DIGESTIVE HEALTH
PHYSICIANS ASSOCIATION®

DHPAssociation.org

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Chairman Jason Smith
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

October 5, 2023

Dear Chairman Smith,

The Digestive Health Physicians Association is pleased to provide comments and suggestions regarding your RFI on improving access to care in rural areas.

DHPA® includes over 100-member gastroenterology practices from 39 states in every region of the country. Our more than 2,500 physicians provide care to approximately three million patients annually and diagnose approximately one out of every six new cases of colon cancer each year.

Physicians in DHPA member practices are on the front lines providing innovative pharmaceutical and biological treatments for patients with complex chronic diseases such as Crohn's disease and ulcerative colitis.

The importance of our work to the health of the nation is crucial as, colorectal cancer is the second leading cause of cancer mortality in the United States.[1] This ranking persists despite overwhelming evidence in support of screening measures such as colonoscopy, which provide early diagnosis and treatment of the disease and thus improve outcomes for patients.[2]

Our practices are located in all types of communities—urban, suburban and rural—and most of our practices have numerous office sites, which help them better serve outlying and rural areas and improve patient access by being located in the communities. These sites typically include a physician office, ambulatory surgery center and infusion suite, and may also have diagnostic lab on site in the physician's office. These independent practices are true centers of excellence for GI care and, yet, their geographic footprint and needed infrastructure is much smaller than a hospital, and therefore is more conducive to sparsely populated rural areas.

Nonetheless, patient access in rural areas can certainly be improved for all health care services, including GI procedures. A recent JAMA Surgery study found "Geographic proximity, which has been defined by travel time or physical distance to a health facility (or service supply) in a region, has been identified as a possible barrier to cancer screening and a cause of poorer outcomes for patients.

[1] US Cancer Statistics Working Group. *United States Cancer Statistics (USCS) 1999-2007 Incidence and Mortality Data.* Atlanta, GA: US Dept of Health and Human Services, Centers for Disease Control and Prevention, National Cancer Institute; 2010. http://www.cdc.gov/cancer/colorectal/statistics/

[2] Stock C, Knudsen AB, Lansdorp-Vogelaar I, Haug U, Brenner H. Colorectal cancer mortality prevented by use and attributable to nonuse of colonoscopy. *Gastrointest Endosc*. 2011;73(3):435-443, e5.

There is increasing evidence of a disparity in outcomes for colorectal cancer between residents in urban and rural counties in the United States."[3]

Recommendations:

We have several suggestions for improving patient access to physicians, including GI physicians, in rural areas:

1. Permanently increase the rural floor for the Medicare Geographic Practice Cost Index (GPCI) at 1.0 and raise the physician work and practice expense GPCI to 1.05 in rural areas where HRSA has declared a health professional shortage area;

2. Stabilize physician payments over the long-term to reflect increasing practice costs and secure access in all parts of the country, urban, suburban and rural;

3. Pursue site-of-service payment reforms that reward lower cost sites of care—such as independent physician practices and ambulatory surgery centers—and reduce costs for patients and improve access in rural areas; and

4. Make telehealth flexibilities permanent for patients in urban, suburban and rural communities.

Congress Should Permanently Increase the GPCI floor in Rural Areas

Medicare varies payments to different areas of the country to recognize the difference in costs in different communities. As such, physicians in rural areas have generally been paid less than those in urban areas. Geographic Price Cost Indices (GPCIs) measure geographic differences in input prices and are used by CMS in the calculation of relative value units (RVUs), which are used to calculate Medicare payments for physicians. GPCIs are made up of three components:

1. Physician work (PW) recognizing value of technical skills, time and effort to provide a procedure, comprising 50.9 percent of RVUs.

2. Practice expense (PE), recognizing cost of overhead including labor expenses, overhead, medical supplies and equipment, comprising 44.8 percent of RVUs; and

3. Malpractice insurance (MP), recognizing the cost of professional liability, comprising 4.3 percent of RVUs.

[3] Aboagye et al. "Rural-Urban Differences in Access to Specialist Providers of Colorectal Cancer Care in the United States" *JAMA Surgery*. June 2014

GPCI's are adjusted to reflect the geographic differences in costs for providing services. For example, a PE GPCI of 1.3 indicates that PEs in that area are 30 percent higher than the national average, while a PE GPCI of 0.90 indicates that PEs in that area are 10 percent below the national average. Each physician payment locality is assigned an index value (the area's estimated input cost divided by the average input cost nationally), but these localities can be defined by state boundaries, metropolitan statistical areas (MSAs), or rest-of-state areas (e.g., rest of Missouri). Therefore, some localities include both metropolitan and rural areas, which can impact rural areas with higher GPCIs.[4] Congress chose to narrow the wide disparities in Medicare payments for the same service, recognizing that payments in rural areas were not sufficient to cover practice costs or attract physicians.

Previous lawmaking by Congress established permanent GPCI floors in certain areas to help raise GPCI adjustments in rural communities. These floors include a 1.5 PW GPCI for Alaska[5] and a 1.0 PE GPCI floor for "Frontier States," which are defined in statute as states with at least 50 percent of counties that have a population per square mile of less than six people.[6] Additionally, Congress had previously implemented a PW temporary floor of 1.0 for localities that fall below that, but that floor expires at the end of 2023, as noted in the CY 2024 Physician Fee Schedule Proposed Rule.[7] The PW floor was intended to help providers in rural areas and prevent their reimbursement rates from being excessively deflated.[8]

Recommendation:

Congress should permanently implement a PW floor in rural areas (i.e., those counties that are NOT in a metropolitan statistical area) or 1.0. As PW comprises over 50 percent of physician compensation, this would provide a substantial and permanent pay increase in rural areas. Congress should also establish a PE and PW floor of 1.05 in rural areas that are designated by the Health Resources Services & Administration (HRSA) as Health Professional Shortage Areas (HPSAs) and/or Medically Underserved Areas.

Congress Must Stabilize Physician Payments Over the Long-term

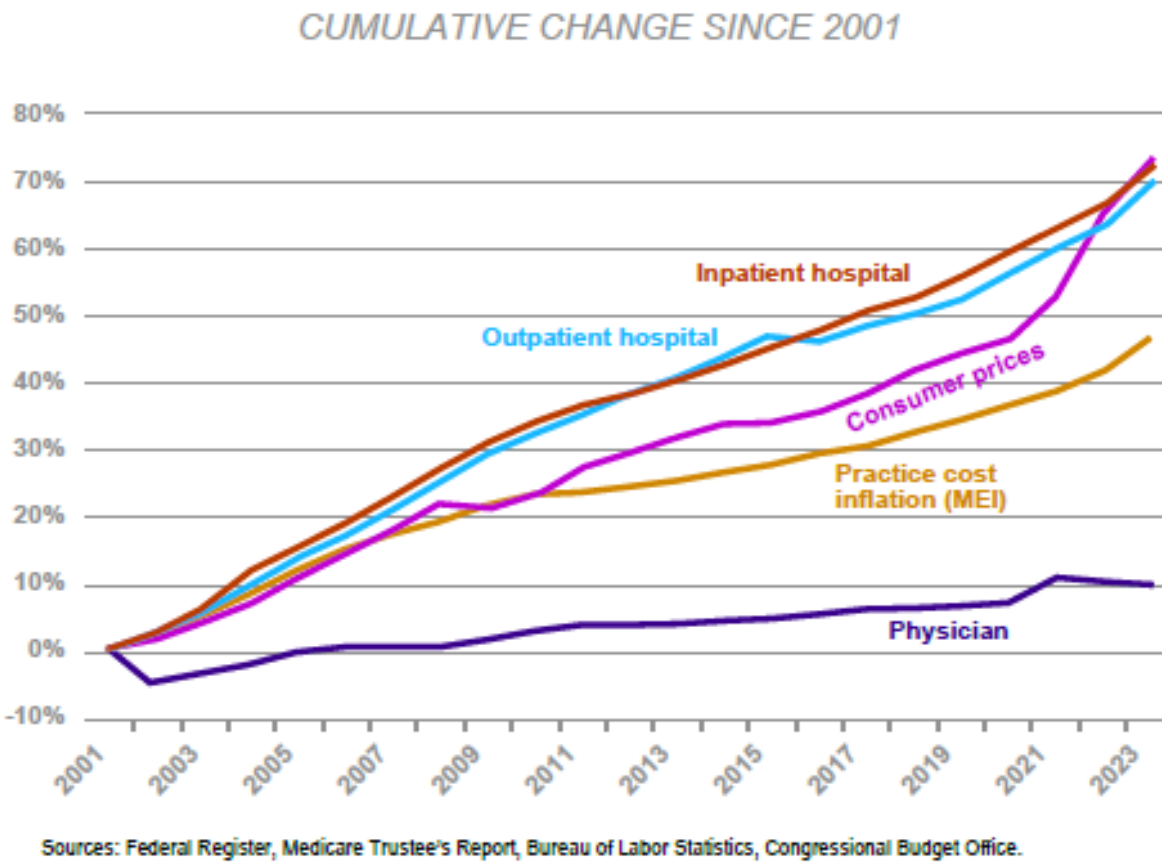
More fundamentally, the entire Medicare physician reimbursement structure must be stabilized and reflect growing practice costs. For the past two decades, physician practices have received minimal payment updates (less than 10 percent cumulatively) while inflation (measured by the consumer price index) has grown more than 50 percent. Physician practices in all parts of the country are grappling with enormous cost challenges, including hiring and retaining nurse and back-office staff and dealing with inflation.

[4] MaCurdy, Thomas, et al., Acumen LLC, "Geographic Adjustment of Medicare Payments to Physicians: Evaluation of IOM Recommendations," July 2012. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/geographic_adjustment_of_medicare_physician_payments_july2012.pdf
[5] Section 1848(e)(1)(G) of the Social Security Act
[6] Section 1848(e)(1)(I) of the Social Security Act
[7] Congress most recently extended the 1.0 PW floor in division CC, section 101 of the Consolidated Appropriations Act, 2021, but that expires on January 1, 2024.
[8] American Medical Association, "Geographic Variation in the Payment Schedule." https://www.ama-assn.org/system/files/geographic-variation-in-the-payment-schedule.pdf

For independent physician practices 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.[9] The chart below illustrates just how preposterous the lack of physician payment updates have become over time, especially when compared to the hospitals and other economic indicators.

Alarmingly, physicians confront a 3.4% payment cut for caring for Medicare beneficiaries once 2024 begins. This cut will further exacerbate shortages and access problems and may accelerate provider consolidation in the hospital setting, as independent practices are not able to maintain economic viability.



[9] 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"

Earlier this year the bipartisan "Strengthening Medicare for Patients and Providers Act" (H.R. 2474) was introduced to counteract these pending physician cuts and provide much needed financial stability to private practices. Linking physician reimbursement to a stable payment update that reflects practice cost increases will help ensure Medicare patients are able to maintain access to their providers, especially those in rural areas who already struggle with health care access, while also enabling practices to be able to keep up with inflation rates and invest in new strategies to provide high-value care.

Inadequate physician reimbursement harms patients, drives up health care costs, and diminishes competition and innovation. Congress must work to establish a long-term payment solution that levels the playing field for independent practices and better equips them to handle periods of high inflation.

Recommendation:

Congress should pass the bipartisan H.R. 2474 to block the pending physician cuts and establish a permanent inflation-based update to reimburse physicians more adequately.

Congress Should Narrow Site of Service Disparities by Rewarding Lower Cost Providers

Hospitals have focused on acquiring physician practices because that strategy simultaneously quashes competition in the local market for services such as outpatient surgery, lab services and advanced imaging and creates downstream revenue through referrals for surgery and ancillary services. The revenue a physician generates for a hospital employer far surpasses the cost of the employed physician's salary. The Merrit Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey, shows that gastroenterologists generate $2,695,277 for hospital employers while receiving an average salary of $487,000.[10]

The degree of vertical health care provider consolidation has been well documented in peer reviewed literature. A recent study by Avalere for the Physician Advocacy Institute found that between 2019 and 2021, hospitals acquired 4,800 additional physician practices, resulting in an 8% increase in hospital-owned practices. The trend is disturbing as by the end of 2021, only about one in four physicians remained independent.[11]

Health care consolidation Is a concerning policy problem because it enables hospitals to raise costs by acquiring physician practices, ambulatory surgery centers and other outpatient competitors and bill substantially more – in many cases double the price – for the same service. As an example, Medicare pays hospitals $1,083 for a colonoscopy but pays just $464 for the identical colonoscopy performed in an ambulatory surgery center (where physicians in independent practices perform these procedures).

[10] Merritt Hawkins, "2019 Physician Inpatient/Outpatient Revenue Survey." February 25, 2019
[11] Physician Advocacy Institute, "PAI-Avalere Report on Physician Employment Trends and Practice Acquisitions in 2019-21: Key Research Findings." April 2022.

Similarly, payments for physician-administered drugs were just a fraction of the cost in physician offices as compared to hospitals: $333 for complex drugs in a hospital and just $132 for the same drug in a physician office. (See charts below depicting the site-of-service payment disparities.) These payment disparities are particularly harmful to patients in rural areas, who have substantially lower income than patients in urban areas. Per capita income in urban America in 2021 was $66,440 while just $49,895 in rural America.[12]

Rural patients with more limited income are paying comparatively more in copayments and deductibles when they receive care at hospitals instead of in independent practices. To the degree Congress can assist independent providers increase market share in rural areas, rural patients with lower incomes will benefit.

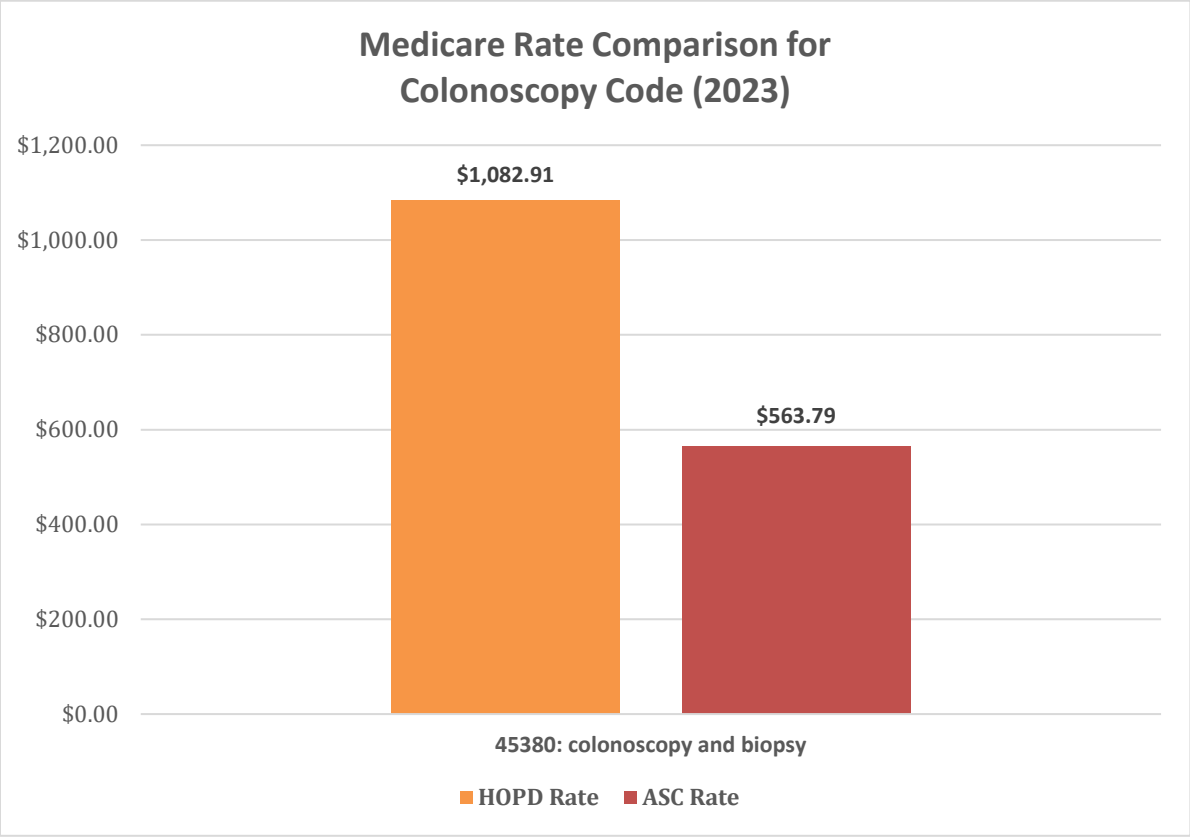


Figure 1: Citations: HOPD Rate = Hospital Outpatient PPS: Addendum B | ASC Rate = ASC Payment Rates - Addenda

[12] https://data.ers.usda.gov/reports.aspx?ID=17854

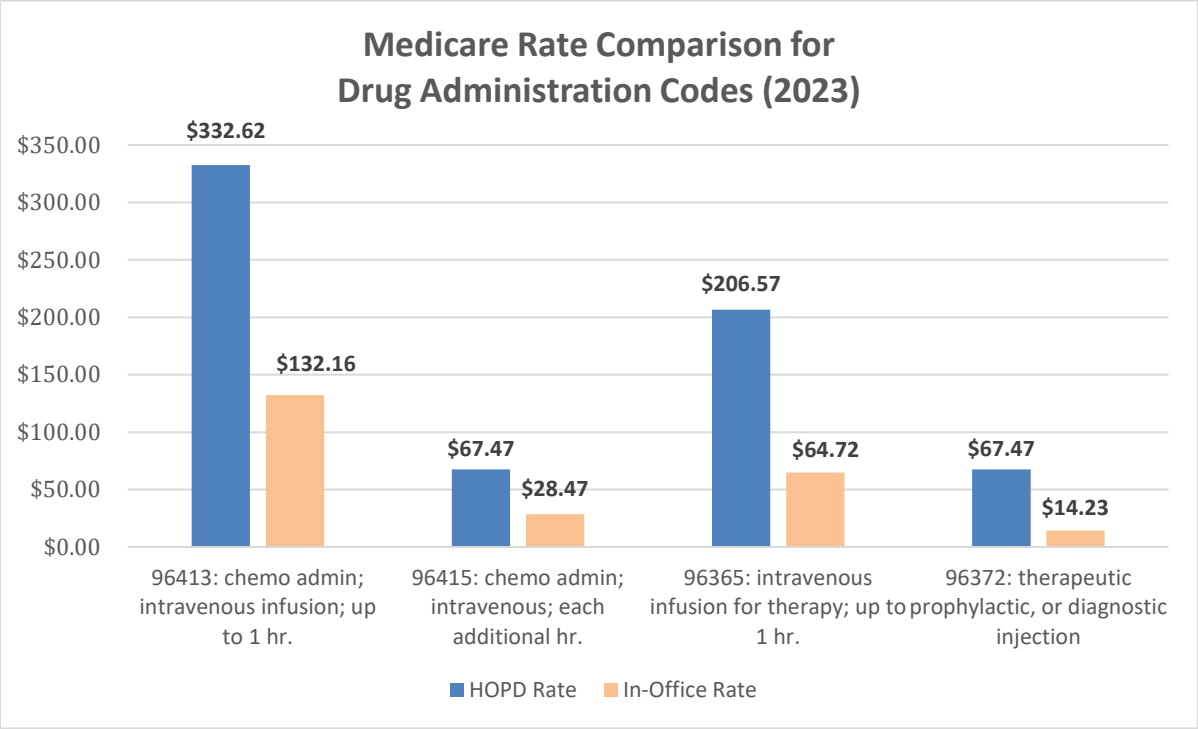


Figure 2: Citations: HOPD Rate = Hospital Outpatient PPS: Addendum B | In-Office Rate = PFS Search

As you know, the Ways and Means Committee and Energy and Commerce Committee have advanced legislation to address one aspect of site-of-service payment disparities: drug administration. "The Lower Costs, More Transparency Act" (H.R. 5378) would phase-down drug administration payments to off-campus hospital outpatient departments (HOPDs) to the level provided in the physician office setting over four years. We believe that proposal can be strengthened by making two modifications:

1. Apply the policy to all HOPD-provided drug administration, not just the off-campus sites; and

2. Reward and incentivize physician and freestanding infusion center providers to take more patients by modestly increasing their payments and modestly decreasing hospital payments.

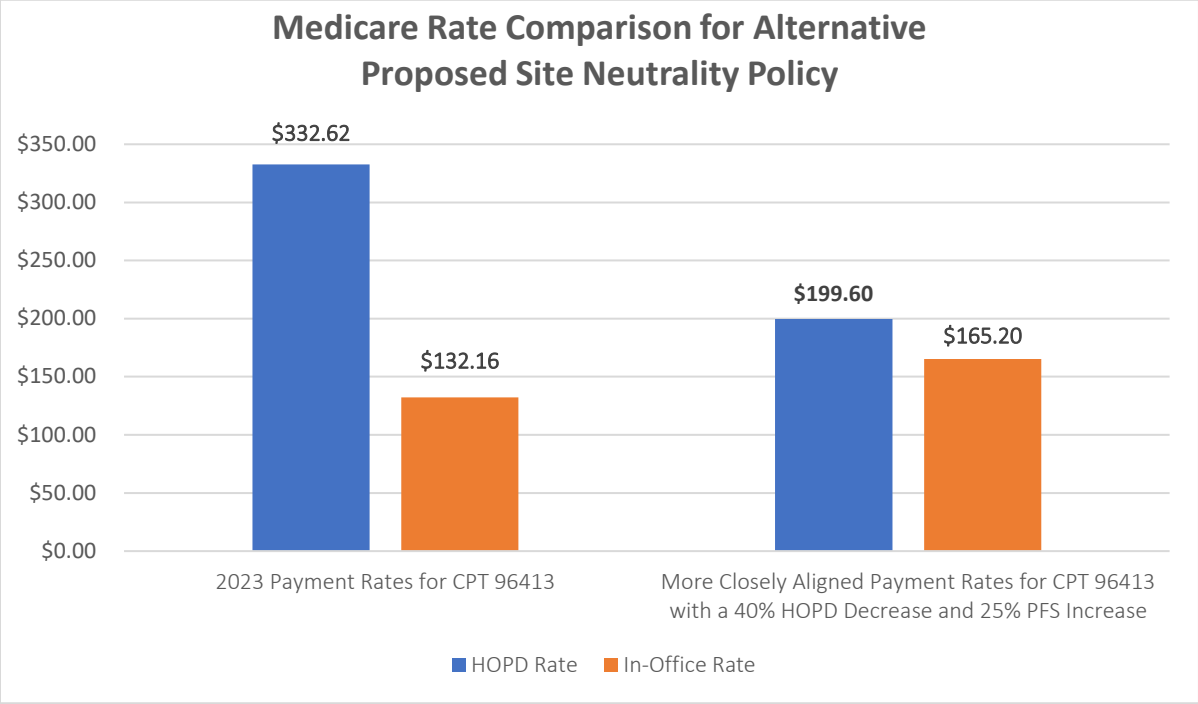
We find no compelling reason to limit application of this site neutrality payment reform only to off-campus HOPDs. After all, many of these large hospital systems are beneficiaries of steep 340B discounts and have many other revenue streams which are not taxed due to their "nonprofit" status.

We believe simply cutting the hospital payment to the physician office rate is not the most thoughtful or effective approach. Instead, we suggest reducing the payment disparities between sites-of-service but not entirely equalizing the payments. As such, the Committee should consider a policy that produces net savings to Medicare by modestly reducing the hospital payment and modestly increasing the physician office payment. Such a policy provides greater incentive for the more efficient setting to adopt more volume and continue to do so over time, while also not being overly punitive to the hospitals.

Importantly, this policy change would more closely align the appropriate payment rates between HOPDs and physician offices while generating savings for Medicare, which are the goals of site neutrality policies. It would also provide incentives for physician practices and freestanding infusion centers to expand their capacity (including in rural communities), remain independent and counter troubling consolidation trends whereby hospitals are rapidly acquiring physician practices and other outpatient providers.

Hypothetical volume data for the complex drug administration code CPT 96413, referenced in Figure 2 above, can be used to demonstrate this proposal and the savings it would still generate for Medicare. If the code was used 500,000 times in 2022 and 52% of that use was in physician offices compared to 48% in HOPD setting, then this proposal would apply. The current $332.62 HOPD payment rate would be reduced by 40% to $199.6 and the $132.16 PFS rate would be increased by 25% to $165.20. This would greatly reduce the payment disparity, as illustrated below.

Medicare would still receive savings, because total Medicare reimbursement for the 500,000 times that CPT code 96413 was used in 2023 (using current payment rates) would total ~$114.3 million (~$79.8 million for HOPDs and ~$34.5 million for physician offices).



However, with the 40% decrease for HOPDs and 25% increase in the physician office setting, Medicare reimbursement would be reduced to total ~$90.9 million overall (~$47.9 million for HOPDs and ~$43 million for physician offices). **Medicare would still see a net savings of approximately $23.4 million.**

Extending Telehealth Flexibility

Telehealth reduces barriers to care for many people, most importantly for those who live in rural areas, those with limited mobility, individuals who lack access to transportation, and for those unable to get time off work or face other scheduling challenges. We have seen first-hand the ability of our patients to access specialized care through telehealth as an effective means of managing those with chronic conditions such as ulcerative colitis and Crohn's disease.

In 2022, several DHPA practices conducted a study among 5,135 of our patients to evaluate the effectiveness of telehealth versus in-person care for patients with gastroenterological issues. Our patients overwhelmingly believed they received a similar quality of care via telehealth compared to in-person visits and expressed a willingness to continue using telehealth due to ease of scheduling, increased flexibility, and shorter wait and/or travel times. [13]
This study also found that the inability to perform a physical exam was not a major detriment of telehealth, thus reducing the potential for health disparities in rural and underserved communities.

A 2021 study titled "Telehealth Interventions and Outcomes Across Rural Communities in the United States" concluded that patients in rural communities reported positive outcomes and experiences of telehealth usage. Many of the benefits include its convenience, effectiveness, and decreased time lost and money saved due to less travel.[14] In June 2023, MedPAC released a report on telehealth that was mandated by the Consolidated Appropriations Act of 2022, that similarly found that beneficiaries were generally satisfied receiving their healthcare via telehealth.[15]

In conclusion, telehealth allows patients to avoid making the difficult decision of having to take significant time off work, incur additional expenses related to transportation and childcare, while maintaining critical access to preventative care for chronic conditions, which if left untreated, could be both costly and harmful to their health.

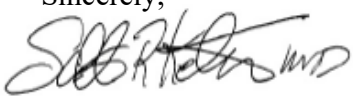
[13] Dobrusin A, Hawa F, Montagano J, Walsh CX, Ellimoottil C, Gunaratnam NT, Patients with Gastrointestinal Conditions Consider Telehealth Equivalent to In-person Care, *Gastroenterology* (2022), doi: https://doi.org/10.1053/j.gastro.2022.09.035
[14] Butzner M, Cuffee Y. Telehealth Interventions and Outcomes Across Rural Communities in the United States: Narrative Review. J Med Internet Res. 2021 Aug 26;23(8):e29575. doi: 10.2196/29575. PMID: 34435965; PMCID: PMC8430850
[15] Medicare Payment Advisory Commission. 2023. *Using Population-Based Outcome Measures to Assess the Impact of Telehealth Expansion on Medicare Beneficiaries' Access to Care and Quality of Care.* Washington, DC: MedPAC.

Recommendation:

Based on all of these studies, and our own interactions with our patients, DHPA strongly recommends that telehealth services that are set to expire at the end of 2024, be made permanent.

We thank the Committee for inviting comment and recommendations on how to improve patient access in rural communities across the country. DHPA stands ready to work with you on these ideas and hope to be a resource on these issues. Please reach out with any questions or requests for additional information to DHPA's President, Dr. Scott Ketover (scott.ketover@mngi.com, 612-870-5408), or to DHPA's representative John McManus (jmcmanus@mcmanusgrp.com).

Sincerely,



Scott R. Ketover, M.D.
DHPA President & Chair
Chair, Health Policy