American Hospital Association

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Glenn M. Hackbarth, J.D.
64275 Hunnell Road
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Dear Mr. Hackbarth:

The Medicare Payment Advisory Commission (MedPAC) recently discussed Medicare payment rate differences between hospital outpatient departments (HOPDs) and freestanding physician offices. Staff put forth a policy option to equalize Medicare payment rates for evaluation and management (E/M) services between HOPD and physician office settings. Such a proposal would substantially reduce Medicare payments to hospitals for outpatient services. **The AHA strongly opposes this proposal for a variety of reasons.** Before considering potential recommendations in this area, we ask your consideration of the following issues that have significant importance to hospitals and Medicare and Medicaid beneficiaries.

The Commission discussed a policy option to reduce Medicare payment rates for non-emergency department E/M services provided in HOPDs so that total Medicare payment rates for these visits are the same across settings. 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.

Additionally, the policy is based on incorrect assumptions about Medicare payment rates to HOPDs. CMS defines hospital E/M visits differently than physician E/M visits and includes additional costs that are not in the physician E/M visits. The mid-level clinic visit is the basis for setting relative weights for all other hospital outpatient services and this change would distort the system. These differences must be recognized.

From an operational standpoint, MedPAC's recommendation likely would lead to significant distortions in the outpatient 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 outpatient prospective payment system (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. If payment for the visit drops by nearly 75

percent, as it would under the MedPAC proposal, this likely would lead to changes in how hospitals charge for E/M services – setting them relative to the payment caps instead of historical costs for the services. This would undermine the process for establishing the relative weights of the entire OPPS, basing the system's relativity on physician payments, not hospital costs.

Further, the policy interferes with health care delivery system reform efforts to achieve better clinical integration through incorporation of physician practices into hospital systems. This policy would hamper integration efforts by creating even greater shortfalls in Medicare funding.

Compounding the problem, Medicare already pays hospitals less than the cost of providing care to Medicare beneficiaries – especially in the outpatient setting. MedPAC's June 2011 Databook showed that 2009 Medicare margins for outpatient services were *negative* 10.8 percent, *negative* 2.4 percent for inpatient services and *negative* 5.2 percent overall. Additional cuts to outpatient payments could endanger Medicare and Medicaid beneficiary access to these services.

Hospitals already are underpaid for these services and recommending that payments for each of these services be reduced by 71% or more, as detailed in the table below, is excessive and harmful. MedPAC's proposal would cap "total" payment for E/M services at the rate paid to physicians for providing the services in their offices. Therefore, for a visit coded as 99201, the physician would receive the standard amount for the service in the hospital setting (column B). The hospital would receive the difference between the physician payment in the office (column A) and the physician payment in the hospital (column B), or $41.11 - $25.82 = $15.29.

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

	A	B	C	D	E	F
CPT code	Doctor Payment (in office)	Doctor Payment (in hospital)	Current Hospital Payment	Hospital Payment (New Policy) A-B=D	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%
99215	$137.60	$107.03	$128.48	$30.57	-$97.91	-76%

Even if MedPAC recommends making payments for E/M visits site neutral, then, we believe that adjustments should be made in a budget neutral manner within the OPPS by redistributing any amount removed from the E/M services to all other services in the OPPS.

HOPDs treat higher-severity patients.
MedPAC staff proposed a principle that patients should have access to settings that provide the most appropriate level of care. We agree and note that physicians refer more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. Although MedPAC's policy option targets a specific set of services, E/M, 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 who receive an E/M service also undergo more complex procedures and have more comorbidities and complications compared to those treated in physician offices. We urge the Commission to more fully analyze and consider this issue.

Stand-by capacity must be covered.
Medicare must continue to recognize the higher costs of hospital care due to stand-by capacity and capability. MedPAC should not set a precedent of limiting hospitals' ability to spread across all services the costs of ensuring emergency "stand-by" capability and capacity. These capabilities and capacities include such critical services as around-the-clock availability; emergency back-up for other settings of care; disaster preparedness; and a wider range of staff and equipment. The ability and expectation to ramp up services, rescue and respond is greater in HOPDs than in physician offices. HOPDs provide back-up capabilities, including higher staffing levels; the ability to admit patients; availability of blood and transfusion services; availability of life-saving technology (e.g., crash cart); and the full range of on-call specialists. This back-up capability is available at the hospital for all patients – even those whose care originated at other sites, including physician offices, while all stand-by costs are borne only by the hospital.

HOPDs have higher costs associated with myriad regulatory requirements.
The regulatory requirements with which hospitals must comply have a significant importance to the Medicare program, as well as to beneficiaries and other patients, but all impose associated costs. Most of these regulations apply to the hospital as a whole, increasing costs for inpatient services and for on-site and off-site HOPD services. This added regulatory burden includes:

- EMTALA;
- hospital licensure requirements in all states;
- the Medicare conditions of participation, such as:
  - ✓ infection control requirements to provide a "sanitary environment," have a designated infection control officer and maintain and use data to drive down infections;
  - ✓ fire safety standards;
  - ✓ guidelines regarding patient's rights, such as informed consent, as well as a grievance process;
  - ✓ requirements that hospitals maintain a facility-wide quality assurance and performance improvement plan with written plans of implementation, including collecting and

analyzing and using quality data to identify opportunities for improvement and engaging in improvement projects; and
  - ✓ more stringent standards and enforcement for drug administration and pharmaceutical services;
- cost report filing; and
- additional regulation and stricter enforcement from other state and federal agencies such as Food and Drug Administration, Environmental Protection Agency and Occupational Safety and Health Administration, for activities such as:
  - ✓ hospital blood services;
  - ✓ hospital reprocessing of single-use medical devices;
  - ✓ hospital pharmacy compounding activities;
  - ✓ hospital medical and pharmaceutical waste processing; and
  - ✓ bloodborne pathogen regulation.

All of these hospital-wide requirements have associated costs. Such costs are therefore legitimately reflected in higher Medicare reimbursement for services furnished in HOPDs compared to free-standing physician offices.

HOPD E/M visits are different than physician E/M visits.
It is inappropriate for MedPAC to compare payments between the OPPS and the Physician Fee Schedule (PFS) without further evaluating the differences between the OPPS and PFS. The unit of payment under the OPPS is clinically similar groups of procedures and services called ambulatory payment classifications (APCs) while the unit of payment under the PFS is a single procedure or service. APCs package the costs of ancillary supplies and services together with the primary service to a far greater degree than the PFS. While Commission staff correctly noted that E/M services paid under the OPPS generally have fewer ancillary costs packaged than other, procedural OPPS services, these differences still need to be acknowledged and accounted for when attempting to explain the difference in OPPS and PFS payment rates.

Most notably, while the PFS entails a separate payment equal to average sales price (ASP) plus 6 percent for all drugs furnished during an E/M visit, the OPPS packages the cost of drugs whose daily cost falls below a certain threshold ($70 in calendar year 2011) into the payment for the service with which they are billed. Services provided on the same day that are integral to the primary procedure (e.g. guidance, image processing, imaging supervision and interpretation, diagnostic radiopharmaceuticals, contrast media, and observation) are also routinely packaged in an APC payment but not in a PFS payment. This lesser degree of packaging in the PFS makes services paid under that system seem less costly on their face, but in reality, they actually simply encompass fewer additional services. Any arbitrary adoption of this type of proposed payment change would necessitate other APC packaging changes.

It is also incorrect to conclude that because a free-standing physician office and an HOPD use the same Current Procedural Terminology (CPT) code to report an E/M outpatient visit, the amount and intensity of resources used in that encounter are the same and thus should be paid at the same rate. Physician office coding is based on the *physician* resources required while hospital outpatient E/M coding is based on *facility* resources required. In fact, in 2000, when the OPPS began, CMS laid out OPPS E/M coding principles that recognized that the descriptors for the E/M codes – which were designed to reflect the activities of physicians – did **not** adequately describe the range and mix of services provided by hospitals.

CMS instructed hospitals to develop their own internal hospital guidelines to determine the level and assignment of clinic or emergency CPT E/M codes to report facility resources. CMS's principles for coding and reporting of hospital facility services require that each hospital's internal guidelines follow the intent of the CPT code descriptor and be reasonably related to the intensity of *hospital* resources represented by the different levels of effort included in the code. CMS's principles also require that the guidelines be based on hospital facility resources, *not physician resources.* Therefore, it is inaccurate for MedPAC to assume that a particular E/M level of service furnished in a HOPD should be paid as if that service were furnished in a physician office.

Payment amounts should be set appropriately.

MedPAC's proposal assumes that the PFS payment rate somehow reflects the "correct" rate to pay for an E/M visit when, in fact, it is difficult to determine how well Medicare payment rates (especially PFS payment rates) reflect the actual costs of specific services. It is fair to say that the differences in the payment rates for similar services across ambulatory settings are largely artifacts of the very different and complex methodologies that Congress enacted and that CMS implemented under the OPPS and the PFS. But OPPS payments generally are based directly on hospital data: audited cost reports and claims data. In contrast, the PFS (and specifically the practice expense component) is based on voluntary responses to physician survey data. While the Commission's discussion centered around whether Medicare should act as a prudent purchaser and refrain from paying more for a service in the HOPD setting than in the physician office setting, it is equally correct to question whether the lower paying setting is paying enough.

We appreciate your consideration of this very important issue. If you have any questions, please feel free to contact me or Roslyne Schulman, director for policy development, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President

Cc: Mark Miller, Ph.D.
MedPAC Commissioners