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Medicare's move toward site-neutral payment

The question of whether Medicare should pay different amounts for the "same" service depending on which setting it is delivered is an old issue for the Centers for Medicare & Medicaid Services (CMS).

That question often has been raised whenever changes have been made to individual payment systems—such as when the outpatient prospective payment system (OPPS) was adopted to pay for ambulatory care—because these types of payment changes generally alter existing relationships between payments for the same services offered in different settings.

Earlier this year, in a controversial move, CMS issued a proposed rule outlining its intent to change the OPPS to align payments made for services delivered in hospital outpatient clinics designated as *off-campus hospital outpatient departments* with payments made for the same type of services delivered in a physician's office. It would still allow, however, that locations billing as an off-campus hospital outpatient department before November 2015 would be "excepted" from the change, or "grandfathered."

Impact of the Final Rule

The final rule, released Nov. 9, 2018, retains the grandfather exception but modifies the outpatient payment alignment proposal somewhat. It states that, beginning Jan 1, 2019, CMS will pay clinic visits at off-campus hospital outpatient departments (referred to in the rule as provider-based departments) at 70 percent of the OPPS full payment rate, and that, beginning Jan. 1, 2020, the payments will be reduced to 40 percent of the full OPPS payment rate.

These changes modify an earlier final rule from 2017 that implemented site-neutral payment provisions from the Bipartisan Budget Act of 2015, providing that payments to off-campus hospital outpatient departments should be paid at about 50 percent of the outpatient hospital rate.

Because physician fee schedule payments are lower than the OPPS payment, aligning payments to off-campus hospital outpatient departments with the former payment rate would save Medicare money, estimated at $380 million for CY19. Moreover, because the physician payments are reimbursed under Part B, where beneficiaries make a 20 percent coinsurance payment, the payment reduction also saves beneficiaries money on their coinsurance.

CMS's Justification for the Change

CMS argues that it was able to make this adjustment by exercising its authority to use a method that controls unnecessary increases in hospital outpatient services. Yet many have questioned whether CMS can legally apply such authority in this way, to the point that the American Hospital Association (AHA) is leading a lawsuit against the Trump administration over the move.

CMS hopes the reduction in payments made to hospital outpatient departments for these previously excepted clinic visits will promote increased competition in the physician services market. The agency has been concerned that payment differentials, such as for these types of clinic visits, provide one more factor that has been encouraging hospitals to purchase physician practices, thereby reducing potential competition in the physician services market.

Hospitals' Counterargument

In challenging CMS's change, the AHA has argued that the patients hospitals see in outpatient settings are "different" (e.g., have more complex needs). To support this assertion, the AHA commissioned a KNG Health Consulting analysis comparing patients seen in outpatient departments with patients seen in independent physician offices. The analysis used a 5 percent sample of Medicare claims for the period of 2010-16 involving at least one outpatient visit or visit to an independent physician office in each year, and it added information about socioeconomic characteristics of a beneficiary's county of residence and clinical characteristics from the Medicare claims data. The KNG report concluded that the individuals who used off-campus hospital outpatient departments are indeed sicker—they are more likely to be on Medicare under the age of 65 because of serious health problems, and where they are older than 85, they tend to be poorer and from lower-income communities, and therefore more likely to be dually eligible for Medicare and Medicaid.

Hospitals have used the KNG findings to argue that, because their patients exhibit greater medical complexity, they may require a deeper level of care than do patients who receive their care in physician's offices. Although the argument that the hospitals' patients are different seems valid, at least with respect to the characteristics cited, it is not obvious why these characteristics should affect the costs of producing routine care in a clinic, whether it is in a physician office or an off-campus hospital facility.

Hospitals also have argued, however, that their costs are higher because of services that they need to provide that physicians generally do not provide in their offices, including the need to be open with service availability on a 24/7 basis and having to provide at least stabilizing services to any patient, irrespective of the patient's ability to pay. Higher costs, however, are not a compelling rationale for higher payments for providing a set of specific services, particularly given the strong interest in moving away from cost-based payment models to payments rates that are appropriate for providing care in the least intensive site of care where the service can be provided safely. To the extent that the higher payments are exacerbating the move by physicians away from practicing independently from hospitals, the downside of compensating hospitals in this manner brings an additional unnecessary cost.

Challenging Trends

There are, indeed, indicators that many hospitals are under financial stress. Profitability margins hit their lowest point in a decade in 2017. Outpatient visits grew faster than inpatient admissions, and government payment relative to other payment continues to grow. With the continuing growth in baby boomer retirement, these trends are likely to continue. The repeal of the individual mandate effective in 2019 may exacerbate these trends because the numbers of uninsured will likely increase to some extent.

For years, Americans have complained about paying more for health care than people in other countries. However, the downside of putting pressure on payment through competition or other means is that some institutions may not be able to survive. Special payments go to hospitals that treat a disproportionate number of uninsured or who deliver a relatively high share of uncompensated care through disproportionate share hospital (DSH) payment. Although the ACA's Medicaid expansion and increased subsidization of people without employer-sponsored insurance or other public insurance were seen as valid reasons for the act also to reduce the amount of funding for the DSH program, asking whether the payments are at an appropriate level remains a valid question. And the same question is valid with respect to paying more for care delivered in hospital outpatient departments. ■

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