

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

CPT code	A	B	C	D	Hospital Payment Cut Per Visit	
	Doctor payment in office (CY 2013)	Doctor payment in hospital (CY 2013)	Current Hospital Payment (CY 2013)	New Hospital Payment (A-B=D)	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.

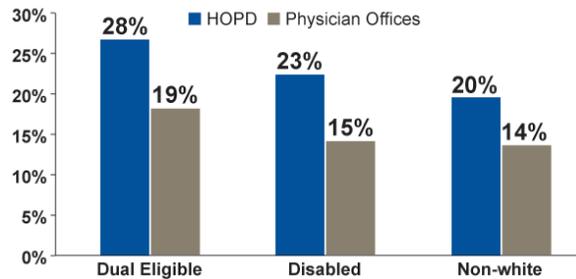
WHY?

- **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, 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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Hospital outpatient departments serve a higher mix of vulnerable populations

Percent of Visits by Selected Patient Demographic Characteristics, HOPD vs. Physician Offices, 2009



Source: Data prepared by the Moran Company based on 5% Carrier and Denominator Claims Record 2009 data, January 6, 2009

- **Patients who are too sick for physician offices are treated in HOPDs.** 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 have greater costs than physicians providing the same service in their offices.** HOPDs must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements than do freestanding physician offices. CMS acknowledged this in its July 19 proposed rule for the 2014 physician payment system:

“When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively.”¹

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 freestanding physician practices.
- **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.

¹ CMS-1600-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule (Vol. 78, No. 139), July 19, 2013, p. 43296.



Additional Hospital Outpatient Services at Risk for Site-Neutral Cuts

THE ISSUE

Congress is considering capping “total” payment for a set of 66 groups of services (referred to as ambulatory payment classifications (APCs)) furnished in hospital outpatient departments (HOPDs) at the rate paid to physicians for providing the services in their private offices. This would cut hospital payments by 2.7 percent, or \$900 million, in one year. This proposal reflects recent Medicare Payment Advisory Commission (MedPAC) discussions about expanding its “site-neutral” payment recommendation for hospital evaluation and management (E/M) services to other HOPD services. The services in these 66 APCs are routine outpatient services that are integral to hospitals’ service mission. However, MedPAC identified them as candidates for site-neutral cuts because MedPAC staff analysis showed that they met several criteria, including being frequently performed in physician offices, infrequently provided with an emergency department visit and having minimal patient severity differences across settings.

Unlike the E/M proposal, MedPAC has not yet formally recommended this policy amid stakeholder and commissioner concerns that such steep payment cuts could

have unintended consequences for patient access to care and hospitals’ ability to continue to provide emergency standby services.

Under the policy being considered, a hospital would be paid a residual amount calculated as the difference between the payment rate the physician would receive under the Medicare Physician Fee Schedule (PFS) for a service furnished in his or her private office and the PFS rate paid for the service furnished in a HOPD. The policy results in steep cuts at the service level. For instance, under this policy, the hospital’s payment for a level II echocardiogram without contrast (APC 0269) would drop from \$387.13, the average amount currently paid under the outpatient prospective payment system (OPPS), to \$127.29 – a 67 percent reduction. This one service accounts for more than a quarter of the projected savings.

If this expanded site-neutral policy were combined with the \$900 million in E/M cuts also being considered by Congress, these payment policies would decrease hospital outpatient revenues by 5.4 percent, or \$1.8 billion, per year. As a result, they would further reduce Medicare outpatient margins from negative 11 percent in 2011 to negative 15 percent, all else being equal.

AHA POSITION

The AHA strongly opposes legislation that would reduce Medicare payment rates for these 66 APCs to a residual amount of the Physician Fee Schedule payment rate or to the rate paid in Ambulatory Surgery Centers (ASCs).

Impact of Cutting Certain HOPD Services by Code: Medicare CY 2013 Payments for a Sample of HOPD Services

APC	Description	Current Average Hospital Payment for APC	Average Hospital Payment for APC if Paid at the Residual PFS Amount	Percent Change in Hospital Payment for APC	Aggregate Cut in Hospital Payment for APC if Paid at the Residual PFS Amount
0269	Level II Echocardiogram Without Contrast	\$387.13	\$127.29	-67%	\$276.8 million
0207	Level III Nerve Injections	\$561.94	\$348.31	-38%	\$150.0 million
0209	Level II Extended EEG, Sleep, and Cardiovascular Studies	\$788.07	\$533.92	-32%	\$82.7 million
0238	Level I Repair and Plastic Eye Procedures	\$241.11	\$41.38	-83%	\$13.0 million
0365	Level II Audiometry	\$91.18	\$6.96	-92%	\$6.9 million
0382	Level II Neuropsychological Testing	\$182.82	\$25.87	-86%	\$1.9 million

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While this MedPAC approach has generated a great deal of interest in Congress as a way to generate significant savings for the federal government, an alternate site-neutral proposal being considered by MedPAC and Congress would base payments for HOPD services on the rates Medicare pays for services in ASCs. The impact of this alternate approach also would be significant; currently, Medicare pays for covered surgical services in ASCs at approximately 60 percent of the rate that it pays for similar services in the HOPD. MedPAC is considering a policy that would reduce HOPD payment for 12 APCs that are commonly performed in ASCs to the ASC level. MedPAC estimates that this policy would reduce hospital outpatient revenues by \$590 million per year or a 1.7 percent decrease in HOPD Medicare revenue.

Unlike physician offices and ASCs, hospitals play a unique and critical role in the communities they serve by providing a wide range of acute-care and diagnostic services, supporting public health needs, and offering many other services that promote the health and well-being of the community. In addition, hospitals provide emergency standby services such as:

- **24/7 Access to Care:** The provision of health care services, including specialized resources, 24 hours a day, seven days a week (24/7), 365 days a year.
- **The Safety Net:** Caring for all patients who seek emergency care regardless of ability to pay.
- **Disaster Readiness and Response:** Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.

These critical roles, while often taken for granted, represent essential components of our nation's health and public safety infrastructure. **It is critical that Congress**

consider these unique roles of hospitals and refrain from imposing site-neutral payment cuts on HOPD services.

For example, hospitals currently provide \$41 billion of uncompensated care annually. By contrast, many physicians and ASCs do not serve Medicaid and charity care patients.

In addition, despite its importance, hospitals' standby role is not explicitly funded. There is no payment for a hospital and its staff to be at the ready until a patient with an emergency need arrives. Without such explicit funding, the standby role is built into the cost structure of full-service hospitals and supported by revenue from direct patient care – a situation that does not exist for physician offices, ASCs or any other type of provider.

Hospitals today face challenges in maintaining this role, such as increasing demand, staffing and space constraints, greater expectations for preparedness, the erosion of financial support from government payers, and the loss of patients to other settings that do not have the added costs of fulfilling the standby role.

WHY?

- Hospitals already 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.
- HOPDs 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, such as care for low-income patients and services for patients with multiple chronic conditions.
- HOPDs serve a higher percentage of disabled patients than physician offices. HOPDs also serve a higher percentage of dual-eligible patients and non-white patients than physician offices and ASCs.
- Patients who are too sick for physician offices or too medically complex for ASCs are treated in the HOPD. Physicians refer more complex patients to HOPDs for safety reasons, because hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices and ASCs, HOPDs treat patients with a higher average risk for complications.
- HOPDs have more comprehensive licensing, accreditation and regulatory requirements than do free-standing physician offices and ASCs.
- Payment should reflect HOPD costs, not physician or ASC 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 and has been held flat for years due to the cost of various physician payment "fixes." ASCs do not even report costs.
- The Medicare payment systems for physicians, ASCs and HOPDs are complex and fundamentally different, with many moving parts. Practically speaking, this makes the application of MedPAC's site-neutral policy unstable, with any number of small technical and methodological decisions changing the outcome significantly. Basing hospital payments on such a volatile methodology could have unintended consequences.