

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-18

Subject: Addressing the Site-of-Service Differential
(Resolution 817-I-17)

Presented by: Paul A. Wertsch, MD, Chair

1 At the 2017 Interim Meeting, the House of Delegates referred Resolution 817, “Addressing the Site
2 of Service Differential,” which was introduced by the New Mexico Delegation and assigned to the
3 Council on Medical Service for a report back to the House of Delegates at the 2018 Annual
4 Meeting. Resolution 817-I-17 asked:

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6 That our American Medical Association (AMA) study the site-of-service differential with a
7 report back no later than the 2018 Interim Meeting, including: a) the rising gap between
8 independent practice expenses and Medicare reimbursement, taking into account the costs of
9 the regulatory requirements; b) the increased cost of medical personnel and equipment,
10 including electronic health record (EHR/EMR) purchase, software requirements, and ongoing
11 support and maintenance; c) the expense of maintaining hospital based facilities not common
12 to independent practices, such as burn units and emergency departments, and determine what
13 payment should be provided to cover those explicit costs; and d) the methodology by which
14 hospitals report their uncompensated care, and the extent to which this is based on actual costs,
15 not charges; and
16

17 That our AMA advocate for a combined Health Care Payment System for patients who receive
18 care that is paid for by the Centers for Medicare & Medicaid Services, that: a) follows the
19 recommendation of MedPAC to pay “site-neutral” reimbursement that sufficiently covers
20 practice expenses without regard to whether services are performed under the Hospital
21 Outpatient Prospective Payment System (HOPPS) or the Physician Fee Schedule (PFS);
22 b) pays appropriate facility fees for both hospital owned facilities and independently owned
23 non-hospital facilities, computed using the real costs of a facility based on its fair market value;
24 and c) provides independent practices with the same opportunity to receive reimbursement for
25 uncompensated care as is provided to hospital owned practices.
26

27 Resolution 817-I-17 raised a number of complex cost and payment issues spanning several subject
28 matter areas in need of extensive study. These issues are further complicated by the Medicare
29 program’s use of separate payment methodologies for each outpatient setting (ie, physician offices,
30 hospital outpatient facilities, and ambulatory surgical centers). A current AMA [Issue Brief](#) provides
31 an overview of these payment variations. The Council supports payment policies that are site-
32 neutral to the extent possible without lowering payments overall and that fairly reflect the actual
33 costs of providing services. AMA policy supporting equitable payments across outpatient sites of
34 service, including policy established via Council reports, is appended. The Council recognizes the
35 need for further study, and its deliberations of options for achieving payment parity under the
36 Medicare program are ongoing. Accordingly, the Council intends to submit its final report with
37 recommendations addressing the site-of-service differential at the 2018 Interim Meeting.

Appendix

H-240.979 Intrusion by Hospitals into the Private Practice of Medicine

The AMA urges private third party payers to implement coverage policies that do not unfairly discriminate between hospital-owned and independently-owned outpatient facilities with respect to payment of “facility” costs. (CMS Rep. H, I-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: Res. 116, A-14; Reaffirmation A-14; Reaffirmation A-15)

H-240.993 Discontinuance of Federal Funding for Ambulatory Care Centers

The AMA strongly urges more aggressive implementation by HHS of existing provisions in federal legislation calling for equity of reimbursement between services provided by hospitals on an outpatient basis and similar services in physicians’ offices. (CMS Rep. B, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmation I-98; Reaffirmation I-03; Reaffirmation I-07; Reaffirmed: CMS Rep. 3, A-13; Reaffirmation A-15)

D-240.994 Payment Variations Across Outpatient Sites of Service

Our AMA will work with states to advocate that third party payers be required to: a. Assess equal or lower facility coinsurance for lower-cost sites of service (hospital outpatient department, ambulatory surgical center, or office-based facility); b. Publish and routinely update pertinent information related to patient cost-sharing; and c. Allow their plan’s participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient. (CMS Rep. 3, A-13; Reaffirmation I-17)

H-330.925 Appropriate Payment Level Differences by Place and Type of Service

Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a site neutral payment policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; (5) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (6) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. (Sub. Res. 104, A-98; Reaffirmation I-98; Appended: CMS Rep. 7, A-99; Reaffirmation A-00; Reaffirmation I-03; Reaffirmation A-11; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed: Sub. Res. 104, A-14; Reaffirmed: Res. 116, A-14; Modified: CMS Rep. 3, A-14; Reaffirmation A-14; Reaffirmation A-15; Reaffirmation I-17)

D-330.997 Appropriate Payment Level Differences by Place and Type of Service

1. Our AMA encourages CMS to: (A) define Medicare services consistently across settings and, in particular, to avoid the use of diagnosis codes in determining Medicare payments to hospital outpatient departments and other ambulatory settings; and (B) adopt payment methodology for hospital outpatient departments and ambulatory surgical centers that will assist in leveling the playing field across all sites-of-service. If necessary, the AMA should consider seeking a legislative remedy to the payment disparities between hospital outpatient departments and ambulatory surgical centers. 2. Our AMA will continue to encourage the CMS to collect data on the frequency, type and cost of services furnished in off-campus, provider-based departments. (CMS Rep. 7, A-99; Reaffirmation I-03; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed: CMS Rep. 4, A-13; Appended: CMS Rep. 3, A-14; Reaffirmed: Sub. Res. 104, A-14; Reaffirmation A-14; Reaffirmation A-15; Reaffirmation I-17)

D-390.997 CMS Practice Expense Formula

Our AMA will seek from Congress legislation directing CMS that it include in the RBRVS practice expense allocation all costs incurred by physicians, including those costs incurred in hospitals and ambulatory surgical centers. (Sub. Res. 819, I-99 Reaffirmed: CMS Rep. 5, A-09)

H-400.957 Medicare Reimbursement of Office-Based Procedures

Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. (Sub. Res. 103, I-93 Reaffirmed by Rules & Credentials Cmt., A-96 Reaffirmation A-04 Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmed: CMS Rep. 3, A-14)

H-400.966 Medicare Payment Schedule Conversion Factor

(1) The AMA will aggressively promote the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy with Congress and the Administration concerning physician payment under Medicare. (2) The AMA will work aggressively with CMS, the Bureau of Labor Statistics, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index. (CMS Rep. B, I-92 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CMS Rep. 6, I-08 Reaffirmed: CMS Rep. 1, I11 Reaffirmation: I-12 Reaffirmed in lieu of Res. 113, A-13 Reaffirmation I-13 Reaffirmed: CMS Rep. 3, A-14)

H-400.956 RBRVS Development

(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians. (BOT Rep. 16, A-95 BOT Rep. 11, A-96 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: Sub. Res. 104, A-14 Reaffirmation A-15)

H-400.969 RVS Updating

Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3)

encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC). (BOT Rep. O, I-92 Reaffirmed by BOT Rep. 8 - I-94 Reaffirmed by BOT Rep. 7, A-98 Reaffirmed: CMS Rep.12, A-99 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmation I-10 Appended: Res. 822, I-12 Reaffirmation I-13 Reaffirmed: Sub. Res. 104, A-14 Reaffirmed in lieu of Res. 216, I-14 Reaffirmation A-15)

D-478.996 Information Technology Standards and Costs

1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. 2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards. (Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation I-17)