Whereas, Health care costs continue to rise faster than the rate of inflation, and are now approaching 20% of GDP, and the country cannot afford to continue diverting resources into health care from other sectors of the economy such as education and infrastructure; and

Whereas, Hospitals and hospital owned outpatient clinics are paid under the Hospital Outpatient Prospective Payment System (HOPPS), and are given an annual increase of approximately 3% based on the government’s Market Basket estimate of the cost of providing health care, goods and services by hospitals; and

Whereas, Practice expense has increased by inflation, but also by increased regulatory requirements, including EHRs, data submission to attempt to measure quality, Medicare Advantage plans imposing all the prior authorization requirements of commercial plans but paying at Medicare rates; and

Whereas, Many practices now offer sophisticated outpatient services such as imaging, infusion, extensive laboratory support, etc., and must purchase the same equipment and hire the same personnel as hospitals, but are unable to charge facility fees to cover the infrastructure costs the way hospitals can, further widening the difference in infrastructure expenses between practices and hospitals; and

Whereas, Physician fees paid under the Physician Fee Schedule (PFS) did not increase under the 15 years of the Sustainable Growth Rate (SGR) law, and are only increasing a fraction of a percent under MACRA, thus creating a large and increasing Site of Service Differential between the payment to hospitals and the payment to practices not owned by hospitals, for exactly the same services; and

Whereas, The ongoing widening of the Site of Service Differential has made it increasingly difficult for independent practices to compete with hospital owned practices, resulting in the accelerated acquisition of practices by hospitals and therefore a shift from the less expensive PFS to the much more expensive HOPPS, increasing health care costs and decreasing patient and physician choice, without any proven increase in quality of care; and

Whereas, MedPAC in its June 2017 report and in previous reports to Congress, expressed concerns "that consolidation among and between hospitals and physicians has increased prices without any increase in quality… [and] by creating true 'site-neutral' payments, the Medicare program could be further insulated from the cost of physician–hospital consolidation"; and

Whereas, Hospitals attempt to justify the higher HOPPS payment by claiming that they provide more charity care than independent practices, but there is no good data on the amount of charity care given by hospitals or independent practices, nor any clarity regarding the methods by which uncompensated care is estimated or compared, nor consideration of the fact that under Medicare, hospital owned practices can collect a significant percentage of billed charges for uncompensated care but independent practices cannot; and

Whereas, Practice expense has not been studied since the Practice Expense Advisory Committee completed its work over a decade ago; and

Whereas, Existing AMA Policies (H-330.925 and D-330.997) address payment disparities between hospitals and ambulatory surgery centers, but there is no existing policy concerning the global Site of Service Differential issue and no policy addressing providing equivalent facility fees and equivalent uncompensated care reimbursement to independent practices and hospital owned practices; therefore be it

RESOLVED, That our American Medical Association study the Site of Service Differential with a report back no later than the 2018 Interim Meeting, including:

a) The rising gap between independent practice expenses and Medicare reimbursement, taking into account the costs of the regulatory requirements;

b) The increased cost of medical personnel and equipment, including electronic health record (EHR/EMR) purchase, software requirements, and ongoing support and maintenance;

c) The expense of maintaining hospital based facilities not common to independent practices, such as burn units and emergency departments, and determine what payment should be provided to cover those explicit costs;

d) The methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for a combined Health Care Payment System for patients who receive care that is paid for by the Centers for Medicare and Medicaid Services (CMS), that:

a) Follows the recommendation of MedPAC1 to pay "Site-Neutral" reimbursement that sufficiently covers practice expenses without regard to whether services are performed under the Hospital Outpatient Prospective Payment System (HOPPS) or the Physician Fee Schedule (PFS);

b) Pays appropriate facility fees for both hospital owned facilities and independently owned non-hospital facilities, computed using the real costs of a facility based on its fair market value; and

c) Provides independent practices with the same opportunity to receive reimbursement for uncompensated care as is provided to hospital owned practices. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 10/12/17

RELEVANT AMA POLICY

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


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

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.


Offsetting the Costs of Providing Uncompensated Care H-160.923

Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured; (2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.

Citation: CMS Rep. 8, A-05; Reaffirmation A-07; Modified: CMS Rep. 01, A-17