Budget deal will impact hospital acquisitions of physician practices

Rick L. Hindmand, Emily A. Johnson | Wednesday, November 4, 2015

On Monday, President Barack Obama signed the Bipartisan Budget Act of 2015 into law. Medicare site neutral payment provisions in Section 603 of the act will restrict the ability of health systems to benefit from Medicare hospital outpatient reimbursement rates after acquiring a physician practice or ambulatory surgery center.

This landmark legislation provides the framework for the federal budget for the next two years, ensures the Department of Treasury does not default on its federal debts, replaces the across-the-board spending cuts called “sequestration” with more targeted cuts, and sets forth other policy changes. Given that some of the major changes included in this budget agreement would increase federal spending, lawmakers are required to include “pay-fors” to ensure the net-cost of the legislation does not increase the deficit. One such pay-for involves Section 603 of the act, which will in many cases make acquiring physician practices less attractive to hospitals. It does this by limiting Medicare reimbursement for services provided in new off-campus locations to the amounts that the physician practice would receive for the same services, rather than the higher payments that hospitals have traditionally received under the Outpatient Prospective Payment System (OPPS) after converting physician practices to hospital outpatient departments (HOPDs).

Currently, Medicare reimburses providers differently depending on factors such as the location where the service is provided, the type of provider, and whether the service is inpatient or outpatient. For example, Medicare generally pays hospitals more for physician office visits and related procedures and tests when the services are performed in an HOPD setting than it pays a traditional physician practice for the same services. This is because the hospital receives both a facility fee under OPPS and a professional fee, with the combined amounts generally exceeding the payment that a physician practice would receive under the Medicare Physician Fee Schedule. This reimbursement differential applies even if the same physician provides the same services to the same patient at the same office, in which case the principal difference from the patient’s perspective is often higher out-of-pocket costs. This opportunity for higher reimbursement has been criticized for providing a financial incentive for hospitals to acquire physician practices and shift the practices to HOPD status.

The Medicare Payment Advisory Commission (MedPAC), whose job is to find financial savings in Medicare, has expressed concern that evaluation and management (E&M) visits and other services have been moving from physician offices to HOPD sites, resulting in higher Medicare and beneficiary spending. In order to reduce incentives to shift care to HOPD facilities when the patient does not need hospital-level care, MedPAC recommended adjusting OPPS payment rates so that Medicare payment for E&M office visits would be the same for physician practices and HOPDs, and so that payment rates for various other services would be more closely aligned across physician practice and HOPD settings. Paying the same amount regardless of the site of service is sometimes referred to as “site neutral” payment or “site neutrality.” The White House agrees with MedPAC and has formally requested that Congress adjust Medicare payment polices to reflect a more site neutral approach.

When the accounting of the budget agreement came up short, Congress included site neutral payments to bring in $9.3 billion in savings, allowing the legislation to pass various budget control laws. New off-campus HOPDs will be paid under other Medicare payment systems (typically the Medicare Physician Fee Schedule or the Ambulatory Surgical Center Fee Schedule), rather receiving payment under the OPPS. This new policy will apply to most HOPD items and services (other than hospital emergency department services) furnished on or after Jan. 1, 2017, unless either:

- The HOPD is located within the area that Medicare regulations define as the hospital’s “campus” (generally, the hospital’s main buildings and areas within 250 yards of the main buildings, as well as other areas designated by CMS as part of the campus) or within 250 yards of a remote location; or
- The HOPD billed as an outpatient department prior to Nov. 2, 2015 (the date of enactment).

Even though the payment policy change will take effect on Jan. 1, 2017, grandfathered status will be determined as of Nov. 1, 2015. Practice acquisitions (even if in the pipeline prior to enactment of this legislation) will not have grandfathered status unless outpatient billing began for that practice location prior to enactment.

Though this policy change provides an important step toward site neutrality between new off-campus HOPDs and freestanding physician practices, Section 603 nonetheless departs from site neutrality principles by providing different reimbursement to HOPDs based on whether an HOPD is either grandfathered or is on-campus (and therefore eligible for OPPS reimbursement), or is a new off-campus HOPD (which will be subject to the policy change and therefore be paid under the Medicare Physician Fee Schedule or the Ambulatory Surgical Center Fee Schedule, and not under OPPS). These distinctions may affect expansion through acquisition of physician practices as well as through other means.

The implications of this policy change will depend in part on how the Centers for Medicare & Medicaid Services (CMS) implements Section 603 through upcoming regulations and interpretation, as well as on how hospitals, physicians and other healthcare providers respond to this changing environment. For example, CMS may place additional restrictions on the expansion of HOPDs. Health systems that are considering creating new off-campus outpatient departments or acquiring existing physician practices, ambulatory surgery centers or other healthcare providers to furnish services in an outpatient setting should consider the likely impact of the new policies. Likewise, physicians and other healthcare providers who are considering affiliations or transactions with health systems involving outpatient services should consider the potential impact of Section 603 and upcoming regulations.

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