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.

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 HOPDs, 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 (APCs) 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, which froze physician payments for six years from 2020 through 2025. 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 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 also stem from inadequate Medicare physician payment rates. Notably, Medicare physician pay has barely budged over the last two decades, increasing just 9% from 2001 to 2023, or just 0.4% per year on average. In comparison, Medicare hospital pay has increased roughly 70% between 2001 and 2023, with average annual increases of 2.5% per year for inpatient services and 2.4% for outpatient services. Notably, the cost of running a medical practice has increased 47% between 2001 and 2023, or 1.7% per year. Unlike nearly all other Medicare providers, physicians do not receive an annual inflationary payment update. When adjusted for inflation, which has been at levels not seen since the 1980s, Medicare physician pay has declined 26% from 2001 to 2023, or by 1.3% per year on average.

Recent site neutrality policy changes

For many years, higher payments to HOPDs likely incentivized the sale of physician practices and ASCs to hospitals because hospital-acquired facilities meeting certain criteria (e.g., located within 35 miles of the hospital) were routinely converted to HOPDs and paid higher rates under Medicare's OPPS. Congress and CMS began implementing payment neutrality between HOPDs and physician offices in 2017 by reducing payments for off-campus HOPDs acquired after 2015 to an equivalent amount paid under the PFS, currently set at 40% of the OPPS rate. In 2019, CMS expanded this site neutral policy to clinic visits (HCPCS code G0463) provided at all off-campus HOPDs. CMS implemented this payment reduction over two years, in 2019 and 2020, in a non-budget neutral way that lowers overall Medicare payments.

Where the AMA stands

The AMA supports increasing payment parity without lowering total Medicare payments

Many policy proposals over the years have recommended simplistic, across-the-board solutions to the site-of-service differential that reduce payments to all sites to rates paid in the least costly setting (i.e., lowering all services in the HOPD to PFS rates). However, shrinking payments to the lowest amount paid in any setting does not help physicians. The AMA does not believe it is possible to sustain a high-quality health care system if site neutrality is defined as shrinking all payments to the lowest amount paid in any setting. Additionally, the AMA urges CMS to pay physicians fairly for office-based procedures and, where clinically appropriate, 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. However, 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.

Updated practice expense data is needed

Inflation in the cost of running a practice is measured by the MEI. Because Medicare physician payment has not kept pace with the actual costs of running a practice, the AMA has been urging CMS to update the data used to calculate the practice expense component of the PFS. The Physician Practice Information Survey, last administered in 2007-2008, will be led by the AMA in 2023-2024 to collect representative data on practice expense and hours spent in direct patient care. These data will be collected at the specialty level and shared with CMS to update the Medicare Economic Index (MEI) and the Resource Based Relative Value Scale (RBRVS).

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.

Financial stability and predictability must be ensured

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. Sweeping policies that seek to reduce payments to the lowest amount paid in any setting runs counter to these important goals. As a result, the AMA advocates strongly that the current administration and Congress must **allocate additional funds into the Medicare physician payment system to address increasing physician practice costs**, and that continued budget neutrality is not an option. The AMA further urges Congress to **provide physicians with much needed fiscal stability by passing legislation that provides an inflation-based payment update based on the MEI.**

The way forward: A vision for payment reform

As the current system is unsustainable, the AMA and the Federation of Medicine have developed principles to guide advocacy efforts on Medicare physician payment reform. **Characteristics of a Rational Medicare Physician Payment System** sets forth broad goals, including the following:

Provide financial stability through a baseline positive annual update reflecting inflation in practice costs, and eliminate, replace or revise budget neutrality requirements to allow for appropriate changes in spending growth.