United Specialists for Patient Access

February 7, 2023

Michael E. Chernew, Ph.D.
Chair
Medicare Payment Advisory Commission
601 New Jersey Avenue, N.W., Suite 9000
Washington, D.C. 20001

Re: Viability of Office-Based Specialty Care under the Medicare Physician Fee Schedule

Dear Dr. Chernew:

The United Specialists for Patient Access (USPA) writes to you with significant concerns regarding the ongoing viability of office-based specialty care. USPA represents a broad spectrum of office-based specialists such as 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).

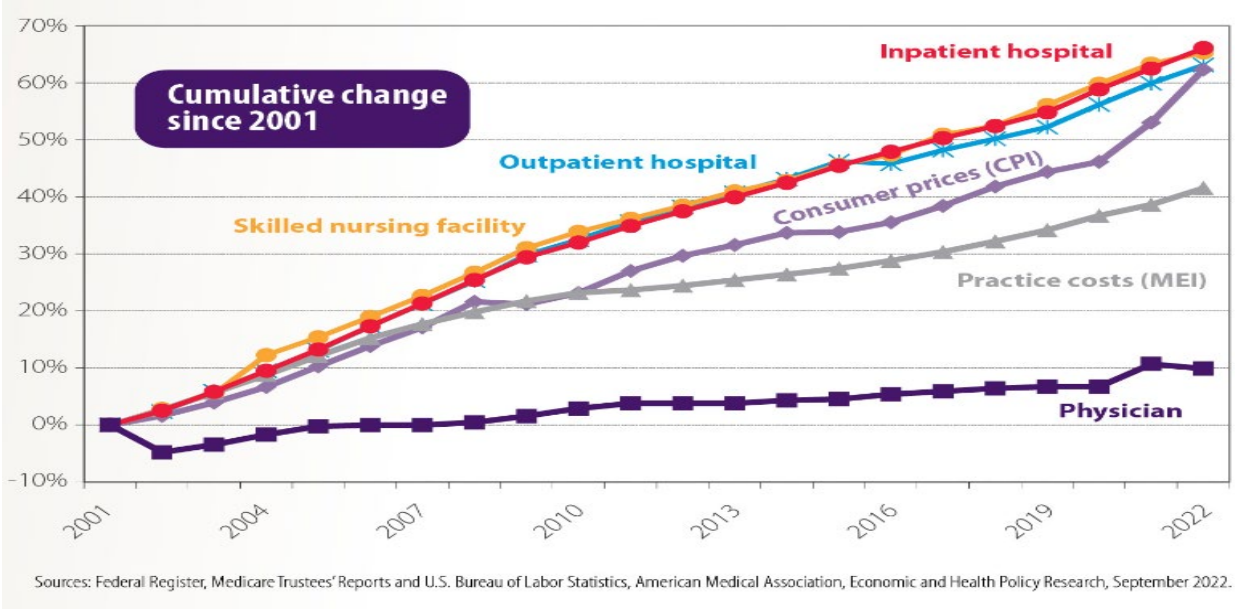
USPA was formed in 2020 after a troubling trend was identified over the past decade of office-based specialty centers closures. USPA believes drivers in this trend include (1) chronic underfunding of the overall PFS, (2) significant shortcomings in physician compensation analyses, and (3) policies to redistribute Physician Fee Schedule (PFS) reimbursement away from specialty care, particularly office-based specialty care. Unfortunately, recent policies contained in the 2021 – 2023 PFS regulations only have accelerated this trend. These policies include the ongoing cuts to the PFS conversion factor due to the 2021 and 2023 PFS "E/M policies" and the ongoing cuts to specialty practice expense relative value units (PERVUs) due to the 2022 PFS "clinical labor policy." USPA is writing to highlight the following concerns:

- Chronic Underfunding of the Medicare Physician Fee Schedule Is a Contributor to Site-of-Service Migration
- Specialty Compensation Analysis Contains Multiple Shortcomings, But Has Been Used to Rationalize Specialty Cuts
- PFS Rebalancing Has Drastically Reduced Specialty Care Compensation, Especially for Office-Based Specialists
- PFS Rebalancing is Inappropriate Given the Nature of Major Medicare Fee Schedules
- Office-Based Center Closures Are Correlated with Health System Consolidation

In light of these concerns, USPA requests that MedPAC review the viability of office-based specialty care and consider recommendations to alleviate the ongoing challenges office-based specialty care physicians face. USPA stands ready to work with MedPAC to that end.

EXECUTIVE SUMMARY

Chronic Underfunding of the Medicare Physician Fee Schedule Is a Contributor to Site-of-Service Migration (ES.1)

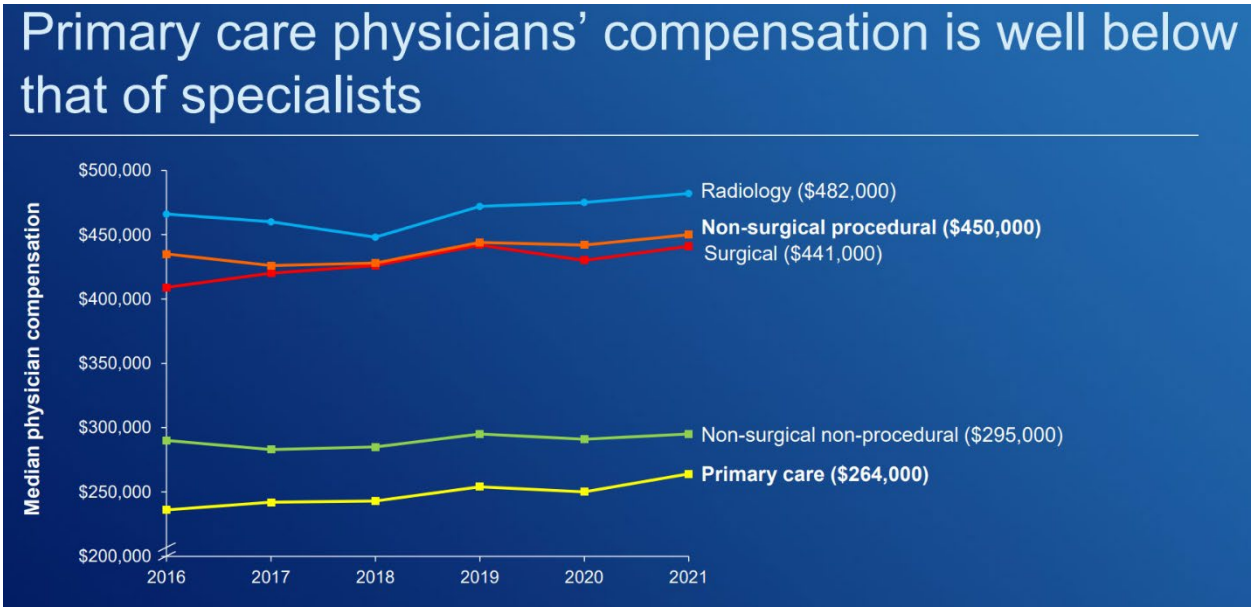


Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics, American Medical Association, Economic and Health Policy Research, September 2022.

- An American Medical Association analysis of Medicare updates (above) shows significant underfunding of PFS updates relative to practice costs (MEI) since 2001.
- MedPAC analyses also show a huge gap between PFS updates and MEI, but discount the gap by comparing MEI to Medicare PFS spending per FFS beneficiary.
- We believe comparing MEI (price) to "Medicare PFS spending per FFS beneficiary" (price * utilization/beneficiary) is inappropriate. Statements by MedPAC that "clinicians have been able to increase the volume and/or intensity of the services they deliver, which has helped to offset the gap" suggest the Commission believes at a macro-level:
    - Clinicians working harder to deal with an aging population is reasonable as a means to offset underfunding in the PFS or
    - Clinicians are overutilizing services in order to offset inflation increases.
- However, we believe the gap between practice costs and reimbursement is too large for clinicians to reasonably view utilization strategies as a means to offset inflation.
- As discussed in detail in Section I below, specialty-level analyses show that reimbursement cuts instead are correlated with specialty-level site-of-service migration and reductions in utilization.
- **In summary, chronic underfunding of the PFS is a significant problem and *specialty-level site-of-service migration and impacts on utilization* should be a critical area of concern for policymakers.[1]**

[1] While MedPAC recommends for 2024 a non-budget neutral add-on payment of allowed charges x 5% for all specialists (and allowed charges x 15% for primary care) for services provided to low-income Medicare beneficiaries, targeted non-budget neutral add-on payments to *office-based* specialists most hurt by ongoing PFS cuts (see ES. 3 below) are critical to stop further office-based center closures. Transcript is available here: https://www.medpac.gov/wp-content/uploads/2022/07/Jan-2023-Meeting-Transcript.pdf

Specialty Compensation Analysis Contains Multiple Shortcomings, But Has Been Used to Rationalize Cuts to Specialists (ES.2)

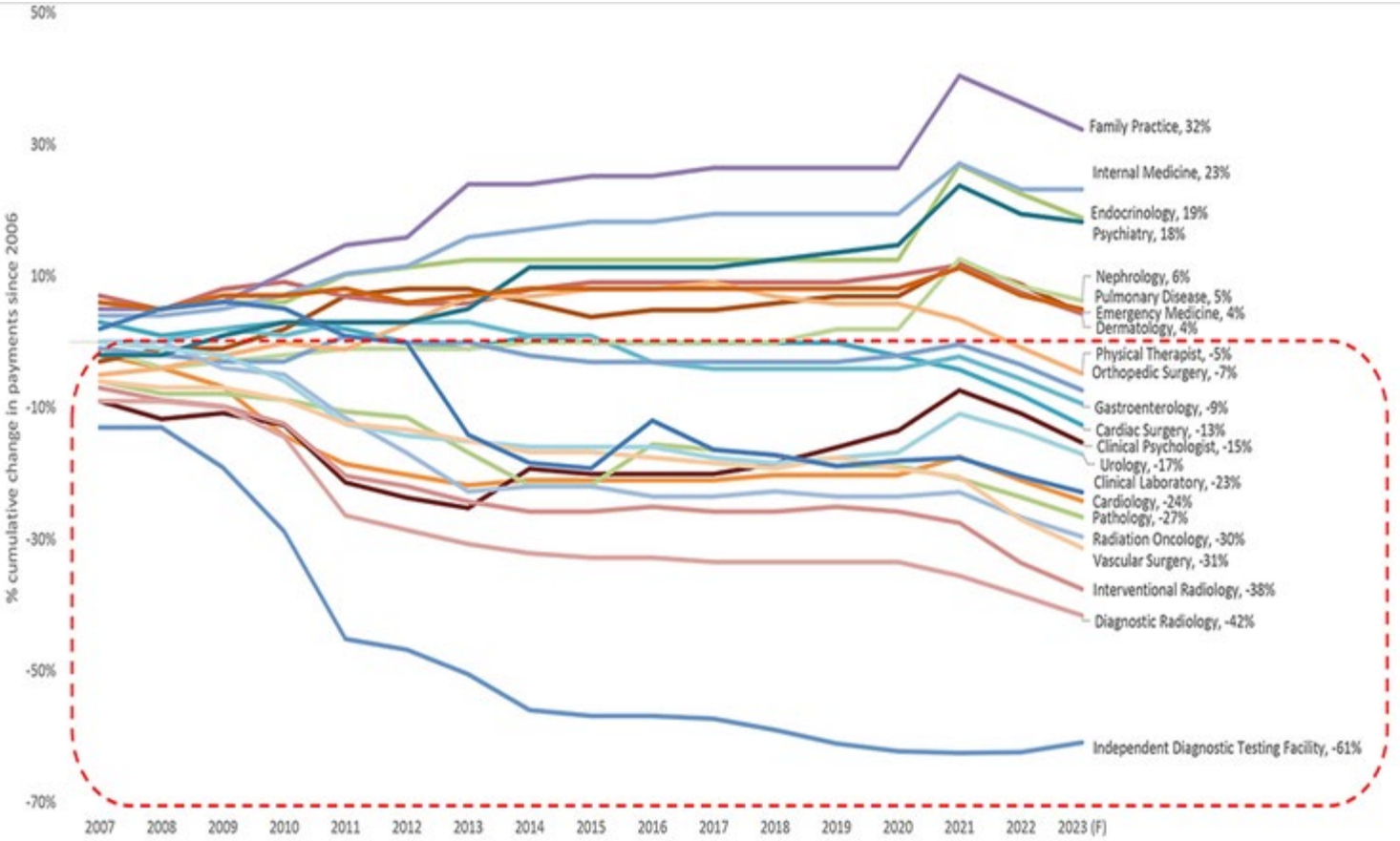


Source: MedPAC Physician Compensation Analysis From November 2022 Meeting[2]

- For many years, MedPAC has cited differences in specialty compensation to assert specialty overcompensation and rationalize specialty cuts (as in the chart above). As discussed in detail in Section II below, USPA has six specific concerns with this analysis:
    - First, MedPAC acknowledges compensation under the PFS (e.g. between radiology and primary care) is *supposed* to reflect differences in practice expenses.
    - Second, MedPAC has never analyzed what *appropriate* compensation differentials might be, nor is it clear if such differentials are knowable.
    - Third, MedPAC does *not* materially include office-based specialists in its compensation survey.
    - Fourth, MedPAC's analysis includes significant spending *outside* of the PFS.
    - Fifth, reimbursement for *office-based* family physicians has increased 19% between 2010 and 2019, while their utilization in the office has dropped by 13% over the same period.
    - Sixth, primary care physicians are *not* the lowest cost providers (e.g. physical therapists' median annual compensation is $95,620).
- **In summary, MedPAC's physician compensation analysis contains multiple shortcomings, but has been a cornerstone in the Commission's arguments to rebalance the PFS to the detriment of office-based specialty care.**

[2] Medicare Payment Advisory Commission, Policy options for increasing Medicare payments to primary care clinicians, 3 November 2022. Presentation is available here: https://www.medpac.gov/wp-content/uploads/2021/10/Payments-for-primary-care-MedPAC-Nov-2022.pdf

PFS Rebalancing Has Drastically Reduced Physician Compensation for Specialty Care, Especially Office-Based Specialists (ES.3)[3]



- Specialists have seen drastic reimbursement cuts since 2006 under the PFS. Impacts range from -5% for physical therapy to -63% for IDTFs with many office-based specialists experiencing cuts of 20% to 40% historically.
- Reimbursement cuts likely are even worse from an *office-based* specialty perspective because PFS impact tables historically have not shown site-of-service impacts.
- Specialty cuts continue through 2025 due to budget-neutrality effects on the conversion factor (CF) from (1) 2021/2023 PFS policies to increase reimbursement to primary care and (2) the 2022 PFS clinical labor policy's cuts of 15% for certain specialty codes.[4][5][6]
- **In summary, PFS rebalancing has drastically reduced compensation for specialty care, especially office-based specialty care.**

[3] HMA Analysis 2007 – 2023 Medicare Physician Fee Schedule Final Rule Impact Tables
[4] With the scheduled inclusion of the new G2211 primary care code in the 2024 PFS and the expiration in 2015 of CF relief provisions in the Consolidated Appropriations Act of 2023, the PFS CF could see an overall reduction of 11% in 2025 relative to the 2020 CF ($36.0896 in 2020 vs. $32.0689).
[5] While MedPAC recommends a 1.25% CF update for 2024 (50% of MEI), the recommendation appears to simply affirm the CAA of 2023 which already provides a temporary 1.25% CF update for 2024 and which expire in 2025.
[6] The 2022 PFS "clinical labor policy" also resulted in significant cuts to specialists to the benefit of primary care because of an update to clinical labor data in the PFS which resulted in a 24% cut to the "direct adjustment factor."

PFS Rebalancing Primarily Hurts Office-Based Specialists Due to the Nature of Major Medicare Fee Schedules (ES. 4)

Key Spending Components of Major Medicare Fee Schedules				
Spending Components	**Inpatient PPS**	**Hospital Outpatient PPS**	**ASC PPS**	**Physician Fee Schedule**
Technical⊥	Included for the Hospital Inpatient setting	Included for the Hospital Outpatient setting	Included for the ASC setting	Included for the Office-Based setting
Professional┼	Not Included	Not Included	Not Included	Included in the PFS, but reimburses for all sites of service including Office-Based settings as well as Inpatient / Outpatient Hospital and ASC settings
⊥ "Technical" refers to Medicare payments primarily for operating and capital costs, but excluding PFS payments for physician work. ┼ "Professional" refers primarily to physician work as well as a small amount (i.e "facility" practice expense relative value units) intended to cover indirect expense of physician costs of operating a medical practice.				

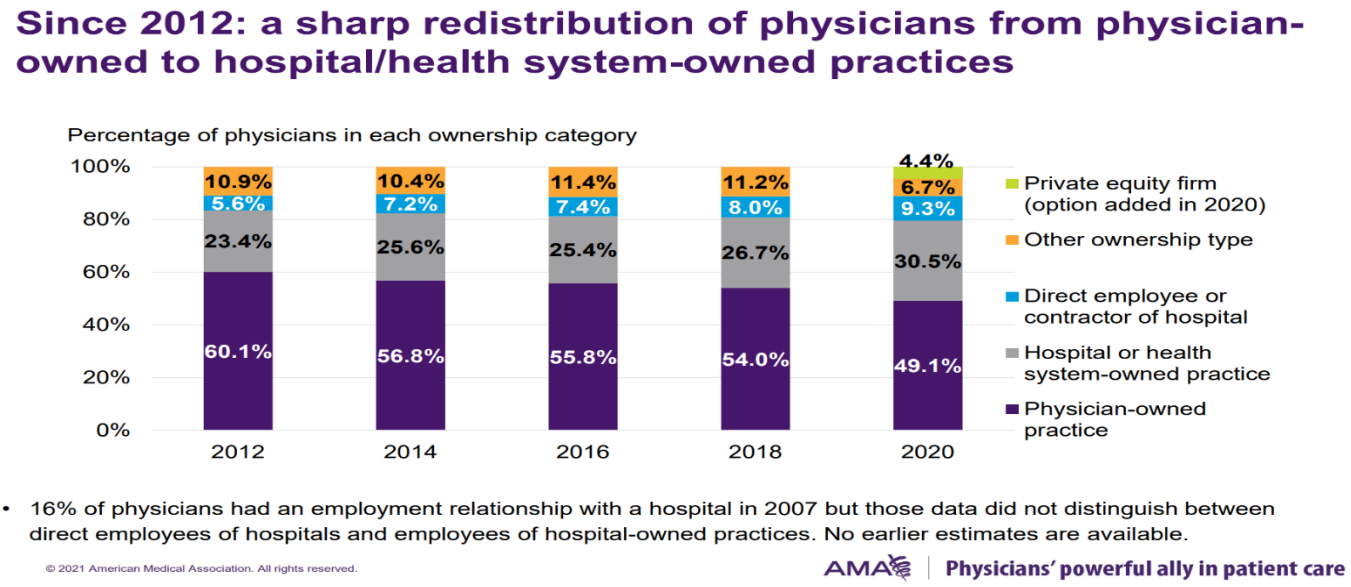
- Major care settings under Medicare include inpatient hospitals, hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and office-based care, but technical and professional reimbursements vary as follows:
  - Both professional *and* technical funding flows to office-based care through the PFS
  - Professional funding for inpatient hospitals flows through the PFS, while technical funding flows through the IPPS
  - Professional funding for hospital outpatient departments flows through the PFS, while technical funding flows through the HOPPS
  - Professional funding for ambulatory surgical centers flows through the PFS, while technical funding flows through the ASC PPS
- As a result, using the PFS as the tool for physician reimbursement redistribution is inappropriate because:
  - As noted in ES.2, MedPAC's physician compensation analysis includes significant spending *outside* of the PFS, including IPPS, HOPPS and ASC technical spending, as well as private payer spending, and
  - Only office-based specialists have the entirety of their funding flow through the PFS, including office-based technical spending.
- **In summary, because of the key spending components of major Medicare fee schedules, PFS rebalancing primarily hurts *office-based* specialists and has been driving office-based center closures.**

Office-Based Center Closures Are Correlated with Health System Consolidation (ES. 5)

Specialty	Additional Reimbursement for a Physician if Vertically Integrated into a Hospital Relative to an Office
Cardiology	262,000
Diagnostic Radiology	162,000
Gastroenterology	231,000
Urology	363,000
Oncology	155,000
Average for All Specialties	114,000
Average for Primary Care	63,000
Average for Medical Specialties⊥	178,000
Average for Surgical Specialties┼	150,000

⊥ Medical specialties include cardiology, dermatology, diagnostic radiology, gastroenterology, neurology, otolaryngology, psychiatry, and oncology.
┼ Surgical specialties include cardiac, colorectal, general, hand, orthopedic, plastic, thoracic, and vascular surgery, as well as neurosurgery, urology, and surgical oncology.

- While PFS pay for office-based specialists continues to decline as seen in ES.3, pay is $150,000 - $178,000 higher for specialists who decide to vertically integrate in a hospital.[7] These trends of lower specialty pay in the office and higher pay in other sites of service provide a clear incentive for sites-of-service migration.



- AMA data shows over the last decade the percentage of physician-owned practices has fallen by 11% and there has been a corresponding 11% rise in (1) physicians employed by a hospital and (2) physician practices owned by hospitals or health systems.[8]
- **In summary, there is a correlation between PFS office-based specialty cuts and health system consolidation.**

[7] Post, Brady PhD et al., *Hospital-physician integration and Medicare's site-based outpatient payments*, Health Serv Res. 2021;56:7–15
[8] Carol K. Kane, *Recent Changes in Physician Practice Characteristics*, 5 June 2021. Available here: https://www.ama-assn.org/system/files/2021-06/june-2021-ppps-ed-session-slides-carol-kane.pdf

I. CHRONIC UNDERFUNDING OF THE MEDICARE PHYSICIAN FEE SCHEDULE IS A CONTRIBUTOR TO SITE-OF-SERVICE MIGRATION

For at least a decade, MedPAC has used a simple – yet flawed – analysis to argue that specialists are overpaid. The analysis has typically shown that certain specialists are compensated at some higher amount of $X, primary care providers are compensated at some lower amount of $Y and, therefore, specialists are overpaid. There are two critical problems with this analysis. The first is that this analysis ignores chronic underfunding of the PFS overall. The second is that there are several shortcomings within the MedPAC physician compensation analysis itself.

Chronic underfunding of PFS overall

While Medicare reimbursement updates under the overall PFS have increased by only 11 percent over the last two decades, the cost of running a medical practice has increased 39 percent over that same period (see AMA's "Medicare Updates Compared to Inflation" chart in ES.1 above). A December 2022 MedPAC presentation provided similar data relating to MEI growing much faster than PFS updates and we are grateful to see that MedPAC acknowledged concern "about the ability of clinicians to cover their input costs."[9][10]

Unfortunately, as discussed below, MedPAC has underestimated the impact of PFS underfunding by comparing MEI to "Medicare PFS spending per FFS beneficiary." We believe this comparison is inappropriate for two key reasons. First, Medicare PFS spending per FFS beneficiary (price * utilization/beneficiary) is an inappropriate comparator to MEI (price). Second, *specialty-level* analyses show that reimbursement cuts are correlated with site-of-service migration and overall reductions in utilization.

Medicare PFS Spending Per FFS Beneficiary is an Inappropriate Comparator to MEI

MedPAC states in its December 2022 presentation that "clinicians have been able to increase the volume and/or intensity of the services they deliver, which has helped to offset the gap." However, MEI is a measure of inflation faced by physicians with respect to their practice costs and we believe it is inappropriate to compare MEI (i.e. updates to price) to Medicare PFS spending per FFS beneficiary (price * utilization/beneficiary). We note that even if it were an appropriate comparator to MEI, MedPAC's own analysis shows Medicare spending per beneficiary has been below MEI in four of the last six years and is projected to be below MEI by several percentage points in the outyears.

In addition, by stating "clinicians have been able to increase the volume and/or intensity of the services they deliver, which has helped to offset the gap," MedPAC seems to imply the Commission believes at a macro-level either:

[9] Medicare Payment Advisory Commission, *Assessing payment adequacy and updating payments: Physician and other health professional services and Supporting Medicare safety-net clinicians*, 3 December 2022. Transcript is available here: https://www.medpac.gov/wp-content/uploads/2021/10/December-2022-MedPAC-meeting-transcript_SEC.pdf

[10] Medicare Payment Advisory Commission, *Assessing payment adequacy and updating payments: Physician and other health professional services and Supporting Medicare safety-net clinicians*, 3 December 2022. Presentation is available here: https://www.medpac.gov/wp-content/uploads/2021/10/Tab-E-Physician-Updates-8-Dec-2022.pdf

- Physicians working harder to deal with an aging population is reasonable as a means to offset underfunding in the PFS[11] or
- Physicians purposefully increase volume to offset inflation increases.[12][13]

Specialty-level analyses show that reimbursement cuts are correlated with site-of-service migration and overall reductions in utilization

We believe clinicians could not materially increase utilization to offset inflation given such a large gap between practice costs and reimbursement. Moreover, we believe specialty-level analyses show that reimbursement cuts are more correlated with site-of-service migration and overall reductions in utilization.

- 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.[14]
    - 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
- Overall Reductions in 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

[11] Medicare per capita volume and intensity slowed between 2010 and 2018 in part due to an influx of younger beneficares from the baby boomer generation but is projected to grow from 2018 through 2028 due to an aging Medicare population. See Cubanski et al., Kaiser Family Foundation, *The Facts on Medicare Spending and Financing*, 20 August 2019. Link available here: https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/

[12] Medicare Payment Advisory Commission, *Assessing payment adequacy and updating payments: Physician and other health professional services and Supporting Medicare safety-net clinicians*, 3 December 2022. Transcript is available here: https://www.medpac.gov/wp-content/uploads/2021/10/December-2022-MedPAC-meeting-transcript_SEC.pdf

[13] Still other assertions by MedPAC also are problematic. For example, in a November 2022 presentation, MedPAC asserts that PFS PERVUs should *decline* over time. However, office-based PERVUs are made up largely of technical components, which, as is evident from ES. 1 above, have grown *above* MEI in other sites of service. The presentation is available here: https://www.medpac.gov/wp-content/uploads/2021/10/Payments-for-primary-care-MedPAC-Nov-2022.pdf

[14] HMA analysis of CMS Physician Fee Schedule Rules and PSPS files, 2010-2019

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.[15] Concurrent with these office-based closures, 2021 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.**[16]

II. SPECIALTY COMPENSATION ANALYSIS CONTAINS MULTIPLE SHORTCOMINGS, BUT HAS BEEN USED TO RATIONALIZES SPECIALTY CUTS

For many years, MedPAC has cited the SullivanCotter Survey to assert specialty overcompensation.[17] In its November 2022 presentation, MedPAC again cited this survey by asserting radiologists were overpaid and at the top of the compensation chart (at $482,000) and primary care was underpaid and at the bottom of the compensation chart (at $264,000). However, a closer look at the survey reveals the following six concerns:

- First, MedPAC acknowledges compensation under the PFS (e.g. between radiology and primary care) is *supposed* to reflect differences in practice expenses.
- Second, MedPAC has never analyzed what *appropriate* compensation differentials might be, nor is it clear if such differentials are knowable.
- Third, MedPAC does *not* significantly include office-based specialists in its compensation survey.
- Fourth, MedPAC's analysis includes significant spending *outside* of the PFS.
- Fifth, reimbursement for *office-based* family physicians has increased 19% between 2010 and 2019, while their utilization in the office has dropped by 13% over the same period.
- Sixth, primary care physicians are *not* the lowest cost providers (e.g. physical therapists' median annual compensation is $95,620).

The SullivanCotter survey notes that reimbursement under the PFS is *supposed* to reflect differences in practice expenses.[18] This position makes sense as many procedural specialists under the PFS procure high-tech equipment and supplies necessary to carry out the services for which they have been trained. Given, therefore, that MedPAC itself acknowledges that there should be reimbursement differentials, the question is not whether there should be reimbursement differentials, but what the appropriate reimbursement differentials should be. To our knowledge, however, MedPAC has never taken a position on what the appropriate

[15] Survey available for download here: https://7c6286a4-24ee-4fee-92b9-ed0f0d031061.filesusr.com/ugd/4d8e3a_450f824be03b407fbab027d9e60e9ff5.pdf
[16] MJBF Braid-Forbes Health Research, LLC, Medicare claims analysis of 36902, September 2021
[17] Urban Institute and SullivanCotter, Analysis of Physician Compensation. Retrieved at: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/contractor-reports/jan19_medpac_disparities_physiciancompensationreport_cvr_contractor_sec.pdf
[18] ibid

reimbursement differentials should be, nor is it clear that MedPAC believes such a thing is knowable.

As it relates to office-based specialists, the SullivanCotter survey is particularly problematic. This is because office-based specialists simply are not significantly represented in the survey. According to the survey:

- "Participants [in the survey] consist of large health systems, hospitals and medical groups. While participation is open to independent practices, they are not a significant source of data."[19]

Also of concern to office-based specialists is that the SullivanCotter survey includes significant spending outside of the Physician Fee Schedule. This is because the SullivanCotter survey uses something called "total care compensation," or TCC. TCC "includes base salary, incentive compensation and other cash compensation" where significant sources of funding for TCC would flow outside of the Physician Fee Schedule methodology, including:

- Facility-based technical payments in the IPPS and OPPS/ASC fee schedules (which MedPAC acknowledges often are paid at higher rates than the office),
- Part B drugs (which are not paid on the basis of the PFS methodology), and
- Private payer payments.

As a result, **not only does TCC materially misrepresent office-based specialty compensation, it also is a key reason why the Physician Fee Schedule is an inappropriate tool to attempt to rebalance funds towards primary care**.

Finally, according to the most recent SullivanCotter survey, "primary care physicians have the lowest median compensation ($241,687)." In fact, however, primary care physicians are *not* the lowest paid provider in the Physician Fee Schedule. Therapists are paid much less than primary care physicians. For example, recent data from the Bureau of Labor Statistics (BLS) found that physical therapists' median compensation is $95,620.[20] This is significant because the 2021 PFS cut physical therapy providers by 9% to pay more for primary care providers, who already are paid 150% more than physical therapists. Moreover, HMA data has found that while office-based primary care provider prices have increased 19% between 2010 and 2019, their utilization in the office-based setting has dropped by 13% over the same period.[21]

III. PFS REBALANCING HAS DRASTICALLY REDUCED SPECIALTY CARE COMPENSATION, ESPECIALLY FOR OFFICE-BASED SPECIALISTS

MedPAC has used the aforementioned SullivanCotter physician compensation analysis for many years to promote a rebalancing of the Physician Fee Schedule away from specialists and towards primary care. USPA believes there have been two significantly negative outcomes as a result of

[19] Urban Institute and SullivanCotter, Analysis of Physician Compensation. Retrieved at: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/contractor-reports/jan19_medpac_disparities_physiciancompensationreport_cvr_contractor_sec.pdf
[20] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Physical Therapists. Retrieved at: https://www.bls.gov/ooh/healthcare/physical-therapists.htm
[21] Health Management Associates, *2021 analysis of Medicare Physician Payments Impact by Specialty and Site of Service*, 2022

PFS rebalancing. First, PFS rebalancing has drastically reduced physician compensation under the PFS for specialty care, especially office-based specialists. Second, PFS rebalancing is correlated with evidence of office-based center closures in the areas of cardiology, radiation oncology, radiology, vascular surgery, and other specialties.

PFS rebalancing has drastically reduced physician compensation for specialty care, especially office-based specialists

There has been a huge reduction in physician compensation under the PFS for specialty care since 2006 (see HMA's "Significant Specialty Variation in Estimated Payment Changes" chart in ES.3 above). Impacts range from -5% for physical therapy to -63% for IDTFs with other negative impacts including -30% for radiation oncology, -31% for vascular surgery, and -42% for diagnostic radiology. While these reimbursement reductions are huge from a specialty perspective, they are even worse from an office-based specialty perspective because PFS impact tables historically have not shown site-of-service impacts.

PFS rebalancing is correlated with evidence of office-based center closures in the areas of cardiology, radiation oncology, radiology, vascular surgery, and other specialties.

PFS rebalancing and the drastic cuts to office-based specialists are correlated to office-based center closures and have been occurring for years. This correlation is evident in a number of the hardest hit specialties, including cardiology, radiation oncology, radiology, and vascular surgery. Below are excerpts from several studies and surveys:

- <u>Cardiology</u>
    - "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."[22]

- 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 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."**[23]

- 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

[22] New York Times, *When Hospitals Buy Doctors' Offices, and Patient Fees Soar*, 6 February 2015
[23] International Journal of Radiation Oncology, *The American Society for Radiation Oncology 2017 Radiation Oncologist Workforce Study*, 2018

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."[24]

- Vascular Surgery
    - "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."[25]**

Unfortunately, this office-based closure trend is almost certain to continue due to ongoing PFS cuts relating to the 2021 and 2023 PFS "E/M policies" (which cut the conversion factor by roughly 10% and 1.5% respectively) and the 2022 PFS clinical labor policy (which cut the direct adjustment factor by 24%). Both of these policies particularly disadvantaged office-based specialists with some providers projected to experience reimbursement reductions of at least 15% through 2025 for certain specialty codes.[26]

IV. PFS REBALANCING PRIMARILY HURTS OFFICE-BASED SPECIALISTS DUE TO THE NATURE OF MAJOR MEDICARE FEE SCHEDULES

While the IPPS, HOPPS and ASC Fee Schedules include only technical payments (e.g. equipment and supplies), the PFS includes technical payments for office-based providers *plus* professional payments (e.g. physician work for performing a procedure or interpreting at diagnostic test) for physicians in *all* settings (e.g. hospital, ASC and office). As a result, **when rebalancing policies budget-neutralize the PFS, these policies are budget-neutralizing dissimilar office-based technical payments with professional component payments provided in all sites of service**. Two key implications flow from this dynamic:

- **Office-based specialists have been particularly harmed from PFS rebalancing policies.** This is due to the fact that it is only office-based technical payments, and not

[24] Journal of the American College of Radiology, *The Shift in Outpatient Advanced Imaging From Private Offices to Hospital Facilities*, 2015
[25] 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
[26] Health Management Associates, *Medicare Physician Fee Schedule 2022 Analyses*, 2022

IPPS, HOPPS or ASC technical payments, which are rebalanced towards other services. While the HMA analysis in ES. 3 clearly shows that specialists overall have been hurt by PFS rebalancing, until last year PFS impact tables only have ever shown overall specialty impacts. It's likely that if PFS impact tables had disaggregated the impacts on office-based specialty care specifically, the PFS rebalancing impacts on office-based specialty care would have been shown to be much worse.

- **PFS rebalancing *excludes* vast amounts of Medicare spending that are *included* in MedPAC's Total Care Compensation analysis.** As noted earlier, IPPS, HOPPS and ASC technical payments continue to increase well above MEI and go towards the TCC compensation differentials that MedPAC uses to allege specialty overcompensation. Stated differently, **PFS rebalancing is inappropriate as the PFS does not include IPPS, HOPPS, ASC and other spending that is included in MedPAC's Total Care Compensation analysis.**

V. OFFICE-BASED CENTER CLOSURES ARE CORRELATED WITH HEALTH SYSTEM CONSOLIDATION

It's critical to understand that the very thing that makes office-based specialists good at what they do (i.e. specialize) also makes them particularly vulnerable to significant swings in payment under the PFS. As an example, studies have shown that dedicated dialysis vascular access centers provide higher quality care to Medicare beneficiaries at a lower cost than hospital outpatient departments. The largest and most rigorous study of vascular access care across sites found, by comparison to patients treated in hospital outpatient departments (HOPDs), patients treated in non-hospital vascular access centers were found to have:

- Lower all-cause mortality,
- Fewer infections, and
- Fewer septicemia-related and unrelated hospitalizations than those treated in the HOPD.[27][28]

Because office-based specialists focus on getting very good at a discrete set of services, they are much more vulnerable to closure than a typical diversified hospital if there is payment volatility for the services they provide. When this happens, these centers become ripe candidates for acquisition by health systems. We were grateful that CMS recently began to acknowledge this concern in the 2023 PFS Proposed Rule:

- "[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 free standing supplier facilities into larger health systems. Their concerns highlight a need to update the information under the PFS to account for

[27] Journal of Vascular Access, *What is the best setting for receiving dialysis vascular access repair and maintenance services?*, 2017

[28] Unfortunately, cuts to office-based dialysis vascular access since 2017 have resulted in significant office-based dialysis vascular access center closures and been correlated with significant increases in catheter rates.

current trends in the delivery of health care, especially concerning independent versus facility-based practices."[29]

This situation also is summed up well in a joint letter from the device trade community in a December 2022 letter to Congress:

- "Other proposals related to the Medicare physician fee schedule being considered by Congress—which would address broadly applicable cuts associated with PAYGO, sequester and the fee schedule conversion factor—would not alone mitigate the much larger payment cuts facing many office-based specialists resulting from the practice expense reductions. Left unaddressed, they could eliminate the physician office as a viable setting of care for many procedures and reduce treatment options for Medicare beneficiaries. **At a minimum, the reductions will lead to a shifting of procedures from the office setting, which is more accessible and clinically appropriate for many beneficiaries, to hospital outpatient departments and ambulatory surgery centers.**"[30]

For its part, MedPAC also has consistently raised concerns about health system consolidation overall. For example:

- In a 2020 report, MedPAC noted:
  - "Researchers have documented increasing levels of hospital–physician integration over a long period of time"; and
  - "One survey found that, from 2012 to 2018, the share of physicians who worked for hospitals increased from 29 percent to 35 percent".[31]
- In November 2022, MedPAC noted that "acquisition of physician practices has shifted billing from offices to HOPDs" in the areas of cardiology and oncology.[32]

And, yet, while MedPAC further concedes that "federal policies do create incentives for physician–hospital integration," **the commission has yet to recognize a link between office-based specialty reimbursement cuts and health system consolidation**.[33] This is unfortunate as MedPAC notes:

- the net results of increases in hospital–physician integration have been higher physician prices, higher spending for commercial payers, and higher spending for Medicare; and
- "[G]rowth in hospital–physician integration leads to higher total spending because prices increase without countervailing efficiencies."[34]

Given the additional reimbursement provided to specialist in vertically integrated hospital, it is no surprise that consistent PFS cuts are correlated with health system migration.

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[29] 87 FR 46389
[30] AdvaMed/MDMA/MITA Letter to Congressional Leadership, 15 December 2022
[31] MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2020
[32] Medicare Payment Advisory Commission, *Policy options for increasing Medicare payments to primary care clinicians*, 3 November 2022. Presentation is available here: https://www.medpac.gov/wp-content/uploads/2021/10/Aligning-payments-MedPAC-Nov-2022.pdf
[33] MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2020
[34] ibid

CONCLUSION

This letter lays out evidence that PFS rebalancing has resulted in large reimbursements cuts for specialists under the PFS and, in particular, that office-based specialists have borne the brunt of these reimbursement reductions. Specifically, there is evidence that office-based center closures in the areas of cardiology, radiation oncology, radiology, urology, and vascular surgery have been due in part to Medicare reimbursement cuts. We also believe these office-based center closures are correlated to the health system consolidation that the country has experienced over the last decade. **We request that MedPAC analyze the migration of services over the last decade from POS-11 to higher cost sites of service and the implications to the healthcare system from such migration. We also request, as interested parties continue deliberations on fundamental PFS reform, that MedPAC support policies that will ensure the viability of office-based specialists in the interim.**

USPA representatives would be happy to meet with you to discuss these issues at your convenience and will be following up with your staff in the coming months with additional information. Should you have any questions, please don't hesitate to contact Jason McKitrick at jmckitrick@libertypartnersgroup.com.

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