DIGESTIVE HEALTH
PHYSICIANS ASSOCIATION®

October 31, 2022

The Honorable Ami Bera
U.S. House of Representatives
172 Cannon House Office Building
Washington, D.C. 20515

The Honorable Earl Blumenauer
U.S. House of Representatives
1111 Longworth House Office Building
Washington, D.C. 20515

The Honorable Larry Bucshon
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Brad Wenstrup
U.S. House of Representatives
2419 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Michael Burgess
U.S. House of Representatives
2161 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Brad Schneider
U.S. House of Representatives
300 Cannon House Office Building
Washington, D.C. 20515

The Honorable Kim Schrier
U.S. House of Representatives
1123 Longworth House Office Building
Washington, D.C. 20515

The Honorable Mariannette Miller-Meeks
U.S. House of Representatives
1716 Longworth House Office Building
Washington, D.C. 20515

Re: Recommendations on Physician Payment Reform

Dear Reps. Bera, Buchson, Burgess, Schrier, Blumenauer, Wenstrup, Schneider and Miller-Meeks:

The Digestive Health Physicians Association (DHPA)® thanks you for the opportunity to comment on the current state of physician reimbursement in Medicare, implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), and how Congress can stabilize the Medicare physician payment system and promote value-based care delivery. Unfortunately, seven years since MACRA's passage, it is clear that the new payment system does not provide payment stability for physicians and has fundamentally failed to move our health care system towards value-based care. For the third year in a row, physicians confront significant payment cuts and then face an indefinite, virtual payment freeze thereafter while their practice costs increase every year.

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In addition, many physicians cannot participate in a value-based payment model because CMS has failed to approve any alternative payment models (APMs) recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), and the Merit-Based Incentive Payment System (MIPS) fails to adequately reward medical practices that deliver high quality care.

DHPA represents over 100 gastroenterology practices from 39 states in every region of the country. Our more than 2,400 physicians provide care to approximately three million patients annually and diagnose more than 25,000 new cases of colon cancer each year. Physicians in DHPA member practices are on the front lines of providing innovative treatments for serious diseases such as colorectal cancer, Crohn's disease, and ulcerative colitis.

Failure of MACRA and Need for Reform

Physicians are the indispensable lynchpin in health care delivery for our seniors and disabled patients in Medicare. No other provider is more important to all facets of care. The physician community was optimistic when Congress finally repealed the fatally flawed Sustainable Growth Rate payment formula that threatened physicians with massive, looming payment cuts after years of kicking the proverbial can down the road and replaced it with MACRA that created the opportunity for a move from fee-for-service (FFS) to value-based care. However, as policymakers and the provider community recognize, MACRA has not lived up to its promise.

MACRA has been riddled with challenges since its inception, as providers struggle to transition from fee-for-service to value-based care through its two tracks—MIPS and APMs. Implementing these programs requires considerable up-front spending for practices and creates extensive administrative burden to comply with reporting requirements, particularly for MIPS. A 2021 study published in JAMA Health Forum found that it costs an estimated $12,811 and takes more than 200 hours per physician to comply with MIPS.[1] And even with that investment of resources, there are serious questions whether these investments result in any meaningful upside for practices—especially for smaller, independent practices where the administrative burden and up-front financing are particularly challenging—and whether the MACRA program actually results in higher-quality care.

In addition to the resource challenges, the structure of the MIPS track was problematic from the start, as it was designed to be budget neutral and provided meager or no payment updates. Physician payments are frozen from 2020 to 2025, then a scant 0.25% annual payment update is provided for 2026 and beyond. MIPS participants can theoretically receive payment bonuses up to 7% or penalties up to 9% based on their performance score within the four categories of the program: quality, cost, promoting interoperability, and improvement activities. However, since the program is designed to be budget neutral, these positive adjustments can only increase and improve if other practices do not increase their own MIPS scores and are actually penalized for

[1] Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. *JAMA Health Forum.* 2021; 2(5):e210527. doi:10.1001/jamahealthforum.2021.0527.

poor performance. The design of MIPS discourages collaborative care and efforts to improve quality across the system, as high-performing practices will be reluctant to share best practices and risk receiving smaller, positive payment adjustments as other practices improve their scores.

Moreover, because many of the MIPS metrics were so meaningless that almost all practices that reported data were not penalized, the upside potential of being a high-achieving practice was negligible. This is evident in a 2021 Government Accountability Office (GAO) report that found only 0.29% of participants received a negative adjustment.[2] Consequently, those that were supposed to receive a positive payment adjustment only received one if their score was considered "exceptional."

The separate $500 million time-limited pot of resources Congress established to reward "exceptional" practices apart from the budget neutral aspect of MIPS was similarly squandered because a staggering 84% of participants were deemed "exceptional," which simply demonstrates that if nearly all are considered exceptional, then none are truly exceptional. As a result, the "exceptional" bonus percentage had to be scaled down from a maximum of 4.69% to 1.79%.

The Medicare Payment Advisory Commission (MedPAC) commented, "MIPS as presently designed is unlikely to succeed in helping beneficiaries choose clinicians, helping clinicians change practice patterns to improve value, or helping the Medicare program reward clinicians based on value."[3] **When the experts advising Congress state the program has been a failure and the facts are equally damning, it is time for Congress to terminate MIPS.**

The payment freeze through 2026, and hardly perceptible 0.25% updates thereafter, are problematic in and of themselves, as the cost of running medical practices has increased 39% since 2001, while Medicare physician payment has fallen 20%, adjusted for inflation in that same time.[4] More recently, the cost pressures on physician practices have become more acute as rampant inflation has hit physician practices. Total Direct Expense per Provider FTE rose to a new high of $619,682 from Q1 in 2022 to Q2, up 2.2% quarter-over-quarter and 7% Year-Over-Year. Physician practices continue to feel the effects of nationwide labor shortages. When adjusted for productivity, staffing levels continue to decline with Support Staff FTEs per 10,000 wRVUs down 4.8% from Q1 2022 as open positions are going unfulfilled.[5]

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[2] Government Accountability Office. (2021) Provider Performance and Experiences under the Merit-Based Incentive Payment System, available at: https://www.gao.gov/assets/gao-22-104667.pdf.
[3] Medicare Payment Advisory Commission Report to the Congress. Medicare and the Health Care Delivery System, p. xvi (June 2017), available at https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_reporttocongress_sec.pdf.
[4] Kevin B. O'Reilly. American Medical Association. Why MedPAC's physician pay freeze recommendation is flawed. 2022, available at https://www.ama-assn.org/practice-management/medicare-medicaid/why-medpac-s-physician-pay-freeze-recommendation-flawed.
[5] Kaufman Hall, Physician Flash Report (August 2022), available at https://www.kaufmanhall.com/insights/research-report/physician-flash-report-august-2022?utm_source=agcy&utm_campaign=physician-report&utm_medium=pr&utm_term=q2-august-220801.

Congress must provide physicians with a reasonable annual payment update or else face further market consolidation and provider shortages as practices are forced to shut down or join large hospital systems that drive up the overall costs of the health care system as well as the financial burden on our seniors and most vulnerable populations.

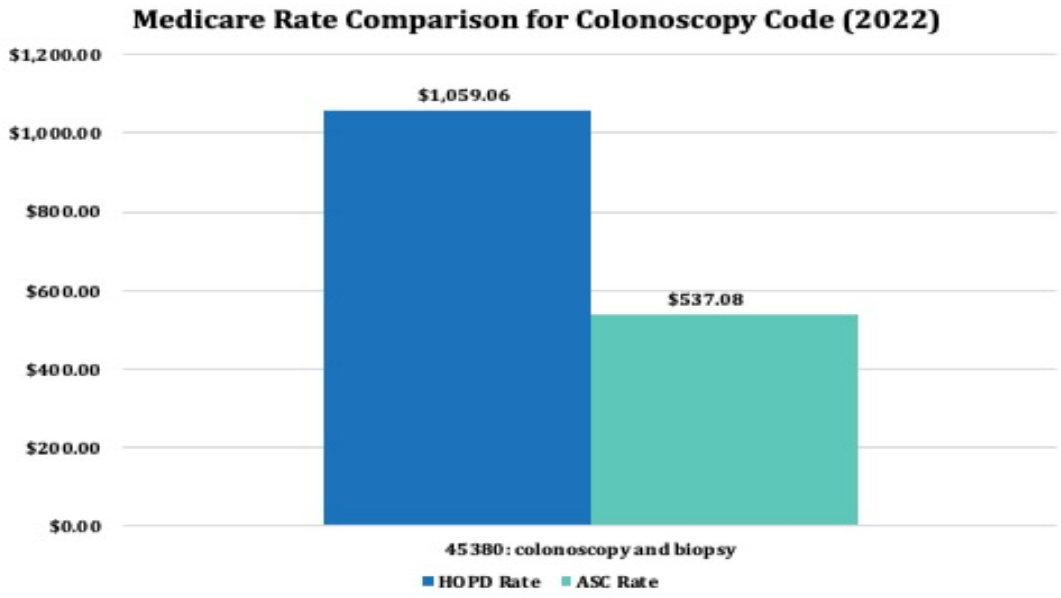
The obvious alternative to the MIPS is to move more practices into APMs, but for many this is not an option as there are no clinically-relevant APMs available. Unfortunately, if practices are not able to enroll in a certified APM between 2019 and 2024, they will miss out on a 5 percent lump sum incentive payment. The APM track is scheduled to receive a 0% annual payment update through 2025, mirroring the MIPS track; for 2026 and beyond, the annual payment update becomes 0.75%. This is 0.50% higher than what providers participating in MIPS would receive and is compounded indefinitely, putting specialty providers with no usable APMs available at a clear disadvantage.

In short, MACRA has failed the physician community and the Medicare population. MIPS does not work and APMs are of virtually no practical utility. Congressional action is clearly needed if we are to realize the objective of shifting from FFS to value-based, pay-for-performance delivery system.

Payment Differentials Between Sites of Care

Independent physician practices, which are able to provide high quality, accessible care in the community, face other challenges as they are forced to compete with hospitals within a system that is designed to favor these larger, more expensive sites of care. Site of service payment differentials are an artefact of a different era that did not anticipate the tremendous technological and clinical innovations which have advanced the complexity and types of care available in outpatient settings and been able to reduce 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 or associated 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 provide mega-hospital systems with additional resources and incentives to acquire physician practices, promote consolidation, limit competition, further drive up costs, and restrict treatment options for patients.

As an illustration of the payment differential that exists in these sites of care, Medicare pays nearly twice as much for a colonoscopy with a biopsy (CPT Code 45380) when furnished in a hospital outpatient department (HOPD) as compared to when the identical colonoscopy with biopsy is furnished in an ASC ($1,059.06 versus $537.08). This is illustrated in the graph below. Most of these 2.7 million colonoscopy procedures can be provided in the ASC setting, yet nearly half are performed in the higher-cost HOPD setting for no good clinical reason.

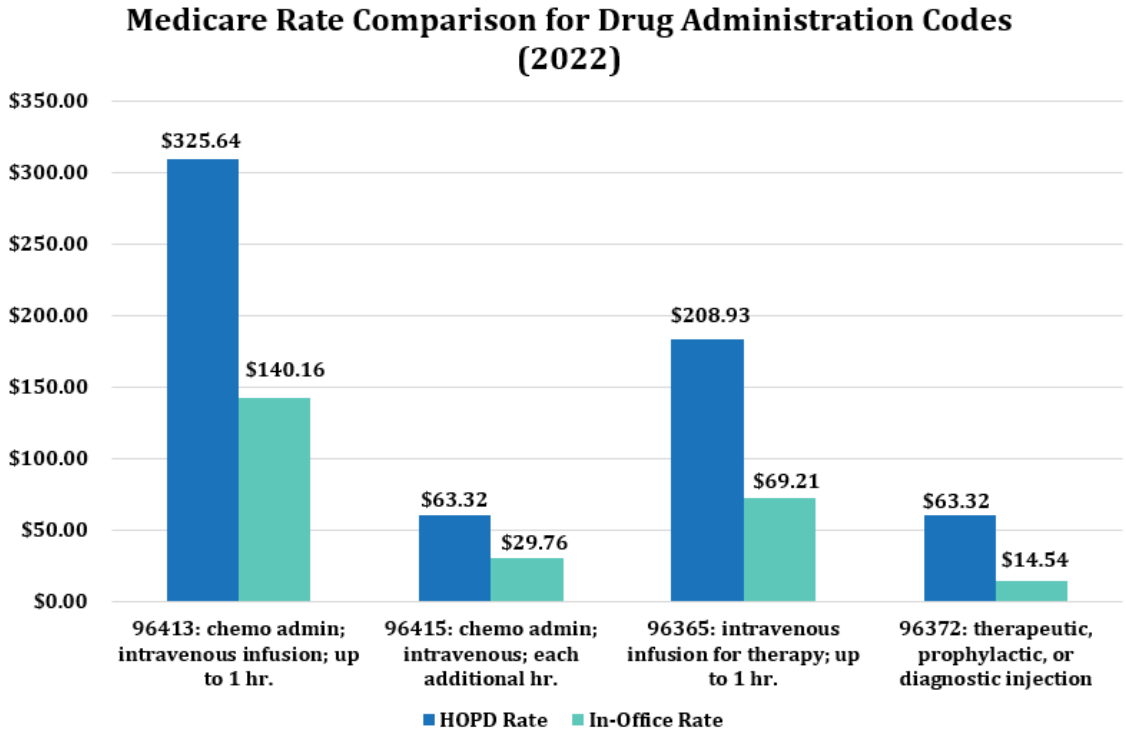


In addition, these payment differentials are growing over time and further disadvantage independent providers and exact a financial toll on Medicare beneficiaries through cost-sharing obligations, because hospitals receive a market basket update (adjusted for productivity), typically 2.2% annually.

If physician reimbursement becomes untenable, more practices will throw their hands up in exasperation and sell to hospitals, which will mean the identical colonoscopies will likely be performed in the higher-cost hospital setting controlled by their employer.

The same holds true for the cost of infusing drugs in physician offices (or associated freestanding infusion centers) as compared to the identical service furnished in hospitals. Medicare pays over twice as much to hospitals to infuse the same drugs that require the same nurse staff time and technical training compared to what Medicare pays in a physician office ($325.64 in the HOPD setting vs. $140.16 in the physician office).[6] This is even more disturbing, because the law caps Medicare beneficiaries' out-of-pocket liability in the HOPD setting at $1,600, yet Medicare beneficiaries who choose to receive their infused drugs in their own doctor's medical office face unlimited liability based on 20% of the total cost.

[6] See CPT code 96413 "Chemo admin; intravenous infusion; up to 1 hr."



In conjunction with these cost disparities, independent providers face anti-competitive consolidation, as hospital systems continue to acquire their practices. A recent Avalere study commissioned by the Physicians Advocacy Institute found that the percentage of hospital-employed physicians grew by 11% from 2019 to 2022, resulting in ***more than half of all physicians (52.1%) being hospital-employed by January 2022***.[7] The current physician payment structure incentivizes hospitals to expand their overall revenue through further consolidation in order to limit competition in the local market, create downstream revenue through referrals of surgical procedures and ancillary services, and pay providers salaries that are well below the revenue that they generate. An example of this latter point is presented in the Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey that shows Gastroenterologists generating $2.97 million in revenue while receiving a salary from the hospital of $487,000.[8]

Congress should promote greater transparency for patients across sites of care and reduce payment disparities between HOPDs, on the one hand, and physician offices and ASCs, on the other, for identical procedures. Thus far, MACRA has failed to stave off consolidation and has not

[7] Physicians Advocacy Institute. COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2021 Prepared by Avalere Health, p.12 (April 2022) available at http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf.
[8] Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey, p. 11, available at https://www.merritthawkins.com/uploadedFiles/MerrittHawkins_RevenueSurvey_2019.pdf.

supported physician practices as a competitive counterbalance to higher cost hospitals and health systems. Congress should implement changes that encourage a more robust and competitive market, ensuring that independent practices will be able to compete and deliver value-based care.

APMs to Support Independent Specialty Practices

There is tremendous frustration in the physician community over the lack of APMs available for specialty-related care delivered outside of hospitals and the system used to develop, evaluate, and approve these APMs. According to a survey by the Medical Group Management Association, only 19% of MACRA participants surveyed were in the Advanced APM track.[9] It is not for lack of interest. Congress created the PTAC so that ideas on value-based care could be generated from the diverse physician community, understanding that not all good ideas are derived from the government. ***Over 40 APMs were submitted to PTAC, and while 17 were recommended to the Health and Human Services Secretary for approval or pilot testing, CMS failed to implement any of them.***[10] In 2019, several PTAC members resigned on the ground that PTAC had failed in its mission to introduce more physician-focused APMs and that HHS was opposed to implementing ideas submitted from providers in the field with first-hand experience on what would and would not work for their patients. Clearly there is a disconnect here that needs to be addressed. The only way these physician-generated ideas can be explored for real-world testing is if they are implemented (at least on a pilot basis) and then CMS can evaluate which ones hold promise and can be expanded or alternatively abandoned if they do not show promise in improving quality or lowering costs.

Gastroenterologists submitted one of the first APM applications to PTAC in Project Sonar, which focused on improving care for patients with Inflammatory Bowel Disease (IBD). The two forms of IBD—Crohn's Disease and Ulcerative Colitis—are among the most significant, chronic gastrointestinal conditions, affecting upwards of 1.5 million Americans. The key to Project Sonar, which has been deployed with great success for the benefit of commercially-insured patients with IBD, is the combined use of evidence-based medicine coordinated with proactive patient engagement.[11] Project Sonar was the first proposal recommended by PTAC. It was designed around a value-based care solution for patients with IBD. Although the Secretary of HHS never implemented Project Sonar, it has been embraced by commercial payors, including many Blue Cross Blue Shield plans, where it has resulted in savings of 7.4 to 15%. As a result of the lack of progress on PTAC-recommended proposals, it is not surprising that PTAC has not received a

[9] Medical Group Management Association. Which Track of MACRA Will You Participate in during 2020? January 20, 2020. Available at: https://www.mgma.com/data/data-stories/which-track-of-macra-will-you-participate-in-durin

[10] Physician Focused Payment Model Technical Advisory Committee. PTAC Proposals and Materials, available at: https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-proposals-materials#1061

[11] Public Comment from Digestive Health Physicians Association to Physician-Focused Payment Model Technical Advisory Committee (Jan. 20, 2017) re: Project Sonar Advanced APM ("DHPA Comment on Project Sonar"), available at: https://aspe.hhs.gov/sites/default/files/private/pdf/255731/ProjectSonarPublicComments.pdf

proposal in the last two years. Medicare should be leading on health care delivery innovation, not lagging behind the commercial market.

This leads us to a fundamental recommendation: allow for practices to pilot test a PTAC-approved APM model. This is not allowed under current law, but granting such permission for initiatives such as Project Sonar would allow participants to show CMS and other policymakers how the model would work and perform in real-world settings for the benefit of Medicare beneficiaries. Once the pilot period concludes and an appropriate amount of data has been collected and analyzed, CMS could make its final approval or denial decision. If approved, this would allow for other practices to more easily replicate real-world use of the piloted model and to benefit from lessons learned during the pilot to allow for more effective, broad-scale implementation.

Additionally, improved and affordable access to CMS data could help inform the development of APMs. To gain access to Medicare claims data, otherwise known as Limited Data Set Standard Analytical Files, one must submit a request, which can take weeks for CMS to process, and the files themselves are extremely costly. One year of data in the HOPD and ASC settings costs $4,500, and typically multiple years of data are needed to assess trends.[12] This process can be costly, in addition to all the time and resources being used to develop these APMs in the first place, putting small, independent practices at an even greater disadvantage as compared to hospital systems.

DHPA Recommendations for Improving MACRA:

1. Terminate the MIPS program because its has not helped physicians deliver value to patients, has not helped patients choose physicians that deliver value effectively, and has been extremely costly and burdensome to physicians.

2. Provide physicians with a reasonable annual payment update based on input costs such as the Medicare Economic Index; physicians are the only major provider group that does not receive annual payment updates reflecting their input costs.

3. Address payment disparity issues between sites of care that are driving high health care costs, stymieing competition, and preventing independent practices from being able to innovate and deliver value-based care. Reforms should begin to close the disparity of payments for identical services, including physician-administered drugs and colonoscopy where the hospitals receive double the payment as physician practices for the identical services.

4. Require CMS to initiate pilot tests (e.g., minimum of 3-5 Metropolitan Statistical Areas for three years) of PTAC-recommended APMs—such as Project Sonar—for evaluation and possible expansion or termination based on well-defined metrics for quality care

[12] CMS, Standard Analytical Files (Medicare Claims), available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/StandardAnalyticalFiles.

improvement and Medicare savings.

5. Increase affordable access to CMS claims data to better inform and develop APMs.

Conclusion

DHPA is supportive of Congressional efforts to improve MACRA and push for a continued transition away from FFS care to value-based, pay-for-performance care. We recommend that Congressional action focus on terminating the failed MIPS program, providing predictable, annual updates that reflect increasing practice costs, reducing disparities in the cost for identical services between sites of care, and adjusting the process for APM approval in order to enhance APM development and to improve participation in value-based care by independent physicians. We stand ready to work with you and be a resource as policy changes are developed. DHPA's Chair of Health Policy, Dr. Scott Ketover, can be reached at scott.ketover@mngi.com, and DHPA's advocates John McManus and Tracy Spicer can be reached at jmcmanus@mcmanusgrp.com and tspicer@dcavenuesolutions.com.

Sincerely,

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President

Scott R. Ketover, M.D.
Chair, Health Policy

cc: Kevin Harlen, DHPA Executive Director
Howard Rubin, Esq., Katten Muchin Rosenman LLP