Over the past decade, hospitals have been rapidly building outpatient clinics or purchasing existing independent ones. It was a lucrative business strategy because such clinics could charge higher rates, on the premise that they were part of a hospital. Medicare's recent rule change puts a damper on all that.

Eric Lewis' plans of expanding his community hospital's reach have been derailed.
As CEO of Olympic Medical Center, he oversees efforts to provide care to roughly 75,000 people in Clallam County, in the isolated, rural northwestern corner of Washington state.

Last year, Lewis planned to build a primary care clinic in Sequim, a town about 17 miles from the medical center's main campus of a hospital and clinics in Port Angeles.

But those plans were put aside, Lewis says, because of a change in federal reimbursements this year. Medicare has opted to pay hospitals that have outpatient facilities "off campus" a lower rate — equivalent to what it pays independent doctors for clinic visits.

Over the past decade, hospitals have been rapidly building outpatient clinics or purchasing existing independent ones. It was a lucrative business strategy because such clinics could charge higher rates, on the premise that they were part of a hospital.

With its new policy, Medicare is essentially saying that an off-campus office is an off-campus office, regardless of whether it's owned by a hospital, a group of doctors or a solo practitioner.

Taking that position will save Medicare — and possibly patients — money.

The federal insurer bore the brunt of its members' extra charges, but beneficiaries sometimes picked up part of that expense through deductibles and copayments. Patients with commercial insurance often were blindsided by high bills — going to what seemed to be a normal primary care clinic, only to discover they were charged a hospital facility fee, for example.
Health policy analysts say the new policy represents an important step in rationalizing payments. Part of a strategy called "site neutral" payment, the new policy has its roots in the Obama administration and was part of the Bipartisan Budget Act of 2015.

"You don't care about where [your treatment is] happening. You care that it's a safe and inexpensive procedure," says Gerard Anderson, director of the Johns Hopkins Center for Hospital Finance and Management. "And the facility fee just adds to the cost with very little added value."

The new payment structure may financially hurt some hospitals, he and other experts acknowledge. But making reimbursements more uniform across providers facilitates competition and may lead commercial insurance to follow suit — which could translate to more savings for patients.

This year, the policy's two-part phase-in cut Medicare payments for clinic visits to outpatient departments by 30%, according to the rule finalized in November. By 2020, the payment rates will be cut by 60% compared with what they were last summer.

The Centers for Medicare & Medicaid Services estimates that the change will save the federal government $380 million this year and patients an average of $7 every time they visit a hospital-owned clinic. Clinic visits are the most commonly charged service for hospital outpatient care under Medicare.

It could also cut down on consolidation in the industry, health care economists say, by closing the loophole that created incentives for hospitals to purchase independent
physician practices and charge higher rates for services at taxpayers' expense.

The American Hospital Association filed a lawsuit late last year alleging that CMS overstepped its authority when setting the new reimbursement schedule. Olympic Medical Center is among the plaintiffs.

The hospital association claims that the new rule infringes on a precedent Congress set with the 2015 budget law. That legislation standardized Medicare payments for clinic visits to physicians' offices and new hospital outpatient facilities, but allowed most hospital-affiliated departments that existed at that time to continue receiving a higher rate, according to a comment letter from the Medicare Payment Advisory Commission. The group is a nonpartisan agency that advises Congress.

The differential for site-based payments was designed originally to help hospitals offset the higher costs they incur for maintaining the staff and equipment to handle a wide variety of treatments, says Christopher Whaley, an associate policy researcher at the research organization Rand Corp.

But that financial relief became an incentive for hospitals to buy independent practices, says Dr. Ateev Mehrotra, associate professor of health care policy and medicine at Harvard Medical School. Hospitals were able to charge higher prices for services performed at newly acquired clinics.

Mehrotra says the new CMS rule could be a way to slow down the trend.

"This isn't going to fully put the brakes on it," he says, "but it could be one push on the brakes here — to kind of push that consolidation down."

Some health care analysts have urged the government to expand the number of services covered by the site-neutral policy, including paying hospitals' on-site clinics a rate equivalent to what independent doctors receive.
Hospitals acknowledge that the change implemented by CMS could lead to savings in the health care system, but they say it comes at the cost of patients' convenient access to medical care. In Washington state, Lewis anticipates a loss of $1.6 million for his hospital.

The lack of a clinic in Sequim means ailing patients there will not be able to get care close to their homes, Lewis says.

"If you're well-to-do financially, these aren't big problems," Lewis adds. "But I think the poorest, elderly, sickest of our society will pay the price of this policy."

Melinda Hatton, general counsel for the hospital association, agrees. "I think access trumps a couple extra dollars in copays every single time," she says.

On the other hand, many independent physicians support the change. Marni Jameson Carey, executive director of the Association of Independent Doctors, says she hopes the rule will curb consolidation.

According to a recent report by the consulting firm Avalere, the number of hospital-owned physician practices more than doubled from 35,700 to 80,000 between July 2012 and January 2018. Hospitals own more than 31% of all physician practices, the report found.

Jameson Carey says such mergers can also cause problems for the local economy. When a nonprofit hospital acquires an independent clinic, it effectively removes a tax-paying business from the area. That's because nonprofit hospitals are exempt from paying certain federal, state and local taxes — in exchange for providing community benefits.

"So, not only do they [hospitals] get the facility fee," Jameson Carey says, "they don't have to pay taxes."

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