February 18, 2016

The Honorable Fred Upton, Chairman
The Honorable Frank Pallone, Jr., Ranking Member
U.S. House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Upton and Ranking Member Pallone,

The Physicians Advocacy Institute (PAI) appreciates the opportunity to respond to your letter calling for input from the health care community regarding Section 603 of the Bipartisan Budget Act of 2015, which equalizes payments for services provided in newly acquired off-campus hospital outpatient departments after January 1, 2017.

PAI is a not-for-profit advocacy organization whose mission is to advance fair and transparent payment policies and contractual practices by payers and others in order to sustain the profession of medicine for the benefit of patients. PAI’s Board of Directors includes CEOs and former CEOs from nine state medical associations, including California, Connecticut, Georgia, Nebraska, New York, North Carolina, South Carolina, Tennessee and Texas, as well as a Kentucky physician.

PAI is pleased to share a just-released report that provides a comprehensive examination of Medicare payment rate differentials across service settings. Prepared by Avalere Health and entitled “Medicare Payment Differentials Across Outpatient Settings of Care,” the report assesses the Medicare payment differential for three common services routinely performed in hospital outpatient department (HOPD) and physician office settings: echocardiograms, colonoscopies, and evaluation and management services.

The report confirms that for all three types of services, Medicare spends more when patients receive services in a HOPD instead of a physician office. For instance, the study found that cardiac imaging payments are more than triple when patients receive care at a hospital outpatient department instead of a physician’s office – roughly $2,100 vs. $655, respectively.
For the first time, researchers considered Medicare payments for an entire ‘episode of care’ to gain a better perspective on how the site of the initial procedure affects utilization and payment amounts over a full episode of treatment. The total payments per episode include all Medicare payments for services surrounding the primary service, including both preparatory and follow-up care.

As noted in the report’s Executive Summary, a major takeaway from the study is that “when care is initiated in the typically higher-paying HOPD setting, the services that follow also result in higher spending relative to when care is initiated in the office setting.” The extent of the differential in Medicare spending for the three types of services is highlighted by the following findings:

- Episode-of-care payments for echocardiograms averaged $5,148 when provided in HOPDs, compared to $2,862 when provided in a physician’s office.
- Episode-of-care payments for colonoscopies and related services for Medicare patients are nearly 35 percent more when performed in HOPDs instead of physician offices.
- Episode-of-care payments for evaluation and management services for new patients were 29 percent more when delivered at HOPDs than if delivered in physician offices.

Avalere researchers adjusted their findings to account for risk factors and demographic characteristics that can impact the cost of providing services. The study concludes that differences in patient populations treated in the office and HOPD settings account for only a small portion of the differences in payments across settings.

We hope this report will prove useful as Congress continues to consider policies to align payment for the same services provided in different settings and protect Medicare beneficiaries from the burden of unnecessary additional cost-sharing.

If you have any questions, please contact me at k2strategiesllc@gmail.com.

Sincerely,

Kelly C. Kenney
Executive Vice President, Physicians Advocacy Institute

Attachment