Congress of the United States
Washington, DC 20515

June 17, 2015

The Honorable John Boehner
Speaker
H-232, The Capitol

The Honorable Kevin McCarthy
Majority Leader
H-107, The Capitol

Dear Speaker Boehner and Leader McCarthy:

Given President Obama's proposed repeal of the in-office ancillary services exception (IOASE) in his budget—and the recent trend of previously undiscussed offsets becoming pay-fors for unrelated spending—the GOP Doctors Caucus would like to draw your attention to new data underscoring the importance of invigorating competition among health care providers. While the increasing consolidation of health care providers raises anti-competitive and cost concerns for patients and Medicare alike, new studies show that retaining the ability of physician practices to offer comprehensive care can keep costs down.

A recent JAMA study examining 4.5 million patients found: 1) expenditures per patient were 10.3% higher for physician groups owned by hospitals than independent practices, and 2) expenditures were 19.8% higher for physician groups owned by multi-hospital systems.[1] Increasing payment disparities between the physician office and hospitals for identical services often make it difficult for physician practices to remain economically viable. For example, Medicare payment for advanced imaging is 36% to 53% higher in the hospital outpatient department than in a physician office.

It should be no surprise that such policies have discouraged many physicians from continuing to operate free-standing practices in their communities. Payment cuts to cardiology services often provided in the office led to a tripling of cardiologists employed by hospitals between 2007 and 2012.[2] A recent study by Merritt Hawkins found a substantial shift toward the employed physician model with more than 90% of new physician job openings at hospitals and other facilities and just 10% in independent practice settings.[3] This is an unfortunate outcome for patient care and the profession of medicine.

Despite these alarming trends and cost implications to the health care system, the president's budget would make it illegal for integrated physician practices to provide "ancillary services," such as advanced imaging, radiation therapy, anatomic pathology, and physical therapy. But new studies by Milliman—commissioned by the American Medical Association and the Digestive Health Physicians Association—show that utilization of ancillary services in physician practices

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[1] Robinson JC, Kelly Miller K. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. JAMA 312.16 (2014): 1663-1669

[2] American College of Cardiology survey, released September 10, 2014

[3] Merritt Hawkins. Report: Over 90% of new physician jobs feature employment by hospitals or other facilities (press release). June 30, 2014.

is a small percentage of total spending on ancillary services and is declining or growing more slowly than in hospital settings. [4]

The studies examined utilization across all sites of service from 2008-2012 and 2009-2013, respectively. Highlights of the studies include the following:

- **Advanced Imaging**: Physician offices (which include free-standing, non-self-referred sites) comprised just 28% of total utilization in 2012. The five-year annual trend from 2008-2012 showed utilization declining by 3.8% in physician offices compared to 1.1% in outpatient hospital departments.

- **Physical Therapy**: Physician offices comprised just 18% of utilization in 2012 and grew at a 1.4% annual trend from 2008-2012.

- **Intensity-Modulated Radiation Therapy**: IMRT utilization in physician offices (which includes non-self-referred sites) declined from 59% in 2008 to 53% in 2012 and total allowed charges grew at an annualized rate of 0.6% from 2008-2012 in physician offices compared to 7.3% in hospital outpatient departments.

- **Pathology**: GI-related anatomic pathology grew more slowly in professional settings (physician office and labs) at an annual rate of 1.2% from 2009-2013 compared to 3.5% in the outpatient hospital setting during that period. Medicare cut the major code for GI-related pathology services by nearly 37% in 2013, or $300 million.

Promoting provider risk-sharing arrangements through Alternative Payment Models is a critical component of the landmark Medicare Access and CHIP Reauthorization Act. Research has indicated that independent physician practices are both the lowest cost and highest quality site of service in APM models—the largest cost savings are in ancillary services such as radiation and Part B medications, where independent physician groups were 34% less costly than hospitals.[5]

Yet, the Obama administration's proposal to repeal the IOASE contradicts care coordination and integration necessary to deliver these innovative APMs. Such a policy would only fragment care and result in more delivery being furnished in higher cost settings.

We encourage you to reject repeal of the IOASE as an offset for any future legislation, and we look forward to working with you to expand patient choice on where to receive high quality, affordable care and to support competition in the health care market place.

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[4] American Medical Association, Milliman Study, March 2015
http://www.ama-assn.org/ama/pub/advocacy/topics/in-office-ancillary-services-exception.page
Digestive Health Physicians Association, Milliman Study, February 2015
http://cqrcengage.com/dhpa/file/Mqq6fLiKQM1/03-2009-2013%20Medicare%20Utilization%20Analysis.pdf

[5] McWilliams JM, Chernew ME, Zaslavsky AM, et al. Delivery system integration and health care spending and quality for Medicare beneficiaries. (2013) JAMA internal medicine, 173(15), 1447-1456.

Sincerely,