Medical EconomicsAcquisitions

New facility fees rule could slow practice acquisitions

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By Jeff Bendix

Hospital systems may no longer be quite as eager to acquire independent medical practices now that the government is scaling back a significant financial incentive for doing so.

Under a rule that took effect January 1, Medicare is reducing its payments for services and procedures at many hospital-owned outpatient departments, bringing them closer to what it pays physicians in independent practice for the same services and procedures.

The higher payments to hospital outpatient departments results from Medicare's use of a payment schedule that includes a "facility fee" paid to the hospital, in addition to the payment for the physician's services. Its payments to independent doctors do not include a facility fee.

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The new rule reduces facility fee payments by 50%. However, it applies only to outpatient facilities not on a hospital's main campus and where providers had not timely billed for their services as of November 2, 2015. Hospital-owned emergency departments are also exempt, regardless of their location.

"Several things give hospitals the appetite to acquire independent facilities, but one of the most important is the opportunity to charge more for the same service," says Marni Jameson Carey, executive director of the Association of Independent Doctors. "And it drives up [healthcare] costs astronomically."

From the perspective of medical practices, however, that change could turn out to be a double-edged sword. Practices wishing to stay independent won't find themselves tempted by as many, or as lucrative, buyout offers. Conversely, practices that want to sell themselves will have to work harder to make themselves attractive to a suitor, and are likely to find fewer of them.

Reining-in costs

Concerns over the impact of facility fees, which had been percolating among healthcare policy experts for more than a decade, crystallized in a 2012 Medicare Payment Advisory Commission (MedPAC) report to Congress. The report singled out facility fees for driving up Medicare costs without improving the quality of care.

It noted, for example, that Medicare was paying about 80% more for a typical 15-minute evaluation and management (E/M) visit in a hospital outpatient department than for the same visit in a freestanding physician office.

That difference, MedPAC said, gave hospitals an incentive to buy practices and freestanding procedural facilities and convert them to outpatient departments. It also resulted in higher costs to Medicare as well as to the program's beneficiaries, in the form of higher copays.

Partly in response to the report, Congress addressed the issue of facility fees in the Bipartisan Budget Act of 2015. A section of that law calls for the Centers for Medicare & Medicaid Services (CMS) to make Medicare payments "site neutral"—that is, the total reimbursement for the service or procedure should be the same, regardless of where it was provided.

The rule is the first step in a multi-year process of implementing site payment neutrality, according to Leslie Goldsmith, JD, an attorney with the law firm Baker Donelson based in Baltimore, Maryland.

"They [CMS] were having a difficult time teasing out site neutrality on a service-by-service basis," she says. "They're still working on it and hope to come up with a more refined methodology after 2018, but for now this [rule] is kind of a placeholder."

Fees create unfair advantage

Carey notes that the incentive facility fees create for hospitals to acquire independent medical practices reduces competition in the healthcare system and leads to higher costs for insurance companies and patients. In addition, buying up practices adds to their patient bases, which adds to their competitive advantage over smaller, independent practices in negotiating contracts with insurers.

"A hospital with 200,000 patients is going to have a lot more pull with insurers than an independent practice with 2,000 patients," she says. That ability to negotiate higher reimbursements, in turn, gives hospitals the ability to offer more lucrative offers to independent practices, thereby perpetuating the acquisition cycle.

The same advantage applies in competing for young physicians, according to Steven Peltz, CHBC, principal of Peltz Practice Management & Consulting Services in Brewster, New York.

"When a kid comes out of residency, with the money hospitals get from facility fees they can offer him maybe $170,000 a year to start, regardless of what they generate in the first year or two of their contract. There's no way private practices can compete with that."

Peltz adds that limiting future facility fees will reduce anxiety among remaining independent practices "because they will no longer be seeing as many of their colleagues being scooped up by hospitals. We all experience the herd mentality where if we see a trend going on around us we start worrying, 'should I be doing this too?'"

Inderpal Chhabra, MD, FACP, an internist in the New York City borough of Queens, has been watching hospitals buy up other independent practices almost since he opened his own practice 17 years ago. "But that incentive will go down if they are not allowed to bill for facility fees," he says.

Chhabra adds that he's seen the impact such fees can have on his own patients. He cites the example of a patient who he used to send to a free-standing facility for stress tests. The charge there was about $600.

"Then one year I sent him to a hospital for the exact same procedure and the charges were over $2,000. The patient brought in their explanation of benefits and said, 'Doc, what's going on?'"

Straining doctor-patient relationships

That corrosive impact on the doctor-patient relationship is a big reason why Spencer Kroll, MD, Ph.D., an internist in Morganville, New Jersey, is happy to see facility fees go away. Primary care physicians (PCPs) work hard to build relationships both with patients and with specialists to whom they refer patients for treatment, he says.

But with facility fees driving up the cost of care at hospital-owned practices, "that PCP may no longer be able to call that specialist they've built the relationship with because it's no longer the economically appropriate choice for the patient.

"It's really putting a lot of strain on the traditional doctor-patient relationship," he says. "When I send someone to a hospital facility it can sometimes explode into a lot more charges than the patient is expecting, but by that point it's out of my control."

Kroll thinks doing away with facility fees could cause hospitals to "think twice" about buying practices. "The potential for financial loss [because they can no longer charge the fees] means it may no longer be worthwhile to them."

Acquisition market slows, but won't stop

Of course, the ability to charge facility fees is not the sole reason hospitals like to purchase primary care practices, so the new rule will not completely stop them from doing so, experts note. That's mainly because primary care practices are the major source of referrals to specialists and to the hospital's inpatient facilities. Both of these are, generally, far more lucrative to a hospital system than are primary care services.

"These systems thrive by spreading geographically and acquiring more and more patient lives, and in order to do that they need to own the referral sources driving patients to the hospitals," says Susanne Madden, chief executive officer of the Verden Group, a practice consulting firm.

Even so, consultants who work with independent practices say they've seen a change in the market for them recently. "Hospitals have gotten more conservative in their offers over the last year or so," says Chris Zaenger, CHBC, principal of Z Management Group and a *Medical Economics* editorial consultant. "I'm seeing fewer acquisitions, and a lot more expectations on the doctors [in acquired practices] in terms of things like work hours and higher RVU [relative value unit] targets" the last couple of years, he says, partly in anticipation of new rules regarding facility fees.

Importance of preparation

For practices interested in selling themselves to a hospital system, the new facilities fee rule further highlights the importance of thorough preparation, consultants say. Peltz advises collecting data on the number of times the practice has billed each CPT code during the past three or four years, as well as what specialists it has referred patients to, how many and for what reasons.

"You want to load your gun with bullets, so that when XYZ hospital system comes along you can tell them 'here's what we have,' and they can quickly translate that data into revenue for them and come up with an offer to buy the practice," he says.

Zaenger stresses the importance of practice efficiency and use of up-to-date in its technology and facilities. "Buyers are looking for well-oiled machines that they don't have to put a lot of time and money

into," he says. "A practice that still has old equipment and is using paper charts won't be attractive" to a potential buyer.

Conversely, a busy practice in a modern facility, one that has met meaningful use requirements and reported quality data, whose doctors are board-certified and staff members are well-trained, he says, "these are going to be attractive features to a hospital, and will strengthen your chances of concluding a sale that you're happy with."