Chapter 8 -- Hospital Outpatient Prospective Payment System (OPPS)

The previous chapter was about how hospitals get paid by Medicare for their INPATIENT services. This chapter is about how clinics and hospitals, and durable medical equipment (DME) companies, and home health companies get paid for their products and services.

If you not had any experiences with DME companies, good for you. When you become old you almost certainly will. These are the companies that provide hospital beds in people's homes, CPAP equipment and supplies, oxygen tanks and so forth. They generally get paid by Medicare and other payers to provide these kinds of things. They should provide very professional services that help people stay out of hospitals and nursing homes. They are a very important part of the medical care system in the United States.

Home Health Providers usually employ nurses to visit people at home and help people stay at home and out of hospitals and nursing homes. Most or all hospice care in the United States is provided through home health providers. Again, these companies are a very important part of the medical care system in the United States.

In recent years there has been a big policy initiative to keep patients OUT of hospitals and nursing homes in part because institutional care is very costly to provide. MANY surgeries that required inpatient care are now performed ON AN OUTPATIENT BASIS. Surgeries that used to routinely require perhaps two nights in a hospital are now done on an outpatient basis. I have had my own local experience with what I remember as the "theater of the blue hairnets." It is, for better or worse, a production line.

It may actually be a step in the direction of improving the quality of care. There are reasons NOT to want to be in a hospital bed overnight. Patients can acquire medical problems while in even the best of hospitals. But the primary reason for the shift from inpatient to outpatient services is to try to constrain costs.
Under capitation, hospitals want to minimize their occupancy rates. And Medicare and other providers don't want to have to pay for inpatient services unless it is REALLY NECESSARY.

So this chapter is similar to Chapter 7. The difference is that it is about how providers get paid for outpatient services rather than inpatient services.

The fancy word for not being in the hospital is ambulatory care. This is not necessarily about an ambulance. This is about being ambulatory -- being able to walk or at least be mobile in a wheelchair or something.

I got confused about the references in the chapter to pass-through devices and pass-through payments. This is apparently about a physician sending blood samples (for example) to a medical lab for analysis, and the lab changing THE PHYSICIAN for its services, and the physician then "billing" Medicare under GLOBAL PAYMENT. In other words, the lab's bill "passes through" the physician's office, rather than the lab getting paid directly by Medicare (or another provider).

Well, on the face of it, this kind of makes sense. Under GLOBAL PAYMENT the payer does not have to deal with so many claims. But the problem is that the hospital or physician has an INCENTIVE to "mark up" the charges of the lab (for example). The upshot seems to be that providers need attorneys or other specialists to understand what the rules are and how they work, when dealing with Medicare and other providers.

(And realize that when Medicaid is involved, that is a whole other ball game and that different states administer Medicaid differently. And then there is the issue of people with multiple coverages, and so forth.)

And then there are rules about PLAN OF CARE and transfers of care and so forth.

Again, the idea behind PROSPECTIVE PAYMENT SYSTEMS is to shift at least some of the financial risks onto providers (inpatient or outpatient). Providers need to be "on their toes" to not only get it right medically, but to also get it right financially.

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This is a good place to add a part that is apparently not included in our textbook. There is A LONG HISTORY of medical care policy in the United States. The pattern is that one solution becomes the roots of a new problem and the need for another solution.

You should recognize at least these three national policies.

THE HILL-BURTON ACT OF 1945.

The idea was to build hospitals that were needed in rural areas. To get the legislation passed they wound up building more hospitals everywhere, including urban areas. This INCREASED ACCESS to care but contributed to rising costs. In the old days, an empty hospital bed tended to get filled because it paid hospitals to keep their occupancy rates high. This act
created EXCESS CAPACITY in some markets. Because of this act many small rural hospitals were built in the United States with taxpayer money.

PUBLIC LAW 93-641: The health Planning and Resource Development Act of 1974. This created national CERTIFICATE OF NEED requirements intended to REDUCE the purchase of expensive new technologies like full-body CT scanners. In fact, it SPED UP the purchase of such equipment and actually INCREASED aggregate medical care spending by hospitals and other providers.

THE BALANCED BUDGET ACT OF 1997: created these prospective payment systems (PPSs) to shift at least some of the financial risks onto PROVIDERS and away from insurance companies an payers like Medicare.

Now, we are in a situation in which many small hospitals are at risk of closing. Many of these are probably the hospitals built years ago with federal funds under the Hill-Burton Act.

WITH THE BEST OF INTENTIONS, policy tends to both solve old problems and create new problems.

We may never arrive at a SINGLE PAYER SYSTEM, that would give the federal bureaucracy the ability to take hold of costs, precisely because THE AMERICAN PEOPLE do not trust the federal bureaucracy to do so.

WHATEVER SYSTEM OF PAYMENTS AND INCENTIVES, providers and others will "work" the system in their own interests, ESPECIALLY if changes threaten their standard of living and their financial survival as institutions.

I suppose the "TAKE AWAY" is that only medical care organizations that are SMART ENOUGH to understand these PROSPECTIVE PAYMENT SYSTEMS are likely to survive financially. And even then, some providers (like small rural hospitals) may simply not be able to survive. In that case, FINANCIAL BURDENS become SOCIAL BURDENS and people literally live or die as consequences.