REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-18)
The Site-of-Service Differential
(Resolution 817-I-17)
(Reference Committee J)

EXECUTIVE SUMMARY

The site-of-service differential is a longstanding payment policy issue stemming from the Medicare program's use of separate payment systems in its rate-setting calculations. This report addresses disparities in Medicare Part B payment for covered items and services across outpatient care settings, including the offices of physicians and other health professionals, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs). Most outpatient procedures can be provided across multiple clinical settings, and although the choice of outpatient site for many services has no discernible effect on patient care, it significantly impacts Medicare's payment for such services and patient cost-sharing expenses. Generally speaking, Medicare pays higher rates for outpatient services performed in hospital facilities than to physician offices or ASCs for furnishing the same service to similar patients. The scope of the payment differential varies, depending on the procedure.

This report describes ongoing disparities in Medicare payment for outpatient procedures across care settings, explains how Medicare determines payments for outpatient services in each setting, compares Medicare physician payment updates to inflation, and summarizes relevant American Medical Association (AMA) policy and activity. The Council recommends reaffirmation of existing AMA policy as well as new policy addressing the site-of-service differential. The Council recommends that the AMA support Medicare payment policies for outpatient procedures that are site-neutral without lowering total Medicare payments. The Council further recommends that the AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting.

While the focus of this report is the site-of-service differential, the Council recognizes that broader physician payment issues must also be addressed. To help build the case for future Medicare payment reforms that support site-neutrality without lowering total Medicare payments, the Council recommends that the AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) 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.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-18

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

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee J (Steven Chen, MD, Chair)

At the 2017 Interim Meeting, the House of Delegates referred Resolution 817-I-17, "Addressing the Site of Service Differential," introduced by the New Mexico Delegation, for report back at the 2018 Annual Meeting. The Board of Trustees assigned this item to the Council on Medical Service. Resolution 817-I-17 asked the American Medical Association (AMA) to:

> 1) 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; and d) the methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges; and
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> 2) Advocate for a combined health care payment system for patients who receive care that is paid for by the Centers for Medicare & Medicaid Services (CMS), that: a) follows the recommendation of MedPAC to pay "site-neutral" reimbursement that sufficiently covers practice expenses without regard to whether services are performed under the Hospital Outpatient Prospective Payment System (OPPS) 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.

This report describes ongoing disparities in Medicare payment for outpatient procedures across care settings, summarizes relevant AMA policy and activity, and presents policy recommendations addressing the outpatient site-of-service differential.

BACKGROUND

The site-of-service differential is a longstanding payment policy issue stemming from the Medicare program's use of more than a dozen separate payment systems—some of which are based on the location where services are provided—in its rate-setting calculations. Several of these payment systems base payments on the location where services are provided. This report addresses disparities in Medicare Part B payment for covered items and services across outpatient care

settings, including the offices of physicians and other health professionals, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs). Most outpatient procedures can be provided across multiple clinical settings, and although the choice of outpatient site for many services has no discernible effect on patient care, it significantly impacts Medicare's payment for such services and patient cost-sharing expenses. Generally speaking, Medicare pays higher rates for outpatient services performed in hospital facilities than to physician offices or ASCs for furnishing the same service to similar patients. The scope of the payment differential varies, depending on the procedure, and in some cases may be difficult to ascertain because units of payment differ across payment systems. Furthermore, the payment differential may extend beyond primary services to entire episodes of care. One analysis found that payments for cardiovascular imaging, colonoscopy, and evaluation and management services are higher when furnished in HOPDs, and that the higher payments extend to related services provided to patients as part of episodes of care associated with these procedures.[1] The variations in payment persisted after controlling for patient demographic and severity differences, thereby attributing a substantial portion of the pay disparities to the payment systems themselves.[2]

The Council previously studied aspects of the site-of-service differential—and confirmed that Medicare payments for many procedures are higher when furnished in HOPDs—during the development of Council Report 3-A-13, "Payment Variations across Outpatient Sites of Service," and Council Report 3-A-14, "Medicare Update Formulas Across Outpatient Sites of Service." Council Report 3-A-13 compared Medicare payments for five common procedures performed across outpatient settings, and built upon the AMA's substantial policy supporting site neutrality by encouraging private payers to incentivize outpatient care delivery in lower-cost settings. Council Report 3-A-14 found that existing Medicare payment formulas have contributed to growth in the volume of outpatient services provided in hospitals and hospital-owned facilities, even when these services can be safely performed in lower-cost settings. Council Report 3-A-14 focused primarily on equalizing payments between HOPDs and ASCs because payments to these settings are based on the same Medicare payment system (OPPS), with ASCs paid at lower rates. Developing policy addressing payment disparities between hospital-owned facilities and independent physician practices is more complex because, under current statute, the rate-setting for items and services in these outpatient sites is based on separate Medicare payment systems that calculate payments for different units of service.

Medicare Payment Rates for Off-Campus Provider-Based Hospital Departments

For many years, higher payments to HOPDs likely incentivized the sale of physician practices and ASCs to hospitals because acquired facilities meeting certain criteria (eg, located within 35 miles of the hospital) were routinely converted to HOPDs and allowed to charge higher OPPS rates for services performed at these off-campus facilities. However, a provision in the Bipartisan Budget Act of 2015 (BBA) disallowed provider-based billing by hospitals for newly acquired physician practices and ASCs. The Congressional Budget Office estimated in 2015 that this provision would save $9.3 billion over 10 years.[3] Beginning in 2017, off-campus entities acquired after enactment of the BBA—in November 2015—were no longer permitted to bill for services under the OPPS, and instead required to bill under the applicable payment system (PFS). Since 2017, CMS has paid for services at non-excepted off-campus provider-based hospital departments using a PFS relativity adjuster that is based on a percentage of the OPPS payment rate. Currently, CMS regulations stipulate that these services be paid 40 percent of OPPS payment rates,[4] although provider-based departments acquired prior to November 2015 continue to bill under the OPPS. In July 2018, CMS proposed extending site-neutral payments to include clinic visits provided at off-campus provider-based hospital departments acquired prior to November 2015, that were excepted from the BBA provision.[5] CMS proposed to reduce payment rates for clinic visits at hospital-owned physician

practices located off the hospital campus from $116 with $23 cost-sharing to $46 with $9 cost-sharing.[6] At the time this report was written, the CMS proposal had not been finalized.

Hospital Employment of Physicians

It is possible that Medicare payment reductions for services provided at off-campus provider-based hospital departments acquired after November 2015 have contributed to a leveling off of hospital acquisitions of physician practices. Data from the AMA's 2012, 2014, and 2016 Physician Practice Benchmark Surveys, which yield nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week, demonstrate recent stability in the ownership structure of physician practices. Analyses of the surveys found that the share of physicians who worked directly for a hospital or in practices that were at least partially owned by a hospital remained unchanged between 2014 and 2016—at 33 percent.[7] This percentage represented an increase from 29 percent in 2012. Although detailed information on practice ownership structure is not available for years prior to 2012, research suggests that in 2007-2008, only 16 percent of physicians worked directly for a hospital or in practices that were at least partially owned by a hospital.[8]

Medicare Payment Systems for Outpatient Services

The separate methodologies used for rate-setting under the OPPS and the PFS are at the root of the outpatient site-of-service differential (see Table 1). Under current law, Medicare's payment systems do not account for the fact that many outpatient services can be provided safely and at lower cost to Medicare and patients outside of the hospital setting. Because there is no linkage between OPPS and PFS payment systems, Medicare may pay dramatically different rates for the same services based on whether they are provided in hospital facilities or physician offices.

Table 1: Medicare Payment Systems for Physician Offices, Hospital Outpatient Departments, and Ambulatory Surgical Centers

Site	**Physician Office**	**Hospital Outpatient Department**	**Ambulatory Surgical Center**
Payment System	Physician fee schedule (non-facility rate)	Physician fee schedule (facility rate) plus OPPS rate	Physician fee schedule (facility rate) plus ASC payment system (based on relative weight under the OPPS)
Basis for Updates	Medicare Access and CHIP Reauthorization Act (MACRA)	Hospital market basket	Consumer price index for all urban consumers
Unit of Payment	Individual service	Ambulatory payment classification	Ambulatory payment classification

For services furnished in physician and other practitioner offices, Medicare pays for units of service billed under the PFS. There is a single payment for each service which amounts to 80 percent of the PFS rate, with the patient responsible for cost-sharing that covers the remaining 20 percent. 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 based on clinical and cost similarities.

Formulas unique to each payment system are then used to annually adjust payment rates for inflation, which may actually widen existing payment disparities. HOPD updates are based on the hospital market basket, and annual updates to the PFS were established by MACRA. The Medicare program currently uses the consumer price index for all urban consumers (CPI-U) to annually update ASC payment rates, although—consistent with AMA policy—CMS recently proposed updating ASC rates using the hospital market basket instead of the CPI-U for a five-year period. If this proposal is finalized, CMS will examine whether the change incentivizes a migration of services to lower-cost ASC settings over the five-year period.

Medicare Physician Payment Updates Compared to Inflation

Medicare payments for physician services have for many years failed to keep pace with the actual costs of running a practice. From 2001 to 2017, Medicare physician pay rose just six percent (0.4 percent per year on average), although Medicare's index of inflation in the cost of running a practice increased 30 percent (1.7 percent per year on average). Economy-wide inflation, as measured by the Consumer Price Index, has increased 39 percent over this time period.[9] Adjusted for inflation in practice costs, Medicare physician pay has declined 19 percent from 2001 to 2017, or by 1.3 percent per year on average.

During the same time period, Medicare hospital pay has increased roughly 50 percent, with average annual increases of 2.6 percent per year for inpatient services, and 2.5 percent per year for outpatient services. Medicare skilled nursing facility pay has increased 51 percent between 2001 and 2017, or 2.6 percent per year.[10] There are some significant differences between hospitals and physician practices that may lead to higher costs of providing care in HOPDs. For example, hospitals maintain operations 24/7, and also standby capacity for handling emergencies, although payment for standby costs is included in Medicare's payment for emergency department services.[11]

Uncompensated/Inadequately Compensated Physician Practice Expenses

The need for sustainable physician payments under the Medicare program is compounded by numerous uncompensated administrative tasks that are extremely costly to practices and reduce time spent with patients, yet increase the work necessary to provide medical services. CMS alone publishes thousands of pages of regulations affecting physician practices every year, including rules governing the reporting of quality measures, the Recovery Audit Contractor (RAC) Program, MACRA implementation, and Medicare's numerous payment systems. Utilization management has become so burdensome that in 2017 the average physician reported completing 29 prior authorizations per week, a process that required 14.6 hours of work or the equivalent of two business days.[12] In addition to navigating a plethora of payer protocols and utilization management requirements, physician practices have to purchase, manage and update electronic health records (EHRs) to document the care they are providing. Incorporating EHR technology into practice workflows is costly and consumes a significant amount of physician time that could otherwise be spent with patients. Notably, a 2016 *Annals of Internal Medicine* study found that, for every hour of clinic time spent with patients, physicians spend approximately two hours per day during office hours, and another one to two hours outside of office hours, on EHR and desk work.[13] According to a 2016 *Health Affairs* study, physician practices across four common specialties spend over $15.4 billion annually to report quality measures, with physicians on average spending 2.6 hours per week on these measures.[14] Many physician practices also provide high-technology outpatient

services (ie, infusions and/or imaging) that were once the domain of hospitals and for which practices are not adequately compensated under the PFS.

Hospitals that treat a disproportionate share of low-income patients receive additional payments to offset the financial effects of treating these patients. Traditionally, disproportionate share hospital (DSH) payments were based on hospitals' share of Medicaid patients and Medicare patients with Social Security Disability Insurance. Beginning in 2014, DSH payments were calculated as 25 percent of that payment amount, and hospitals also began receiving uncompensated care payments from a pool of funds equal to 75 percent of the DSH payment received under the traditional formula, minus an amount that increases in proportion to decreases in the uninsured population.[15] Part of this pool is distributed to hospitals based on the share of uncompensated care they provide.[16] Physician practices are not eligible for either DSH or uncompensated care payments, despite the fact that most physicians (89 percent) treat Medicare patients and, in 2016, most also had Medicaid (82.6 percent) and uninsured (75.6 percent) patients.[17] There have been questions as to whether Medicare DSH and uncompensated care payments are appropriate proxies for the amount of uncompensated care provided by hospitals, and Medicare Payment Advisory Commission (MedPAC) has recommended that uncompensated care payments to hospitals be based on actual uncompensated care data.

Expert Policy Recommendations for Reducing Payment Variations

To address shifts in outpatient care to higher cost sites-of-service (eg, hospital-owned facilities), which increase costs to the Medicare program and its patients, several policy options have been proposed to equalize payments across settings for certain services. After the MedPAC found that payments to HOPDs for 15-minute evaluation and management visits were 80 percent higher than payments to physician offices for the same service, it recommended in 2012 that HOPD payments for these services be reduced to physician office rates.[18] In 2014, MedPAC recommended that differences in payment rates between HOPDs and physician offices be eliminated by reducing HOPD rates for 66 ambulatory payment classifications. These groups of services were selected by MedPAC based on patient severity being similar in HOPDs and physician offices, and because they are frequently furnished in physician offices.[19]

A 2011 RAND Health analysis examined several policy options for addressing Medicare payment differentials across outpatient sites, such as increasing uniformity in the units of service across payment systems, and basing payment rates on the least costly setting. This analysis concluded that basing payment differentials on justifiable cost differences would promote payment equity across outpatient sites-of-care and value-based care, but would also be administratively burdensome. Determining justifiable cost differences would also be impractical.[20]

The Office of the Inspector General (OIG) has also recommended reductions in HOPD payment rates to those of less costly settings, and has even recommended pursuing legislative changes to OPPS budget neutrality provisions so that payment rates to HOPDs could be reduced without offsetting those reductions with payment increases.[21] Several administrations have also proposed equalizing payment variations via budget proposals, and President Trump's budget published in February 2018 proposed applying physician office rates to all hospital-owned physician offices located off the hospital campus. As stated previously, CMS has proposed extending site-neutral payments to include clinic visits provided at off-campus hospital-owned facilities.

It is clear that most of the policy options identified to date have recommended leveling the site-of-service playing field by reducing payment rates to the amounts payable in the least costly outpatient setting. Although CMS has not implemented the MedPAC or OIG recommendations, in

2014 the agency identified approximately 200 services for which physician office payments were higher than HOPD or ASC rates and proposed lowering physician fees for these services. Most experts, including MedPAC, believe that Medicare payments to physician offices, HOPDs and ASCs will continue to be based on the program's current payment systems for the foreseeable future. The combined payment system called for in the second resolve of Resolution 817-I-17 would require legislative changes that would face significant obstacles in a Congress that is hamstrung by partisanship and budgetary concerns. Opponents, including hospitals and other stakeholders whose payment rates would be affected, are likely to counter that physicians' facility costs are already covered through the practice expense component of the PFS.

Moreover, convincing Congress to redesign Medicare's payment systems would be extremely difficult. Given existing pressures to reduce health care costs, there is also a risk that advocating for a combined payment system could encourage Congress or CMS to design a system that lowers payments to all providers and/or does not provide relief for independent physician practices. CMS could also choose to impose the OPPS payment system, on which HOPD and ASC payments are based, on physician practices. Doing so would mean that units of service currently paid separately under the PFS would be grouped together into an ambulatory payment classification, which is the unit of payment under the OPPS.

Updating Physician Practice Expenses Paid under the PFS

Alternatively, the Council considered requesting that CMS update the inputs used to calculate the indirect practice expense component of the PFS, which is analogous to OPPS facility fees and which is based in part on 10-year-old survey data that no longer reflect current practice arrangements or the relative costs of running a practice. Updated data are urgently needed to ensure that practice expenses under the PFS more accurately reflect the costs to physician practices of furnishing office-based services. However, it is important to recognize that any practice expense changes under the current system will need to be budget neutral.

Payments under the PFS are required by statute to be based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service.[22] In brief, RVUs are established for work, practice expense, and malpractice expense categories, which are adjusted for geographic cost variations. These values are multiplied by a conversion factor to convert the RVUs into payment rates. Statutory budget neutrality provisions require that annual adjustments to the RVUs that increase by more than $20 million must be offset by cuts in other RVUs or through a cut in the conversion factor.[23]

CMS establishes separate facility-and nonfacility-based practice expense RVUs for services furnished in facility settings (eg, HOPD or ASC) and in nonfacility settings (eg, physician offices). Facility-based RVUs are generally lower than nonfacility-based RVUs, so that HOPDs and ASCs receive facility payments under the OPPS whereas physician offices receive a facility fee under the PFS. Nonfacility practice expense RVUs are intended to reflect all of the direct and indirect practice expenses associated with furnishing a service in a physician office.

Direct expenses include cost inputs related to clinical labor, medical equipment and supplies. Indirect expenses include administrative labor, rent, billing services, and other office-related expenses that cannot be directly attributed to a service. In its proposed rule for CY 2019, CMS proposed updated pricing recommendations for 2,017 supply and equipment items currently used as direct practice expense inputs. The proposal is based on a report from a CMS contractor that used market research resources and methodologies to determine the updated prices.[24] As described in the following section, survey data are used by CMS to determine the indirect practice expenses

incurred per hour worked.[25] Each procedure is then assigned practice expense RVUs that are supposed to reflect the practice expenses required to provide the service relative to those required to provide other procedures.

The need for accurate data on practice costs is significant, considering many of the points raised in Resolution 817-I-17. Physician practices have experienced significant increases in practice expenses due to cumbersome regulations, quality measure requirements, EHRs (purchases, software upgrades, ongoing support and maintenance), complex payment and utilization management protocols, costly equipment used to provide, for example, imaging or infusions, and other costs that have changed dramatically since practice expense survey data was collected a decade ago. It may also be challenging for many independent and small group practices to accurately determine their total practice expenses when completing surveys about the costs of running a practice.

The Physician Practice Information Survey (PPI Survey)

In 2010, CMS began basing indirect practice expenses on the PPI Survey, a multispecialty, nationally representative survey of both physicians and non-physician practitioners paid under the PFS that was administered by the AMA over a period of time in 2007 and 2008. The PPI Survey collected data from 3,656 respondents across 51 medical specialties and health care professional groups.[26] Participating practices were asked to fill out expense worksheets that itemized expenses such as payroll, supplies and equipment. They were also asked about the costs of managing a practice, charity care, time spent on quality improvement activities, and the acquisition, operating and maintenance costs associated to EHRs. PPI Survey data were used by CMS to confirm the accuracy of PFS practice expense data. As required by statute, CMS uses medical oncology supplemental survey data from 2003 for practice expenses per hour for oncology drug administration services. For specialties that did not participate in the PPI Survey, CMS develops proxy practice expense values by crosswalking practice expense data from specialties providing similar services.[27]

Section 220 of the Protecting Access to Medicare Act of 2014, allocates funds for CMS "…to collect and use information on physicians' services in the determination of relative values in the formulae for setting physician's fees."[28] The AMA/Specialty Society RVS Update Committee and other entities have encouraged CMS to use these funds to conduct an updated survey on practice expense data. Even CMS has expressed concerns regarding the accuracy of the outdated data used to determine practice expense RVUs but, lacking other sources, the agency continues using PPI Survey data to inform physician payments under the PFS. The collection of physician practice expense data is a necessary first step which will enable comparisons to hospital cost and payment metrics and provide insight into the costs of care provided in hospital-owned and independently-owned practices.

AMA POLICY

The AMA has substantial and long-standing policy supporting equitable payments across outpatient sites of service. Policy H-240.993 calls for equity of payment between services provided by hospitals on an outpatient basis and similar services in physicians' offices. AMA policy also supports defining Medicare services consistently across settings and encouraging the CMS to adopt payment methodologies that assist in leveling the playing field across all sites of service (Policy D-330.997).

Policy H-330.925 encourages CMS to fairly pay physicians for office-based procedures and adopt a site-neutral payment policy for hospital outpatient departments and ambulatory surgical centers; advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; advocates that in place of the CPI-U, CMS use the hospital market basket index to annually update ASC payment rates; and encourages the use of Current Procedural Terminology (CPT) codes across all sites of service as the only acceptable approach to payment methodology.

Policy H-400.957 encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense RVUs reflect the true cost of performing office procedures. Policy H-400.966 directs the AMA to 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 concerning physician payment under Medicare.

Policy D-240.994 directs the AMA to work with states to advocate that third-party payers be required to assess equal or lower facility coinsurance for lower-cost sites of service; 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 of service as chosen by the physician and the patient. Furthermore, AMA policy 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 (Policy H-240.979). Policy H-390.849 directs the AMA to advocate for the adoption of physician payment reforms that promote improved patient access to high-quality and cost-effective care, do not require budget neutrality within Medicare Part B, and are based on payment rates that are sufficient to cover the full cost of sustainable medical practices.

AMA ACTIVITY

Enhancing Practice Efficiency and Promoting Physician Satisfaction

A strategic focus area within the AMA is working diligently to help physicians succeed in a rapidly changing health care environment. From advancing health care delivery and payment reforms that promote affordable care to restoring and preserving physician professional satisfaction, the AMA is driving practice transformation by translating regulatory requirements into actionable information; developing and disseminating practice improvement strategies and tools; establishing national benchmarks for physician burnout, leading to organizational level changes; and producing evidence-based research. To accelerate advancements in—and support for—physician and care team well-being, the AMA sponsors conferences that bring top investigators and thought leaders together to debate and advance health policies.

Encouraging Value-Based Payment

The AMA has been working for several years to encourage the development and implementation of Medicare payment models that will improve the financial viability of physician practices in all specialties, and help independent practices of all sizes remain independent; give physicians more resources and greater flexibility to deliver appropriate care to their patients; minimize administrative burdens that do not improve the quality of patient care; enable physicians to help control aspects of health care spending that they can influence, rather than having Medicare use inappropriate mechanisms to control costs such as payment cuts, prior authorization or non-

coverage of services. Since the passage of MACRA, the AMA has been accelerating its efforts to help national medical specialty societies and other physician organizations to develop, refine and implement alternative payment models (APMs) that will achieve these goals. Ideally, payment under these models should extend across sites of care.[29] AMA policy (Policy H-385.913) recognizes that APMs should provide adequate resources to support the services physician practices need to deliver to patients. The AMA has urged the US Department of Health and Human Services to reconsider testing a number of APMs as recommended by the Physician-Focused Payment Model Technical Advisory Committee.[30]

Improving Price Transparency

As the health care market evolves, patients are increasingly becoming active consumers of health care services rather than passive recipients of care in a market where price is often unknown until after the service is rendered. Achieving meaningful price transparency can help lower costs and empower patients to make informed care decisions, including decisions about where to receive certain outpatient services. Many patients may not be able to readily distinguish between hospital-owned and independent practices, and may not understand how choice of outpatient setting impacts their cost-sharing expenses. The AMA supports measures to expand the availability of health care pricing information that allows patients and their physicians to make value-based decisions when patients have a choice of provider or facility.

DISCUSSION

The AMA has long supported and advocated for fair, equitable and adequate Medicare payments across outpatient sites of service, as well as payment policies that support value-based care and encourage use of the most cost-effective care setting. The policy priority established by the Council in previous reports addressing the site-of-service differential has been to ensure patient access to services in the most clinically appropriate setting, depending on their needs and the severity of their conditions. While an HOPD may be the appropriate setting for certain medically complex patients, the migration of many services from physician offices to hospital-owned facilities is of significant concern not only because of increased costs to the Medicare program, but also because it has become increasingly difficult for practices in certain specialties to remain competitive or even sustain operations because of declining payment rates and the increased costs to practices of dealing with regulatory and administrative burdens. The Council continues to be concerned for independent physician practices, and for Medicare patients who incur higher cost-sharing expenses for outpatient services provided in hospital facilities whose care could have been safely provided in lower-cost settings. The Council believes that policy proposals addressing the site-of-service differential must be patient-centric and ensure adequate payment that supports the costs of providing high-quality, high-value physician services.

Accordingly, the Council recommends reaffirming four existing policies that guide AMA advocacy regarding the site-of-service differential: Policy H-240.993, which calls for equity of payment between services provided by hospitals and similar services provided in physician offices; Policy D-330.997, which supports defining Medicare services consistently across settings and encouraging CMS to adopt payment policies that assist in leveling the playing field across all sites of service; Policy H-400.957, which encourages CMS to expand the extent and amount of payment for procedures performed in physician offices, to shift more procedures from the hospital to the office setting, and to seek to have practice expense RVUs reflect the true cost of performing office procedures; and Policy H-400.966, which promotes the compilation of accurate physician practice cost data as the basis for informed and effective advocacy concerning Medicare physician payment.

Building on these policies, the Council recommends that the AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. This policy recommendation enables ongoing AMA advocacy in support of site-neutral payments while at the same time seeking solutions that do not simply lower payments for services to amounts paid to the least costly setting. The Council is mindful that there is the potential for physicians to be adversely affected as Congress and the Administration promote site-neutrality based solely on cost as a means of reining in health care spending.

The site-of-service differential impedes the provision of high-value care because it incentivizes payment based on the location where a service is provided. Payment should be based on the service itself, and not the location where it is provided. Accordingly, the Council recommends that the AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting.

After extensive exploration of the "combined health care payment system" described in the second resolve of Resolution 817-I-17, the Council concludes that the practice expense component of the PFS is analogous to the facility fee paid under the OPPS, and that the valuation of the practice expense component needs to be updated to accurately reflect the costs of running a practice. The Council further believes that if physicians are paid a facility fee as called for in the second resolve, that fee is likely to be smaller than the current one and might not make up for the probable elimination of the practice expense differential in the current system. Rather than seeking the statutory changes to implement a combined payment system that pays facility fees for both hospital-owned and independent physician practices—which would be extremely challenging to accomplish in a Congress hamstrung by partisanship and a trillion-dollar deficit—the Council recommends urging CMS to update the data used to calculate the practice expense component of the PFS. The Council believes that CMS should conduct a survey similar to the PPI Survey to confirm the accuracy of practice expense data, given the many changes that have occurred since the survey was administered in 2007 and 2008, and that this survey should be administered every five years to ensure that timely data are used to inform PFS calculations. The Council believes that CMS should collect data to ensure that all physician practice costs are captured. Examples of data that must be collected by CMS include administrative and other costs that cannot be directly attributed to a service, costs of managing the practice, costs of providing uncompensated care, costs of navigating payer protocols and utilization management requirements, costs of purchasing, managing and updating EHRs, and costs related to quality measures and improvements.

Advocating for regular ongoing collection of physician practice expense data that more accurately reflect the costs of sustaining a practice is a viable option that could be impactful in the nearer term although, under Medicare's current system, PFS payments would be redistributed rather than increased overall. The updated data could be used to help measure differences in the costs of providing services in physician offices and hospital settings, and would inform future AMA advocacy on broader payment reforms.

To address concerns regarding the methodology used for DSH and uncompensated care payments to hospitals and the care provided by many physicians for which they are not fully compensated, the Council recommends that the AMA encourage CMS to both: a) base DSH and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care.

While the focus of this report is the site-of-service differential, the Council recognizes the need to address broader physician payment issues. The Council further recognizes that achieving site-

neutral payments for outpatient procedures will require increases in Medicare payment for physician services so that physician practices can be sustained and patient choice of care setting is safeguarded. To help build the case for future Medicare payment reforms, the Council recommends that the AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) 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.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 817-I-17, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-240.993, which urges more aggressive implementation by the US Department of Health and Human Services of existing provisions in federal legislation calling for equity in payment between services provided by hospitals on an outpatient basis and similar services in physician offices. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy D-330.997, which encourages the Centers for Medicare & Medicaid Services (CMS) to define Medicare services consistently across settings and adopt payment methodology for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) that will assist in leveling the playing field across all sites-of-service. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-400.957, which encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense relative value units reflect the true cost of performing office procedures. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-400.966, which directs the AMA to 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 concerning physician payment under Medicare. (Reaffirm HOD Policy)

5. That our AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. (New HOD Policy)

6. That our AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting. (New HOD Policy)

7. That our AMA urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured. (New HOD Policy)

8. That our AMA encourage CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care. (New HOD Policy)

9. That our AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) 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. (Directive to Take Action)

Fiscal Note: $100,000 to $200,000

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