

# Outpatient Evaluation & Management Services

## THE ISSUE

A 2012 Medicare Payment Advisory Commission (MedPAC) recommendation 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.

However, in the 2014 outpatient prospective payment system (PPS) final rule, the Centers for Medicare & Medicaid Services (CMS) collapsed the 10 separate E/M codes for hospital outpatient clinic visits, and replaced them with one new code representing a single level of payment for all outpatient clinic visits. The previous clinic visit codes reflecting five levels

of resource intensity and the distinction between new and established patients are no longer recognized in the outpatient PPS. The adoption of a single code for all hospital outpatient clinic visits means a one-to-one coding match between HOPD and physician E/M codes no longer exists to implement MedPAC’s recommendation. **MedPAC has not revisited its recommendation or its impact analysis since CMS finalized the E/M code collapse policy.** MedPAC had estimated its policy would reduce Medicare spending by \$900 million per year and \$9 billion over 10 years, by reducing hospital payment between 65 percent and 80 percent for 10 of the most common outpatient services.

## AHA POSITION

Given CMS’s sweeping changes to the coding structure for E/M hospital outpatient clinic visit services, it is unclear how Congress could enact MedPAC’s ill-advised recommendation to equalize Medicare payment rates for E/M services between HOPDs and physician office settings. However, even if it is possible, the AHA strongly opposes such legislation 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 HOPD 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 than physician offices.

## WHY?

- **Hospitals already suffer negative margins treating Medicare patients in HOPDs.** According to MedPAC’s June 2015 data book, Medicare margins were *negative* 12.4 percent for outpatient services in 2013. Additional cuts to HOPDs threaten beneficiary access to these services.
- **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 who are burdened with more severe chronic conditions and, in Medicare, have higher prior utilization of hospitals and emergency departments.

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- **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 underserved populations. For example, relative to patients seen in physician offices, patients seen in HOPDs are:
  - 2.5 times more likely to be Medicaid, self-pay or charity patients
  - 1.8 times more likely to be dually eligible for Medicare and Medicaid
  - 1.8 times more likely to live in high-poverty areas
  - 1.7 times more likely to live in low-income areas
  - 1.7 times more likely to be Black or Hispanic
- **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 free-standing physician offices. CMS acknowledged this in its July 19, 2013 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.”<sup>1</sup>

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 public hospitals would be hardest hit by the cuts.** Of special concern is the disproportionate impact that this policy likely would have on major teaching hospitals and public hospitals. Impact data from before CMS changed the clinic visits coding structure show that, 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 for urban, public hospitals, which would face a 4.6 percent cut.
- **Payment should reflect HOPD costs, not physician payments.** HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician fee schedule (and specifically the practice expense component) is based on responses to physician survey data.
- **Capping E/M payment would lead to distortion of the hospital outpatient payment system.** 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 the E/M clinic visit.

<sup>1</sup> 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.