February 4, 2022

The Honorable Kevin Hern
U.S. House of Representatives
1019 Longworth House Office Building
Washington, D.C. 20515

The Honorable Rick Allen
U.S. House of Representatives
570 Cannon House Office Building
Washington, D.C. 20515

The Honorable Victoria Spartz
U.S. House of Representatives
1523 Longworth House Office Building
Washington, D.C. 20515

Dear Heathy Future Task Force Affordability Subcommittee Members:

The physician and provider organizations below are pleased to provide comments and suggestions to the Healthy Futures Taskforce, particularly as related to Section IV of the Affordability Subcommittee's January 10 Request for Information entitled "Increasing Competition and Identifying Anti-Competitive Consolidation."

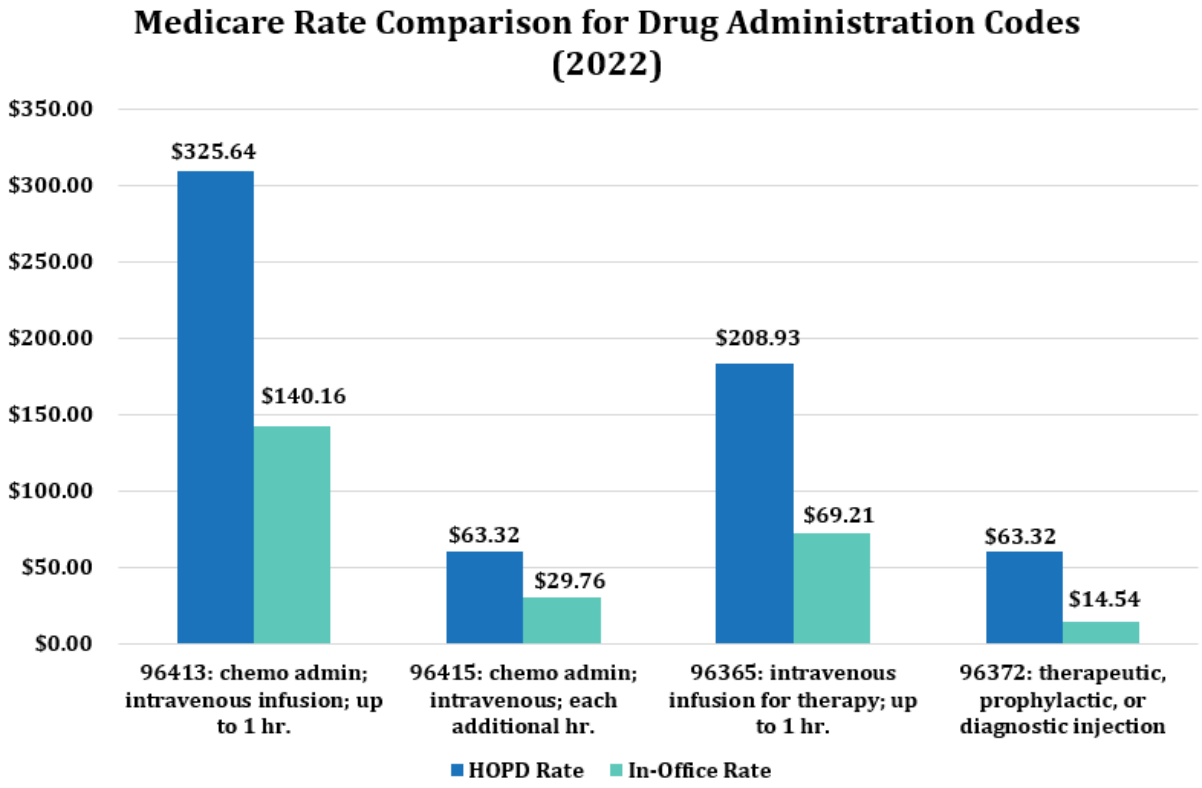
Physician Offices & Ambulatory Surgery Centers are More Cost Efficient than Hospitals but Recent Trends are Disturbing

Site of service payment differentials are an artefact of historical realities that did not anticipate the tremendous technological and clinical innovations which have advanced the complexity and types of care available in outpatient settings and, concomitantly, reduced costs associated with the delivery of that care. Yet, the policy of paying hospitals substantially more (in some cases twice as much) for the identical services provided in a physician office, infusion center or ambulatory surgery center (ASC), paradoxically, acts as a disincentive to pursuing innovations that shift care out of the higher cost hospital setting, thereby perpetuating inflationary cost trends and inhibiting patient access. These payment differentials waste taxpayer and beneficiary dollars and also provide mega-hospital systems with additional resources and incentives to acquire physician practices, promote consolidation, limit competition and restrict treatment options for patients.

A recent study by Avalere for the Physician Advocacy Institute found that the percentage of hospital-employed physicians increased by more than 70 percent from July 2012 through January 2018. During that timeframe, hospital acquisitions of physician practices more than doubled. In 2017 and 2018 alone, an additional 8,000 physician practices were

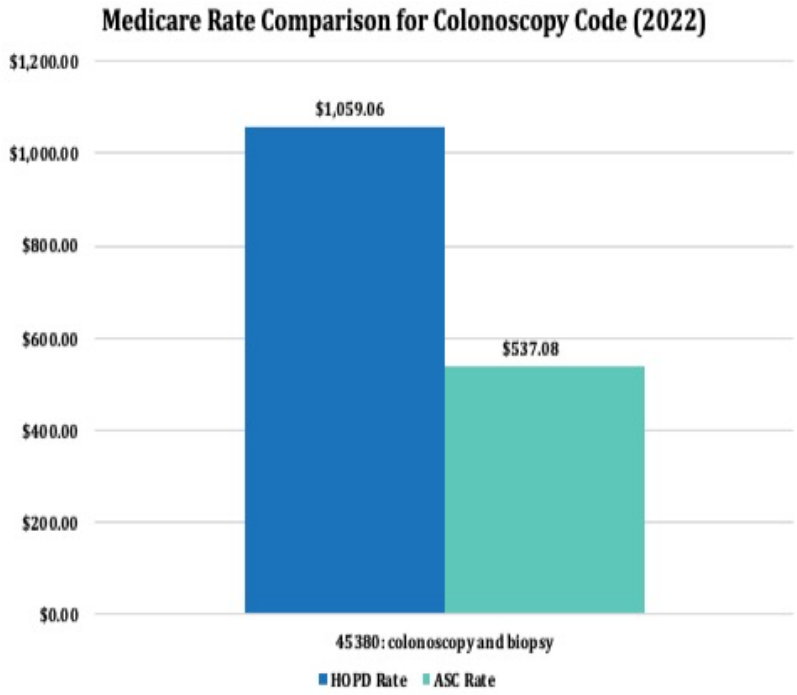
acquired by hospitals. The trend is disturbing—with the proportion of independent physicians steadily dropping from 48.5 percent in 2012 to 31.4 percent in 2018.[1]

This trend should be of great concern to policymakers. Hospitals cost a lot more than physician practices, even when furnishing the identical health care services.[2] As an example, Medicare pays hospitals more than twice the amount as physician offices for the infusion of the identical drug that requires the same nurse staff time and technical training; i.e. for the CPT code 96413 "Chemo admin; intravenous infusion; up to 1 hr." the HOPD rate is $325.64 vs. the in-office rate of $140.16.



The same holds true when comparing identical services furnished in hospital outpatient departments (HOPDs) as compared to ambulatory surgery centers (ASCs). As but one example, a colonoscopy with a biopsy is reimbursed at nearly double the rate in HOPDs compared to ASCs, $1,059.06 vs. $537.08. There is no clinical reason that about half of colonoscopies continue to be performed at hospitals.

[1] http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf
[2] Berkeley Research Group, "Site-of-Care Shift for Physician-Administered Drug Therapies: Update"



At a macro level, hospital spending is growing much faster than physician spending, due to both price and utilization increases. The Medicare Payment Advisory Commission (MedPAC) March 2018 report found that from 2011 to 2016, program spending and beneficiary cost-sharing on services furnished in HOPDs increased by 51 percent, from $39.8 billion to $60 billion.[3] MedPAC noted, "[a] large source of growth in spending on services furnished in hospital outpatient departments (HOPDs) appears to be the result of the unnecessary shift of services from (lower-cost) physician offices to (higher-cost) HOPDs."

Analogous results were observed on the commercial side: A University of California, Berkeley study that reviewed 4.5 million commercial HMO enrollees found hospital-owned organizations incurred 19.8 percent higher expenditures than physician-owned organizations for professional, laboratory, and pharmacy services.[4]

Hospitals have focused on acquiring physician practices because that strategy simultaneously quashes competition in the local market for services such as outpatient surgery and radiation therapy and creates downstream revenue through referrals on surgery and ancillary services. The revenue a physician generates for a hospital employer far surpasses the cost of the employed physician's salary.[5] A few examples, as presented in the Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey, include urologists generating $2,161,458 while receiving an average salary of $386,000,

[3] MedPAC March 2018 Report: Chapter 3 – Hospital Inpatient and Outpatient Services
[4] Robinson JC, Miller K. Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California. JAMA. 2014;312(16):1663–1669. doi:10.1001/jama.2014.14072
[5] Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey

gastroenterologists generating $2,695,277 while receiving an average salary of $487,000, and ophthalmologists generating $1,440,217 while receiving an average salary of $300,000.

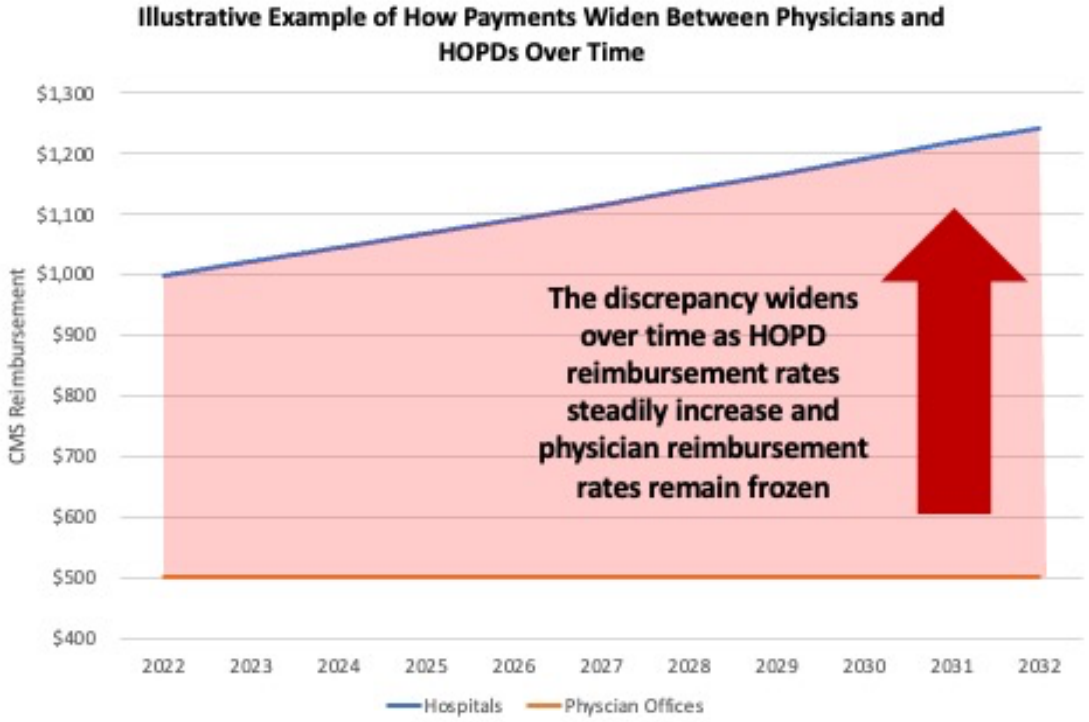
PHYSICIAN GENERATED REVENUE VS. AVERAGE SALARIES

Specialty	Average Revenue	Average Salary*
Cardiology (Invasive)	$3,484,375	$590,000
Cardiology/Non-Inv.	$2,310,000	$427,000
Cardiovascular Surgery	$3,697,916	$425,000
Family Practice	$2,111,931	$241,000
Gastroenterology	$2,965,277	$487,000
General Surgery	$2,707,317	$350,000
Hematology/Oncology	$2,855,000	$425,000
Internal Medicine	$2,675,387	$261,000
Nephrology	$1,789,062	$272,000
Neurology	$2,052,884	$301,000
Neurosurgery	$3,437,500	$687,000
OB/GYN	$2,024,193	$324,000
Ophthalmology	$1,440,217	$300,000
Orthopedic Surgery	$3,286,764	$533,000
Otolaryngology	$1,937,500	$405,000
Pediatrics	$1,612,500	$230,000
Psychiatry	$1,820,512	$261,000
Pulmonology	$2,361,111	$418,000
Urology	$2,161,458	$386,000

What should Congress Do to Assist Independent Practices and Foster Competition Among Healthcare Providers?

1. Reduce the disparity in payments between HOPD and the physician office and/or ASC for identical procedures. H.R. 19 includes a provision that implements this policy for Part B drug administration. That is a good start and could be expanded to any number of other procedures and services including radiation therapy, colonoscopy and other endoscopic procedures, and outpatient surgery. A policy that reduces the full amount of the disparity is preferred but even closing the disparity by 50 percent would be a helpful reform.

2. Provide physicians with a reasonable annual payment update. Under current law, physician payments for caring for Medicare beneficiaries are frozen indefinitely. Furthermore, they are subject to sequester (a 2% reduction to payments), which will be phased back in this year. Physician practices are grappling with enormous cost challenges, including hiring and retaining nurse and back-office staff. For independent physician practices outpatient facilities to successfully compete with large hospital systems, they need a predictable annual payment update reflecting their increased practice costs – a market basket. Hospitals are projected to receive an annual 2.2 percent increase over the decade, while physician payments will be frozen indefinitely.[6] The illustrative example below shows the increasing discrepancy between what HOPDs and physician offices are reimbursed over a ten-year period, as a result of these payment policies: hospital payments would increase from $1,000 to $1,243 over 10 years, while physician payments remain stagnant at $500. That is not sustainable and must be reformed.



3. Establish a threshold of charity care in the tax code for non-profit hospital status. Currently, hospitals do not have to provide a specified level of charity care in order to be categorized "non-profit" and thus exempt from state, local and federal taxation and to be eligible for the 340B drug discount program. A recent study in *Health Affairs* documented that for-profit hospitals actually provide about 50 percent more charity care than non-profit hospitals (3.8 percent vs 2.3 percent).[7] Congress should

[6] CMS Office of the Actuary "2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds"
[7] Bai, et al. "Analysis Suggests Government and Nonprofit Hospitals' Charity Care is Not Aligned with Their Favorable Tax Treatment". *Health Affairs*, April 2021

establish a minimum threshold of bona fide charity care for hospitals to reap the many benefits of their non-profit status, including not paying taxes and being made eligible for hugely profitable 340B drugs which they dispense at substantial markups. What metric for a hospital's non-profit status can be more important than providing indigent patients, needed free care? We suggest a threshold equal to the amount for-profit hospitals provide: 3.8 percent.

4. Repeal the Inpatient Only (IPO) List. CMS recently reversed the reform the Trump Administration had initiated and that was only in the first year of a three-year phase-in by reinstating the inpatient only list of 298 procedures. CMS simultaneously removed 256 procedures that had been added to the ASC-payable list. This reversal occurred despite the acknowledged blistering pace of technological innovation and the sustained trend of increased volume and complexity of cases safely moving into the outpatient setting such that the healthcare intelligence firm Sg2 projects that 85 percent of all healthcare procedures will be performed on an outpatient basis by 2028.[8] Arbitrarily defining an IPO list creates an unnecessary barrier and presumes that the government knows better than practicing physicians when it comes to determining the appropriate sit of service in which to perform a procedure.

   Not only does the elimination of the IPO list and expansion of the ASC Covered Procedures List (CPL) promote beneficiary access to safe and convenient sites of care while expanding access to innovation, but it also contributes to *significant* savings in Medicare spending as surgical procedures in the ASC are paid half the amount as the hospital. ASCs have already saved Medicare $28 billion from 2011 to 2018[8] and could save much more if physicians had the ability to move appropriate procedures to that setting. This can occur in a more robust way by eliminating the inpatient only list and restoring those procedures to the ASC-payable list.

5. Cap out-of-pocket cost-sharing in for Part B drugs and ASCs at HOPD Cap While beneficiaries receiving care at hospital outpatient departments have a cap on their cost-sharing (currently $1,556 per procedure), those who receive the identical Part B drug in a physician offices or device-intensive procedure in an ASC do not and are subject to unlimited 20% coinsurance. As a result, beneficiaries are subject to higher out-of-pocket liability for certain high-cost Part B drugs and device-intensive procedures even though Medicare saves money when they receive their care at physician offices, outpatient infusion centers and ambulatory surgery centers instead of a hospital.

   The lack of a beneficiary copay cap in the physician office for Part B drugs and in the ASC for surgical procedures creates perverse incentives to provide care in the more expensive hospital setting and also impairs access to needed, nondiscretionary care.

[8] "Reducing Medicare Costs by Migrating Volume from Hospital Outpatient Departments to Ambulatory Surgery Centers" ASCA (Oct 4, 2020).

The issue primarily impacts those beneficiaries who lack supplemental coverage and are disproportionately minority beneficiaries.

Conclusion

There is no single remedy to encouraging more competition in the provider sector, but government can take important, targeted steps to level the playing field. The Medicare program and tens of millions of Medicare beneficiaries will benefit from these changes by increasing access to more affordable health care. We stand ready to work with you and Members of both parties on these ideas.

Sincerely,

American Academy of Ophthalmology
American Association of Clinical Urologists
Digestive Health Physicians Association
Infusion Providers Alliance
LUGPA (Large Urology Group Practice Association)
Outpatient Ophthalmic Surgery Society

For further information or any questions on these comments, please contact John McManus with the McManus Group at jmcmanus@mcmanusgrp.com.