The Financial Importance of Place of Service (POS)

By

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The obvious is usually hidden in attempting to control the cost of Healthcare. To the untrained eye, it would seem the only way to reduce costs would be to reduce the unit-cost of the services provided. Reducing both the pay to physicians and to facilities. Other countries have taken this approach, and over time, fail to adapt and create long backlogs and eventually have to ration necessary care. This idea fails to acknowledge the well documented economic anomaly in Healthcare is that the Physician is both a supplier and demander of Healthcare. It is the Physician that ultimately controls the cost of care, because the doctor alone can demand where that service is provided. By not **giving economic incentives** to reward the doctor to choose the most clinically appropriate and less costly place of service several things happen. Facilities (Hospital Chains) buy physician practices, eliminate their offices, and force them to do services at their facility. For example, a Hospital chain, buys the practice of a doctor specializing in pain management. A patient comes in and instead of the doctor giving the patient a cortisone shot in his office, he now has to give that same patient a cortisone shot in a hospital. Same physician reimbursement, but now the payer (both company and government) pay a hefty facility charge. These facility charges can be thousands of dollars per service, a new source of funds for the hospital, but ultimately driving up the cost of care while supporting facility monopolies and reducing competition.

The best medical groups in the country managed Commercial Emergency Room visits at around 78 per 1,000, the least effective groups at around 170 visits per 1,000. (217% higher from best to worst) If we take the cost of a doctor office relative to an ER visit (of at least 250% higher), the resultant overall cost for the same service is 542% higher to the payer. Management of where utilization occurs is paramount to lowering overall cost of care, to the payer and ultimately the subscriber.

When I was working in the Strategy area of Surgical Care Affiliates (SCA) one of my responsibilities was to illustrate the economic savings of moving surgeries from an Outpatient Hospital (POS 22) to an Ambulatory Surgical Center (POS 24). Usually, the historically split was 70% Hospital Inpatient and 30% Ambulatory Surgical Center. By moving the clinically appropriate surgeries to an overall 30% Hospital Inpatient to 70% Ambulatory Surgical Center, the resultant savings was typically ***45% of the facility charge*** per surgery. On an overall basis, for example one client, with 35,000 members, this resulted in an annual saving of $8.0 million per year. The patient had ease of access, better care, and lower costs.

I would be remised if I didn't mention that the primary care physician is pivotal in reducing overall costs. The primary care physician is the first point of patient contact. On average 4,000 visit Per 1,000 in a Commercial Population. The primary care physicians are responsible for screening, getting early diagnosis which leads to less costly procedures later on, and most importantly, guiding people who need care to the most appropriate and less costly Place of Service. Their service and managing overall costs are not free, and needs to be **built-in to create and reward effective selection of Place of Service alternatives**.

While at Health Net, I designed and created a Risk-Adjusted Shared Risk Program that was adopted by most major medical groups in California. If you are a payer, an at-risk Physician Group, an ACO and are interested in setting up such a program, I think I can be of help.