

Changes Impacting Medicare Reimbursement and Provider Status Ahead for Hospitals & Off-Campus Facilities: Hospitals Must Rethink Approaches to Future Acquisitions & Synergies

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For many years now, hospitals have used provider-based rules, allowing freestanding diagnostic and treatment facilities to be treated as part of the hospital for the purpose of Medicare payment. The use of these rules governing Medicare payments has also included physician offices operated as part of the hospital and included in the hospital's Medicare provider number. As a result, hospitals have received a Medicare reimbursement based on the outpatient hospital fee schedule as opposed to the physician fee schedule or ambulatory surgery center rates resulting in a higher reimbursement.

Provider-based status can extend to a physician office. Many hospitals have converted certain physician offices to hospital clinics or hospital outpatient departments. In this construct, the practice bills Medicare separately for facility fees and physician fees. The physician fee is adjusted downward for the use of the hospital facility, but the total still exceeds the payment for an identical physician office visit. In a December 2015 report from the General Accounting Office, it was found that the separate billing related to consolidation of physician practices by hospitals had increased spending by \$51 for the average office visit.

The consolidation of physician practices, the merger of ambulatory surgery centers and freestanding imaging centers are just part of the offerings by hospital systems that have seen an increase in Medicare dollars. This trend is happening within the hospitals themselves as hospitals are redefining or relocating ancillary services that were once physician-based to hospital outpatient departments. These changes have contributed to the increased spending by Medicare in hospital outpatient departments. The rise in payments has been significant given that Medicare Part B for outpatient services rose from \$22.4 billion in 2007 to \$36.3 billion in 2013. This represents an annual increase of 8.3 percent compared to only 5.8 percent in all of Medicare Part B spending during the same period. [\[i\]](#)

There are a number of key drivers related to the higher hospital outpatient spending, including more outpatient surgeries and continued growth demand for emergency and other outpatient services. Still, hospitals have consistently, through acquisition, demonstrated the ability to move existing volumes by establishing a larger provider-based setting with the acquisition of ambulatory surgery centers and imaging centers. In many cases, hospitals have acquired physicians' practices with a significant ancillary component, especially in the fields of cardiology and oncology. In the case of a hospital, it makes sense to consolidate a cardiology practice's stress testing, Holter monitors and the like to the hospital. This strategic approach of incorporating physician practices and onsite medical testing systems not only makes good business sense for the higher Medicare and managed care reimbursements, but it also has value for the overall operation in working with economies of scale. This is particularly true with medical

oncology where, under the provider-based status, some of the drugs will qualify for 340(b) pricing.

Hospitals that have acquired physician practices may or may not have made the decision to treat the office as part of the hospital, allowing for the higher total payments, as noted by the GAO. Still, many hospitals have elected to continue to treat the acquired physician practice as a separate office, ultimately not incorporating them into the hospital. The conversion to a hospital department will often carry a number of hidden costs. For example, the provider-based clinic requires two claims to Medicare: One is billed as a hospital on Form UB-04 for payment of the facility related to all testing conducted. The other bill is found on Form CMS-1500 for the professional provider component.

For non-Medicare/Medicaid patients, the hospital will likely have to bill one consolidated claim consistent with historical practices. Often, this means two different billing systems, creating a scenario with two patient accounts for the same visit and a sometimes-confused Medicare patient. Another expense consideration for hospital administrators is the cost related to having the practice office included in the hospital license, particularly in the area of space cost, including renovations and code requirements, the need to merge employees under the hospital benefit plans and policies required by accreditation. Given the administrative burden, many hospitals have elected not to treat acquired physician practices as part of the hospital. However, hospitals have been moving certain ancillary tests to the hospital operations.

A Time of Change Related to Provider Status Has Arrived With the Bipartisan Budget Act of 2015

On November 2, 2015, President Obama signed the Bipartisan Budget Act of 2015 into law. Section 603 contained changes to the definition of provider-based clinical operations, effective for those entities not already deemed as provider-based on the date of enactment. Due to the recent passage of new legislation, the ability to migrate services to the higher fee schedule in the future is limited to practices and services located within 250 yards of a hospital campus. The new definition is effective January 1, 2017 and applies to any entity not deemed provider-based prior to November 2, 2015. The change in the definition of a provider-based clinical operation will impact the way hospitals view their acquisition and development strategy going forward.

Prior to the change in the law, a location might qualify as provider based if it was within 35 miles of the main facility. Additionally, under the old construct, a facility might qualify if it met other criteria. The variables for the other criteria include the distance from the main campus, management structure and whether it was a joint venture. The new law limits provider-based clinical operations to hospital campuses defined as being within 250 yards of the hospital's main buildings.

Some of the location scenarios impacted by the new provider-based definition include:

- **Clinical operations and satellite hospitals not within 250 yards of the hospital's main campus.** In this scenario, Medicare reimbursement will be limited to the physician fee schedule, ASC or

other applicable fee schedules.

- **A newly constructed or acquired imaging center located five miles away.** Services provided at these facilities will no longer qualify as provider-based. These facilities will be paid as an independent diagnostic testing facility under the physician fee schedule.
- **Certain services provided within the hospital campus.** With the introduction of the new criteria, a hospital can encounter restrictions on certain services within its campus. For instance, if a hospital features an oncologist office that is within a mile of its chemotherapy services, the new law will not allow the two services on the same campus. Under the law, the two services (even where cancer treatment is concerned) are seen to benefit the other. As a result, the reimbursement advantage that existed from converting to provider-based will largely evaporate.

A Future Filled With Questions That Must Be Addressed

Questions about the specific definitions will continue until proposed regulations are published in the summer of 2016. Among the key questions thus far are the following:

- What constitutes the “main buildings” from which the 250 yards will be measured? Which building is a main building? What is the one primary location? How will the new law impact all buildings connected providing hospital services? How will it impact all buildings connected on campus regardless of the nature of service?
- From where is the 250 yards measured?
 - What is the starting point of the measurement? Will it be measured from the main entrance, any hospital entrance, any portion of the buildings and so on?
 - What is the ending point of the measurement? Will it be measured to the entrance of the provider-based service, to the building in which it is located, to the center of the provider based service and so on?
- Given that the provider-based definition now includes services located within 250 yards of a satellite, will the satellite continue to have limitations? For example, in the past, a provider-based unit located away from the main campus had restrictions on the terms of a management or joint ventures agreement. These were related to employment of staff and reporting lines to the health system executive management.
- Provider-based facilities existing on November 2, 2015, and more than 250 yards from the main or a satellite campus may continue as provider-based. With that stated, will these facilities be allowed to expand (services and/or size) in the existing location? And if so, how will that be structured?
- Free-standing emergency rooms can continue to be treated as provider-based. The law states the following: “...other than items and services furnished by a dedicated emergency department (as defined in section 489.24(b) of title 42 of the Code of Federal Regulations).” Given those changes, one question will be what services can be located in a freestanding emergency room and can they be made available to non-emergency patients? For example, could you have a CT

scanner in the emergency room license?

- If so, can it treat non-emergency services?
- If not, can the emergency room buy CT scans using “under arrangements”?

Moving Forward & Planning Under the New Law

In many cases, the new location will clearly *not* be within 250 yards of a hospital campus and the hospital can proceed on the basis of the non-hospital reimbursement. In these instances, the following should be taken into consideration by hospitals:

- Determining if the acquisition of services and practices still makes financial sense without the benefit of HOPD payment rates. This may require additional financial due diligence.
- Forecast options for operations, including the following:
 - Determining if it makes sense to relocate services to the main campus or a satellite.
 - Evaluating the cost of providing services within a hospital facility versus the cost of a seller’s location, or alternatives for other locations.
 - Evaluating the cost of operating a hospital vs. a freestanding operation.
- The ability to develop an understanding of any billing process or management changes if the provider setting changes.
- If the decision is made not to be hospital-based, administrators must understand the applicable payment system.
- Administrators must be vigilant against improperly sharing managed care fee schedules between key competitors.
- If the services are within or around the 250-yard limit, the following must be considered:
 - How comfortable is the hospital that it will be in the 250-yard limit? If not, can the project be delayed pending proposed regulations?
 - How does a future hospital expansion impact the 250-yard requirement? (Note: Hospitals have a long history of expansion and growth).
 - Do special rules apply to the satellite campus?
- Can existing (prior to November 2, 2015) provider-based services located off campus be expanded or relocated?
 - In the same space?
 - In the same building or contiguous space?
 - On the same “non-hospital” campus?
 - Can it include new services of the same nature (MRI and imaging) or of differing services (PT v. Radiology)?

Further Change Could Be on the Horizon

It is critical that a hospital remain aware of the changing regulatory environment and be flexible in the handling of off-campus plans within the activities related to both development and acquisitions. The

regulations, when published, will certainly answer many of our anticipated questions. However, they are quite likely to raise new questions and issues. No doubt hospitals will find themselves in unique scenarios not addressed in the regulations. In some cases, the resolution of certain issues and the criteria may rest with the Center for Medicare and Medicare Services' (CMS) regional offices or with the individual state licensing board. Monitoring the changes will require strategic thinking, strong financial analysis and good legal advice.

For services performed outside the 250-yard limit, it may make sense for hospitals to consider joint venturing a given service with one of the many niche providers in the outpatient arena (e.g., imaging centers, urgent care, physical therapy, occupational medicine and ambulatory surgery). The niche providers are experienced at working within the lower fee schedules. These operations typically have excellent control on expenses and effective marketing programs. The niche provider will appreciate the existing brand recognition and managed care relationships available from the hospital. Both parties can benefit by sharing capital investment, creating a win-win situation.

This change is only the first shot to be fired, taking aim at a movement for site-neutral payment. Over time, budget constraints will cause Medicare to look again at the definition of provider-based units. The next comprehensive review in this area will likely include some of the grandfathered provider-based units. It is likely that the next round of changes will be particularly focused on the more pricey services like outpatient surgery and high-value imaging.

It is likely that the issue of site-neutral payments will not be limited to Medicare. Managed Care companies are already considering how to lower contracted fees for services that compete with the non-hospital locations. To further examine the impact of site-neutral payments, we invite you to review our previous article titled "Understanding the Power of Price Transparency in Healthcare".

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General Accounting Office, December 2015, Medicare, Increasing Hospital- Physician Consolidation Highlights Need for Payment Reform

We Can Help!

Are you prepared for Medicare reimbursement and provider status changes that will be put into place with the implementation of Bipartisan Budget Act of 2015? The Elliott Davis Decosimo Healthcare Team features the resources and expertise necessary to provide your organization with an in-depth and detailed review to address the implications you face under the new law. To discuss your situation, contact your Elliott Davis Decosimo healthcare advisor or our Healthcare Practice leader Ken Conner at 866-417-4059.



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