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Alternative Hospital/Physician Strategies to Create a More Effective and Efficient Community Delivery System

Over the last 20+ years, hospitals and physicians have been exploring a variety of strategies to both offset declining income and rising costs and preserve market share and admissions. In the late 80s and early 90s, hospitals and health systems went on a buying spree of primary care groups with the belief that managed care was going to focus on prepaid, capitated payment mechanisms that pushed a gatekeeper model. By controlling the gatekeeper, they would be better assured of controlling admissions. However, the spread of global capitation never gained traction. Managed care utilization controls were ineffective, and government efforts to reduce utilization remain insignificant. Providers have since consolidated to increase their market power, and employers are taking utilization management into their own hands by placing more financial risk on employees. As a consequence, employees (i.e., consumers) are demanding freedom of choice. To wit, in 1996, the number of patients enrolled in PPOs, HMOs, or private plans was almost evenly split. In 2006, PPO plans were the dominant payer mechanism at 60%. HMOs were 20%. In 2005, health savings account deposits were $1.2 billion. In 2008, they are projected to be $30.4 billion. Added to the above dynamics was the fact that many of the primary care groups that were purchased were not among the best-performing groups. That, along with the hospitals'/health systems' underestimation of the infrastructure and skills required to effectively manage medical groups led to enormous operating losses and, ultimately, divestitures.

In this decade, the attention of hospital/health system CEOs, as well as administrators of multispecialty groups, was redirected toward key specialists, including orthopedics, cardiology, and gastroenterology. So while in the previous decade primary care groups were willing to seek acquisition by their local hospital as a means toward financial security (i.e., "flight"), specialists have tended to react in a more aggressive fashion by seeking to expand their scope of services in search of new income (i.e., "fight"), which also places their local hospitals' financial performance and viability at risk. Although hospitals are experiencing a rise in inpatient demand and margins are improving, unless hospitals recognize the need for collaboration with their medical staff, potentially using a variety of models, they run the risk of being "gutted" of their key, most profitable service lines.

What's interesting about all of the strategies and tactics described above is that they involve either an enormous investment by the hospital and/or they require the hospital to potentially put a significant portion of its margins from key service lines into joint venture play ("Fifty percent of what I currently have is better than a 100 percent of nothing."). With that being the case, is there an alternative that can bring incremental income to a medical group, either single or multispecialty, while not at the expense of the hospital's bottom line? Moreover, how can a medical group achieve such benefits while maintaining its independence? The answers may lie, in part, with provider-based reimbursement.

Provider-based reimbursement

So what is "provider-based" reimbursement? Physician or clinic services furnished in a traditional free-standing clinic location and setting is generally reimbursed by Medicare under the Medicare physician fee schedule with a single, global rate. Those same services furnished in a provider-based setting are reimbursed in two separate components:

- Hospital facility payment under the ambulatory payment classification (APC) rate for the outpatient hospital services.
- Separate payment for physician services under the Medicare physician fee schedule, but reduced for the hospital site of service.

The bottom line: The combination of the APC payment and the reduced fee schedule amount can be substantially greater than the global fee schedule payment for traditional free-standing clinics. For example, using an "under arrangements" contract as a joint-venture mechanism for radiology services for **both** the clinic and hospital may allow the venture to net better financial performance than if both the hospital and clinic continued to separately operate and bill for those services. Similarly, through a properly structured professional services agreement (PSA), a clinic can achieve substantively higher Medicare reimbursement for all of its services. This is true for both single specialty as well as primary care-based multispecialty groups.

Nearly every physician practice should evaluate the potential differences in Medicare reimbursement when billed as a provider-based department of the hospital. It should then determine if the requirements to be able to bill under the provider-based rules (listed below) are both achievable and worth the effort and changes. Typically, primary care practices with relatively high Medicare utilization will benefit most from provider-based status. These specialties include internal medicine and family practice. The historically low Medicare utilization in pediatric and OB/GYN practices often prevents these specialties from benefiting as much. Surgical specialties, such as orthopedics, urology, and cardiovascular surgery, have relatively high Medicare utilization; however, the bulk of their services are provided in a hospital surgery department or ambulatory surgery center. These settings are already considered provider-based, and the Medicare reimbursement for these services would be largely unaffected by a change to provider-based status.

Critical access hospitals

What about critical access hospitals (CAHs)? The concept of provider-based status clearly applies in the CAH setting. The payment methodology, however, is significantly different. Instead of the APC payment system for hospital outpatient services, the CAH receives cost-based payment for Medicare services. Therefore, a provider-based clinic in a CAH would receive a hospital facility payment based on cost as reported on the Medicare cost report and a separate payment for physician services under the Medicare physician fee schedule but reduced for the hospital site of service. The combination of the cost-based payment and the reduced fee schedule amount may be greater than the global fee schedule payment for traditional free-standing clinics. However, the addition of a provider-based department to the CAH Medicare cost report may have unintended results. For example, hospital administrative and other costs will be allocated to the provider-based clinic through the cost report step-down methodology. This could result in lower costs being allocated to hospital services and could, therefore, negatively impact the hospital's cost reimbursement. A more detailed analysis of the Medicare reimbursement impact is required before proceeding with a change to provider-based clinic status in a CAH setting.

To be able to bill under provider-based rules, several requirements must be met, including:

- Licensure
  - — The clinic and the hospital must be operated under the same license (which is not to imply hospital ownership of the clinic)
- Clinical integration
  - — To include clinical privileges, chief medical officer, quality assurance and utilization review, and medical records (unified retrieval systems)
- Financial integration
  - — Shared income along with management and operations costs as reported on the Medicare Cost Report (MCR)
- Public awareness
  - — Clinic is publicly viewed as a part of the hospital (i.e., department)
- Operation of the clinic under the control of the hospital
  - — Can be achieved through a properly structured PSA and lease agreements (e.g., facility, equipment, etc.) to preserve the independence of the medical group
- Administrative integration
  - — Direct supervision, accountability, integration (HR, billing, payroll)
- Location in immediate vicinity
  - — Not more than 35 miles away or must meet the 75/75-service-area test
- Split bill for Medicare patients while other payers may be globally billed
- Meeting "incident to" rules for services provided to patients

The advantages

The primary advantage of provider-based status is that it can offer an opportunity for increased reimbursement for services furnished to Medicare beneficiaries. While this may not be the case in every instance, increased payments of 50 percent or more can be realized. Increased payments because of provider-based status can mean the difference between red ink on the bottom line of a medical practice and a break-even or slightly profitable financial position.

The following examples represent the aggregate difference in provider-based revenue when compared to a free-standing clinic. The provider-based revenue projection is for varying primary care-based medical groups with no lab or other ancillary services (part of hospital currently). Physician productivity is very typical, and each is paid a market-competitive compensation package. It is further assumed that expenses are held constant from one scenario to the next.

	Sample A	Sample B	Sample C	Sample D
Total Medicare payment — free-standing	$750,000	$3,030,000	$3,933,000	$1,935,000
Total Medicare payment — provider-based	$1,180,000	$4,860,000	$5,847,000	$2,750,000
Total payment increase	$430,000	$1,830,000	$1,914,000	$815,000
% increase in total payment	57.3%	60.4%	48.7%	42.1%

To reiterate, the mainstream thinking has been that a clinic must be owned and operated by the hospital in order to qualify as a department of the hospital and, therefore, provider-based reimbursement. As referenced above, however, with a well-structured professional-services agreement that properly allocates responsibilities for management and employment of nonphysician staff and describes the appropriate areas of integration, both administrative and clinical, together with fair-market-value building and equipment leases, a clinic can retain a reasonable level of independence (including retention of its professional corporation) and still achieve significantly improved financial performance. Moreover, such improvement in financial performance is not delivered at the expense of the hospital's operating margin, as is so often the case with service-line joint ventures.

In summary, in earlier publications (Partners' January 2004 Perspective), we detailed some alternative hospital-physician strategies that could create a more efficient and effective community delivery system. The key to those strategies was to pursue collaboration over competition. By assessing the requirements, benefits, and costs connected with provider-based reimbursement, hospitals and physicians can pursue truer integration for the community's benefit while not abdicating a clinic's independence, which is so important to so many physicians.

Davis has diverse experience including commercial banking, medical group administration, HMO development, and venture capital. His 25 years of experience in health care management in strategic and tactical planning give him the unique ability to understand all aspects of healthcare management and help him to provide proactive and practical solutions to those issues.

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