The Economic Viability of Freestanding Centers: Can They Survive?

As reimbursement models continue to change, freestanding office-based care remains valuable but should be approached carefully.

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There are multiple advantages to working in and/or owning a freestanding interventional lab. Foremost is the opportunity to offer patients and families a significantly better medical experience than they are likely to have in a larger hospital setting. An office-based lab has easier access for patients and referring offices, streamlined scheduling, as well as fewer delays to the procedures and to discharge than would be seen in a large hospital lab. The staff often see the office-based setting as a more desirable place to work, and the best personnel can be recruited for these positions. The personnel tend to be highly specialized and are happier in their jobs, which translates to higher levels of patient and family satisfaction. Physicians are directly responsible for the entire episode of patient care and must ensure that their employed staff deliver optimal customer satisfaction, and many physicians are happy to have more control over the environment to which their patients are exposed.

In addition, care provided in a freestanding center has the potential to be less expensive. An office-based practice does not have the constraints of trying to cover other unrelated departments that hospitals must deal with. Also, because physicians directly own many of these facilities, they become much more educated and aware of the actual costs of the procedures. They are more tuned into variations in costs for devices and think carefully about using a more expensive brand if a less expensive one will provide the same outcome.

HISTORY OF PAYMENT DEVELOPMENT FOR FREESTANDING CENTERS

When the concept of freestanding labs was initiated at least 10 years ago, all of the aforementioned factors were considered important. Additionally, at that time, owning a freestanding lab had the potential of being a means of offsetting the coming trend of decreasing professional payments for physicians. By capturing some of the technical components of payments, physicians could continue to support income despite getting paid less for their services.

In order to make freestanding centers viable, it was necessary to develop a methodology for setting the technical component values for diagnostic and interventional procedures. Almost all codes were still components and not yet bundled, and historically, the surgical codes included larger portions of the professional work value, and the radiologic supervision and interpretation codes had more of the technical value for the procedures. The technical value was not applicable outside of a hospital setting for most of the codes and procedures. The technical value paid for most codes in an office setting was not enough to pay for the actual technical costs of running a center or for devices and equipment essential to interventional procedures.

Adding methodology to include values for the technical portions of procedures in a freestanding arena was a new concept for the American Medical Association's Relative-Value Scale Update Committee (RUC) and for the Centers for Medicare & Medicaid Services (CMS), and it took several years of consideration before the current methodology was solidified. There was debate over whether the costs should come out of Medicare Part A or Part B budgets. It was decided that the value would be placed in the practical expense (PE) component of valuation, and over time, data were presented to the PE subcommittee of the RUC, PE values were assigned to codes, and the RUC sent these suggested values forward to CMS for approval. Gradually, more procedures were identified as being safely provided in a freestanding environment, and PE inputs were assigned to additional codes. All applications for new CPT codes take into consideration whether the new procedure could be performed in an office setting, and if they can, PE values are established when physician work values are established. This process has led to an expansion of the number of possible services provided in a freestanding lab.

PROPOSED AND FINAL RULES FOR 2014

It was not clear that the strategy of offsetting loss of professional income with technical income would be a reasonable long-term strategy. It was initially recognized that there was a window of opportunity, but it was clear even 10 years ago that significant changes in payment for health care were coming, and the long-term viability was not clear. As with all medical costs, carriers are trying to find ways to cut the costs of care in every way conceivable. This includes payments for freestanding centers. The CMS Medicare Physician Fee Schedule Proposed Rule, released on July 8, 2013, articulated CMS's thoughts regarding payment for office or freestanding services. It suggested a marked change in methodology for determining payments that would have caused dramatic decreases in payments for many vascular interventions.

This methodology was not limited to vascular interventions and spanned the gamut of all outpatient services (including pathology, for instance). This alarmed most entities that would have been involved, sparking considerable discussion and public comment to CMS and raising concerns about the effects these changes would create. Everyone waited anxiously until the delayed Final Rule was published in late November. The Final Rule did not include the proposed changes to methodology for determining payments for freestanding labs. However, in the Final 2014 Rule, CMS discussed their ongoing concerns about the existing methodology, and made it clear that they are concerned that they are overpaying for these services.

Due to other factors used in the calculation of payments, there are cuts to the technical component portion of payments (about 10%) for 2014. In addition, other pieces of the technical component are being examined. It should be assumed that CMS will continue to look for ways to save money and cut costs for services in freestanding centers.

HOW CAN WE SUPPORT OFFICE-BASED PRACTICE?

Does this mean that payments will be cut so low that labs will not remain viable? Not necessarily, but there are some steps to consider taking in order to help create the best opportunity for continued patient access to the advantages of freestanding centers.

As technical payments decrease, it becomes even more important to closely manage the actual costs of each procedure. Careful choice of which patients are suitable to be treated in an office setting, consideration of which procedures can be supported, and attention to the costs of equipment stocked in the lab will be crucial. Finding ways to increase efficiency in the lab without sacrificing quality of care or the safety of the patient may be required if the lab is to continue to be profitable.

Data demonstrating quality, safety, and excellent patient outcomes are needed to support continued coverage and payment for procedures in nonhospital labs. There are very little data published in peer-reviewed literature substantiating the care provided to patients in freestanding labs. Participation in registries, as they become available, will allow pooling and analysis of larger patient populations. This should support the publication of articles discussing office-based care.

In some regions, a formal credentialing process for office-based centers is currently lacking. Carriers have seen a rise in centers charging for large numbers of high-cost procedures provided by health care professionals without obvious credentials to say that they are trained to perform these procedures. Carriers and patients want some assurance that they are paying for quality care. As a step toward addressing this concern, the Intersocietal Accreditation Commission developed a new accreditation program for vein centers and is now accepting accreditation applications.

THE FUTURE

Payment levels for office-based labs are dropping, and one must assume that this trend will continue. Future payment models may look significantly different than the historic fee-for-service models physicians in the United States have known. Opening and operating a freestanding center at this time should be done carefully and cautiously, but there are definite patient advantages to this system that suggest it should be supported and fostered. In addition, it is likely easier to manage costs and deliver good outcomes in a smaller office-based practice than in a larger hospital environment. In an age where reimbursement models are changing, managing costs and delivering good outcomes are business traits that will be advantageous. Patients will seek out providers who prove they deliver good care, and payers will seek physician partners that help them provide quality care and share in the overall risks of providing that care. ■

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The November 2013 article, "New CPT Codes for 2013" contained an error in the discussion of new codes for stent placement (37236-37239). These codes would be used to report placement of covered stents for aneurysms except for vessels where there are codes specific for the vessel being treated. The November article used the example of popliteal aneurysm, but there is an existing CPT code for placement of a popliteal stent (37226), and this code would be used to report treatment of a popliteal aneurysm with a covered stent rather than one of the new, generic arterial stent codes.