Case Example

Outpatient Evaluation & Management Services

Franklin Community Health Network

THE ISSUE:

Congress is considering a Medicare Payment Advisory Commission (MedPAC) recommendation that would cap "total" payment for non-emergency department evaluation and management (E/M) services in hospital outpatient departments (HOPDs) at the rate paid to physicians for providing the services in their private offices. For example, for a visit coded as 99201, the physician would receive the standard amount for the service in the hospital setting ($25.87). The hospital would receive the difference between the physician payment in the office ($42.55) and the physician payment in the hospital, or $42.55 - $25.87 = $16.68.

This would reduce the hospital payment between 67 percent and 80 percent for 10 of the most common outpatient hospital services. This proposal is estimated to reduce Medicare spending by $1 billion per year and $7 billion over 10 years.

THE HOSPITAL STORY:

Franklin Community Health Network (FCHN) is a rural integrated health network led by 65-bed Franklin Memorial Hospital. Located in western Maine, the hospital's service area spans 2,800 square miles and has a population of approximately 40,000. FCHN employs approximately 85 percent of the physicians and other providers in its geographic service area, often subsidizing their practices to enable access to essential medical services for the community. The primary county served is an economically deprived area; the network's payer mix includes a disproportionately high percentage of Medicare (45%) and Medicaid (20%) patients.

FCHN has five provider-based (hospital outpatient-based) facility locations, all of which abide by the hospital's charity care and financial assistance guidelines. While many private providers in the same geographic area have been able to remain open by severely limiting access to Medicaid and uninsured patients, FCHN's clinics have experienced a significant increase in overall charity care. In the past five years, the health network's overall charity care has increased by 325 percent. In the last 12 months, the FCHN's provider-based clinics provided $750,000 in charity care and financial assistance (3.5% of costs).

Support for the FCHN's ability to provide otherwise unavailable services for Medicaid and self-pay patients is only part of what the additional $1.8 million in additional reimbursement through provider-based payment provides. This funding also enables FCHN to pay physicians sufficiently to retain current physicians and to recruit future physicians. With provider-based payment, FCHN is able to increase access to both primary and specialty care that would otherwise be unavailable in the community, including ear, nose and throat services, obstetrics services, orthopedic surgery, dermatology, general surgery, outpatient oncology services and cardiology services.

FCHN also incurs additional costs related to Joint Commission accreditation, compliance with other regulations specific to provider-based entities, charity care and financial assistance, a more comprehensive and integrated information technology system, and physician salaries and benefits that are more inclusive and competitive than the typical independent physician office.

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THE IMPACT:

Even with provider-based payment, all five of FCHN's outpatient clinics are losing money. In fiscal year (FY) 2012, the primary care clinics combined lost $3.5 million. If payment for E/M services were to be cut, the organization anticipates reductions in both primary care physicians and other specialties. Cuts to E/M services, together with recent changes in state and federal reimbursement, would make FCHN's ability to provide the current level of services to Medicaid and uninsured patients unsustainable, as the hospital had a financial loss in FY 2012 of $3.7 million, and to-date has a financial loss of $1.1 million in the first four months of FY 2013. The anticipated reductions in primary and specialty care would severely limit access to care, remove current benefits of care coordination and the associated wrap-around services and be potentially detrimental to rural physician recruitment and retention. These wrap-around services include dedicated nurse care support services, chronic disease management and education provided through the provider-based clinics.