York, and Texas. For an explanation of why we selected these eight States, see Appendix A, "Methodology."

the services rendered to patients.[6] E&M services are differentiated by place of service, new or established patient, and level of E&M service. The level of E&M service performed reflects the complexity of the service. In general, the more complex the visit, the higher the level of code will be. CPT codes 99201 through 99215 are used by physicians for office or other outpatient visits for E&M services that are differentiated from one another based on the foregoing criteria. During CYs 2010 through 2013, hospitals used these CPT codes to bill for the same services when rendered at a provider-based facility. Effective January 1, 2014, CMS instructed hospitals to use Healthcare Common Procedure Coding System (HCPCS) code G0463 to bill for E&M services.[7] In effect, for purposes of the OPPS, CMS rolled the 10 CPT codes that were paid based on 10 levels of intensity of care into 1 HCPCS code paid at 1 rate.

Provider-Based and Freestanding Facilities

At the time that CMS implemented the OPPS (effective July 1, 2000), there was no definition of the term "provider-based." CMS noted in the preamble to the first OPPS final rule that, since the beginning of the Medicare program, some hospitals (known as "main providers") had owned and operated other facilities that were financially and clinically integrated with the main provider, and CMS permitted the subordinate facilities to be considered provider-based.[8] CMS also noted that there were financial incentives for hospitals to acquire control of nonprovider treatment settings such as physician offices. As part of the initial OPPS final rule, CMS promulgated regulations (42 CFR § 413.65) to define "provider-based" facilities and distinguish them from freestanding facilities, in part, to avoid the risk of increasing program payments with no commensurate benefit to the Medicare program or its beneficiaries.[9]

There are two types of facilities or organizations that can be granted provider-based status: a department of a provider or a provider-based entity. Physician practices owned by hospitals can be granted provider-based status as a department, specifically a hospital outpatient department (HOPD).[10] To qualify as a department, the HOPD must operate under the name, ownership, and financial and administrative control of the hospital. The financial operations of

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[6] **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2010 through 2017 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 document should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

[7] HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies. More will be said on this change to the "G" code in Appendix C.

[8] 65 Fed. Reg. 18434, 18504 (Apr. 7, 2000).

[9] The effective date of 42 CFR § 413.65 was delayed until January 10, 2001 (65 Fed. Reg. 58919 (Oct. 3, 2000)). For details on this regulation and other Federal requirements, see Appendix B.

[10] We use the terms "provider-based facility" and "provider-based facilities" interchangeably with "HOPD" and "HOPDs." Readers should not confuse a "provider-based facility" with a "provider-based entity," as the latter is a regulatory defined term that differs somewhat from the regulatory defined term "HOPD" (42 CFR § 413.65(a)(2)).

the HOPD must be fully integrated within the financial system of the main provider as evidenced by shared income and expenses and the costs of the HOPD must be reported in a cost center of the main provider (42 CFR §§ 413.65(a)(2) and (d)). Providers seeking a determination by CMS of provider-based status for a facility must submit an attestation stating that the facility meets all regulatory requirements (42 CFR § 413.65(b)).

A freestanding facility, on the other hand, is an entity that furnishes health care services to Medicare beneficiaries "that is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity."

Payment Differences for Certain Evaluation and Management Services Based on Setting

Medicare Payment Rates

Under the provisions of section 1833(t) of the Act, CMS established a payment system for hospital outpatient department services. Similarly, under the provisions of section 1848 of the Act, CMS established a fee schedule for physicians' services. Specifically, under its Federal rulemaking authority, CMS established the Medicare OPPS and PFS and publishes changes and revisions to the OPPS and PFS annually, in the form of final rules, in the Federal Register.

This report focuses on two different types of facility settings under which Medicare makes payments to health care providers for office or other outpatient visits for E&M services—provider-based and freestanding facilities. The differences between these two types of facility settings for payment purposes are twofold. One difference is the number of payments Medicare makes for E&M services. The other is the total amounts paid for these services.

For E&M services provided in a provider-based facility, Medicare makes two payments. One of these is an OPPS payment to the hospital for its costs related to the delivery of patient care services, which expressly excludes physician services paid for under the PFS (42 CFR §§ 419.2, 419.22(a) and 415.102(a)). The second is a Part B payment to the physician under the PFS for personally furnished services that contribute directly to the diagnosis or treatment of the beneficiary (42 CFR § 415.102(a)). Therefore, when a physician renders a service in a provider-based facility, there are generally two claims: one claim submitted by the physician under the PFS and one submitted by the hospital under the OPPS.[11]

> When a physician renders a service in a provider-based facility, there are generally two claims submitted to Medicare: one claim submitted by the physician under the PFS and one submitted by the hospital under the OPPS.

[11] Critical access hospitals are excluded from the OPPS (42 CFR § 419.20(b)(2)) and can elect to bill the facility and professional service on the same claim (42 CFR § 413.70(b)(3)).

For services provided in a freestanding facility, Medicare (Part B) makes just one payment, under the PFS. PFS payments consist of three main components: the physician's work, the practice expense, and the malpractice insurance expense. If a physician renders services in an office that they own, the physician is paid the PFS "nonfacility rate" that includes all three components. Hospitals can also choose to operate facilities they own as freestanding facilities, in which case the hospitals would receive Medicare payments for physician services at the PFS nonfacility rate.[12] In these cases, the facilities would not receive a payment under the OPPS. Therefore, freestanding facilities submit only one claim to Medicare for reimbursement.

Freestanding facilities submit only one claim (covering both physician and facility services) to Medicare for reimbursement.

For E&M services provided in a provider-based facility, the physician's work and the malpractice insurance expense components of the PFS payment are same as when the services are provided in a freestanding facility, but the practice expense component is reduced (42 CFR § 414.22(b)).[13] This reduction reflects the assumption that the practice expense component reflects the operating costs of the physician's office—and these costs are included in the payment made to the hospital under the OPPS when services are rendered in a provider-based facility. This is a payment at the PFS "facility rate."

Under the OPPS, Medicare pays the hospital for costs associated with outpatient services on a rate per service basis that varies according to the assigned ambulatory payment classification (APC) (42 CFR §§ 419.2 and 419.31)). Generally, costs consist of labor (e.g., nurses), use of procedure or treatment rooms, certain drugs, biologics and other pharmaceuticals, medical and surgical supplies and equipment, and other ancillary costs associated with patient care (42 CFR § 419(b)). Medicare payments for E&M services rendered at provider-based facilities reflect the higher costs of hospitals compared to those of freestanding facilities (footnote 2; Appendix C). For most services, the combined Medicare OPPS and PFS payments for E&M services rendered at a provider-based facility are higher than the single PFS payment for E&M services rendered at a freestanding facility.

For most services, the combined Medicare OPPS and PFS payments for E&M services rendered at a provider-based facility are higher than the single PFS payment for E&M services rendered at a freestanding facility.

[12] When hospitals own physician practices and employ physicians to work at these facilities, physicians typically assign benefits to the hospital pursuant to Section 1842(b)(6)(A) of the Act and chapter 1, section 30.2.6 of the *Medicare Claims Processing Manual*. Under those circumstances, the PFS payment would be made to the facility rather than to the physician.

[13] The practice expense component reflects the costs of maintaining a physician's office practice: rental of office space, purchase of supplies and equipment, staff salaries and benefits, and similar types of costs.

Beneficiary Coinsurance

E&M services rendered at a provider-based facility increase not only cost to the Medicare program, but also the coinsurance liability of the beneficiary for those services. When a Medicare beneficiary receives services in a provider-based facility, the beneficiary is required to make coinsurance payments for two separate claims (one for the physician service and one for the outpatient visit) (42 CFR §§ 410.3(b), 413.65(g)(7), and 419.40); 81 Fed. Reg. 79562, 79699 (Nov. 14, 2016)).

When a Medicare beneficiary receives services in a provider-based facility, the beneficiary is required to make coinsurance payments for two separate claims (one for the physician service and one for the outpatient visit).

By contrast, when a Medicare beneficiary receives services in a freestanding facility, the beneficiary is required to make one coinsurance payment because only one payment is made to the freestanding facility from the PFS. The freestanding facility does not receive payment from the OPPS. When a Medicare beneficiary receives services in a freestanding facility, the beneficiary makes only one coinsurance payment.

When a Medicare beneficiary receives services in a freestanding facility, the beneficiary makes only one coinsurance payment.

Medicare Payment Advisory Commission Concerns With the Payment Differences and Recommendations to Congress To Equalize Payments

In recent years, several MedPAC reports (footnote 2) have expressed concerns that Medicare and beneficiary payments to provider-based facilities were higher than the payments for the same services in freestanding facilities. These reports conveyed that the payment differences:

- have created an incentive for main providers to acquire physician practices to enable higher remuneration,
- can confuse beneficiaries when they receive two coinsurance bills for one office visit, and
- result in higher Medicare payments without creating clear benefits for patients.

For details on relevant findings from these MedPAC reports, see Appendix C.

Federal Legislation and Rulemaking Addressing Payment Differences

Congress has enacted legislation and CMS has promulgated rules and regulations to address payment differences between E&M services provided at provider-based facilities and freestanding facilities. The Bipartisan Budget Act of 2015 (BBA) changed the payment methodology for provider-based facilities that came into existence on or after November 2,

2015, such that these provider-based facilities would receive payments under "the applicable payment system" (i.e., the PFS) rather than the OPPS.[14] Through Federal rulemaking subsequent to passage of the BBA, in particular the CY 2018 PFS final rule and the CY 2019 OPPS final rule, CMS has demonstrated ongoing efforts to equalize payments between provider-based and freestanding facilities. For details on these provisions of Federal legislation and rulemaking, see Appendix C.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $3.95 billion in actual payments that Medicare and beneficiaries made for E&M services they received at provider-based facilities in the eight selected States, with dates of service from CY 2010 through CY 2017 (audit period).[15] The eight judgmentally selected States (selected States) were California, Colorado, Florida, Louisiana, Michigan, Missouri, New York, and Texas (see Appendix A). To determine the amount of payments made to the physicians and provider-based facilities (including the coinsurance payments made by beneficiaries), we developed a database of payments from the National Claims History files based on Medicare Part B OPPS and PFS claims for E&M services performed in provider-based facilities. We then compared those payments to what would have been paid to physicians providing E&M services at freestanding facilities based on the yearly Medicare PFS nonfacility rate established for each of the eight States.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology.

FINDINGS

The Medicare program and its beneficiaries could have realized potential cost savings for E&M services but instead paid substantially more for such services rendered at provider-based facilities than they would have paid for the same type of services rendered at freestanding facilities during our audit period in the selected States. The Medicare program paid $3.2 billion and beneficiaries paid $794 million (almost $4 billion combined total) for E&M services performed at provider-based facilities in the selected States during our audit period.[16] Both the Medicare program and its beneficiaries could have realized significant savings for E&M services

[14] P.L. No. 114-67 § 603 (Nov. 2, 2015).

[15] Our review included beneficiary coinsurance but, as explained in Appendix A, not beneficiary-paid deductibles.

[16] Specifically, the Medicare program paid $3,156,691,897 and beneficiaries paid $794,274,579, for a combined total of $3,950,966,476.

if those services had been paid as if provided at freestanding facilities in which the beneficiaries would be required to make only one payment rather than two. If the provider-based facilities and hospitals in the selected States had been paid only at the freestanding PFS nonfacility rate for our audit period, the Medicare program could have realized cost savings of $1.3 billion and its beneficiaries could have realized cost savings of $334 million. Combined savings for this timeframe could thus have totaled over $1.6 billion.[17] (See Table 1 later in this report.)

If the provider-based facilities and hospitals in the selected States had been paid only at the freestanding PFS nonfacility rate for our audit period, the Medicare program could have realized cost savings of $1.3 billion and its beneficiaries could have realized cost savings of $334 million. Combined savings for this timeframe could thus have totaled over $1.6 billion.

In the CY 2018 OPPS final rule and CY 2019 PFS final rule, CMS took steps intended to equalize payments for E&M services between excepted and nonexcepted provider-based facilities (discussed just below) by adjusting the rates downward such that both types of these facilities would be paid at 40 percent of what they would have been paid under the OPPS ("40-percent adjuster"), effective January 1, 2019. If the 40-percent adjuster had been in effect during our audit period, the potential cost savings of these changes to the Medicare program and its beneficiaries in the selected States for our audit period could have been a combined $1.4 billion.[18] However, the combined $1.4 billion in potential cost savings would still have been less than the $1.6 billion in potential cost savings if E&M services had been paid at the freestanding PFS nonfacility rate.

FEDERAL REQUIREMENTS FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES AT PROVIDER-BASED FACILITIES AND FREESTANDING FACILITIES

Federal regulations describe the criteria and procedures for determining whether a facility has met the requirements for provider-based status (42 CFR § 413.65).

Federal regulations provide that a physician rendering services at a provider-based facility will be paid the PFS facility fee rate and a physician rendering services at a freestanding physician office will be paid the PFS nonfacility fee rate (42 CFR § 414.22(b)(5)(i)).

The BBA and Federal regulations prohibit off-campus provider-based facilities that came into existence on or after November 2, 2015 (that is, nonexcepted facilities), from receiving payments under the OPPS effective January 1, 2017 (BBA § 603; 42 CFR §§ 419.22(v) and 419.48). However, section 603 of the BBA does not apply to off-campus provider-based

[17] Specifically, the Medicare program could have realized cost savings of $1,314,389,626 and its beneficiaries could have realized cost savings of $333,699,011, for a combined total of cost savings of $1,648,088,637.

[18] Specifically, the potential cost savings resulting from full implementation of the CY 2018 and CY 2019 final rules could have totaled (for the Medicare program and its beneficiaries) $1,387,872,857. (See Appendix F, Table 10.)

facilities that existed and were billing as such prior to November 1, 2015; these facilities were thus "excepted" from these provisions of the law.

The BBA and Federal regulations also excepted items and services furnished by dedicated emergency departments (on- or off-campus), as well as on-campus facilities and facilities within 250 yards of a remote location of the hospital (BBA § 603; 42 CFR §§ 419.48(a) and (b) and 413.65(a)(2)).

Under Medicare Part B, the beneficiary is responsible for paying cost-sharing, which is generally about 20 percent of both the OPPS hospital payment amount and the PFS facility allowed amount (42 CFR §§ 410.3(b)(1) and 413.65(g)(7)). "Because the sum of the OPPS payment and the [PFS] facility payment is greater than the PFS nonfacility payment for most services, there is generally a greater cost to both the beneficiary and the Medicare program for services furnished in facilities and paid through both an institutional payment system like the OPPS and the [PFS]" (81 Fed. Reg. 79562, 79711 (Nov. 14, 2016)).

For details on Federal requirements, see Appendix B.

COST SAVINGS TO MEDICARE AND BENEFICIARIES IF EVALUATION AND MANAGEMENT SERVICES IN THE SELECTED STATES HAD BEEN PAID AT THE FREESTANDING NONFACILITY PHYSICIAN FEE SCHEDULE RATE

The Medicare program and its beneficiaries could have realized potential cost savings for E&M services but instead paid substantially more for such services rendered at provider-based facilities than they would have paid for identical services rendered at freestanding facilities during our audit period in the selected States. The Medicare program paid $3.2 billion and beneficiaries paid $794 million (almost $4 billion combined) for E&M services performed at provider-based facilities in the selected States during our audit period (footnote 16).

The Medicare program paid $3.2 billion and beneficiaries paid $794 million (almost $4 billion combined) for E&M services performed at provider-based facilities in the selected States during our audit period.

See Appendix D for details on our analysis of these Medicare program and beneficiary payments by State.

Both the Medicare program and its beneficiaries could have realized significant savings for E&M services if those services had been paid as if they were provided at a freestanding facility. In such a case, the beneficiaries would be required to make only one coinsurance payment rather than two and the cost-sharing would generally be lower because it would be based only on the freestanding facility rate. Table 1 on the following page shows the difference, for our audit period in the selected States, between: (1) what the Medicare program and its beneficiaries paid to physicians and provider-based facilities ("Actual Payments") and (2) what the Medicare

program and beneficiaries would have paid if the services had been paid at the rate paid when services are rendered at freestanding facilities ("PFS Nonfacility Rate").

Table 1: Actual Payments Compared to Payments if Made at the Nonfacility Physician Fee Schedule Rate

	Medicare	Beneficiaries	Total
Actual Payments	$3,156,691,897	$794,274,579	$3,950,966,476
PFS Nonfacility Rate	1,842,302,271	460,575,568	2,302,877,839
Payment Difference	**$1,314,389,626**	**$333,699,011**	**$1,648,088,637**

These findings support the statements made in the MedPAC reports (discussed further in Appendix C) that the Medicare program and its beneficiaries paid more for E&M services rendered in provider-based facilities than they paid for the same services when rendered in freestanding facilities. In line with the terms articulated in the 2014 MedPAC report to Congress cited in Appendix C, CMS should be a prudent purchaser and should not pay more for a service in one setting than in another if the same service could be safely provided in different settings.

If the provider-based facilities and hospitals in the selected States had been paid only at the freestanding PFS nonfacility rate for our audit period, the Medicare program could have realized cost savings of $1.3 billion and its beneficiaries could have realized cost savings of $334 million. Combined savings for this timeframe could thus have totaled $1.6 billion (footnote 17). See Appendix D and Appendix F, Table 10, for more details concerning differences in payments and potential cost savings.

POTENTIAL COST SAVINGS IF THE PHYSICIAN FEE SCHEDULE 40-PERCENT ADJUSTER RATE HAD BEEN APPLIED TO OUTPATIENT PROSPECTIVE PAYMENT SYSTEM PAYMENTS MADE TO NONEXCEPTED PROVIDER-BASED FACILITIES

For CY 2018, nonexcepted facilities were paid at 40 percent of what they would have been paid under the OPPS. Physicians furnishing services in these nonexcepted facilities were paid the PFS facility rate. (The CY 2018 final rule did not affect the provider-based facilities covered by this audit.[19]) The CY 2019 final rule required application of the 40-percent adjuster rate to both excepted and nonexcepted provider-based facilities to equalize payments between them. (This final rule would have affected the excepted provider-based facilities in this audit.)

If application of the 40-percent adjuster rate had been in effect during our audit period, the potential cost savings of these changes for E&M services in the selected States for our audit

[19] We did not analyze the impact of the CY 2017 OPPS final rule and CY 2018 PFS final rule on provider-based facilities that were nonexcepted. CMS applied modifier code "PN" to nonexcepted provider-based facilities, and those facilities were paid with the 40-percent adjuster rate applied to their OPPS payment. We therefore did not include the nonexcepted facilities in our data for this aspect of our analysis.

period could have been a combined $1.4 billion for the Medicare program and its beneficiaries (footnote 18). (See Appendix E and Appendix F, Table 10, for details on these potential cost savings.) Nevertheless, the combined $1.4 billion in cost savings for the Medicare program and its beneficiaries would have been less than the cost savings could have been (i.e., the $1.6 billion we have identified in this report) if E&M services had been paid at the freestanding PFS nonfacility rate.

The combined $1.4 billion in cost savings for the Medicare program and its beneficiaries would have been less than the cost savings could have been if E&M services had been paid at the freestanding PFS nonfacility rate.

PROVISIONS IN REGULATIONS THAT PERMITTED DIFFERENCE IN PAYMENTS BETWEEN PROVIDER-BASED FACILITIES AND FREESTANDING FACILITIES POINT TO THE NEED FOR A LEGISLATIVE OR REGULATORY REMEDY

For E&M services performed during our audit period, Medicare and its beneficiaries paid substantially more for hospital claims at provider-based facilities than they would have paid for the same type of services at freestanding facilities because Federal regulations in effect at the time permitted this payment disparity.

The CY 2018 and CY 2019 final rules, as well as changes to the provider-based facility payment system conveyed in the President's proposed FY 2021 budget (Appendix C), demonstrate CMS's ongoing efforts to equalize payments between provider-based and freestanding facilities. The CY 2019 final rule was challenged in Federal court, but was ultimately upheld (footnote 31 in Appendix C) and became effective as of January 1, 2019, after some delay in implementation.[20] We determined that even after implementation of this final rule, provider-based facilities would continue to receive higher payments for E&M services than freestanding facilities would. As a result, a legislative remedy or further regulatory change is needed to more effectively achieve CMS's goal of equalizing payments between these two types of facilities.

RECOMMENDATION

We recommend that CMS pursue legislative or regulatory changes to lower costs for both the Medicare program and beneficiaries, by equalizing payments as appropriate between provider-based facilities and freestanding facilities for E&M services.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS did not directly agree or disagree with our recommendation, but it referred to regulatory action it had taken through notice-and-comment rulemaking and stated: "We will continue to monitor the impacts of this policy to ensure that people with Medicare continue to have access to quality care. However, the changes necessary

[20] CMS, *MLN Connects*, "Payment for Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments," Jan. 14, 2021.

to further implement this recommendation may require legislative action. Any proposals for legislative changes would be in the President's Budget."

CMS's comments appear in their entirety as Appendix G.

We commend CMS for the regulatory action it has taken and its commitment to continue monitoring these payment differentials. We note that CMS's comments are closely aligned with the findings and recommendation in this report. However, provider-based facilities still continue to receive higher payments for E&M services than freestanding facilities would receive. Therefore, we continue to recommend that CMS pursue additional legislative or regulatory changes to lower costs for both the Medicare program and beneficiaries, by equalizing payments as appropriate between provider-based facilities and freestanding facilities for E&M services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $3,950,966,476 that Medicare and beneficiaries paid for E&M services (Medicare program payments totaling $3,156,691,897 and $794,274,579 in beneficiary coinsurance) they received at provider-based facilities in the selected States, with dates of service from CY 2010 through CY 2017 (our audit period).

We obtained provider-based claims to develop a database of payments based on Medicare Part B and OPPS claims for E&M services performed in office settings. We created a Structured Query Language (SQL) code, which we matched against the National Claims History files. We did so to select line items for the same beneficiary and physician office visit, with the same date of service, from the Part B and OPPS claims databases for our audit period. We used revenue center codes on Medicare OPPS claims to identify a specific accommodation, ancillary service, or billing calculation, such as an office visit. (Revenue center codes 0510 through 0519 are used to report claims in an office setting, such as an outpatient clinic.) We structured our database to include only those claims with the applicable HCPCS and CPT codes for the E&M services that were the subject of this audit; these codes report E&M services provided by a physician in an office or outpatient setting.[21]

We performed audit work (our analyses as reflected in Appendices C, D, and E) from September 2013 through March 2022. This extended timeframe was the result of legislative and rules changes that occurred at various points during our audit work that caused us to adjust our audit methodology, update our audit analysis, and report on the results of that updated analysis.

METHODOLOGY

To accomplish our objective, we performed the following actions:

- We reviewed applicable Federal requirements and CMS guidance.

- We judgmentally selected eight States for our review. We first judgmentally selected two States from the Region that conducted this audit: Colorado and Missouri. We later expanded our audit scope to include six additional States that were part of the OIG's Healthcare Fraud Enforcement and Prevention Action initiative. Those States are California, Florida, Louisiana, Michigan, New York, and Texas. These six States were identified by the Departments of Justice and Health and Human Services as having areas identified as "health care fraud hot spots." The population of Medicare beneficiaries in these eight States made up more than 36 percent of the total Medicare population nationwide, and the Medicare

[21] See also our discussion in "Evaluation and Management Services" earlier in this report.

expenditures for these eight States totaled over 42 percent of all Medicare expenditures.

- We obtained Medicare Part B PFS and OPPS claims in the selected States with revenue center codes 0510 through 0519 (Clinic Services), HCPCS code G0463, and CPT codes 99201 through 99215 (Office or Other Outpatient Services) for E&M services provided during our audit period.

- To identify the provider-based physician office visits, we matched the Part B and OPPS claims by beneficiary, HCPCS or CPT code as appropriate, revenue center code, and date of service to determine whether the claims were for the same service and were billed to both Medicare Part B and OPPS.

- We matched the Medicare Part B and OPPS claims to determine, for each case, the amount that Medicare actually paid for each provider-based physician office visit using the Medicare Part B PFS facility fee amount plus the Medicare OPPS amount.

- We determined the amount of beneficiary coinsurance paid for provider-based physician office visits from the Medicare Part B and OPPS payment systems.

- We calculated potential cost savings (Appendix D) by comparing the amounts that Medicare paid for the provider-based physician office visits, and the amounts that beneficiaries paid in coinsurance, with the amounts that would have been paid for E&M services by Medicare and the beneficiaries if the physician office visits had been provided at freestanding facilities (using the Medicare PFS for each geographic area in the selected States).

- We analyzed payment methodologies and their effects in the context of CMS's final rules concerning the 40-percent adjuster rate. This analysis (Appendices E and F) considered the effect of these final rules and determined potential cost savings as well as costs to the Medicare program and its beneficiaries.

- Because of the legislative and rule changes that occurred during the timeframe of our audit, we discussed the results of our audit with CMS officials on November 13, 2014, February 28, 2018, and February 12, 2020.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: FEDERAL REQUIREMENTS

Federal regulations describe the criteria and procedures for determining whether a facility has met the requirements for provider-based status (42 CFR § 413.65). The regulations define a department of a provider as a facility or organization owned by a main provider whose purpose is "furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider . . . ." (42 CFR § 413.65(a)(2)).

Federal regulations provide that a physician rendering services at a provider-based facility will be paid the PFS facility fee rate and a physician rendering services at a freestanding physician office will be paid the PFS nonfacility fee rate (42 CFR § 414.22(b)(5)(i)).

Federal regulations provide that when a Medicare beneficiary receives services in a provider-based facility, the beneficiary is required to make coinsurance payments for two separate claims (one for the physician service and one for the outpatient visit) (42 CFR §§ 410.3(b)(1), 413.65(g)(7), and 419.40)).

The BBA and Federal regulations prohibit off-campus provider-based facilities that came into existence on or after November 2, 2015 (that is, nonexcepted facilities), from receiving payments under the OPPS effective January 1, 2017 (BBA § 603; 42 CFR §§ 419.22(v) and 419.48). However, section 603 of the BBA does not apply to off-campus provider-based facilities that existed and were billing as such prior to November 1, 2015; these facilities were thus "excepted" from these provisions of the law.

The BBA and Federal regulations also excepted items and services furnished by dedicated emergency departments (on- or off-campus), as well as on-campus facilities and facilities within 250 yards of a remote location of the hospital (BBA § 603; 42 CFR §§ 419.48(a) and (b) and 413.65(a)(2)).

Federal regulations provide that CMS uses HCPCS codes and descriptors (footnote 7) to identify and group the services within each APC group (42 CFR § 419.2(a)).

Federal regulations provide that under the OPPS, Medicare pays the hospital for outpatient services on a rate per service basis that varies according to the assigned ambulatory payment classification (APC) (42 CFR § 419.31)).

Under Medicare Part B, the beneficiary is responsible for paying cost-sharing, which is generally about 20 percent of both the OPPS hospital payment amount and the PFS facility allowed amount. "Because the sum of the OPPS payment and the [PFS] facility payment is greater than the PFS nonfacility payment for most services, there is generally a greater cost to both the beneficiary and the Medicare program for services furnished in facilities and paid through both an institutional payment system like the OPPS and the [PFS]" (81 Fed. Reg. 79562, 79711 (Nov. 14, 2016)).

APPENDIX C: MEDICARE PAYMENT ADVISORY COMMISSION CONCERNS WITH THE PAYMENT DIFFERENCES AND RELEVANT FEDERAL LEGISLATION AND RULEMAKING

MEDICARE PAYMENT ADVISORY COMMISSION CONCERNS

The 2012 MedPAC report to Congress stated that because Medicare payments for physician E&M services rendered in provider-based facilities are higher than payments for the same services rendered in freestanding physician offices, there is an incentive for main providers (e.g., hospitals) to acquire physician practices to enable higher remuneration. This report also stated that beneficiaries can be confused when they receive two coinsurance bills for one office visit. The report further stated:

> When hospitals convert [freestanding] physician office buildings to OPD [outpatient department] status, they spend money to comply with life safety codes and take on the cost of generating additional bills for the hospital's facility payment [i.e., its OPPS payment]. For E&M office visits, these additional expenditures result in higher Medicare payments but fail to create clear benefits for patients. To improve efficiency of the health care system, Medicare should be discouraging, not encouraging, expenditures by health care providers that do not benefit patients.

This MedPAC report also recommended that Medicare reduce the OPPS payment rates for E&M services so that the payments for E&M services are the same whether the service is provided in a provider-based facility or a freestanding physician office.

The 2014 MedPAC report to Congress stated:

> The Commission's position is that Medicare should ensure that patients have access to settings that provide the appropriate level of care. From this perspective, if the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service in one setting than another. These payment differences between settings may cause Medicare and beneficiaries to pay more than necessary.

This report further stated that the Medicare payment system creates little or no incentive to improve quality of care and that "[t]he Commission is concerned by any increase in Medicare spending per beneficiary without a commensurate increase in value such as higher quality of care or improved health status."

The March 2014 MedPAC report to Congress also referred to arguments made by stakeholders in support of the provider-based arrangement that results in higher payments to provider-based facilities. According to this report, some stakeholders have asserted that hospitals (that is, main providers) could use the additional Medicare payments to subsidize enhancements such as standby capacity, access to care for low-income patients, efforts to improve care

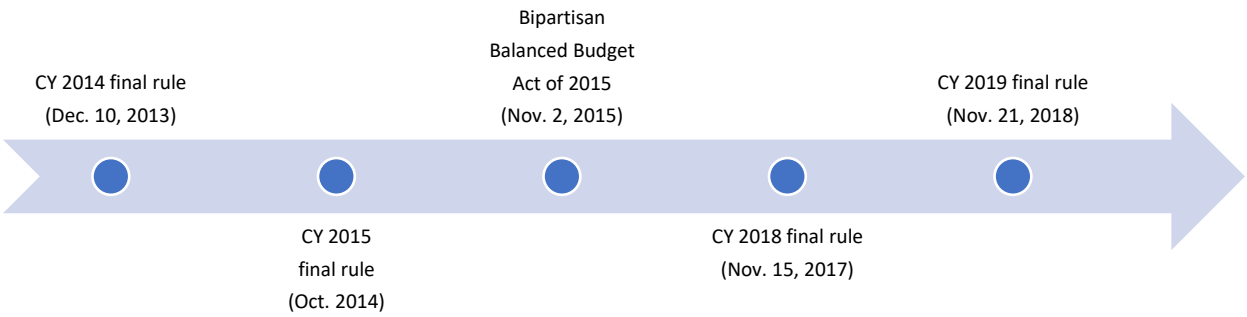
coordination, and community outreach. Stakeholders have further argued that, in comparison with freestanding physician offices, provider-based facilities incur higher overhead costs (associated with more stringent building codes, life-safety codes, and staffing requirements) and higher costs for billing and for financially integrating their outpatient departments into the hospital.

The 2017 MedPAC report to Congress referred to the BBA (footnote 14) and Congress's actions to "equalize rates between new off-campus [provider-based facilities] and [freestanding] physician offices." However, this MedPAC report noted that "emergency departments (EDs) and existing [provider-based facilities] will continue to receive the higher [provider-based] facility fees [i.e., OPPS payments]." This MedPAC report recommended, as the earlier MedPAC reports had done, that payment rates for E&M services in provider-based facilities be adjusted to the same rate as payment rates for E&M services provided in freestanding physician offices.

FEDERAL LEGISLATION AND RULEMAKING ADDRESSING PAYMENT DIFFERENCES

Congress has enacted legislation and CMS has promulgated rules and regulations to address payment disparities between E&M services provided at provider-based facilities and freestanding facilities, as depicted in the figure below and discussed in greater detail later in this section.

Figure: Federal Legislation and Rulemaking Regarding Payments to Provider-Based Facilities



- **CY 2014 OPPS Final Rule**:[22] This final rule consolidated the reporting of (and thus the payments for) E&M services into a single HCPCS code. Before CY 2014, hospitals billed Medicare under the OPPS for E&M services rendered at a provider-based facility using CPT codes 99201 through 99215. Effective January 1, 2014, CMS created HCPCS code G0463 to be used by hospitals billing for E&M services for which physicians continued to bill using CPT codes 99201 through 99215 under the PFS.[23] In effect, for purposes of the

[22] 78 Fed. Reg. 74826, 75042 (Dec. 10, 2013).

[23] G0463: Hospital outpatient clinic visit for assessment and management of a patient.

OPPS, CMS rolled the 10 CPT codes that were paid based on 10 levels of intensity of care into 1 HCPCS code paid at 1 rate.

- **CY 2015 PFS Final Rule**:[24] This final rule implemented procedures to help CMS differentiate provider-based from freestanding facilities and evaluate the financial impact of hospitals' increased use of provider-based facilities. CMS stated that, based on the MedPAC's continued questioning of the appropriateness of increased Medicare payment and beneficiary cost-sharing when freestanding physician offices become provider-based facilities, it wanted to seek a better understanding of the growing trend of hospital acquisition of freestanding physician offices and how that impacted the Medicare program and beneficiaries. Accordingly, CMS announced that it was replacing place of service (POS) code 22 (outpatient hospital department) with two new POS codes for use by physicians on PFS claims—one to identify outpatient services furnished in on-campus locations of a hospital and another to identify services furnished in off-campus hospital provider-based departments. CMS also announced that it was creating a two-digit HCPCS modifier, "PO," for use by hospitals on OPPS claims to indicate that services were provided at a provider-based facility.[25]

- **The Bipartisan Budget Act of 2015 (BBA)**:[26] This legislation made an important, if incremental, change in the payment methodology for provider-based facilities. Congress amended section 1833(t) of the Act to prohibit provider-based facilities that came into existence on or after November 2, 2015, from receiving payments under the OPPS effective January 1, 2017. Payment for such providers was thenceforth to be made under "the applicable payment system" other than the OPPS. The BBA did not make changes to payments to provider-based facilities that existed and were billing as such prior to November 2, 2015.

- **CY 2017 OPPS Final Rule**:[27] One year after passage of the BBA, CMS formalized a payment methodology that included a "PFS Payment Adjuster" to reduce Medicare payments to some provider-based facilities. Specifically, CMS stated that the PFS would be the "the applicable payment system" for provider-based facilities that were not

[24] 79 Fed. Reg. 67548, 67569-67572 (Nov. 13, 2014).

[25] On August 6, 2015, CMS announced that, effective January 4, 2016, POS code 19 was to be used for off-campus provider-based facilities and POS code 22 was to be used for on-campus outpatient hospitals. CMS also stated: "Claims for covered services rendered in an Off Campus-Outpatient Hospital setting, or in an On Campus-Outpatient Hospital setting, if payable by Medicare, shall be paid at the facility rate." Medicare Claims Processing Transmittal 3315 (Change Request 9231; Aug. 6, 2015). In the CY 2015 OPPS final rule, CMS announced the creation of HCPCS modifier "PO" that could be used voluntarily by hospitals for CY 2015 and must be used by hospitals beginning January 1, 2016, to indicate services performed in a provider-based facility. 79 Fed. Reg. 66770, 66910-66914 (Nov. 10, 2014).

[26] See footnote 14.

[27] 81 Fed. Reg. 79562, 79710-79729 (Nov. 14, 2016).

grandfathered under the BBA (i.e., "nonexcepted facilities").[28] For CY 2017, nonexcepted facilities were to use modifier "PN" and would be paid at 50 percent of what they would have been paid under the OPPS. Physicians furnishing services in these nonexcepted facilities would be paid the PFS facility rate.

- **CY 2018 PFS Final Rule**:[29] In this final rule, CMS reduced the "PFS Payment Adjuster" from 50 percent to 40 percent for nonexcepted facilities effective January 1, 2018.

- **CY 2019 OPPS Final Rule**:[30] CMS announced in this final rule that it would begin phasing in equalized payments between excepted and nonexcepted provider-based facilities. Noting a 2018 MedPAC report's statement that a large source of growth in spending on services furnished in provider-based facilities appeared to be the result of a shift in services from freestanding physician offices to provider-based facilities, CMS stated that it "consider[ed] these shifts in the site of services unnecessary if the beneficiary can safely receive the same services in a lower cost setting but instead receives care in a higher cost setting." CMS also noted that "many off-campus departments converted from physicians' offices to [provider-based facilities] without a change in the acuity of patients seen." Moreover, CMS stated that, "[t]o the extent that similar services can be safely provided in more than one setting, we do not believe it is prudent for the Medicare program to pay more for these services in one setting than another." Accordingly, effective for the CY 2019 OPPS, CMS decided to pay excepted off-campus provider-based facilities the same as nonexcepted facilities for clinic visit services described by HCPCS code G0463. CMS stated that it would phase in the payment reduction, paying approximately 70 percent of the OPPS rate in CY 2019 and 40 percent beginning in CY 2020.[31]

[28] As part of the CY 2017 OPPS final rule, CMS added 42 CFR § 419.48 to Federal regulations. CMS stated that provider-based facilities that existed *prior* to November 2, 2015, were "excepted off-campus provider-based department[s]." Accordingly, for this report we refer to any off-campus provider-based facilities that came into existence *on or after* November 2, 2015, as "nonexcepted facilities."

[29] 82 Fed. Reg. 52976, 53019-53031 (Nov. 15, 2017).

[30] 83 Fed. Reg. 58818, 59004-59015 (Nov. 21, 2018).

[31] On September 17, 2019, a U.S. District Court vacated the downward payment adjustment for E&M services provided in excepted provider-based facilities, stating the CMS had exceeded its statutory authority. *American Hospital Association v. Azar*, 410 F. Supp. 3d 142 (D.C.D.C. 2019). On July 17, 2020, a Federal appellate court reversed the District Court's decision. *American Hospital Association v. Azar*, 964 F.3d 1230 (D.C. Cir. 2020). This final rule and judicial activity occurred after our audit period. Whether the final rule did or did not affect actual payments in CYs 2019 and 2020 is immaterial to our audit because we applied the 40-percent payment adjustment retroactively in a hypothetical fashion.

- **HHS Fiscal Year 2021 Budget in Brief**:[32] As part of the President's proposed FY 2021 budget, CMS proposed that Medicare make "site-neutral payments between" on-campus provider-based facilities, off-campus provider-based facilities, and freestanding physician offices.

[32] The President of the United States' FY 2021 Budget: "Putting America's Health First," pp. 82–83. Available online at https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf (accessed on Jan. 24, 2022).

APPENDIX D: DIFFERENCES IN MEDICARE AND BENEFICIARY PAYMENTS MADE TO PROVIDER-BASED FACILITIES AND FREESTANDING FACILITIES FOR EVALUATION AND MANAGEMENT SERVICES PERFORMED DURING CALENDAR YEARS 2010 THROUGH 2017

MEDICARE PAYMENTS TO PROVIDER-BASED FACILITIES

Difference in Medicare Payment Methodologies for Provider-Based Facilities and Freestanding Facilities Under the Outpatient Prospective Payment System and Part B Physician Fee Schedule Facility Fee

As a representative example at the claim level for CPT code 99215, Table 2 shows the effect on the Medicare program of the difference in payment methodologies for provider-based and freestanding facilities. Specifically, Table 2 shows the difference ($57.89) between what Medicare paid for E&M services performed at a provider-based facility ($176.10) and what Medicare would have paid if the service was provided at a freestanding facility ($118.21), in the context of HCPCS code G0463 for the OPPS payment and CPT code 99215 for the Part B PFS payment.[33] (The amounts are based on a physician office visit for E&M services billed in Colorado for CY 2017.)

Table 2: Example of Provider-Based Facility Payments Compared to Freestanding Facility Payments

OPPS Payment (Provider Component) (A)	Medicare Part B PFS Facility Fee (Professional Component) (B)	Provider-Based Total Payment (A + B)	Medicare Part B PFS Nonfacility Fee (C)	Difference ((A + B) – C)
$85.28	$90.82	$176.10	$118.21	**$57.89**

Aggregate Effect of Provider-Based Billing Arrangement on Medicare Payments in the Selected States

For E&M services provided in the selected States during our audit period, Medicare paid $1,314,389,626 more for services performed in provider-based facilities than it would have paid for the same type of services if performed at freestanding facilities in the same States.

Table 3 on the following page compares, on an aggregate basis for our audit period, what Medicare actually paid for E&M services performed at provider-based facilities in each of the

[33] See footnote 6 for the AMA copyright notice. CPT code 99215 denotes the highest level of care for established patients being seen in the office for E&M services.

selected States with what Medicare would have paid for the same type of services in the same States if those services had been performed in freestanding facilities.

Table 3: Medicare Provider-Based Facility Payments Compared to Freestanding Facility Payments by State for CYs 2010–2017			
State	**Provider-Based Facility Payments (Actual) (A)**	**Freestanding Facility Payments (B)**	**Difference (A – B)**
California	$670,974,710	$374,050,914	$296,923,796
Colorado	92,027,306	55,469,075	36,558,231
Florida	303,840,435	185,375,684	118,104,751
Louisiana	98,581,982	60,683,413	37,898,569
Michigan	667,571,901	394,784,247	272,787,654
Missouri	197,389,521	114,343,287	83,046,234
New York	653,742,279	376,576,577	277,165,702
Texas	472,923,763	281,019,074	191,904,689
Totals	**$3,156,691,897**	**$1,842,302,271**	**$1,314,389,626**

BENEFICIARY COINSURANCE PAYMENTS TO PROVIDER-BASED FACILITIES

Medicare Regulations Require Two Beneficiary Coinsurance Payments That Result in Higher Cost-Sharing for Services Performed at Provider-Based Facilities

Table 4 on the following page shows the difference ($14.48) between beneficiary coinsurance payments for E&M services performed at a provider-based facility ($44.03) and what those payments would have been if the service was provided at a freestanding facility ($29.55), in the context of HCPCS code G0463 for the OPPS payment and CPT code 99215 for the Part B PFS payment. (The payments are based on a physician office visit for E&M services billed in Colorado for CY 2017.)

Table 4: Example of Provider-Based Facility Compared to Freestanding Facility Beneficiary Coinsurance Payments				
OPPS Coinsurance (A)	**Medicare Part B PFS Coinsurance (B)**	**Provider-Based Coinsurance Total Payment (A + B)**	**Freestanding Medicare Part B PFS Coinsurance (C)**	**Difference ((A + B) − C)**
$21.33	$22.70	$44.03	$29.55	**$14.48**

Aggregate Effect of Provider-Based Billing Arrangement on Beneficiary Coinsurance Payments in the Selected States

For E&M services provided in the selected States during our audit period, the effect on Medicare beneficiaries of the difference in payment methodologies was that beneficiaries paid $333,699,011 more in coinsurance to provider-based facilities than they would have paid for the same type of services if performed at freestanding facilities.

Table 5 on the following page compares, on an aggregate basis for our audit period, what beneficiaries paid in coinsurance for E&M services performed at provider-based facilities in each of the selected States with what they would have paid in coinsurance for the same type of services in the same States if those services had been performed in freestanding facilities.

Table 5: Beneficiary Coinsurance Payments for Provider-Based Compared to Freestanding Facilities			
State	Provider-Based Facility Beneficiary Coinsurance Payments (Actual) (A)	Freestanding Facility Beneficiary Coinsurance Payments (B)	Difference (A – B)
California	$169,300,507	$93,512,729	$75,787,778
Colorado	21,565,013	13,867,269	7,697,744
Florida	76,515,744	46,343,921	30,171,823
Louisiana	24,909,007	15,170,853	9,738,154
Michigan	168,174,169	98,696,062	69,478,107
Missouri	49,877,816	28,585,822	21,291,994
New York	164,710,637	94,144,144	70,566,493
Texas	119,221,686	70,254,768	48,966,918
Totals	**$794,274,579**	**$460,575,568**	**$333,699,011**

MEDICARE REGULATIONS PROVIDE DIFFERENT PAYMENT METHODOLOGIES FOR PROVIDER-BASED FACILITIES AND FREESTANDING FACILITIES

These higher payments occurred because under current regulations, Medicare pays provider-based facilities at higher payment rates than the rates it pays to freestanding facilities for the same type of services.

EFFECTS OF DIFFERENT PAYMENT METHODOLOGIES ON MEDICARE PROGRAM AND ON BENEFICIARIES

For E&M services provided in the selected States during our audit period, the combined effect on the Medicare program of this difference in payment methodologies was that Medicare paid $1,314,389,626 more for services performed in provider-based facilities than it would have paid for the same type of services at freestanding facilities in the same States. In addition, for the same timeframe and the same States, beneficiaries paid $333,699,011 more in coinsurance for E&M services performed at provider-based facilities than they would have paid for the same type of services if performed at freestanding facilities. The cumulative effect of the difference in payment methodologies was that Medicare and beneficiaries combined paid $1,648,088,637 more for E&M services performed at provider-based facilities in the selected States than they would have paid to freestanding facilities in the same States for the same services. See Table 1 earlier in this report.

APPENDIX E: EFFECTS OF THE PHYSICIAN FEE SCHEDULE 40-PERCENT ADJUSTER RATE ON THE DIFFERENCES IN MEDICARE AND BENEFICIARY PAYMENTS MADE TO PROVIDER-BASED FACILITIES AND FREESTANDING FACILITIES FOR EVALUATION AND MANAGEMENT SERVICES PERFORMED DURING CALENDAR YEARS 2010 THROUGH 2017

EFFECT OF THE 40-PERCENT ADJUSTER RATE ON DIFFERENCES IN PAYMENTS MADE TO PROVIDER-BASED AND FREESTANDING FACILITIES

To illustrate the effect of the 40-percent adjuster rate on the Medicare program of the difference in methodologies for calculating payments made to provider-based and freestanding facilities, Table 6 shows the difference ($6.73) between what Medicare paid for E&M services performed at a provider-based facility ($124.94) and what Medicare would have paid if the service had been performed at a freestanding facility ($118.21), in the context of HCPCS code G0463 for the OPPS payment and CPT code 99215 for the Part B PFS payment.[34] (The payments are based on a physician office visit for E&M services billed in Colorado for CY 2017.)

Table 6: Example of Provider-Based Facility Payments With OPPS 40-Percent Adjuster Compared to Freestanding Facility Payments

OPPS (Provider Component) 40% (A)	Medicare Part B Facility Fee (Professional Component) (B)	Provider-Based Total Payment (A + B)	Freestanding Medicare Part B Nonfacility Fee (C)	Difference ((A + B) – C)
$34.12	$90.82	$124.94	$118.21	**$6.73**

Therefore, the difference in payments made to provider-based and freestanding facilities decreased from $57.89 (without the 40-percent adjuster rate applied; Table 2) to $6.73 (with the 40-percent adjuster rate applied) if the E&M services were paid under CPT code 99215.

Aggregate Effect of Provider-Based Billing Arrangement When the 40-Percent Adjuster Rate Is Applied to Medicare Payments in the Selected States

For E&M services provided in the selected States during our audit period, the effect of applying the 40-percent adjuster rate to provider-based payments was that Medicare would have paid $207,812,078 more for services performed in provider-based facilities than it would have paid for the same type of services if performed at freestanding facilities in the same States.

[34] See footnote 6 for the AMA copyright notice. CPT code 99215 denotes the highest level of care for established patients being seen in the office for E&M services.

Table 7 compares, in each of the selected States and on an aggregate basis for our audit period, what Medicare would have paid for E&M services performed at provider-based facilities if the 40-percent adjuster rate had been applied with what Medicare would have paid for the same type of services if they had been performed in freestanding facilities.

Table 7: Medicare Program Provider-Based Facility Payments (40-Percent Adjuster Rate Applied) Compared to Freestanding Facility Payments by State CYs 2010–2017

State	40% Adjuster Rate (Provider-Based) (A)	Freestanding (B)	Difference (A – B)
California	$424,754,082	$374,050,914	$50,703,168
Colorado	61,840,583	55,469,075	6,371,508
Florida	201,446,939	185,375,684	16,071,255
Louisiana	65,720,124	60,683,413	5,036,711
Michigan	437,249,936	394,784,247	42,465,689
Missouri	127,567,289	114,343,287	14,224,002
New York	420,728,318	376,576,577	44,151,741
Texas	309,807,078	281,019,074	28,788,004
Totals	**$2,050,114,349**	**$1,842,302,271**	**$207,812,078**

Therefore, the total difference in payments for all eight States would have decreased from $1,314,389,626 (without the 40-percent adjuster rate applied; Table 3) to $207,812,078 (with the 40-percent adjuster rate applied) for E&M services under CPT code 99215.

Effect of the 40-Percent Adjuster Rate on Differences in Beneficiary Coinsurance Payments Between Provider-Based and Freestanding Facilities

Table 8 on the following page shows the effect of applying the 40-percent adjuster rate on the difference ($1.68) between beneficiary coinsurance payments for E&M services performed at a provider-based facility ($31.23) and what those payments would have been if the facility had been freestanding ($29.55), in the context of HCPCS code G0463 for the OPPS payment and CPT code 99215 for the Part B PFS payment. (The payments are based on a physician office visit billed for E&M services billed in Colorado for CY 2017.)

Table 8: Example of Provider-Based Facility Payments With 40-Percent Adjuster Rate Applied to OPPS Payments Compared to Freestanding Facility Beneficiary Coinsurance Payments				
OPPS Coinsurance 40% Adjuster Rate (A)	**Medicare Part B PFS Coinsurance (B)**	**Provider-Based Coinsurance Total Payment (A + B)**	**Freestanding Medicare Part B PFS Coinsurance (C)**	**Difference ((A + B) – C)**
$8.53	$22.70	$31.23	$29.55	**$1.68**

Therefore, the difference in beneficiary coinsurance payments between provider-based and freestanding facilities would have decreased from $14.48 (without the 40-percent adjuster rate applied; Appendix D, Table 4) to $1.68 (with the 40-percent adjuster rate applied; Table 8 above) for E&M services under CPT code 99215. In other words, beneficiaries would have paid $12.80 ($14.48 minus $1.68) less with the application of the 40-percent adjuster rate.

Aggregate Effect of Provider-Based Billing Arrangement on Beneficiary Coinsurance Payments in the Selected States

For E&M services provided in the selected States during our audit period, the effect of applying the 40-percent adjuster rate to provider-based payments was that Medicare beneficiaries would have paid $52,403,701 more in coinsurance to provider-based facilities than they would have paid for the same type of services if performed at freestanding facilities.

Table 9 on the following page compares, on an aggregate basis for our audit period and with the 40-percent adjuster rate applied, what beneficiaries would have paid in coinsurance for E&M services performed at provider-based facilities in each of the selected States with what they would have paid in coinsurance for the same type of services in the same States if those services had been performed in freestanding facilities.

Table 9: Medicare Program Provider-Based Facility Payments (40-Percent Adjuster Rate Applied) Compared to Freestanding Facility Beneficiary Coinsurance Payments CYs 2010–2017			
State	Provider-Based (A)	Freestanding (B)	Difference (A – B)
California	$106,710,188	$93,512,729	$13,197,459
Colorado	13,880,024	13,867,269	12,755
Florida	50,586,671	46,343,921	4,242,750
Louisiana	16,525,460	15,170,853	1,354,607
Michigan	109,705,871	98,696,062	11,009,809
Missouri	32,327,552	28,585,822	3,741,730
New York	105,527,896	94,144,144	11,383,752
Texas	77,715,607	70,254,768	7,460,839
Totals	**$512,979,269**	**$460,575,568**	**$52,403,701**

Therefore, the total difference in payments for all eight States would have decreased from $333,699,011 (without the 40-percent adjuster rate applied; Table 5) to $52,403,701 (with the 40-percent adjuster rate applied) for E&M services under CPT code 99215.

EFFECTS OF THE PHYSICIAN FEE SCHEDULE 40-PERCENT ADJUSTER RATE PAYMENT METHODOLOGY ON MEDICARE PROGRAM AND ON BENEFICIARIES

Application of the 40-percent adjuster rate would have significantly reduced Medicare and beneficiary payments to provider-based facilities. However, for E&M services provided in the selected States during our audit period, the combined effect of applying the 40-percent adjuster rate to provider-based payments was that Medicare still would have paid approximately $207,812,078 more for services performed in provider-based facilities than it would have paid for the same type of services at freestanding facilities in the same States. In addition, for the same timeframe and the same States, beneficiaries still would have paid approximately $52,403,701 more in coinsurance for E&M services performed at provider-based facilities than they would have paid for the same type of services if performed at freestanding facilities.

The cumulative effect of the difference in payment methodologies was that even with the 40-percent adjuster rate applied, Medicare and beneficiaries still would have paid a combined $260,215,779 more for E&M services performed at provider-based facilities in the selected States than they would have paid to freestanding facilities in the same States for the same type of services.

APPENDIX F: ANALYSIS OF DIFFERENCES IN PAYMENTS BETWEEN THE DIFFERENT PROVIDER-BASED PAYMENT METHODOLOGIES

Table 10 shows the difference between what was actually paid to provider-based facilities in the selected states and what the Medicare program and beneficiaries would have paid if the services had been paid with the 40-percent adjuster rate applied.

Table 10: Actual Payments Compared to Payments if Made With the 40-Percent Adjuster Rate (Provider-Based Facilities)

	Medicare	Beneficiaries	Total
Actual Payments	$3,156,691,897	$794,274,579	$3,950,966,476
40-Percent Adjuster Rate	2,050,114,349	512,979,269	2,563,093,619
Difference in Payments	$1,106,577,548	$281,295,310	$1,387,872,857

Note: Numbers do not add to totals because of rounding.

For E&M services provided in the selected States during our audit period, Medicare paid $1,106,577,548 more for services performed in provider-based facilities than it would have paid if the 40-percent adjuster rate had been applied. Also, beneficiaries paid $281,295,310 more for these services in these facilities than they would have paid if the 40-percent adjuster rate had been applied.

Table 11 on the following page shows the differences in payments between the different methodologies. Medicare and beneficiaries would have paid $1,387,872,858 less (Medicare would have paid $1,106,577,548 less and beneficiaries would have paid $281,295,310 less) if the 40-percent adjuster rate had been applied than the amounts that were actually paid.

However, as we described in Appendix E, the Medicare program and its beneficiaries would have saved an additional $260,215,779 ($207,812,078 on the part of the Medicare program and $52,403,701 on the part of beneficiaries) if they had paid for these services under the Medicare PFS nonfacility rate (i.e., with no OPPS payment) instead of having paid with the 40-percent adjuster rate applied.

Table 11: Comparison of Evaluation and Management Payments by Methodology[35]

Methodology	OPPS Payments	Part B Program Payments	Total Program Payments	Beneficiary OPPS Copay	Beneficiary Part B Copay	Total Beneficiary Copay	Total Payments by Methodology
(1) Actual Payment:[36]	$1,844,295,912	$1,312,395,985	$3,156,691,897	$468,825,518	$325,449,061	$794,274,579	$3,950,966,476
(2) 40-Percent Adjuster Rate:	737,718,364	1,312,395,985	2,050,114,349	187,530,208	325,449,061	512,979,269	2,563,093,619
(3) PFS Nonfacility Rate:[37]	0	1,842,302,271	1,842,302,271	0	460,575,568	460,575,568	2,302,877,839

	OPPS Payment Variance	Part B Program Payment Variance	Total Program Payment Variance	Beneficiary OPPS Copay Variance	Beneficiary Part B Copay Variance	Total Beneficiary Copay Variance	Total Payment Variance
Difference in Payments (1) – (2)	$1,106,577,548	$0	$1,106,577,548	$281,295,310	$0	$281,295,310	$1,387,872,858
Difference in Payments (2) – (3)	$737,718,364	($529,906,286)	$207,812,078	$187,530,208	($135,126,507)	$52,403,701	$260,215,779

Note: Numbers do not add to totals because of rounding.

[35] For this table only, we use the short term "copay" to mean "coinsurance."

[36] "Original" refers to payments made under the original provider-based payment methodology that was in place before the imposition of the CY 2018 and CY 2019 final rules.

[37] The amounts shown in this row equate to what Medicare would have paid at the PFS nonfacility rate if these were freestanding facilities.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: May 12, 2022

TO: Amy J. Fontz
Deputy Inspector General for Audit Services
Office of Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare and Beneficiaries Paid Substantially More to Provider-Based Facilities in Eight Selected States in Calendar Years 2010 Through 2017 Than They Paid to Freestanding Facilities in the Same States for the Same Type of Services (A-07-18-02815)

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 serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes. As such, CMS is committed to providing people with Medicare with high quality health care while, at the same time, working to protect the Medicare Trust Funds.

When a person with Medicare receives services in a hospital outpatient department, the total payment amount for the services made by Medicare is generally higher than the total payment amount made by Medicare when the individual receives those same or similar services in a physicians' office. Medicare pays a higher amount for services furnished to enrollees in the hospital outpatient department because it generally pays two separate claims for these services—one under the Outpatient Prospective Payment System (OPPS) for the institutional services and one under the Medicare Physician Fee Schedule (PFS) for the professional services furnished by a physician or other practitioner. People with Medicare are responsible for the cost-sharing liability, if any, for both of these claims, often resulting in higher total cost-sharing than if the service had been furnished in a physician's office.

Congress enacted section 603 of the Bipartisan Budget Act of 2015 (BBA of 2015), on November 2, 2015, which amended section 1833(t) of the Social Security Act (the Act) to change the way items and services furnished by certain off-campus provider-based departments (PBDs) are paid. Off-campus PBDs that were billing for covered outpatient department (OPD) services under the OPPS prior to the date of enactment of the BBA of 2015 (as well as off-campus hospital outpatient departments of providers subject to other exceptions added by sections 16001 and 16002 of the 21st Century Cures Act) could continue to be paid under the OPPS. Items and services furnished to people with Medicare by newly created off-campus PBDs (those that were not billing for covered OPD services under the OPPS prior to the date of enactment of the BBA of 2015) would no longer be considered covered OPD services for purposes of OPPS payment and would instead be paid under the "applicable payment system," which CMS determined to be the PFS.

To implement the section 603 amendments, the CY 2017 OPPS/Ambulatory Surgical Center (ASC) final rule with comment period established that nonexcepted facilities (those that were not grandfathered under the BBA) would be paid at 50 percent of what they would have been paid under the OPPS and that physicians furnishing services in these nonexcepted facilities would be paid the PFS facility rate. The CY 2018 PFS final rule reduced the payment for nonexcepted facilities to 40 percent.

While the changes required by the section 603 amendments to section 1833(t) of the Act addressed some of the concerns related to shifts in settings of care and overutilization in the hospital outpatient setting, the majority of hospital off-campus departments continued to receive full OPPS payment (including off-campus emergency departments and excepted off-campus departments of a hospital), which is often higher than the payment that would have been made if a similar service had been furnished in the physician's office setting.

These differences in payment rates unnecessarily shifted services away from the lower paying physician's office to the higher paying hospital outpatient department. The CY 2019 OPPS/ASC final rule with comment period adopted a method to control the unnecessary increase in the volume of the hospital outpatient clinic visit service, by utilizing a PFS-equivalent payment rate – the same rate paid to non-excepted off-campus hospital outpatient departments – when that service is furnished at excepted off-campus hospital outpatient departments. The clinic visit is the most common service billed under the OPPS. This policy has resulted in lower copays for people with Medicare and savings for the Medicare program.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS pursue legislative or regulatory changes to lower costs for both the Medicare program and beneficiaries, by equalizing payments as appropriate between provider-based facilities and freestanding facilities for E&M services.

CMS Response

A stated above, CMS has taken regulatory action through notice and comment rulemaking to address payment differentials for clinic visits furnished by off-campus hospital outpatient departments within our statutory authority, as appropriate. We will continue to monitor the impacts of this policy to ensure that people with Medicare continue to have access to quality care. However, the changes necessary to further implement this recommendation may require legislative action. Any proposals for legislative changes would be in the President's Budget.

CMS thanks OIG for the work done on this issue and looks forward to working with OIG in the future.