DIGESTIVE HEALTH
PHYSICIANS ASSOCIATION

Chairman Fred Upton
Energy & Commerce Committee
2125 Rayburn House Office Building
Washington DC 20515

Chairman Joseph Pitts
Energy & Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

February 19, 2016

Dear Chairmen Upton and Pitts:

On behalf of the more than 1,300 gastroenterologists who belong to our 60 independent gastroenterology (GI) member practices across the country, the Digestive Health Physicians Association (DHPA) is pleased to provide our views on the site-of-service provision in the Bipartisan Budget Act of 2015 (P.L. 114-74). DHPA is the voice of independent GI practice with physicians providing integrated GI care for more than 2.5 million patients annually in approximately 3.5 to 4 million distinct patient encounters.

We believe in physician-led care and are proud to provide a high quality and cost-efficient alternative to the hospital-based model, including in our physicians' own ambulatory surgery centers (ASCs) that compete directly with hospitals to provide critical GI care. These ASCs provide vital access to patients for colonoscopies to screen and treat colorectal cancer, the second-leading cause of cancer death in the country. As you are aware, Medicare pays hospital outpatient departments substantially more than ASCs for the identical care. For example, Medicare pays hospitals $793 for a lesion removal colonoscopy and diagnostic colonoscopy but ASCs just $429 for exactly the same procedures. Hospitals receive $747 for an upper GI endoscopy biopsy, yet ASCs receive just $404 from Medicare for that procedure. In short, the same procedure, same equipment, same physician, and same medical outcome result in twice the cost in the hospital setting.

While ASCs are providing a substantial portion of these essential GI procedures, this growing disparity makes it difficult for independent physician practices to remain financially viable. This problem is compounded because Medicare reimbursements for gastroenterologists' professional services

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continue to shrink, with a particularly severe cut for colonoscopy in this year's Physician Fee Schedule.

The combination of shrinking professional revenues and artificially depressed outpatient rates is making it increasingly difficult for gastroenterologists to remain independent. And this Medicare reimbursement differential is not unique to GI care. Other specialties are experiencing disparities as large as three-fold. For example, Medicare pays $655 for an advanced image ordered by a cardiologist in the physician office but $2,100 in the hospital. We are concerned that this artificial payment disparity is driving the rapid acquisition of physician practices, ASCs, and other community providers by hospitals across the country.

We supported the site-of-service provision in the Bipartisan Budget Act of 2015, which prospectively arrests the Medicare windfall for hospitals' future acquisitions of physician practices and ASCs. We would oppose any "grandfather" provision that reopens the statute. Such a provision would make it easier for hospitals to acquire competing physician practices and ASCs for the specific purpose of benefitting from the associated payment disparities. We are concerned that even a narrowly crafted grandfather provision could be exploited, allowing vertical provider consolidation to continue unabated. Rather than weakening its modest site-neutrality reform, Congress should build on it by equalizing Medicare and Medicaid payments across sites of care for all non-emergency procedures that have substantial volume in the more efficient, independent setting (for example, where at least 40 percent of services are performed in a lower-cost, non-hospital surgical center setting).

There is no clinical or economic reason for roughly half of all colonoscopies to be performed in a higher-cost, less personal hospital setting. Recent peer-reviewed literature documented that physician-led care can deliver enormous efficiency. A 2014 Health Affairs study authored by Munnich and Parente found that procedures at ASCs take 31 minutes – or 25 percent less time – than in hospitals. This translates to a savings of $363 to $1,000 per case. The study also found that high-risk patients treated in an ASC were less likely to require expensive emergency services than similar patients treated in hospitals using the same procedures. In light of these findings, Congress should be exploring increased incentives to deliver more care in the most efficient setting.

Congress has an enormous opportunity to reduce expenditures while preserving high-quality care for patients by supporting ASCs. An April 2014 Health and Human Services Office of Inspector General (OIG) report found that ASCs saved Medicare $7 billion from 2007 to 2011. In that same report, the OIG also estimated that reducing HOPD payments to the ASC rate for low-risk and no-risk procedures could save Medicare an additional $15 billion and beneficiaries $4 billion in reduced copays. Congress is leaving money on the table by not fundamentally reforming this payment differential.

The Digestive Health Physicians Association stands ready to work with you and other committees of jurisdiction to encourage greater competition, high quality care and efficiencies in Medicare. We thank you for reaching out to stakeholders on how the current site-of-service provision can be strengthened.

Sincerely,

Scott R. Ketover

Scott Ketover, MD
DHPA President and Chairman of the Board