An Update on the Economic Viability of Freestanding Centers

As CMS refines reimbursement policies, how do office-based vascular labs fit into the evolving payment models?

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In the January 2014 issue of *Endovascular Today*, I wrote an article on the economics of freestanding centers, striking a somewhat cautionary note. That article followed the 2013 Proposed Rule, which had included significant decreases in payments for many endovascular procedures when performed in a freestanding center. Those cuts were ultimately not activated at that time, but the Centers for Medicare & Medicaid Services (CMS) made it clear that they would continue to look critically at payments in freestanding centers, alerting parties interested in freestanding centers that changes may be coming.

In September 2015, payments for freestanding centers are relatively stable. However, as with medicine in general, there is great interest in finding ways to deliver better medical care that costs less. As I discussed in the 2014 article, anyone running a freestanding center or contemplating investment in a freestanding center needs a solid business plan and needs to be alert to changing payment policy.

The proposed methodology for determination of the cuts to freestanding payments in the 2013 Proposed Rule was found to be flawed, making it less likely that CMS will return to that particular concept. But with Medicare Access and the CHIP Reauthorization Act of 2015 (MACRA) legislation delineating continued pressure to move away from fee-for-service to risk-based payment models, freestanding practices will need to determine how they fit into the new models. For instance, is it better (or even possible) to be part of an accountable care organization?

DETERMINATION OF PAYMENTS FOR FREESTANDING CENTERS

The payment for the technical component of a service provided in freestanding centers (termed *nonfacility*) is different than payment for the same service when performed in a hospital or ambulatory surgical center (both referred to as *facilities*). Payment in a nonfacility is based on the practice expense (PE) value determined at the American Medical Association's Relative Value-Scale Update Committee (RUC) for each CPT code describing a service that could be provided in a nonfacility setting. The PE value is based on expert testimony describing the personnel, equipment, and overhead that is required to provide the service. CMS has the option to accept the RUC recommendation for the PE value, but they can also elect to alter that value. CMS publishes their recommended PE value for each CPT code annually in the Proposed Rule. If anyone disagrees with their proposed

valuation, there is a period for public comment when the proposed value can be discussed, with final valuation published by CMS in the Final Rule each year.

The RUC has established values for many portions of services. For instance, there is an established value for use of an angiography suite for a given amount of time. Based on the expert input regarding length of a procedure, a value is assigned for use of the angiography suite for the procedure. The RUC also has determined values for personnel such as a registered nurse (RN) or registered technologist (RT) and assigns additional value to the service based on the expert input of what personnel would typically be used for the service and the length of time each staff devotes to the service. The value of that time may vary during the service. For instance, during a procedure, the RN devotes their entire attention to a single patient. When the patient is in recovery, the RN may be managing several patients. Therefore, the time for the nurse would be valued at a lower rate for an individual period during recovery than during the procedure.

For components of a service that may be unique to that service, RUC adds the expense of those components to the service. The total of all the technical parts of the service result in the recommended PE value.

REFINEMENT OF THE PE VALUATION PROCESS

The process of valuation continues to be refined by all parties, including the medical society advisors to the RUC, the RUC panel, and CMS. Initially, broad considerations were identified to achieve cost savings. As this refinement progresses, smaller details are being considered, and CMS is trying to carefully determine what resources are actually used for individual services. A recent RUC valuation for nonvascular interventional services determined that the services could be provided in a fluoroscopy room that is significantly less expensive than an angiography suite. Even though it would cost the freestanding center more to invest in a fluoroscopy room in addition to the angiography suite if the center has only angiography suite(s), CMS argues that the angiography suite is not necessary and lowered the PE value for the service. CMS is also interested in knowing exactly what centers are paying for equipment rather than relying on the retail value for any individual device. Adjustments to these values would alter the profit margins for some centers.

ACCREDITATION

There continues to be concern about verification of qualifications for provision of services in freestanding centers, as well as ongoing assurance of quality care at these centers. Unlike hospital facilities and ambulatory surgical centers, which have established credentialing criteria, freestanding centers may not have oversight of credentialing criteria and committees. This has led to discussions for freestanding accreditation (see "Focusing on Safety Initiatives for Office-Based Labs," page 46), an area that will require monitoring in the future. Mandatory accreditation could add to the expense of operating a freestanding center but could be a requirement for payment in the future.

NEW TECHNOLOGY

The methodology for payment of new technology is different in the freestanding (nonfacility) arena than in a hospital. CMS has ways to pay additionally for new technology that costs more than the established PE value for a service if that service is provided in a facility, either on an inpatient or outpatient basis. That same methodology does not currently apply to freestanding centers. For example, if it is determined that a drug-coated balloon is the best therapy for a given patient, there is no way to recoup the additional cost of that balloon in the office, while additional payment may be made to a facility for the service. This differential may incentivize shift of patients to the facility for treatment, where the actual cost for the service is likely higher. It may also lead a provider to try to treat the patient without the benefit of the drug-coated balloon, which could be problematic if a procedure that is initially lower-cost results in recurrence of disease and the need for additional intervention.

SUMMARY

At this time, the outlook for freestanding centers is cautiously optimistic. The advantages to patient care remain strong (easier access, lower costs, personalized care). Finding ways to capitalize on the advantages while managing changing payment policy and overall costs will be important to the future economic viability for freestanding practices. ■

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