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IN FOCUS

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Hospital Ownership: Medicare Sources of Information

Congress's understanding of hospital ownership is crucial in exercising its legislative and oversight role with respect to health care costs, quality, and access. The Centers for Medicare & Medicaid Services (CMS)—the agency that administers the Medicare program—collects ownership information from Medicare health care providers and suppliers, including hospitals. This data collection focuses primarily on program integrity, such as ensuring accurate and proper Medicare, and fraud, waste, and abuse prevention and detection. This specific focus can make it difficult to use CMS data to determine ownership's effect on health care cost, quality, and access.

Although CMS's data collection may satisfy reporting requirements for the purposes noted above, the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) have determined the Medicare ownership data are not sufficiently detailed, complete, or accurate to capture the complex business, organizational, and corporate structures in the health care sector. The data do not permit systematic analyses of the effects of ownership type on health care cost, quality, and access; this type of analysis is essential for Congress to develop informed policies and conduct effective oversight.

This In Focus addresses two Medicare sources of hospital ownership information—the Provider Enrollment, Chain, and Ownership System (PECOS) and the Cost Report e-Filing (MCReF) system. Content in these systems is organized by the event or activity that triggers reporting by a hospital—initial enrollment and revalidation of enrollment in Medicare; a change of ownership (CHOW), merger, acquisition, or consolidation; and the annual cost report submission required by some hospitals and other health care providers, though not all. Limitations of these data sources are also discussed, focusing on limitations for purposes of robust congressional oversight of hospital ownership.

PECOS and MCReF data generally are available free of charge. There are also nongovernment sources of ownership information that require paid subscriptions; these data sources are outside the scope of this In Focus.

Hospital Enrollment in Medicare

Social Security Act (SSA) Section 1866(j) gives CMS authority to collect information from hospitals (and other providers) for purposes of enrolling and periodically revalidating in Medicare. Under this authority, CMS promulgates regulations that, among other things, specify the kinds of information it collects; this includes ownership. Hospitals submit this information to CMS electronically through PECOS or by transmitting a completed Form CMS-855 by mail. This data collection activity is subject to the Paperwork Reduction Act (PRA; 44 U.S.C. §§3501-3521) and thus receives Office of Management and Budget review and clearance. (For information about PRA, see CRS In Focus IF11837, *The Paperwork Reduction Act and Federal Collections of Information: A Brief Overview*.)

The information hospitals report includes their *Internal Revenue Service (IRS) designation* (proprietary, nonprofit, or disregarded entity); *business structure* (corporation, limited liability company, partnership, sole proprietor, other, federal or state government); and whether the hospital is an Indian Health Service (IHS) facility or physician-owned. (For further detail about physician ownership, physician self-referral, and Stark law, see CRS Report RS22743, *Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview*.)

Hospitals must disclose any entities and individuals with a 5% or greater direct, indirect, or mortgage/security ownership interest. Hospitals also must report all general, limited, and non-limited partnerships, regardless of the percentage ownership interest.

CMS instructs hospitals to report ownership information that includes investment firms, such as private equity and real estate investment trusts, banks and bank holding companies, and trusts and their trustees. Hospitals also must submit an organizational chart that identifies the entities listed above, their relationship to the hospital, and their relationship to each other. If the hospital is organized as a corporation, it also must report the names of its officers and directors.

The aforementioned ownership types are defined in regulation or other CMS documents, such as the Form CMS-855 for purposes of Medicare.

Hospital Change of Ownership, Merger and Acquisition, and Consolidation

CMS requires hospitals to report CHOWs, mergers, acquisitions, and consolidations electronically through PECOS or by mail on a completed Form CMS-855.

For a CHOW, the new owners report ownership information as if the hospital were newly enrolling in Medicare; this information includes the legal name of the acquired and the acquiring hospital/organization, the locations of main campuses and any off-campus services and departments, and contact information.

Hospitals that merge with, or are acquired by, other hospital(s) report the legal business name of the acquiring and acquired hospital(s).

Hospitals that consolidate with another hospital(s)—creating a new hospital or health care entity that did not previously exist—report the legal business name of each individual consolidating hospital, as well as the legal business name and tax identification number of the newly created hospital or health care entity.

Medicare Hospital Cost Report

SSA 1815(a) and CMS regulations require that hospitals enrolled in Medicare submit an annual cost report to CMS. Hospitals may submit their cost reports electronically through MCReF or mail the completed cost report form. The Medicare cost report contains financial and descriptive information about a hospital. CMS uses cost report data to calculate the correct amount of Medicare payments and applicable payment adjustments.

One field in the Medicare cost report—the "type of control" field—categorizes a hospital's ownership structure. Ownership is grouped into three broad categories: governmental, proprietary (i.e., for-profit), and voluntary (i.e., nonprofit). Each of these categories is further broken down into subcategories:

- **Proprietary ownership** has four subcategories: (1) individual, (2) corporation, (3) partnership, and (4) other.
- **Voluntary nonprofit** has two subcategories: (1) church and (2) other.
- **Governmental** has seven subcategories: (1) federal, (2) city-county, (3) county, (4) state, (5) hospital district, (6) city, and (7) other.

Unlike the ownership terms and structures referenced in the Medicare enrollment process (see "Hospital Enrollment in Medicare"), CMS does not define the type of control categories and subcategories used for the hospital cost report. This introduces potential variability (i.e., lack of standardization) of ownership data across hospitals.

Medicare cost report data, including type of control, are publicly available for download directly from CMS's website through the Healthcare Cost Report Information System. Downloading requires use of software such Oracle, SAS, SPSS, Microsoft SQL, or DB2; CMS does not offer technical support for using these tools, which could be an access barrier for some researchers.

Limitations of Medicare Hospital Ownership Information

Medicare cost report ownership data are limited in both scope and level of detail, given that the data's primary purpose is to ensure accurate and appropriate Medicare payments, not to analyze complex ownership structures. For example, Medicare pays general acute care hospitals a fixed base payment for each inpatient stay by a Medicare beneficiary; this base payment rate is subject to numerous adjustments, the amount of which depends on a hospital's characteristics (e.g., urban, rural, teaching hospital). The cost report collects data used to determine which Medicare payment adjustments a hospital qualifies for and the amount of such adjustments. Ownership data are self-reported, do not affect Medicare payment adjustments, and lack sufficient detail to provide insight into today's complex hospital corporate structures, including ownership.

PECOS ownership data are more detailed than cost report data but have limitations in terms of purpose, accuracy, and completeness. The primary purpose of PECOS data is to support Medicare's provider enrollment process and monitor fraud and abuse rather than to comprehensively and accurately identify complex hospital corporate structures, including ownership.

The GAO (2010, 2015, 2023), MedPAC (2021), and Office of Inspector General for the Department of Health and Human Services (HHS-OIG (2009, 2015) have identified limitations of PECOS data. These limitations include (1) incomplete and inaccurate ownership information, (2) not capturing the full hierarchy of owner entities, and (3) self-reported data that CMS has limited ability and resources to verify. For example, both GAO (2023) and MedPAC (2021) relied on non-Medicare data sources to supplement PECOS data to perform their respective ownership analyses. They noted that the supplemental data sources had their own limitations. Other analysts have described methodological and technical challenges of linking data from disparate sources, including lack of a common identifier to link records from multiple data sources. Thus, relying on multiple data sources for ownership information is cumbersome and time-consuming, and the information still may be incomplete and inaccurate.

Considerations for Congress

To more thoroughly examine policy-relevant questions about hospital ownership and its effects on health care costs, quality, and access and to inform congressional oversight and legislation, Congress may consider options to address the following challenges, among others, with the existing hospital (and other health care provider) ownership data.

- **Align Purpose with Information Collected:** Ensure the data elements and detail align with the kind of information Congress and CMS need to draw generalizable conclusions about ownership and its effect on health care cost, quality, and access.
- **Monitor Accuracy, Completeness:** Ensure CMS continuously monitors hospital ownership reporting compliance, to include accuracy and completeness of the data submitted to CMS.
- **Ensure Data Relevance and Standardization:** Ensure the data remain relevant as hospital financial and business structures evolve while maintaining standardization that permits comparison over time.
- **Assess Data Collection and Burden:** Address possible trade-offs between comprehensive data collection and the administrative and cost burden on hospitals and CMS.

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