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Hospitals Chafe Under Medicare's New Payment Rule For Off-Campus Clinics

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Eric Lewis' plans for expansion have derailed.

As chief executive officer 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 in Port Angeles.

But those plans were put aside, Lewis said, because of a change in federal reimbursements this year. Medicare has opted to pay hospitals with outpatient facilities that are '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.

Making that statement 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 experts said the new policy represents an important step in rationalizing payments. The new policy – part of a strategy called 'site-neutral' payment – has its roots in the Obama administration and was part of the Bipartisan Budget Act of 2015.

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'You don't care about where [your treatment is] happening. You care that it's a safe and inexpensive procedure,' said 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 hurt some hospitals financially, he and other experts acknowledged. But making reimbursements more uniform across providers facilitates competition and may lead commercial insurance to follow suit – which could translate to more savings.

The policy's two-part phase-in cut Medicare payments for clinic visits to outpatient departments by 30% this year, according to the rule finalized in November. By 2020, the rate will be cut another 30%.

The Centers for Medicare & Medicaid Services (CMS) estimates 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 because their copayments will be lower. Clinic visits are the most commonly charged service for hospital outpatient care in Medicare.

It could also cut down on consolidation in the industry, experts said, 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 in December alleging that CMS overstepped its authority when setting the new reimbursement schedule. Olympic Medical Center is among the named 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, said Christopher Whaley, an associate policy researcher at the research organization Rand Corp.

But that relief became an incentive for hospitals to buy independent practices, said Dr. Ateev Mehrotra, associate professor of health care policy and medicine at Harvard Medical School. Hospitals could charge higher prices for services performed in newly acquired clinics. Mehrotra said 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 said, 'but it could be one push on the brakes here to kind of push that consolidation down.'

Some experts 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 acknowledged the change implemented by CMS could lead to savings in the health care system, but they say it comes at the cost of patient access. 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, he said.

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

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



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On the other hand, many independent physicians support the change. Marni Jameson Carey, executive director of the Association of Independent Doctors, echoed the experts' hope that the rule will curb consolidation. According to a report by the consulting firm Avalere Health, 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 researchers said.

Jameson Carey said these 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 said, but also, 'they don't have to pay taxes."

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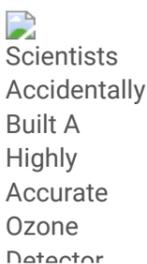
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