



# Leveling the Playing Field: The Impact of Equalizing Payment for Evaluation & Management Visits on Physician Practice Consolidation

Over the last 10 years, hospitals across the country and in Arizona and have been steadily merging and purchasing physician practices. In some specialties, more than 50 percent of physicians are now hospital-based employees

management patient visits (E&M).

In 2013, the *Denver Post* reported on a vivid example of this phenomenon with a patient who received two cardiac stress tests: the first in the physician's office; the second after the physician's practice was purchased by a hospital. The first test cost \$2,100; the second test cost \$8,000, due to an added facility fee.

Similarly, in 2013, the Medicare Payment Advisory Commission (MedPAC), an independent congressional panel that reviews Medicare, noted that a routine 15-minute office visit cost \$72.50 at a doctor's office, but \$123.88 if billed as a hospital outpatient visit.

MedPAC expressed concerns about the financial incentives for shifting services from physician offices to hospital outpatient departments. As a result, MedPAC recommended that payment variations for the same services in different ambulatory settings be



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rather than owners of their practice.

The trend in consolidation has been driven in part by the goals of the Affordable Care Act to encourage coordination of care and to reward value instead of volume. Another reason is that Medicare fee-for-service pays hospital-based physicians more than office-based physicians for identical non-emergency evaluation and

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equalized. This recommendation was recently adopted by the United States Government Accountability Office (GAO) in its December, 2015 report to Congress entitled, "Medicare, Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform."

The GAO found that between 2007 and 2013 the number of vertically consolidated hospitals increased from about 1,400 to 1,700. Meanwhile, it noted that the number of vertically consolidated physicians almost doubled from about 96,000 to 182,000.

Not surprisingly, it found that hospitals have more E&M visits performed in higher

paid hospital outpatient departments than lower paid physician offices.

Because Medicare pays for the same physician E&M services at a higher rate when performed at a hospital outpatient department, it found that Medicare expenditures for outpatient services grew at a rate of 8.3% annually, increasing from 22.4 billion to 36.3 billion dollars. It noted that the difference in payment rates provides an incentive for hospitals to acquire physician practices and to increase healthcare costs.

The Centers for Medicare and Medicaid Services (CMS) does not have the authority

to equalize payment rates for E&M visits between outpatient departments and physician offices to achieve Medicare savings. Therefore, the GAO recommended that Congress fix discrepancy.

To address the practice of hospitals acquiring physician offices and billing at higher reimbursement rates, President Obama proposed in his Fiscal Year 2016 budget to impose site neutrality for E&M visits.

In the Bipartisan Budget Act of 2015 (BPA), a compromise was reached. The BPA establishes site-neutral payment policy for newly-acquired, provider-based, off-campus hospital outpatient departments after November 2, 2016.

However, provider-based facilities acquired before the law's enactment may continue to bill under the Hospital Outpatient Prospective Payment System.

In contrast, any newly acquired physician practices after the date of enactment are prohibited from doing so for items and services furnished after January 2, 2017.

The reaction to the BPA and the possibility future expansion of site-neutral payment policies has been fierce. Since the site-neutral policy became effective, hospital industry groups have argued to Congress that the compromise policy will financially harm hospitals, potentially cause outpatient departments at teaching hospitals to close,

impact charity care and cause some hospitals to close.

It remains to be seen whether Congress will address existing hospital-based physician practices and other areas of inequality in site payments in future legislation. The potential savings involved would suggest that Congress will.

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The two primary reasons to consolidate are the economics of scale and the potential for improved contracting with payors, hospitals, and other organizations. The economics of scale include, among other things, efficiencies and cost savings in technology investment, risk management, marketing, joint purchasing, developing Stark compliant ancillary revenues, billing and collection, and benefit plans.

The challenges, of course, are loss of autonomy, incompatibility, significant financial risk, and uncertainty of outcomes. A list of some of the issues to consider are featured in the inset.

Not everyone wants to be employed by a hospital. Although solo or small practice may be a part of the past, physician practice consolidation is a viable practice option that likely has a bright future. **AM**

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## Consolidation: Issues to Consider

### Getting Started

- Letter of Intent
- Mission Statement
- Confidentiality Agreement
- Cost Sharing Agreement / Capital Account
- Feasibility Study
- Timeline and Meeting Schedule
- Accountant and attorney input

### Due Diligence

- Practice Assets /Liabilities
  - Leases for offices and equipment
  - List of payors
  - Malpractice policies
  - Software systems and EMR
  - Employees
  - Outstanding liens / loans
  - Benefit plans
- Antitrust Issues
  - Fee schedules / Insurer payment information
    - No sharing of reimbursement, marketing, strategic plans and other competitively sensitive information during negotiations (may use third-party to aggregate data)
- Buy-In Methodology

### Business Plan

- Financial Model of Post-Consolidation Practice
  - Proforma
    - Costs / Contributions
    - Impact on revenues
      - Short and long term
  - Line of credit for initial cash flow interruption

### Structure

- New Practice Entity
  - Limited Liability Company (LLC) or Professional Corporation (PC)
    - Governed by Operating Agreement or Bylaws
      - Board of Managers / Directors
      - Centralized decision making body
      - Voting representative of Group
      - Majority and supermajority rights
      - Withdrawal / buy-out
      - How are decisions made
      - Committees
      - Non-Competition Agreements
      - Consolidated billing, accounting and financial reporting
  - New Payor Contracts
    - Single billing number
  - Employs Physicians and Staff
    - Compensation Formulas
      - Shareholder / Member / Employee
    - Allocation of Revenues and Expenses