Report in Brief
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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.