United Specialists for Patient Access

October 5, 2023

The Honorable Jason Smith
Chairman
U.S. House Committee on Ways and Means
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
U.S. House Committee on Ways and Means
Washington, DC 20515

Submitted electronically via: WMAccessRFI@mail.house.gov

Re: Request for Information on How Misaligned Medicare payment incentives and consolidation may be driving facility closures

Dear Chairman Smith and Ranking Member Neal:

The United Specialists for Patient Access (USPA) appreciates the opportunity to offer its comments to the House Committee on Ways and Means regarding how misaligned Medicare payment incentives and consolidation may be driving facility closures. USPA represents a broad spectrum of office-based specialists such as anesthesiologists, cardiologists, dialysis vascular access providers, limb salvage specialists, phlebologists, physical therapists, radiation oncologists, radiologists, urologists, and vascular surgeons, as well as specialty societies and the device and equipment manufacturers that support them. In particular, USPA advocates on behalf of specialty providers in the office-based setting (place-of-service [POS] 11).[1]

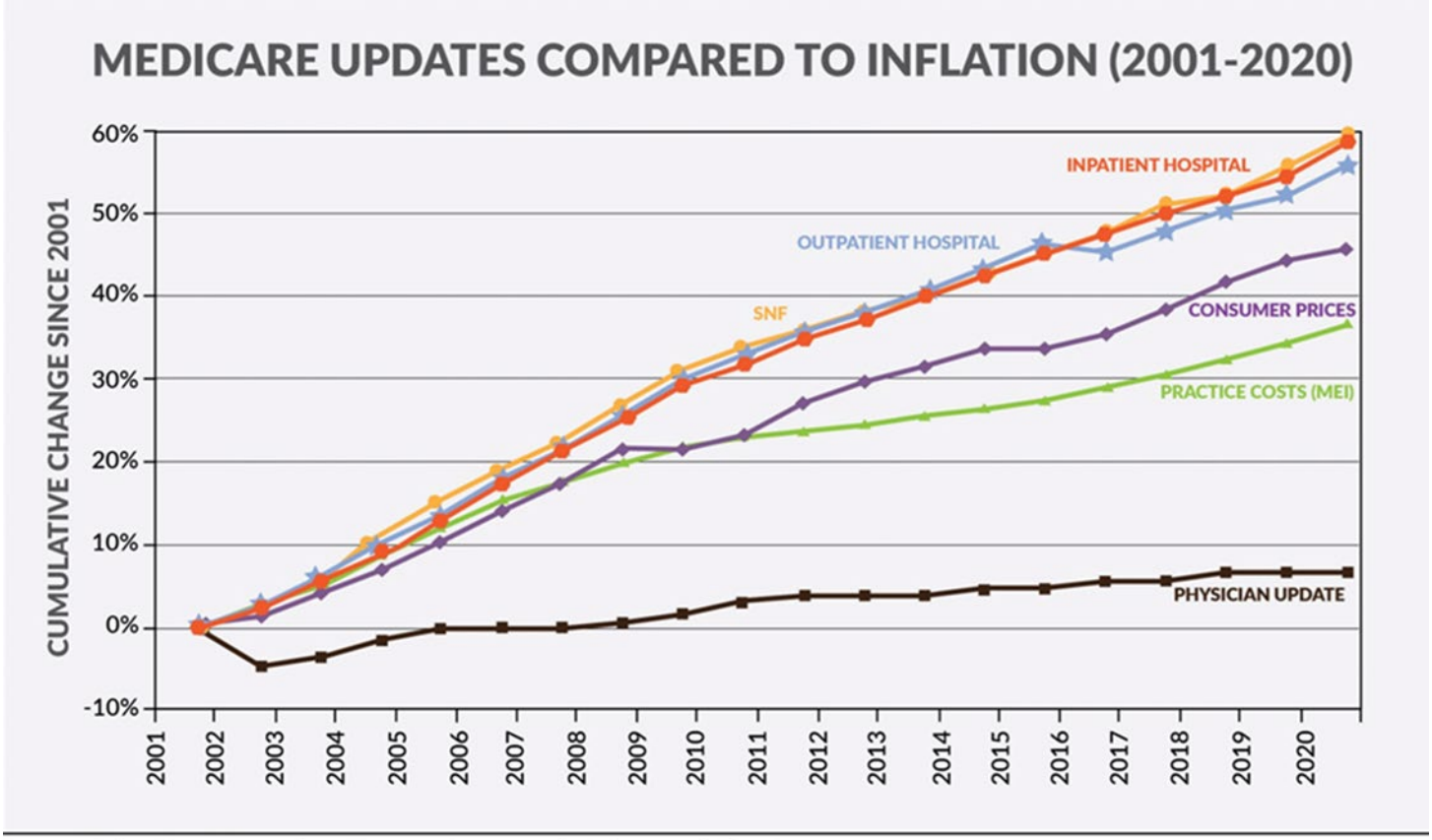
Office-based specialty care is a critical component of rural healthcare in the US. A recent study found, however, that rural Medicare beneficiaries have less access to ambulatory care specialists. This study also revealed that reduced access to ambulatory care specialists contributes to the sizable difference in preventable hospitalization and mortality rates between rural and urban beneficiaries. The authors note that policies to expand primary care access in rural areas without specialty care access are unlikely to reduce rural health disparities.[2] A primer on office-based specialty care is referenced in the footnotes and contains an appendix with multiple examples of office-based specialty care and its importance for rural and underserved communities.[3]

Unfortunately, access to office-based specialty care has been greatly affected since 2006 due to ongoing Medicare cuts under the Physician Fee Schedule. In the 2024 Physician Fee Schedule

[1] For more information about USPA, please see https://www.uspaccess.org/
[2] Johnston KJ. (2019, December). Lack of Access to Specialists Associated with Mortality and Preventable Hospitalizations of Rural Medicare Beneficiaries. Health Affairs. 38(12). https://doi.org/10.1377/hlthaff.2019.00838
[3] The Moran Company, *A Primer on Office-Based Specialty Care, Other Major Ambulatory Care Settings, and Medicare Reimbursement*, Prepared for: The United Specialists for Patient Access (USPA), May 2023. Available here: https://www.uspaccess.org/_files/ugd/4d8e3a_bca766bc31054e5e9c41d5e503eda505.pdf

Proposed Rule, CMS states that, "[I]nterested parties have presented high-level information to CMS suggesting that Medicare payment policies are directly responsible for the consolidation of privately-owned physician practices and freestanding supplier facilities into larger health systems."[4] Two key charts below indicate the dynamics that are responsible for this effect.

First, an American Medical Association analysis of Medicare updates shows significant underfunding of PFS updates relative to practice costs (MEI) since 2001. The black line in the chart labeled, "Physician Update," represents updates to the Physician Fee Schedule "conversion factor" going back to 2001. It clearly shows that the PFS is woefully underfunded relative to "Practice Costs," which are represented by the Medicare Economic Index (MEI). It is worth noting that other sites-of-service have been reimbursed well above MEI since 2001.

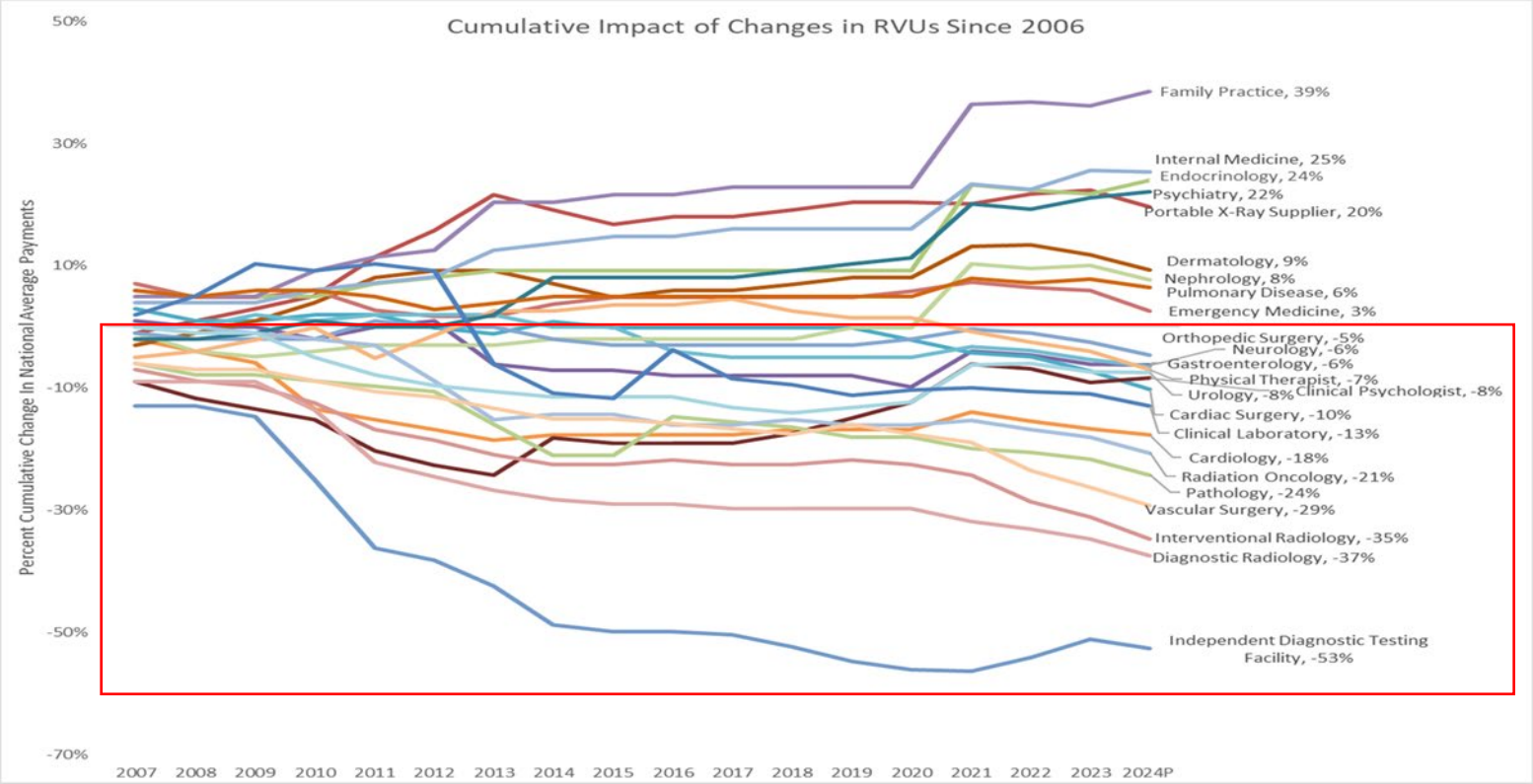


It is for this reason that the American Medical Association and other stakeholders support "growing the pie" by implementing a permanent conversion factor inflation update to the PFS through H.R. 2474, the Strengthening Medicare for Patients and Providers Act. This bill would stop the ever-widening gap between practice costs and PFS reimbursement.

However, the chart above tells only half of the story as *PFS payments = Conversion Factor * Relative Value Units (RVUs)*. While practice costs have far outstripped growth in the PFS

[4] 88 FR 52681

overall, *within the PFS*, the office-based specialists have been particularly harmed by *RVU* cuts, as RVUs determine how money is distributed within the PFS "pie." As shown in the chart below, since 2006 office-based specialists have seen cuts of up to 53% in some cases.[5] H.R. 3674, the Providing Relief and Stability for Medicare Patients Act of 2023 is needed to stop those hit hardest by ongoing RVU cuts: office-based specialists. For a more in-depth analysis of how PFS rebalancing has hurt office-based specialists, please refer to the USPA's February 2023 letter to MedPAC.[6]



Reduced Access to Office-Based Specialty Care

2023 Multi-Societal Survey

Ongoing cuts to office-based specialists are key contributors to center closures and health system consolidation. In February of 2023, a multi-societal survey distributed across multiple specialties, including vascular surgery, interventional radiology, and interventional cardiology, to predominately non-hospital physicians found:

- 87% of respondents "believe Medicare cuts have a moderate or greater impact on the practice,"
- 53% of respondents "believe the likelihood of the practice's success is unlikely,"
- 22% of respondents "are likely to become a hospital employee if cuts continue,"

[5] The Moran Company. Cumulative Impact of Changes in RVUs Since 2006.
[6] United Specialists for Patient Access, Letter to MedPAC, 2023, page 5. Available here: https://www.uspaccess.org/_files/ugd/4d8e3a_1b507a04157348148cec597af5f0a03a.pdf?index=true

- 21% of respondents "are likely to sell their practice if cuts continue,"
- 17% of respondents "are likely to retire if cuts continue," and
- 8% of respondents "retired, sold, or closed their practice from 2021 to 2022."[7]

Historical Specialty-Level Analyses

Historical specialty-level analyses show that reimbursement cuts have been correlated with site-of-service migration to the hospital and/or reductions in office-based utilization for years.

- Site-of-Service Migration
    - Analysis by HMA for the 2010-2019 period found, for urology and radiation oncology, that office-based reimbursement cuts accompanied significant drops in office-based utilization and increases in utilization in the hospital-based setting.[8]
        - Urology
            - Office-based urology price: 13% cut
            - Office-based urology utilization: 19% reduction
            - Hospital-based utilization: 17% increase
        - Radiation Oncology
            - Office-based radiation oncology price: 22% cut
            - Office-based radiation oncology utilization: 18% reduction
            - Hospital-based utilization: 35% increase
- Reductions in Office-Based Utilization
    - Cardiology
        - Analysis by HMA for the 2010-2019 period found for cardiology that reimbursement cuts in both the office and hospital-based settings accompanied drops in utilization in both settings. Specifically, office-based and hospital-based reimbursement was reduced by 7% over the period and utilization decreased by 28% and 36% in the hospital and office-based settings, respectively.
    - Dialysis Vascular Access
        - A 39 percent reduction to a key dialysis vascular access code (36902) in the 2017 Physician Fee Schedule resulted in significant center closures in the office-based setting. An American Society of Diagnostic and Interventional Nephrology (ASDIN) survey in 2018 found that reimbursement levels were so inadequate that (1) more than 20 percent of respondents surveyed stated their centers had closed due to the cuts contained in the CY 2017 Physician Fee Schedule Final Rule and (2) more than 30 percent of respondents indicated their intention to close their center in the future.[9] Concurrent with these office-based closures, 2021

[7] John Blebea, MD, MBA et al. Multi-Societal Survey on the Impact of Medicare Cuts to Physician Reimbursement, Presented at the 2023 Outpatient Endovascular and Interventional Society Annual Meeting
[8] HMA analysis of CMS Physician Fee Schedule Rules and PSPS files, 2010-2019
[9] Survey available for download here: https://7c6286a4-24ee-4fee-92b9-ed0f0d031061.filesusr.com/ugd/4d8e3a_450f824be03b407fbab027d9e60e9ff5.pdf

Medicare claims data confirmed a decrease in office-based vascular access services of more than 30 percent since 2017 as well as an *overall* reduction in vascular access maintenance services of 12 percent counting all sites of service.[10]

- Newspaper and Societal Journal Data
  - Cardiology
    - "In 2009, the federal government cut back on what it paid to cardiologists in private practice who offered certain tests to their patients. Medicare determined that the tests, which made up about 30 percent of a typical cardiologist's revenue, cost more than was justified, and there was evidence that some doctors were overusing them. Suddenly, Medicare paid about a third less than it had before.

      But the government didn't cut what it paid cardiologists who worked for a hospital and provided the same test. It actually paid those doctors more, because the payment systems were completely separate. In general, Medicare assumes that hospital care is by definition more expensive to provide than office-based care.

      You can imagine the result: Over the past five years, the number of cardiologists in private practice has plummeted as more and more doctors sold their practices to nearby hospitals that weren't subject to the new cuts. **Between 2007 and 2012, the number of cardiologists working for hospitals more than tripled, according to a survey from the American College of Cardiology, while the percentage working in private practice fell to 36 percent from 59 percent. At the time of the survey, an additional 31 percent of practices were either in the midst of merger talks or considering it. The group's former chief operating officer once described the shift to me as "like a migration of wildebeests."**[11]

  - Radiation Oncology

    "Compared to the 2012 survey, the workforce has shifted away from private practice and toward nonacademic hospitals and academic/university systems. This shift assumes a magnified significance when we look back 15 years to the 2002 workforce, which was 76% private practice and 17% academic. Survey results may offer some clues regarding the forces behind these changes. A third of ROs who changed employer did so because of practice merger/buyout or a desire for stability. It would appear that ROs are susceptible to market forces and

[10] MJBF Braid-Forbes Health Research, LLC, Medicare claims analysis of 36902, September 2021
[11] New York Times, *When Hospitals Buy Doctors' Offices, and Patient Fees Soar*, 6 February 2015

healthcare delivery consolidations manifested in hospital acquisitions of satellite facilities and healthcare networks.

Another possible clue lies in findings about compensation models. Almost 40% of respondents reported a change in their compensation plan in the 3 years before the survey, resulting in a workforce compensated primarily by fixed salaries or base salaries with additional compensation possible, with only a minority in pure productivity models. The top reason for compensation plan changed practice reorganization is likely a reflection of the rising dominance of large healthcare networks. **The second most common reason - change in practice financial position - may speak to the downward pressures on physician compensation owing to declines in reimbursement, particularly for freestanding radiation oncology facilities. Among ROs who had a change in compensation plan, private practitioners were the hardest hit, with over half experiencing a pay cut. Conversely, academics were relatively shielded, with three-quarters reporting a higher or steady income."**[12]

- Radiology

  "These changes suggest that outpatient advanced imaging is beginning to shift out of private offices and into HOPDs, which is of concern for several reasons. First, Medicare and the commercial payers pay more to hospitals for these studies than they do to private offices, so costs will increase. **Second, although no firm data indicate the number of private office imaging facilities in the United States, reductions in private office utilization likely mean that some of these facilities are closing, probably as a result of the many reductions in imaging reimbursement in recent years.** The reductions include: those in the Deficit Reduction Act; the multiple procedure payment reductions; the utilization factor increase; and the practice expense revaluation, in addition to the aforementioned code bundling. These cuts drastically affected the technical-component reimbursements paid to private offices. Fewer facilities means reduced access for patients, as well as less competition among providers. Third, private offices generally offer better ambience and quicker service than hospital settings, and patients generally find visits to offices to be more pleasant. Thus, at a time when patient-centered care has become paramount, the patient experience may suffer. These trends need to be followed in future years to see whether they continue and how serious the aforementioned concerns become."[13]

- Vascular Surgery

[12] International Journal of Radiation Oncology, *The American Society for Radiation Oncology 2017 Radiation Oncologist Workforce Study*, 2018
[13] Journal of the American College of Radiology, *The Shift in Outpatient Advanced Imaging From Private Offices to Hospital Facilities*, 2015

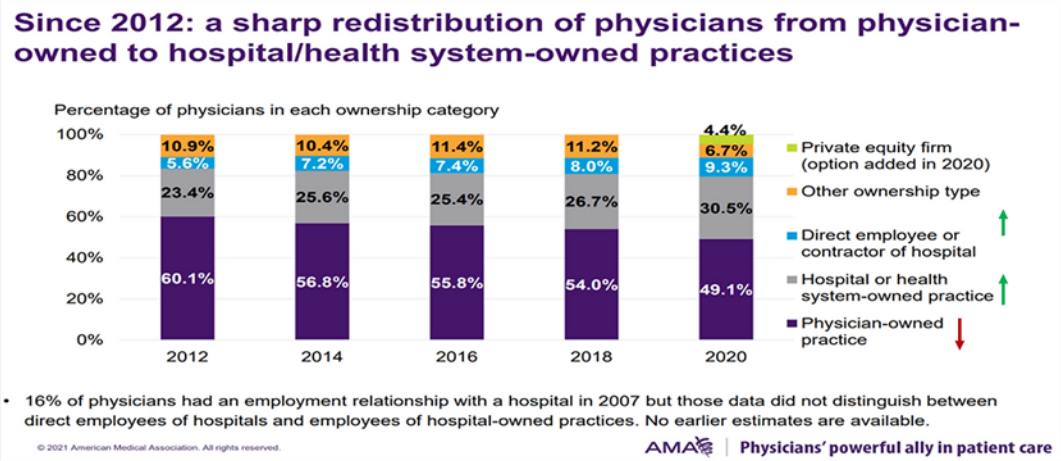
> "The emotional and economic effects of the COVID-19 pandemic on physicians have been significant. For vascular proceduralists, the additive effects of the cuts in reimbursement instituted by Medicare in 2022 portend even greater challenges for the financial viability of office practices, OBLs, and OBL/ASC. The requirement for budget neutrality in Medicare Part B payments for physicians, no adjustment for inflation in physician payments since 2001, and the annual inflation rate now at 9.1%, a 40-year high, indicate impending economic hardships for physicians providing outpatient vascular care in the nonfacility setting. **It appears that structural changes in the CMS physician reimbursement calculations are required to prevent irreparable harm and allow for continued viable independent private practice care of vascular patients."**[14]

Ongoing Cuts to Office-Based Specialists are a Catalyst for Health System Consolidation

According to the American Medical Association, over the last decade the percentage of physician-owned practices has fallen below 50% and there has been a sharp rise in (1) physicians employed by a hospital and (2) physician practices owned by hospitals or health systems. (see "a sharp redistribution of physicians from physician-owned to hospital/health system-owned practices" below).[15] Given that the reimbursement for medical specialties is, on average, $178,000 more in a vertically integrated health system, the incentive is clear for beleaguered **office-based providers who may no longer be able to sustain further cuts in the Physician Fee Schedule to simply close their centers and continue the migration to large health systems.**[16] As noted by the Medicare Payment Advisory Commission (MedPAC), "the preponderance of evidence suggests that hospital consolidation leads to higher prices."[17]

[14] Society for Vascular Surgery, *Expected changes in physician outpatient interventional practices as a result of coronavirus disease 2019 and recent changes in Medicare physician fee schedule*, 2022
[15] American Medical Association, *Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020*, Carol K. Kane, PhD, June 2021
[16] Post, Brady PhD et al., *Hospital physician integration and Medicare's site-based outpatient payments*, Health Serv Res. 2021;56:7 15
[17] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2022

Physician-Owned Practices Have Decreased 11% as Hospital Ownership of These Practices Has Increased 11%



American Medical Association, *Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020*, Carol K. Kane, PhD, June 2021

2022 PFS Clinical Labor Cuts Continue Troubling Office-Based Center Closure Trend

The most recent round of office-based specialty cuts are contained in the 2022 PFS, which currently are being phased-in through 2025. The table below highlights code reductions contained in the 2022 PFS Proposed Rule.

Disease/Service	Health Inequity	2022 PFS
Venous Ulcer / Endovenous radiofrequency ablation	Black patients present with more advanced venous insufficiency than White patients[18]	Key Code (36475) Cut by 23%
ERSD / Dialysis Vascular Access	Black and Latino patients start dialysis with a fistula less frequently despite being younger[19]	Key Code (36902) Cut by18%
Cancer / Radiation oncology	Black men are 111 percent more likely to die of prostate cancer; Black women are 39 percent more likely to die of breast cancer[20]	Key Code (G6015) Cut by 15%
Peripheral Artery Disease / Revascularization	Black Medicare beneficiaries are three times more likely to receive an amputation[21] Latino are twice as likely[22]	Key Codes (37225) Cut by 22%

[18] Vascular and Endovascular Surgery, *Advanced Chronic Venous Insufficiency: Does Race Matter?*, 26 December 2016
[19] *Racial/Ethnic Disparities Associated With Initial Hemodialysis Access*. JAMA Surg.2015 Jun;150(6):529-36. doi: 10.1001/jamasurg.2015.0287
[20] Cure, *Cancer Sees Color: Investigating Racial Disparities in Cancer Care*, Katherine Malmo, 16 February 2021
[21] Dartmouth Atlas, *Variation in the Care of Surgical Conditions: Diabetes and Peripheral Arterial Disease*, 2014
[22] J. A.Mustapha, *Explaining Racial Disparities in Amputation Rates for the Treatment of Peripheral Artery Disease (PAD) Using Decomposition Methods*, J. Racial and Ethnic Health Disparities (2017) 4:784–795

Fibroid / Uterine Fibroid Embolization	Uterine fibroids are diagnosed roughly three times more frequently in Black women[23]	Key Code (37243) Cut by 21%

Office-Based Specialty Closures Result in Higher Medicare Beneficiary Coinsurance

Site-of-service migration also results in higher Medicare patient coinsurance. For the same codes listed above, site-of-service differentials under the 2024 Hospital Outpatient PPFS and Physician Fee Schedule Proposed Rule are as follows:

Disease / Service	**Hospital***	**Medicare Beneficiary Coinsurance****	**Office***	**Beneficiary Coinsurance ****	**Higher Medicare Pay in the Hospital**	**Higher Medicare Beneficiary Coinsurance in the Hospital**
Venous Ulcer / Endovenous radiofrequency ablation (36475)	$3,332	$664	$1,038	$208	**$2,284**	**$457**
ERSD / Dialysis Vascular Access (36902)	$5,729	$1,146	$1,164	$233	**$4,565**	**$913**
Cancer / Radiation oncology (77385: Hospital; G6015: Office)	$579	$116	$350	$70	**$229**	**$46**
Peripheral Artery Disease / Revascularization (37225)	$17,765	$3,553	$8,404	$1,681	**$9,361**	**$1,872**
Fibroid / Uterine Fibroid Embolization (37243)	$11,135	$2,227	$8,230	$1,646	**$2,905**	**$581**
* Global Medicare payment including any technical and professional component ** 20% Medicare Coinsurance						

Removing High-Tech Supply and Equipment PERVUs from the PFS

At a 2020 RUC meeting, the AMA RUC recommended CMS separately identify and pay for high-cost disposable supplies.[24] USPA believes such an approach has merit and could apply to high-tech supply and equipment services broadly provided in the office. Removing high-tech supply and equipment services from the PFS could necessitate new "place of service" designations for such services and more appropriate inclusion in the larger ambulatory technical (i.e. OPPS/ASC) fee schedule. We believe the inclusion of certain high-tech supply and

[23] University of Michigan, *Understanding Racial Disparities for Women with Uterine Fibroids*, Beata Mostafavi, 12 August 2020
[24] https://www.ama-assn.org/system/files/oct-2020-ruc-recommendations.pdf

equipment services in the larger ambulatory technical (OPPS/ASC) fee schedule would the best way for CMS to provide an "evidentiary basis to shape optimal PE data collection and methodological adjustments over time," given previous CMS statements that, "we continue to seek the best broad based, auditable, routinely updated source of information regarding PE costs."[25] Removing high-tech supplies and equipment from the PFS also would free up resources within the PFS to achieve its primary raison d'être: reimbursement for physician work.

REQUEST: We urge Congress to pass H.R. 2474 to stop the ever-growing gap between medical inflation and overall PFS reimbursement. We also urge Congress to pass H.R. 3674 to stop those hit hardest by ongoing RVU cuts: office-based specialists. Finally, we urge CMS and Congress to focus on PFS reform that removes certain high-tech supply and equipment services from the PFS to provide stability to office-based specialty providers and free up resources within the PFS to focus on professional reimbursement and overall PFS reform.

Conclusion

We look forward to continuing to work with Ways and Means and the Congress to reform the Physician Fee Schedule and ensure the viability of office-based specialists. If you have additional questions regarding these matters and the views of the USPA, please contact Jason McKitrick at (202) 465-8711 or by email at jmckitrick@libertypartnersgroup.com .

[25] 83 FR 59455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APPENDIX

Additional Information on H.R. 3674, Providing Relief and Stability for Medicare Patients Act of 2023

- **Press Statement on H.R. 3674**
- **Med Device Support Letter on H.R. 3674**
- **Clinical Labor Coalition Support Letter on H.R. 3674**
- **2023 Multi-Societal Survey on Office-Based Center Closures**
- **Letter to MedPAC on How its Policies are Driving Office-Based Specialty Closure**
- **Primer on office-based specialty care**
- **Fast Facts on Office-Based Center Closure and Site-of-Service Migration**