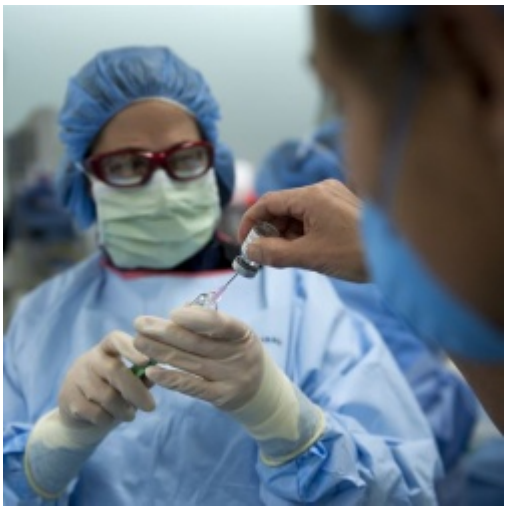
Published on *American Council on Science and Health* (https://www.acsh.org)

Location, Location, Location

By Chuck Dinerstein, MD, MBA — October 15, 2018



Hospital based Care [1]

Evidently, it is as accurate in medicine as it is in real estate, it is all about location, location, location. An analysis by an independent physician advocacy group, Physicians Advocacy Institute, showed Medicare payments differs for identical care for four procedures based on where the care is provided. They calculate that Medicare paid $2.7 billion more for care provided in the more expensive hospital-based setting than office and that patients, in turn, spent $411 million more in co-payments and deductibles. It is a lesson that teaches us about direct and indirect costs, gaming the system and shifting responsibility.

Direct costs are the expenses incurred in providing the procedure, the physician, nurses, perhaps an anesthesiologist and any equipment used only for that case, disposable things like drapes and needles. Indirect costs are for expenses to provide a place for the procedure to be performed, the building, the heating and cooling, security, maintenance. Direct costs can be calculated with some precision; indirect costs are estimates that vary greatly depending upon your accounting needs. I can shift costs from one area to another by indirect costs.

Medicare recognizes two components to payments; one is the payment to the physician to perform the procedure itself; the second element is payment for the facility where the procedure was performed. For the physician using their office as the site of care, the facility payment is rolled into their physician payment. For care delivered at a hospital-based location, the facility payment is made separately. Medicare sets its payment for facilities based upon surveys of those costs nationwide.

The four procedures are

- colonoscopy – examining your large intestine with a scope

- echocardiography – examining your heart and its motion using an ultrasound
- arthrocentesis – draining fluid from your joints with a needle
- cardiac catheterization – examining your coronary arteries with a tube, x-rays, and contrast.

All of these procedures can be performed safely in both offices and hospital-based sites as long as the same people and equipment are available. Cardiac catheterization is infrequently performed in an office-based or physician-owned ambulatory care center because of the significant capital costs of owning or renting the X-ray equipment.

Playing the game

1. Hospitals opened their ambulatory care sites to provide a lower indirect cost site for procedures. These centers had none of the hospital's big expenses, 24 hour a day care, lots of expensive testing equipment, etc. But they could assign these sites higher indirect costs. By padding the information they provided Medicare, Medicare paid them a significant greater facility payment. They found a way to generate more revenue.
2. Hospitals acquired physicians as they merged to form larger health systems. These physicians provided procedural care in the hospital's ambulatory care sites. Hospitals built more of these centers at increasing distances from the hospital itself. You could claim the new sites allowed them to deliver care closer to the patient, or that it represented new markets for their newly found revenue streams.
3. Medicare recognizes the 'gaming' of the system, the discrepancy in payments between the two locations, and limits hospital-based facilities to within 250 yards of the actual hospital. Legislation reduced payment to those facilities by 50% this year and 60% in 2018, but facilities built before 2015 are exempted thanks to lobbying.
4. Hospitals continue to acquire physician practices and to merge into larger and larger health systems, the rationale being that shared services will lower costs. But the now employed physician no longer performed procedures in their offices but are required to use the health systems' facilities. This resulted in higher costs.

Who is accountable in this scenario? Medicare creates payment regulations; business finds areas to exploit economically and do so; Medicare attempts to limit the exploitation, but politicians intercede on behalf of their constituents – special interests. Back and forth it goes, gaming requires two or more players. Here is the Medscape [2] headline, Hospital Employed Physician Soaked Medicare, Study Says. [1]

Employed physicians' salaries are based on their work and incentives/bonuses like any indistinguishable source of labor. They work in employer-provided facilities; they do not choose. Blaming physicians shift responsibility and distract from what is really going on. Medscape views itself as a physician and patient portal of useful information. They should apologize for what they wrote.

[1] It was subsequently changed to Hospital Employed Physician Cost Medicare More which is less offensive but equally untrue.

Links
[1] http://www.eglin.af.mil/News/Article-Display/Article/813763/eglin-hospital-delivers-unprecedented-complete-cardiac-care/
[2] https://www.medscape.com/viewarticle/888772?src=WNL_trdalrt_171213_MSCPEDIT_dne&uac=170896DN&amp