FACTSHEET

Outpatient Evaluation & Management Services

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 ($25.86). The hospital would receive the difference between the physician payment in the office ($43.89) and the physician payment in the hospital, or $43.89 - $25.86 = $18.03.

This would reduce the hospital payment between 65 percent and 80 percent for 10 of the most common outpatient hospital services. This proposal is estimated to reduce Medicare spending by $900 million per year and $9 billion over 10 years.

Impact of Cutting Hospital Evaluation and Management Services by Code: Medicare CY 2013 Payments for Visit Services

	A	B	C	D	E	F
CPT code	Doctor payment in office (CY 2013)	Doctor payment in hospital (CY 2013)	Current Hospital Payment (CY 2013)	New Hospital Payment (A-B=D)	Hospital Payment Cut Per Visit	
					Dollars	Percent
99201	$43.89	$25.86	$56.77	$18.03	($38.74)	-68%
99202	$74.51	$48.99	$73.68	$25.52	($48.16)	-65%
99203	$107.85	$74.85	$96.96	$33.00	($63.96)	-66%
99204	$164.67	$127.93	$128.48	$36.74	($91.74)	-71%
99205	$203.80	$164.33	$175.79	$39.47	($136.32)	-78%
99211	$20.41	$8.85	$56.77	$11.57	($45.20)	-80%
99212	$43.89	$24.50	$73.68	$19.39	($54.29)	-74%
99213	$72.47	$49.67	$73.68	$22.80	($50.88)	-69%
99214	$106.49	$76.55	$96.96	$29.94	($67.02)	-69%
99215	$142.90	$107.85	$128.48	$35.04	($93.44)	-73%

AHA POSITION

The AHA strongly opposes legislation implementing MedPAC's recommendation to equalize Medicare payment rates for E/M services between HOPDs and physician office settings because:

- Hospitals provide access to critical hospital-based services that are not otherwise available in the community and treat higher-severity patients for whom the hospital outpatient department is the appropriate setting.
- Hospitals have higher cost structures than physician offices due to the need to have emergency stand-by capacity.
- Hospitals have more comprehensive licensing, accreditation and regulatory requirements.

WHY?

- **Hospitals lose money treating Medicare patients in HOPDs.** According to MedPAC's March 2013 report, Medicare margins are negative 11 percent for outpatient services. Additional cuts to HOPDs threaten beneficiary access to these services.
- **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 access to critical hospital-based services that are not otherwise available in the community, such as care for low-income patients and services for patients with multiple conditions.
    - HOPDs serve a higher percentage of dual-eligible patients than physician offices. HOPDs also serve a higher percentage of disabled patients and non-white patients.

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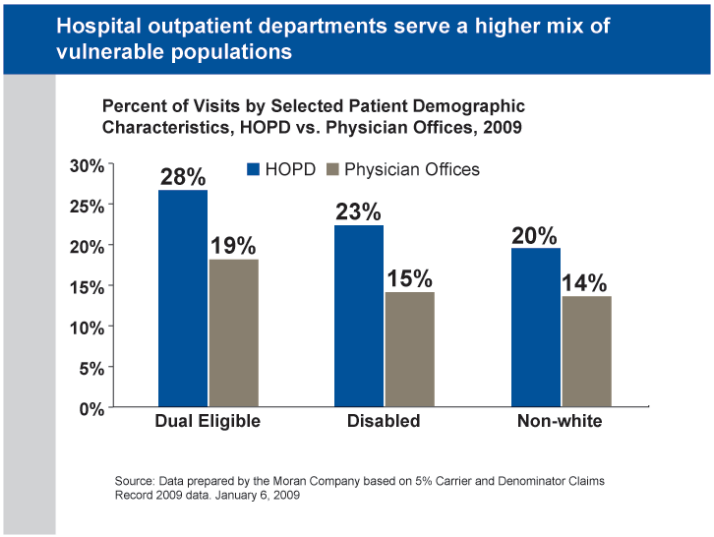

- **Patients who are too sick for physician offices are treated in the HOPD.** Physicians refer more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, HOPDs treat patients with a 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.**
- **Hospitals are on stand-by 24/7/365.** This policy inappropriately ignores the intrinsically higher costs of providing care in a hospital setting that's open 24 hours a day, 7 days a week, 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, EMTALA and Medicaid; emergency back-up for other settings of care; disaster preparedness; 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.*
- **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 5.6 percent cut, and in urban, public safety-net hospitals, which would face a 4.6 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.
- **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.
- **Payment should reflect HOPD costs, not physician payments.** HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician payment schedule (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."
- **Capping E/M payment would lead to distortion of the hospital outpatient payments.** Capping E/M payment as proposed would lead to significant distortions in the outpatient ambulatory payment classification (APC) relative weights due to the artificial payment caps that are no longer related to hospital costs. Each APC has a relative weight based on the geometric mean cost for the procedures in the group relative to the geometric mean cost for a mid-level E/M clinic visit.