

# The End of Medicare Price Discrimination?

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Hospitals have been riding the “facility fee gravy train” for many years. The facility fee is a fee paid to hospitals in addition to the professional service fee when a professional service is rendered in a hospital-owned clinic as opposed to a private physician office. The professional service fee plus the facility fee is often double what a physician is paid for providing the same service in a private office. In the case of non-profit hospitals, the higher fee paid to hospitals by Medicare has the added bonus of being tax-free.

Hospitals argue that the facility fee is needed to compensate for higher overhead costs associated with running a hospital-owned clinic, and that it helps to offset the cost of providing charity care. But, when a hospital purchases a physician practice and provides the same services in the former private physician office, why would overhead costs be higher? We note that in a private physician’s office, overhead costs must be paid out of the professional service fee paid to the private physician.

Physicians have been forced to compete with this unfair advantage provided by government to hospitals, which has led to the closing of private physician offices, physicians becoming hospital employees, and loss of physician autonomy in the practice of medicine. Acquiring private physician practices has been a very lucrative business strategy for hospitals, one which they have aggressively pursued. According to a recent survey:

[From July 2016 through January 2018], 8,000 physician practices were acquired by hospitals, and the percentage of hospital-owned practices increased by 5%.

All regions saw an increase in percentage of hospital-owned practices at every measured time period, with a range of total increase from 91% to 303% by region....

Between July 2012 and January 2018, the number of physician practices employed by hospitals grew by 44,400 practices; a 124% increase over 5½ years....

By January 2018, hospitals owned more than 31% of physician practices.<sup>1</sup>

The site-of-service payment differentials are astounding. A 2016 study reported that Medicare paid \$5,148 for a cardiac imaging episode of care in a hospital-owned clinic as opposed to \$2,862 when provided in a private physician office. Medicare paid \$525 for an Evaluation and Management (E&M) episode of care (“profile 2”) provided in a hospital-owned clinic, and \$406 when provided in a private physician office.<sup>1</sup>

When hospitals acquire a physician’s practice and the physician becomes an employee of a hospital, the physician’s practice style often changes. Much like a production line in a factory, the employed physician’s compensation and

bonuses are tied to production (how many Resource-Based Relative Value Units the physician provides). Hospitals have fully adopted the factory template by referring to various treatments provided by physicians as a “service line.” According to the survey published in February 2019:

When physicians are employed by hospitals or health systems, they perform more services in a HOPD [hospital outpatient department] setting than independent physicians. The higher proportion of services performed in a HOPD setting increases both costs to the Medicare program and financial responsibility for patients....

[In 2017], increased integration of the hospital-physician marketplace resulted in more than \$3.1 billion in increased costs from 2012-2015—Medicare program paid \$2.7 billion more for these services—Medicare beneficiaries faced \$411 million (27%) more in financial responsibility for these services.<sup>1</sup>

According to Health and Human Services Secretary Alex Azar, “Fixing this perverse situation has been talked about for years, by administrations of both parties—and yet this administration [Trump Administration] is the one finally bold enough to do it.”<sup>2</sup>

Under the Obama Administration, an attempt to eliminate the costly and unfair facility fee (Bipartisan Budget Act of 2015) was gutted by a provision that grandfathered-in existing clinics owned by hospitals.

A new Medicare Outpatient Prospective Payment (OPPS) rule, which applies to all off-campus hospital-owned clinics, eliminates this grandfather exception and implements true site-neutral payments. In a press release in November 2018, when the rule was finalized, Centers for Medicare and Medicaid Services (CMS) Administrator, Seema Verma, stated: “President Trump is committed to strengthening Medicare and lowering costs for patients. Today’s rule advances competition by creating a level playing field for providers so they can compete for patients on the basis of quality and care.... The final policies remove unnecessary and inefficient payment differences so patients can have more affordable choices and options.”<sup>3</sup>

The CY (calendar year) 2019 OPPS final rule and its application under the OPPS for CY 2020, is published in the Federal Register (August 9, 2019).<sup>4</sup> The new site-neutral payment rule will be phased-in over a 2-year period that began Jan 1, 2019. Payments to off-campus hospital-owned clinics will be cut by 30% this year, and another 30% in 2020.

The financial impact of this new OPPS site-neutral payment rule will be substantial both for taxpayers and Medicare patients. According to a recent CMS press release:

For example, for a clinic visit furnished in an

excepted off-campus provider-based department, the average beneficiary cost sharing was \$23 in 2018. The current average beneficiary cost sharing is \$16 in 2019 (under the first year of the phase-in). With the completion of the two-year phase-in, the beneficiary cost sharing would be reduced to \$9 for a visit, saving beneficiaries an average of \$14 for each clinic visit they have at an off-campus department in CY 2020.<sup>5</sup>

A CMS Fact Sheet stated: "This proposed change would result in lower copayments for beneficiaries and savings for the Medicare program and taxpayers estimated to be a total of \$810 million for 2020."<sup>6</sup>

Hospitals, of course, are not happy that the Medicare facility fee is ending. The American Hospital Association argues that elimination of these lucrative facility fees will have a negative impact on the quality of care.<sup>3</sup> Yet, given the exorbitantly high compensation packages of hospital CEOs, one wonders whether the true concern may be that cuts may negatively impact CEO compensation. A recent article on 2017 hospital executive incomes reported many in excess of 10 million per year, with the highest listed as \$25 million per year.<sup>7</sup>

Shortly after the OPSS payment rule was finalized in 2018, the American Hospital Association (AHA) and other hospital organizations filed a lawsuit in the U.S. District Court for the District of Columbia, claiming "serious reductions in Medicare payment rates" constitute executive overreach.<sup>2</sup> Hospitals aim to preserve the Obama-era grandfather exemption for existing hospital-owned outpatient clinics.

Other factors that will impact the amount hospitals are actually paid under the OPSS payment system include a proposed update to OPSS payment rates and Evaluation and Management (E&M) Code changes planned for 2021. According to a CMS Fact Sheet: "In accordance with Medicare law, CMS is proposing to update OPSS payment rates by 2.7 percent. This update is based on the projected hospital market-[based] increase of 3.2 percent minus a 0.5 percentage point adjustment for multi-factor productivity (MFP)."<sup>6</sup>

In 2021, CMS plans to pay both hospital outpatient clinics and private physicians less for E&M services provided. Much as when CMS eliminated all consultation codes in the past, CMS seeks costs savings in the Medicare program by manipulating the E&M coding system.

Beginning in 2021, E&M codes for levels 2, 3 and 4 will be replaced with a single visit code, which will pay 14% less than the 2018 payment for a level 4 service.<sup>8</sup> The highest level of service, level 5, will remain intact. In the view of CMS, this change in coding will reduce physician burnout by easing the burden required to document different levels of E&M service. In a press release, CMS administrator Seema Verma stated:

Addressing clinician burnout is critical to keeping doctors in the workforce to meet the growing needs of America's seniors. Today's rule offers immediate relief from onerous requirements that contribute to burnout in the medical profession and detract from patient care. It also delays even more significant changes to give clinicians the time they need for implementation and provides time for us to continue to work with the medical community in this effort.<sup>9</sup>

Although physicians who have been providing level 3 services (one of the most common) will receive a \$20 increase over 2018 rates, physicians who were routinely providing level 4 E&M services will receive a cut of \$24 over 2018 rates. For those physicians, burnout will be replaced by the increased stress over how to meet the costs of running a practice with less payment. The delay in implementation of this change in coding is designed to give certain physicians more time to adjust to the concept of being paid less for what they do.

As we await the outcome of the AHA lawsuit, and whatever additional adjustments to payments or manipulations of codes that CMS may propose, price discrimination in the socialist Medicare program has reached a state of awareness increasing the chances that it may ultimately be eliminated.

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