Wednesday, December 7, 2011

NEED ACTION FROM...	*Hospital leaders*
ACTION...	*Urge your legislators to reject proposals to cut hospital payments to pay for the physician payment fix, including a proposal to cut Medicare payments for hospital outpatient E/M services*
WHEN...	*Immediately*
HOW...	*Call or e-mail your legislators*
WHY...	*E/M payment change would cut $10 billion over 10 years from outpatient hospital department payments; hospital outpatient Medicare margins are already negative 10.8%*

URGE CONGRESS NOT TO CUT HOSPITAL PAYMENTS INCLUDING BILLIONS FROM HOSPITAL OUTPATIENT PAYMENTS

Coming days crucial

Congress is preparing year-end legislation, among which may be prevention of the scheduled 27.4 percent reduction in Medicare payments to physicians set to begin on January 1. The cost to prevent that payment cut is $21 billion for one year and $38 billion for two years. Congress will need to offset this amount, and a number of options to reduce hospital payments, among others, are under consideration, including reductions in Medicare bad debt reimbursement and decreased payments to inpatient rehabilitation hospitals by increasing the 60% Rule to 75 percent. One additional option on the table would take $10 billion from hospital outpatient payments by drastically cutting payments for hospital outpatient department (HOPD) evaluation and management (E/M) 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 E/M services at the rate paid to physicians for providing the services in their offices. Therefore, when the visit occurs in an 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 for a mid-level clinic visit from $75.13 to $19.70, a 74 percent reduction. Payment impacts for other E/M services are shown in the table below. This proposal is estimated to reduce Medicare spending by $1 billion per year and $10 billion over 10 years.

Medicare CY 2011 Payments for Visit Services
Current vs. Proposed New Policy

CPT Code	Doctor Payment (in Office)	Doctor Payment (in Hospital)	Current OPPS Payment	Hospital Payment (New Policy)	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%

These services are among the most common outpatient services provided in hospitals. Cuts would affect all hospitals, regardless of whether they employ their physicians.

The AHA strongly opposes this proposal for the following reasons:

Hospitals already lose money treating Medicare patients in HOPDs. According to the June 2011 MedPAC Databook, Medicare margins already are *negative* 10.8 percent for outpatient services. Making additional cuts to HOPDs threatens beneficiary access to these services.

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.

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).

Further, 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."

Even if policymakers chose to make payments for E/M visits site neutral, then, in accordance with existing statutory and regulatory policy, we believe that adjustments should be made within the overall outpatient payment system, in a budget-neutral manner, by redistributing any amount removed from the E/M services to all other services within the OPPS.

Finally, from an operational standpoint, it is difficult to understand how CMS could implement a proposal that would so significantly reduce the payment amount for the HOPD E/M clinic visit services when the mid-level clinic visit is essential to establishing the relativity of all the ambulatory payment classifications (APCs) payment weights within the outpatient payment system. That is, each APC relative weight is set by comparing it to the median cost for a mid-level clinic visit. If the value of the mid-level clinic visit drops by nearly 75 percent, as it would under this proposal, this would make cuts in every service in the entire OPPS.

ACTION NEEDED

Please contact your senators and representative and ask them to oppose any additional cuts to hospitals, including these major reductions to hospital outpatient services. We are supportive of eliminating the planned cuts to physicians, but not by reducing payments to hospitals.