Payment variations across outpatient sites of service

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-owned facilities are higher than rates paid to physician offices or ASCs for providing the same service. The scope of the payment differential varies and is not based on the quality of care provided.

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 services billed under the PFS. There is a single relative value unit (RVU)-based 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 bundled 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. While HOPDs and ASCs receive annual updates based on the hospital market basket, annual updates to the PFS were established by the Medicare Access and CHIP Reauthorization Act (MACRA), which froze physician payment updates at 0% for six years from 2020 through 2025. Beginning in 2026, annual updates will be 0.25% for all physicians except qualifying alternative payment model participants who will receive a 0.75% update.

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 8% from 2001 to 2024, whereas Medicare hospital pay has increased more than 70% during the same time period. Additionally, unlike nearly all other Medicare providers, physicians do not receive an annual inflationary payment update. When adjusted for inflation, Medicare physician pay has declined 29% from 2001 to 2024.

The site-of-service differential puts physicians at a significant disadvantage when competing with HOPDs and can also play a role in incentivizing the sale of physician practices and ASCs to hospitals, since hospital-acquired facilities meeting certain criteria have been routinely converted to HOPDs and paid higher rates under Medicare's OPPS. Congress and the Centers for Medicare & Medicaid Services (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.

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.

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 RVUs of 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 Medicare Economic Index (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, is being fielded by the AMA in 2023-2024 to collect representative data on practice expense and hours spent in direct patient care. These data will be shared with CMS to update the MEI and the practice expense RVUs of 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.