Payment variations across outpatient sites of service

Medicare payment for outpatient services

Patients receive outpatient medical services in a variety of settings, including physician offices, hospital outpatient departments (HOPD) and ambulatory surgical centers (ASC). Although the choice of outpatient site for many services has no discernible effect on patient care, it significantly impacts the amount Medicare pays for a service as well as patient cost-sharing amounts. With some exceptions, payment rates for outpatient services furnished in hospital facilities are higher than rates paid to physician offices or ASCs for providing the same service. The scope of the payment differential varies, depending on the procedure or service.

Dual Medicare payment systems, and separate methodologies used for rate-setting under the Outpatient Prospective Payment System (OPPS) and the Physician Fee Schedule (PFS), are at the root of the site-of-service differential. For services furnished in physician offices, Medicare pays for units of service billed under the PFS. There is a single payment for each service that amounts to 80% of the PFS rate, with the patient responsible for cost-sharing that covers the remaining 20%. For procedures provided in hospital outpatient departments, Medicare pays a reduced physician fee under the PFS plus a facility fee established under the OPPS. Patients are responsible for cost-sharing associated with both the physician fee and the facility fee. Whereas providers generally receive separate payments for each service under the PFS, services paid under the OPPS are grouped together into ambulatory payment classifications (APC) based on clinical and cost similarities. Medicare's ASC payment is largely based on the OPPS, with ASCs being paid a percentage of OPPS rates.

Formulas unique to each payment system are used to annually adjust payment rates for inflation, which may widen existing payment disparities. HOPD updates are based on the hospital market basket, and annual updates to the PFS were established by the Medicare Access and CHIP Reauthorization Act. For many years, the consumer price index for all urban consumers (CPI-U) was used to annually update ASC payment rates. Consistent with AMA policy, in 2019 the Centers for Medicare & Medicaid Services (CMS) began updating ASC rates using the hospital market basket instead of the CPI-U for a five-year period.

Ambulatory Surgical Centers

ASCs are distinct freestanding or hospital-owned facilities that provide same day outpatient surgical care to patients who do not require overnight hospital stays. The list of approved procedures is updated annually. Although Medicare's ASC payment system is linked to the OPPS, rates paid to ASCs are substantially lower than rates paid to HOPDs for providing the same services. Accordingly, patients receiving care in an ASC typically incur lower cost-sharing expenses.

Inadequate Medicare physician pay

Payment differentials between HOPDs and independent physician practices stem in part from inadequate Medicare physician payment rates. Notably, Medicare physician pay has barely budged over the last decade and a half, increasing just 6%from 2001 to 2018, or just 0.4% per year on average. Adjusted for inflation, Medicare physician pay has declined 19% from 2001 to 2018, or by 1.3% per year on average. In comparison, Medicare hospital pay has increased roughly 50% between 2001 and 2018, with average annual increases of 2.5% per year for inpatient services, and 2.4% per year for outpatient services. Notably, the cost of running a medical practice has increased 32% between 2001 and 2018, or 1.7 percent per year.

Recent Medicare policy changes

For many years, higher payments to hospital outpatient departments likely incentivized the sale of physician practices and ASCs to hospitals because hospital-acquired facilities meeting certain criteria (eg, located within 35 miles of the hospital) were routinely converted to HOPDs and paid higher hospital rates under Medicare's OPPS. Beginning in 2017, facilities acquired after November 2015 were no longer permitted to bill for services under the OPPS. CMS has since extended this policy to include clinic visits provided at all hospital-acquired entities located off the hospital campus. As of January 2019, clinic visits by these facilities are paid at a lower rate than the OPPS payment amount and in 2020, payments for clinic visits will be equivalent across all of-campus hospital settings regardless of when they were established.

Where the AMA stands

The AMA supports increasing payment parity
Most policy proposals have recommended simplistic solutions to the site-of-service differential that reduce payments to all sites to rates paid in the least costly setting. However, shrinking payments to the lowest amount paid in any setting does not help physicians. The AMA supports Medicare payment policies that are site-neutral without lowering total Medicare payments.

The AMA also urges CMS to pay physicians fairly for office-based procedures; define Medicare services consistently across settings; and shift more procedures from the hospital to office setting, which is more cost-effective.

Payments should be based on the actual costs of providing services
The site-of-service differential impedes the provision of high-value care because it incentivizes payments that are based on the location where a service is provided. Payment should be based on the service itself, and not where it is provided. The AMA supports Medicare payments that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting. The AMA also advocates for the use of valid and reliable data in the development of any payment methodology for ambulatory services.

Updated practice expense data is needed
Medicare physician payment has not kept pace with the actual costs of running a practice. The AMA urges CMS to update the data used to calculate the practice expense component of the PFS by administering a physician practice survey (akin to the Physician Practice Information Survey administered in 2007-2008) every five years. This survey should ensure that all physician practice costs are captured, including administrative and other costs that cannot be directly attributed to a service, and costs related to managing the practice, providing uncompensated care, navigating payer protocols and utilization management protocols, purchasing, managing and updating electronic health records, and quality measures and improvements.

Cost-effective care should be incentivized
The AMA supports the goal of encouraging care in the least costly setting. Accordingly, the AMA believes that third party payers should assess equal or lower coinsurance for lower-cost sites of service when quality is not an issue; publish and routinely update pertinent information related to patient cost-sharing; and allow their plan's participating physicians to perform outpatient procedures at an appropriate site as chosen by the physician and the patient.

Building the case for future payment reform
The AMA recognizes that achieving site-neutral payments for outpatient procedures will require increases in Medicare physician payment, so that practices can be sustained and patient choice of care setting is safeguarded. To help build the case for future Medicare payment reforms, the AMA is collecting data and conducting research both:

- To document the role that physicians have played in reducing Medicare spending; and
- To facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.

Relevant Council on Medical Service reports include:

- Council Report 4-I-18, The Site-of-Service Differential
- Council Report 3-A-14, Medicare Update Formulas Across Outpatient Sites of Service
- Council Report 3-A-13, Payment Variations Across Outpatient Sites of Service