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Site-Neutrality Among Medical Payments Can Foster Site-Specificity Among Medical Procedures

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ABSTRACT

The site-neutrality among medical payments for the same procedures would essentially achieve the long-lost cause of site-specificity among the medical procedures, so that the clinically safe and healthcare cost aware proceduralists can contribute to reduction of overall healthcare costs of the society by better triaging their procedures among the appropriate sites (office/ambulatory surgery center/hospital). This utopic future of healthcare cost-efficiency can be realized by site-neutrality ensuring the costs of providing healthcare meeting in the middle ground with the charges billed by the healthcare on the society. The potentially overlooked initiative of "(Patient) Safety-in-Healthcare yet (Cost) Savings-in-Healthcare" may be revived for the society whence cost-effective safety of the patients/procedures would become the sole-incentive to allocate particular patients/procedures to an office or an ambulatory surgery center or a hospital.

PERSPECTIVE

Scenario 1: You and your fellow passengers traveling by air are paying for the nth-time differently priced airfares despite the fact that all of you are traveling in the same cabin with the same amenities [1-2].

Scenario 2: You and your fellow passengers traveling by Indian government owned railways are paying the exactly same ticket price, when traveling in the same cabin, unless either you have paid "Tatkal" price ("Instant" travel plan price with surcharges for last-minute travel-booking) or you have received concessions as per the designated travelers' categories allowed by law [3].

Scenario 3: You and your kin undergo the same medical procedure but are both charged at significantly different rates [4-9] due to you having the procedure performed at an office-setting and your kin having the same procedure performed at an ambulatory surgery center (ASC)/hospital-setting. However, neither you nor your kin voice concern as both of your co-payments are similar while the rest of the "payments", or exchange of money, is between the insurance companies (the third party payers) and the health-care facilities. The reason for the significant differences in the charges among the settings is due to the additional essential amenities' costs based on the infrastructural differences among the facilities.

The logical and simple reason for the businesses using variable pricing methods is to balance their costs. However, to more clearly understand the complexly intertwined physician payments (professional fees [10]) and facility payments (facility fees [11]), we present a simple hypothetical case for better communication of the underlying mathematics (as deciphered from the reality of current healthcare economics [12-14]). A patient requires a procedure X. The patient can have the procedure X performed at an office (O), at an ASC (A) or at a hospital (H). The total amount of the bill (also called charges) received by the patient will be denoted as OX in an office, AX in an ASC and HX in a hospital. It is common knowledge that the magnitude of the bill/charges occur in the order of OX<AX<HX. Why is there an absence of site-neutrality in these payments? Why are these medical payments currently site-specific? In offices, the physician in-office payments are all-inclusive for offices' infrastructural costs [14]; whereas, in ASC/hospitals, the physician in-facility payments [14] are separate and hence are lower than the physician in-office payments because the ASC and hospital both independently and separately bill for their facilities' infrastructural costs. Hypothetically, the following scenarios of patient bill/charges could realistically occur: 1) OX=$250 (proceduralist who also owns the office will receive the total charge); 2) AX=$350 (proceduralist will receive $150 while the ASC will receive $200 as facility fees); 3) HX=$450 (proceduralist will receive the same $150 while hospital will receive $300 as facility fees). Therefore, it could be inferred from the hypothetical examples above that although proceduralists' are assuming that they are getting paid more for the procedures in their offices, they are actually getting the same professional fees across the three sites (say $150) while they are receiving "unnamed facility fees" (say $100) for their offices. The third party payers may have realized that (a) the reimbursements for the infrastructural

costs at an office should be lower than the reimbursements for the infrastructural costs pertaining to ASC or hospital services, and (b) the uniformity in the physician offices' infrastructural costs do NOT warrant the physician offices availing flexibility of separately designated facility payments when charging for office-based procedures, as compared to the variability in the infrastructural costs of ASC/hospitals (as per their enormities) warranting separately designated facility payments for the ASC/hospitals.

However, who chooses where the procedure should be performed?

- Is it the patient, whose financial responsibility is solely for the co-payment which may be higher in an ASC than the co-payment in an office-setting and even higher still in a hospital if the co-payment is being calculated as a percentage of OX/AX/HX instead of being a fixed amount?
- Is it the proceduralist, whose decision to perform a procedure at an office/ASC/hospital may be influenced by whether he/she has ownership/privileges in an office/ASC/hospital?
- Is it the facility-owner, whose patients and proceduralists are influenced by facility's assurance of the procedures requiring facility's amenities irrespective of the costs (to the facility) and charges (to the payers)?
- Is it the third party payer, whose responsibility is currently limited to (a) accommodating the infrastructural costs for performed procedures by reimbursing for the facility payments, and (b) negotiating down physician-and-facility billed charges wherein the final reimbursements to the physicians-and-facilities will be less than the actual billed charges, based on the payer's negotiating power secondary to the large population pool of insured clients?

The next question is: What is the real price of anything?

- Is it the price that a person pays based on an original quoted price?
- Is it the price that a person pays when there is a willingness to pay premiums over and above the quoted original prices (scenarios like in-demand or extreme shortage items such as opening night movie-tickets)?
- Is it the price that a person pays during year-long-"sale"-periods wherein the variable-fixed "discounts" are given on the quoted original price all-year-long [15]?

Overall, we have a simple question. If a procedure X can be performed at an office-setting and paid at an accordingly reasonable price, then which clinical situations warrant the same procedure to be performed in a hospital-setting that will cost significantly higher than the office-setting? The causal factors in these scenarios can be, but are not limited to,

- The independence of cost-recovery by the proceduralists in the office-settings acting as the lone providers of patient care
- Hospital-admitted inpatients' requirements for procedures (electively/urgently/emergently) wherein there would be patient safety concerns if the procedures were to be delayed and deferred to an office-setting

- Almost non-existent referrals/transfer/exchange of overlapping patient care among the competitive colleagues of the same specialty working exclusively at either an office or an ASC or a hospital
- Always-open-to-interpretation-guidelines, relying on the individual proceduralist's personal clinical judgment to appropriately decide which procedures should be performed at a hospital or an ASC or an office-setting
- The potential unawareness among the office-based proceduralists that the mathematical differences of "physician-payment-rates" between the offices and the ASC/hospitals [16] are the "facility payments" for their office-costs.

For these ambiguities, the collective responsibility lies with:

- The exclusive-office-setting proceduralists, who may NOT apply for hospital privileges to perform their complex procedures in the advanced hospital-settings. However, the procedures requiring the ASC/hospital-amenities for patient safety are unlikely to be performed by the professional-liability-conscious exclusive-office-based proceduralists in their offices
- The exclusive-ASC/hospital-setting proceduralists, who may NOT be able to transfer their simple patient-procedures to their office-setting colleagues unless developing their own personal free-standing offices
- The ASC/hospital-administrators, who may NOT be able to triage the procedures based on complexity levels, wherein they would have to consider limiting the simple (but their bread-and-butter) procedures that can be otherwise economically performed in the offices, while refocusing on improving the catchment of the complex (but uncommon) procedures which require ASC/hospital care-setting amenities and justify the corresponding extra-costs to the societal healthcare
- The third party payers, who may NOT overtly state that the differences in the total payments (physician payments with or without facility payments) for the procedures in an office-setting vs. in an ASC/hospital-setting were to ensure justifiable reimbursements according to the fixed-and-variable costs' differences among the establishments (offices vs. ASC/hospitals) without ignoring patient-safety

Herein, the Centers for Medicare & Medicaid Services (CMS) motivation to bring forth site-neutral payments [17-23] should NOT be misconstrued as promotion of office-setting procedures over hospital-setting procedures. Rather, essentially, what CMS may be attempting is to enforce the site-neutrality for total payments (physician payments with or without facility payments). Enforcement of site-neutrality would allow proceduralists to more effectively triage their procedures based on procedures' complexity levels, thus automatically delineating the site-specificity for their procedures (office-specific procedures or ASC/hospital-specific procedures) as clinically safe without being cost-prohibitive for the patients as well as the establishments (offices, hospitals and payers).

There is an alternate philosophy, that booming human population growth warrants a corresponding boom in the creation of jobs instead of maintaining the total gross-domestic-product (GDP) stationary which would adversely affect economic resource distribution due to the correspondingly decreasing sizes of GDP-pie-slices. However,

booming healthcare costs (that are essentially the rewards for managing the illnesses-sufferings among the human population) exponentially grow the dependence of overall societal economics on its healthcare economics. Thereafter, to be economically viable and sustainable in the modern times the healthcare economics, with underlying demand-supply business philosophy at its core like any other business, would essentially warrant reaping the profits while managing the illnesses-sufferings among the human population. However, it is our limited understanding that as compared to the essential pie-slice of food economics (catering to satiate the innate human hunger among the booming populations), the growing pie-slice of healthcare economics [24] (predominantly sickness-treatment economics rather than health-promotion economics) may NOT be what the philosophers theorized when promoting the idea of expanding the pie (constantly growing the pie beyond its current total size to match the needs of growing population) [25-26]. We observe globally [27-30], that there are so many questions and so few answers.

- What should be the correct mix of the various industries' contributions to a nation's GDP?
- What appropriate percentage (ceiling point) of national GDP should be the healthcare economics so as to not only ensure the population catered remaining healthier than the comparative populations but also the societal economics sustaining better than the comparative societal economics?

In summary, the site-neutrality among medical payments for the same procedures would essentially achieve the long-lost cause of site-specificity among the medical procedures, so that proceduralists, who are conscientious for patient safety and aware of healthcare costs, can contribute to reduction of overall healthcare costs of the society by better triaging their procedures among the appropriate sites (office/ASC/hospital). This utopic future of healthcare cost-efficiency can be realized by site-neutrality among medical payments so that the costs of providing healthcare can meet in the middle ground with the charges billed by the healthcare on the society. The potentially overlooked initiative of "(Patient) Safety-in-Healthcare yet (Cost) Savings-in-Healthcare" may be revived for the society whence cost-effective safety of the patients/procedures would become the sole-incentive to allocate particular patients/procedures to an office or an ASC or a hospital.

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