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American Medical Colleges
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December 14, 2011

The Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

Dear Majority Leader Reid and Minority Leader McConnell:

On behalf of the nation's teaching hospitals and their hospital outpatient departments (HOPDs), physician faculty, and medical schools, I appreciate your commitment to addressing the flawed Sustainable Growth Rate (SGR) formula and working to prevent the scheduled 27.4 percent cut in Medicare physician payments on January 1, 2012. However, certain changes in HOPD reimbursement included in H.R. 3630, The Middle Class Tax Relief and Job Creation Act of 2011, could have a devastating impact on the ability of teaching physicians to care for Medicare patients in HOPDs; and their ability to train the next generation of health professionals in these outpatient settings.

As you know, the Association of American Medical Colleges (AAMC) is a not-for-profit association representing all 136 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals (including hospital outpatient departments) and health systems, including 62 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 114,000 physician faculty, 75,000 medical students, and 110,000 resident physicians.

Changes to HOPD Policy Must be Appropriately Targeted and Not Across-the-Board

In September, the Medicare Payment Advisory Commission (MedPAC) raised the possibility of equalizing Medicare reimbursements for Evaluation & Maintenance (E&M) services in hospital outpatient departments with payment rates for services in a physician office. Building on this proposal, H.R. 3630 would unfairly impose this policy on all HOPDs starting in 2012.

The AAMC believes that any change of this nature must be further studied and appropriately targeted and not applied in an across-the-board manner that may have serious negative consequences for teaching hospitals and the patients they serve in their HOPDs.

MedPAC Has Not Formally Recommended HOPD Changes While Noting Higher Costs in HOPDs

MedPAC discussed the idea in more detail at its November meeting, but has not yet made any formal recommendation. In its presentation, MedPAC staff noted that there are reasons that costs are higher in hospital-based outpatient departments (HOPDs) than in physician offices:

“Hospitals incur additional costs related to their unique mission and regulatory requirements. Many hospitals maintain standby capacity to handle emergencies, and they are also subject to regulations like EMTALA and Conditions of Participation which do not apply to physicians' offices.” (Ariel Winter, MedPAC staff, MedPAC Meeting, Friday, November 4, 2011)

Congress also has acknowledged that teaching hospitals treat more complex patient populations with a greater severity of illness and provide highly specialized services, including emergency and standby services, which are unavailable elsewhere in a community.

Teaching hospitals and their HOPD partners not only provide care to Medicare beneficiaries, but are also committed—financially and otherwise—to training the next generation of physicians. HOPDs incur additional costs as a result of the role in training America's future physicians and continue these important functions if they receive the same reimbursement as lower-costs physician settings.

The practice expense component of the physician fee schedule in non-facilities does not reflect practice expenses of teaching hospital outpatient departments; the costs of providing E&M services in HOPDs are legitimately higher than in physician offices and should continue to be recognized.

Impact of HOPD Changes are Not Well Understood and Could Negatively Impact Access to Care

Implementing the proposed HOPD cuts without fully understanding the impact on Medicare beneficiaries, teaching hospitals and physicians could also lead to unintended consequences, including:

- A total impact of nearly \$300 million per year across the academic medical center (AMC) community;
- In nearly half of AMCs, more than 50 percent of Medicare visits are provided in hospital-based clinics and this would result in a disproportionate impact on teaching hospitals; and
- A median loss of \$5.5 million per AMC per year among these AMCs with a high proportion of hospital-based clinic activity.

HOPDs serve a critical role in providing care to vulnerable populations. A full understanding of the consequences of eliminating the payment differential is needed so that those patients who are most in need of the services provided at HOPDs are not adversely affected.

Faculty Physicians in HOPDs and Teaching Hospitals Create Strong Partnerships to Improve Quality of Care

It also must be recognized that becoming a hospital-based outpatient department is not a simple matter, but requires compliance with an extensive set of regulatory requirements.

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These requirements were designed to ensure that HOPDs meet certain standards and encourage integration between the main provider (the teaching hospital) and the outpatient department, which are not required in the physician office setting.

Among the myriad of requirements, the main provider (the hospital) and the outpatient department must:

- Operate under the same licensure (except if the State requires separate licenses);
- Have provisional staff with clinical privileges at the outpatient department and the main provider;
- That the main provider has the same level of monitoring and oversight as it does for any other department;
- Integrate medical records for patients into a unified retrieval system of the main provider;
- Integrate inpatient and outpatient services;
- Have financial integration;
- Ensure there is public awareness that the outpatient department is part of the main provider; and
- Operate under the ownership and control of the main provider.

These requirements encourage care coordination and integration between HOPDs and the main hospital provider, which improve patient care, but could be jeopardized if necessary funding is reduced.

Fixing SGR is critical, but should not be done at the expense of care in HOPDs.

For all of the reasons stated above, the AAMC strongly opposes proposed changes to E&M payment rates in the HOPD setting.

While the AAMC appreciates efforts to address the problematic SGR formula, cutting Medicare payments to hospital outpatient departments to pay for an SGR patch is counter-productive and would reduce teaching hospitals' ability to cover necessary training costs and could impact health care access for Medicare beneficiaries across the nation.

We urge you to reject HOPD changes and look forward to working with you to address the long-standing problem of replacing Medicare's physician payment system with a sustainable solution.

Sincerely,



Atul Grover, M.D., Ph.D.
AAMC Chief Public Policy Officer

cc: Senator Max Baucus
Senator Orrin Hatch