Medicare Payment Parity for Doctor Services Gathers Steam

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- Washington policymakers are coalescing around plans to expand Medicare payment parity next year, which could see hospitals' outpatient departments being paid the same rates as doctors' offices for common procedures.
- The plan would be a loss for hospitals, with industry groups warning that further payment changes could force health systems to downsize their workforces to make up for lost revenue.
- Lawmakers have introduced bills aimed at codifying payment parity at the legislative level, which could save the federal government billions of dollars over 10 years, according to the Congressional Budget Office.

Washington policymakers are coalescing around plans to expand Medicare payment parity next year, a policy shift that could see hospitals' outpatient departments being paid the same rates as doctors' offices for a growing number of common procedures.

In **November**, the Centers for Medicare & Medicaid Services moved ahead with plans to align payments for drugs administered in doctors' offices and hospital outpatient departments starting in 2026. These types of adjustments to payment policies could net over **$6 billion** in savings to the federal government over 10 years, according to an analysis of similar proposals from the Congressional Budget Office.

The plan would be a loss for hospitals, with industry groups like the American Hospital Association warning that further payment changes could force health systems to **downsize** their workforces to make up for lost revenue.

The Medicare program has hinted that it could expand payment parity across more services in 2026. According to a **proposed version** of the payment rule released in July, the agency solicited comments from the public on which types of services should be looked at for future payment reforms.

"They've indicated that they'd be considering those comments as part of future rule-making processes," said Zachary Levinson, project director of the KFF Project on

Hospital Costs. “It’s possible that CMS in the future could continue to expand site-neutral payment reforms.”

Lawmakers have also introduced bills aimed at codifying payment parity at the legislative level. In May, Sen. John Kennedy (R-La.) introduced legislation (**S.1629**) that would **align** Medicare payments for diagnostic imaging, skin procedures, biopsies, pathology, and 63 other services commonly performed at doctors’ offices.

For example, under the current system, an allergy skin test conducted in a hospital-owned outpatient clinic would cost Medicare $719. That same procedure at a doctor’s office would have cost just **$176**, according to the Health Research firm Arnold Ventures.

Adopting more aggressive changes, such as those found in Kennedy’s legislation, could save the federal government **$157 billion** over the same period, according to the Congressional Budget Office. The bill is also estimated to shave off around **$94 billion to$134 billion** in premiums and cost-sharing for Medicaid patients over 10 years, according to the Committee for a Responsible Federal Budget and Ellis Health Policy.

Consequences for Hospitals

Supporters of site-neutral payment policies say it also helps slow the pace of hospital consolidation of physician practices, which now own **nearly 35%** of these offices. Once acquired, Medicare payment law allows these companies to bill for care at higher hospital-specific prices.

The trend has real consequences for patients, with a study of California hospitals in the journal Health Affairs finding that areas in the state with the highest consolidation of hospital-owned physician practices saw a **12% increase** in premiums.

Hospital industry groups have raised concerns that the site-neutral policies are unfair because they do not adequately account for the operating costs of running services at different facilities.

“There are real differences in what it costs to run a hospital versus a physician’s office. They don’t have to ensure 24-hour staffing of physicians, nurses, and specialists who

are on call," said Beth Feldpush, senior vice president of policy and advocacy at America's Essential Hospitals.

"Then you look at all the other expenses in running a 24-hour business, such as food services, environmental services, and laundry. Physicians' offices don't have those types of costs," she added.

Implementing further site-neutral payment reforms could also be a financial tipping point for rural and low-income serving urban facilities, which often take on more uninsured patients and have lower operating margins, said Feldpush.

"I think we are going to see hospitals that close, or some stay open but have to shut down some service lines," she said.

Future Legal Challenges

Future payment rulemakings could also open the door for litigation challenging the executive branch's authority to unilaterally dictate Medicare payment policies, said Jeffrey Davis, health policy director at McDermott+ Consulting and former director of regulatory and external affairs at the American College of Emergency Physicians.

In 2019, the American Hospital Association challenged the CMS's move to adopt site-neutral payments for routine visits done at hospital-controlled doctors' offices. In that case, the US District Court for the District of Columbia held that the agency exceeded its authority under the Medicare statute, but the decision was eventually reversed at the US Court of Appeals for the District of Columbia Circuit.

These early wins could give the agency the confidence to go forward with more aggressive changes in the future, though it's too early to tell whether courts will rule the same way, said Davis.

The AHA said in a **public comment** that the CMS's payment proposal would not rest on solid legal ground, especially after a Supreme Court decision in *Loper Bright Enterprises v. Raimondo* ended the legal principle of courts deferring to agencies' interpretation of ambiguous federal statutes.

The agency's reading of the statute "must now stand on its own two feet as the best interpretation of the law. It cannot," the AHA wrote.

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