American Hospital Association

Outpatient Evaluation & Management Services

Congressional leaders are considering a policy that originated with the Medicare Payment Advisory Commission (MedPAC) that would cap “total” payment for non-emergency department evaluation and management (E/M) services at the rate paid to physicians for providing the services in their offices. Therefore, when the visit occurs in a hospital outpatient department (HOPD), the physician would receive the standard amount for the service in a hospital setting and the hospital would receive the difference between the physician payment in the office minus the physician payment in the hospital. This would reduce the hospital payment by at least 71 percent for 10 of the most common outpatient hospital services. This proposal is estimated to reduce Medicare spending by $1 billion per year and $10 billion over 10 years.

Impact of Cutting Hospital Evaluation and Management Services by Code: Medicare CY 2011 Payments for Visit Services

	A	B	C	D	E	F
					Hospital Payment Cut Per Visit	
CPT code	A Doctor Payment (in office)	Doctor Payment (in hospital)	Current Hospital Payment	Hospital Payment (New Policy) A-B=D	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%**

The AHA strongly opposes such a policy because HOPDs:

- treat higher-severity patients for whom the HOPD is the appropriate setting;
- have higher cost structures than physician offices due to the need to have emergency stand-by capacity; and
- have higher costs associated with myriad regulatory requirements imposed on them.

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. These aren’t “made-up” or “accounting” costs; these are real costs for treating America’s seniors. And these costs aren't being covered. 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.

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. Although H.R. 3630 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.

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, 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*. 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. Many times, purchase of a physician practice or new physician employment will not lead to a physician office becoming an outpatient hospital setting.

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, the 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 services provided on the same day that are integral to the primary procedure (i.e., guidance, image processing, imaging supervision and interpretation, diagnostic radiopharmaceuticals, contrast media and observation).

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."

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 the artificial payment caps that are no longer related 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.