American Hospital Association

Outpatient Evaluation & Management Services

Background

The Medicare Payment Advisory Commission (MedPAC) recently adopted a policy 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 offices. Therefore, for a visit coded as 99201, the physician would receive the standard amount for the service in the hospital setting (column B). The hospital would receive the difference between the physician payment in the office (column A) and the physician payment in the hospital (column B), or $41.11–$25.82 = $15.29. This would reduce the hospital payment by at least 71 percent for 10 of the most common outpatient hospital services (see chart below). This proposal is estimated to reduce Medicare spending by $6.8 billion over 10 years. MedPAC's recommendation was considered as a possible offset for the 2012 physician payment fix; however, strong advocacy efforts from the hospital field prevented it from being included in the *Middle Class Tax Relief and Job Creation Act.*

IMPACT OF CUTTING HOSPITAL EVALUATION AND MANAGEMENT SERVICES BY CODE:
Medicare CY 2011 Payments for Visit Services

	A	B	C	D	E	F
CPT Code	Doctor Payment (in office)	Doctor Payment (in hospital)	Current Hospital Payment	Hospital Payment (New Policy) A–B=D	Hospital Payment Cut Per Visit Dollars	Percent
99201	$41.11	$25.82	$52.36	$15.29	–$37.07	–71%
99202	$71.01	$48.93	$75.13	$22.08	–$53.05	–71%
99203	$102.95	$74.75	$99.71	$28.20	–$71.51	–72%
99204	$158.33	$126.39	$128.48	$31.94	–$96.54	–75%
99205	$197.06	$162.41	$168.92	$34.65	–$134.27	–80%
99211	$19.71	$9.17	$52.36	$10.54	–$41.82	–80%
99212	$41.45	$25.14	$75.13	$16.31	–$58.82	–78%
99213	$68.97	$49.27	$75.13	$19.70	–$55.43	–74%
99214	$102.27	$75.77	$99.71	$26.50	–$73.21	–73%
99215	$137.60	$107.03	$128.48	$30.57	–$97.91	–76%

AHA View

The AHA strongly opposes MedPAC's policy to equalize Medicare payment rates for E/M services between HOPD and physician office settings. HOPDs provide access to critical hospital-based services that are not otherwise available in the community and treat higher-severity patients for whom the HOPD is the appropriate setting. In addition, HOPDs have higher cost structures than physician offices due to the need to have emergency stand-by capacity and higher costs associated with myriad regulatory requirements imposed on them. Here is a closer examination of our concerns.

Hospitals already lose money treating Medicare patients in HOPDs. According to the June 2011 MedPAC Databook, Medicare margins are negative 10.8 percent for outpatient services. Making additional cuts to HOPDs threatens beneficiary access to these services. In total, both inpatient and outpatient, America's hospitals

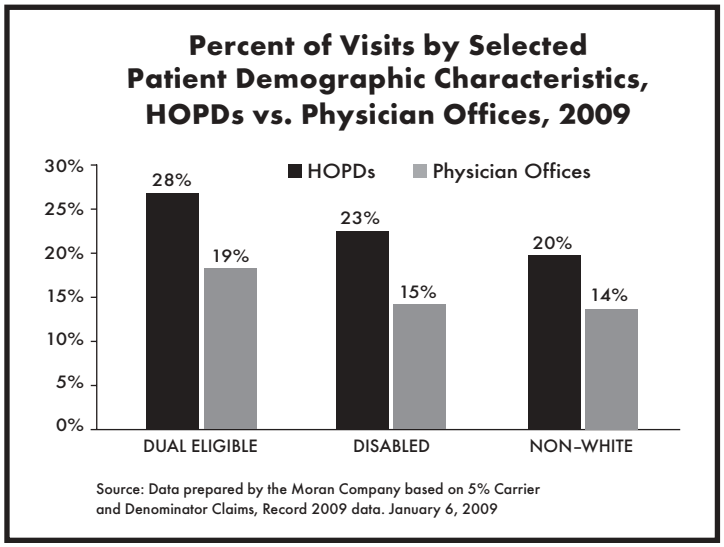
are not paid their costs for treating Medicare patients – losing $5.53 billion or negative 3.8 percent. Sixty-four percent of hospitals are not fully compensated overall for treating Medicare patients.

Teaching and safety-net hospitals would be hardest hit by the cuts. Of special concern is the disproportionate impact that this policy would have on major teaching hospitals and public hospitals. While the overall cut to U.S. hospitals would be 2.8 percent, the impact more than doubles for major teaching hospitals, which would face a 5.8 percent cut, and in urban, public safety-net hospitals, which would face a 4.9 percent cut. These are vital safety-net providers of outpatient services, providing primary care and specialty services in clinics that serve significant numbers of low-income patients. These services are not commonly offered by free-standing physician practices.

Hospital-based clinics provide services that are not otherwise available in the community to vulnerable patient populations. The reduction in outpatient Medicare revenue to hospitals will threaten beneficiary access to critical hospital-based services that are not otherwise available in the community, such as care for low-income patients and services for medically complex patients with multiple co-morbid conditions. Hospitals provide primary care and specialty services in a variety of clinics, which rely on Medicare outpatient E/M payments to continue to fund their operation. The costs in these hospital-based clinics are higher due to more severely ill patient populations requiring greater use of resources, greater regulatory requirements, stand-by capacity costs related to offering emergency department and other services 24/7 and 365 days a year, and also the costs of unreimbursed "wrap-around" services needed to support these vulnerable patient populations – such as transportation, case management and translation services. Cuts of the magnitude described by MedPAC's policy would make it difficult for hospitals to continue to support existing clinics and a disincentive to create new clinics to support the growing needs of these populations.

Patients who are too sick for physician offices are treated in the HOPD. Physicians refer more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, HOPDs treat patients with a higher average risk for complications. An AHA analysis of Medicare data demonstrates that patient severity for E/M clinic visits, as measured using weighted hierarchical condition categories (HCC) scores, is nearly 24 percent higher in HOPDs than in physician offices. The proposed MedPAC policy targets a specific set of E/M services; these services are provided in conjunction with a wide range of procedures, including surgeries and interventional diagnostic tests, which are not necessarily appropriate to provide in physician offices. Patients treated in HOPDs that receive an E/M service also undergo more complex procedures and have more comorbidities and complications compared to those treated in physician offices.

HOPDs serve more patients in vulnerable demographic categories. Because HOPDs serve a more diverse mix of patients, the reduction in outpatient Medicare revenue to hospitals also threatens access to care for certain vulnerable populations. For instance, HOPDs serve 47 percent more patients who are dually eligible for both Medicaid and Medicare than physician offices. HOPDs also serve 53 percent more disabled patients and 43 percent more non-white patients than physician offices. Free-standing physician offices historically have been less willing and able to care for these populations, whose conditions may be more complex to treat or who may be uninsured. By contrast, hospitals generally have more expansive missions and outreach to vulnerable patient populations such as these, and significant cuts in Medicare payment could put such outreach at risk.



How will stand-by capacity be paid?
This policy inappropriately ignores the intrinsically higher costs of providing care in a hospital setting that's open 24/7, 365 days a year. All those unpaid "stand-by capacity" costs – such as around-the-clock availability of emergency services, cross-subsidization of uncompensated care, Emergency Medical Treatment and Labor Act (EMTALA) provisions and Medicaid, emergency back-up for other settings of care, disaster preparedness, along with a wide range of staff and equipment – make hospital-level care more expensive, and these costs are spread across all hospital services, including outpatient E/M services. While some physician practices or clinics have become part of a hospital through various integration efforts, they accept the higher regulatory burden associated with Medicare's conditions of participation, the requirements under EMTALA and other regulatory requirements.

KEY FACTS

Hospitals have more comprehensive licensing, accreditation and regulatory requirements. HOPDs must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements than do free-standing physician offices. This includes hospital licensure requirements in all states, Medicare conditions of participation, as well as additional oversight and regulation by a large number of other government agencies such as the Food and Drug Administration, the Environmental Protection Agency and the Occupational Safety and Health Administration, to name a few. These same standards and requirements are not required of physician offices.

Hospital E/M services include more costs than physician E/M services. Medicare packaging rules differ between HOPDs and physician offices – the outpatient prospective payment system (OPPS) packages the costs of ancillary supplies and services with the cost of a primary service to a far greater degree than does the physician fee schedule (PFS). The lesser degree of packaging in the PFS makes services appear deceptively less costly in physician offices than in HOPDs. Items routinely packaged in the payment for a service in the HOPD (but not in the payment for a similar service in a physician office) include drugs with costs below a certain threshold, as well as other services provided on the same day that are integral to the primary service.

Payment should reflect HOPD costs, not physician payments. The proposal assumes that the physician payment rates somehow reflect the "correct" rate to pay for an E/M clinic visit when, in fact, it is difficult to determine how well Medicare payment rates reflect the actual costs of specific services. HOPD payment rates are based on hospital cost report and claims data. In contrast, the PFS (and specifically the practice expense component) is based on voluntary responses to physician survey data held flat for years due to the cost of various physician payment "fixes."

Hospital E/M codes are defined differently than physician E/M codes. It is incorrect to conclude that when a free-standing physician office and an HOPD use the same Current Procedural Terminology (CPT) code to report an E/M outpatient visit, the amount and intensity of resources used in that encounter are the same and thus should be paid at the same rate. Physician office coding is based on the physician resources required while hospital outpatient E/M coding is based on facility resources required. In fact, Centers for Medicare & Medicaid Services policy dictates that the CPT codes used to represent E/M visit services are applied differently in HOPDs than in physician offices, and therefore one cannot assume that comparable service levels are being provided when a particular CPT code is billed across settings. In addition, the E/M code billed by the hospital is often different than the E/M code billed by the physician for the same patient, because of the different resources used and different definitions.

Distortion of the OPPS. Capping E/M payment in the way proposed would lead to significant distortions in the outpatient ambulatory payment classification (APC) relative weights due to artificial payment caps that are unrelated to hospital costs. The hospital E/M visit is essential to establishing the relativity of all the APC payment weights within the OPPS. Each APC has a relative weight based on the median cost for the procedures in the group relative to the median cost for a mid-level clinic visit.