LUGPA
Integrated Practices Comprehensive Care

May 17, 2023

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Large Urology Group Practice Association Testimony for the Ways & Means Health Subcommittee Hearing:
"Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets"

Chairman Buchanan and Ranking Member Doggett, the Large Urology Group Practice Association (LUGPA) is honored to submit this testimony to the Ways & Means Committee on how to strengthen the health care system. LUGPA represents 150 urology group practices in the United States, with more than 2,100 physicians who, collectively, provide more than one-third of the nation's urology services. But our focus on public policy is on assisting all independent physician practices and the patients we care for.

The U.S. health care system is becoming increasingly consolidated by large hospital systems, which are buying up their competition, driving up prices and shrouding the cost of care from patients who are paying an increasing share of the bill. Congress and the Biden Administration can help reverse these troubling trends by pursuing several fundamental policies:

1. Enforce the hospital transparency rule, which will empower patients to make prudent decisions on where to get their health care;
2. Support independent physician practices by equalizing payments for similar services across different sites-of-service;
3. Require a minimum level of charity care (e.g. 3.8% -- the average amount provided by for-profit hospitals) for a hospital to earn a non-profit designation to be exempt from taxation and eligible for the 340B drug program;
4. Repeal the inpatient only list;
5. Reform the Stark law to eliminate the prohibition of physician ownership of hospitals and codify and simplify the reforms to value-based entities implemented through regulation in 2020.

American Patients Are Bearing the Brunt of Increasing Hospital Power

An increasing share of healthcare expenditures is being transferred to patients. Individual healthcare expenditures in 2023 are double what they were in 2016. Individual healthcare spend is estimated to increase at 9.9% per annum. The US ranks 19th of the G20 nations in share of healthcare costs borne by patients; only the Czech Republic is higher, with patients paying approximately 50% higher than average—in addition, the rate of increase in the US is amongst the highest in the world.[1]

These healthcare costs are severely economically burdensome to patients. A report from the Kaiser Family Foundation found that nearly 1 in 4 patients diagnosed with cancer will declare bankruptcy or lose their home within 5 years of their diagnosis. In 2022, 38% of Americans report delaying important healthcare decisions due to cost concerns. Even more concerning is that these burdens are disproportionately borne by socioeconomically disadvantaged groups.[2]

Hospital mergers and acquisitions are contributing to rising costs of care[3] Once acquired, physicians have been shown to alter referral patterns to use more expensive hospital services.[4,5] Hospitals have focused on acquiring physician practices because that strategy simultaneously quashes competition in the local market for services such as outpatient surgery and radiation therapy and creates downstream revenue through referrals for surgery and ancillary services. This downstream revenue a physician generates for a hospital employer far surpasses the cost of the employed physician's salary.[5] A few examples, as presented in the Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey, include urologists generating $2,161,458 while receiving an average salary of $386,000, gastroenterologists generating $2,695,277 while receiving an average salary of $487,000, and ophthalmologists generating $1,440,217 while receiving an average salary of $300,000.[6]

Sadly, patients are not aware that hospitals can mandate that their employed doctors use hospital-owned services that are vastly more expensive and yet may be less convenient and offer no better care.

Site of service payment differentials are an artefact of historical realities that did not anticipate the tremendous technological and clinical innovations which have advanced the complexity and types of care available in outpatient settings and, concomitantly, reduced costs associated with the delivery of that care. Yet, the policy of paying hospitals substantially more (often more than twice as much) for the identical services provided in a physician office, infusion center or 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 provides mega-hospital systems with additional resources and incentives to acquire physician practices, promote consolidation, limit competition and restrict treatment options for patients. A recent study by Avalere for the Physician Advocacy Institute found that the percentage of hospital-employed physicians increased by more than 70% from July 2012 through January 2018. During that timeframe, hospital acquisitions of physician practices more than doubled. In 2017 and 2018 alone, an additional 8,000 physician practices were acquired by hospitals. The trend is disturbing—with the proportion of independent physicians steadily dropping from 48.5% in 2012 to 31.4 percent in 2018.

This trend should be of great concern to policymakers. The hospitals site of service is vastly more expensive than physician practices, even when furnishing the identical health care services.2[7] As an example, Medicare pays hospitals more than twice the amount as physician offices for the

infusion of the identical drug that requires the same nurse staff time and technical training; i.e. for the CPT code 96413 "Chemo admin; intravenous infusion; up to 1 hr." the HOPD rate is $325.64 vs. the in-office rate of $140.16.

Nonprofit hospitals are abusing their tax-exempt status

Nonprofit hospitals enjoy sizable federal, state and local tax exemptions in exchange for meeting requirements to provide services such as free care for the poor.[8] These hospitals also have access to special federal programs, like the 340B drug discount program, in exchange for the expectation that they adhere to their non-profit obligations and use these programs to support vulnerable patients in underserved communities. Today, about 50 percent of the hospitals in the United States are nongovernment not-for-profit community hospitals.[9] In exchange for their substantial tax savings and goodwill, these hospitals are expected to provide services in the public interest, including free or discounted care and financial assistance to patients who are unable to pay.

We commend the Ways and Means Committee for investigating this issue during last month's Oversight Subcommittee hearing on "Tax-Exempt Hospitals and the Community Benefit Standard." During this hearing, Oversight Subcommittee Chair David Schweikert noted a report by the Kaiser Family Foundation has found that the value of charity care provided by hospitals varies substantially across facilities ranging from 0.1% of operating costs to 7% or more. He also noted that some studies show significant deficits in the community benefits provided as compared to the value of some hospitals' tax-exempt status. Ways & Means Committee Chair Smith also expressed concerns about 340B hospitals providing sufficient community benefits, including charity care for vulnerable patients, and criticized the multimillion-dollar salaries of non-profit hospital CEOs. Several of the hearing witnesses offered recommendations for addressing these issues, such as revising the information included on the Form 990 Schedule H form that hospitals fill out to get a clearer picture of community benefit information.

Recent public reporting by investigative journalists in the New York Times,[10] the Wall Street Journal,[11] and other prominent outlets demonstrate that many not-for-profit hospitals are not fulfilling their mission to serve America's neediest patients.[12] To the contrary, these public reports clearly show that some hospitals are going after the most vulnerable patients through financial duress during hospital intake process and abusive collections practices for unpaid medical bills.[13,14] These stories are even more remarkable when you consider that compliance with recent transparency rules are abysmal, nearly two years after implementation began.[15] A majority of hospitals aren't complying with a CMS rule on price transparency, according to a study published in JAMA. Under the rule, which was finalized in 2019 and took effect in January 2021, hospitals have to publicize their negotiated rates with payers for common services. But early data shows that's often not the case. The study, conducted by researchers at Harvard Medical School, randomly sampled 100 hospitals, as well as the 100 highest-earning hospitals of 2017. Of the randomly selected facilities, 83% were noncompliant with at least one of the rule's requirements. The top-earning hospitals were more compliant but not by much, with 75% noncompliant with at least one requirement.[16]

Even as they do not comply with their obligations borne from their not-for-profit status, these hospitals are increasingly taking advantage of mergers and other business decisions that can actually reduce access and drive up costs for all consumers, without verifiable increase in quality

of care.[17] These types of mergers can deprive communities of critical care and result in workforce wages reductions,[18] even as many hospital executives are seeing massive growth in their income.[19]

Recommendations to Congress and the Biden Administration

1) **Enforce the hospital transparency law**

The hospital transparency rule had two laudable requirements. First, hospitals have to publish discounted cash prices applicable to all uninsured patients and payer-specific negotiated rates for all services. Additionally, hospitals have to publish price data, including expected out-of-pocket costs, for "shoppable services" such as an X-ray that can be scheduled in advance, in an easily understandable format to facilitate shopping across different sites of care, such as a price estimator tool. Hospitals who fail to comply are theoretically liable for $100 per day per patient. But the law has been rarely enforced. CMS should raise the penalty to $500 per infraction and actually enforce the law for the vast majority of hospitals that remain out-of-compliance.

2) **Establish a threshold of charity care in the tax code for non-profit hospital status.**

Currently, hospitals do not have to provide a specified level of charity care in order to be categorized "non-profit" and thus exempt from state, local and federal taxation and to be eligible for the 340B drug discount program. A recent study in Health Affairs, whose author testified at Ways & Means in April, documented that for-profit hospitals actually provide about 50 percent more charity care than non-profit hospitals (3.8 percent vs 2.3 percent)[20]. Congress should establish a minimum threshold of bona fide charity care for hospitals to reap the many benefits of their non-profit status, including not paying taxes and being made eligible for hugely profitable 340B drugs which they dispense at substantial markups. What metric for a hospital's non-profit status can be more important than providing indigent patients, needed free care? We suggest a threshold equal to the amount for-profit hospitals provide: 3.8 percent.

3) **Close the site-of-service payment disparities**

Medicare pays substantially more for services performed on an outpatient basis at hospitals than it does for the same services performed in physician offices and ambulatory surgery centers. This fuels consolidation where these sites can be acquired by hospitals and designated as part of a hospital and paid as such. Congress could eliminate these payment disparities and save $141 billion over 10 years in Medicare. But Congress need not entirely equalize payments to make progress in this area. For example, it could raise physician payments for identical treatments by 25% and lower hospital payments by 50%. This would still provide substantial net savings to the program, but importantly provide much needed resources to physician practices which have received cuts in recent years and confront a decade of payment freezes while hospitals receive compounding market basket payment updates. We do not support the MedPAC recommendation that would cut ASC payments to the physician office rate if just a plurality of volume is provided in the physician office setting. Rather, we recommend keeping the majority rule of physician office volume to trigger lower ASC payments, as is currently the case. The real opportunity for savings is the higher cost procedures that could migrate from HOPD to ASC, where no current site-neutrality payment structure applies.

4) **Repeal the Inpatient Only (IPO) List**.

CMS recently reversed the reform the Trump Administration had initiated and that was only in the

first year of a three-year phase-in by reinstating the inpatient only list of 298 procedures. CMS simultaneously removed 256 procedures that had been added to the ASC-payable list. This reversal occurred despite the acknowledged blistering pace of technological innovation and the sustained trend of increased volume and complexity of cases safely moving into the outpatient setting such that the healthcare intelligence firm Sg2 projects that 85 percent of all healthcare procedures will be performed on an outpatient basis by 2028. Arbitrarily defining an IPO list creates an unnecessary barrier and presumes that the government knows better than practicing physicians when it comes to determining the appropriate site of service in which to perform a procedure.

Not only does the elimination of the IPO list and expansion of the ASC Covered Procedures List (CPL) promote beneficiary access to safe and convenient sites of care while expanding access to innovation, but it also contributes to significant savings in Medicare spending as surgical procedures in the ASC are paid half the amount as the hospital. ASCs have already saved Medicare $28 billion from 2011 to 20188 and could save much more if physicians had the ability to move appropriate procedures to that setting. This can occur in a more robust way by eliminating the inpatient only list and restoring those procedures to the ASC-payable list. This reform should also include necessary new APC payments in the HOPPS for these procedures, or there will be no way to pay for these procedures.

5) Simplify and Modernize the Stark Self-Referral Law

It has been shown that competition in the healthcare market improves outcomes and reduces costs.[21] Regrettably, acquisition of physician practices by hospitals and the increasing trend of hospitals to form monolithic health systems serves only to stifle that competition. An additional example of this is that physicians are barred from owning hospitals and are subject to antiquated laws enacted 35 years ago. The Affordable Care Act permanently barred new physician-owned hospitals and barred growth of current physician-owned hospitals – as a payoff to the hospital industry, which was asked to accept market basket payment reductions to help fund the insurance expansion.

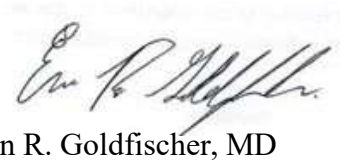
Brian Miller noted as a result of ACA's statutory ban, "more than $275 million of planned economic activity spread across 45 hospital expansion projects ceased. More than 75 new hospitals either planned or under development were prematurely terminated, representing more than $2.2 billion in economic losses. Intangible losses include the loss of the "physician entrepreneur" and user-driven innovation in the face of increasing corporatization of medical practice, both likely contributing to the increase in physician professional dissatisfaction… Premature foreclosure of the POH marketplace inhibited the development of the US version of the "focused factory" model of specialized hospitals or integrated Reversing Hospital Consolidation: model of specialized hospitals or integrated practice units, a feature seen in other markets."[22]

LUGPA worked closely with aligned stakeholders to encourage updating existing regulations governing the Stark statute and strongly supports the administrative reforms made by both CMS and the HHS Office of the Inspector General (OIG) in December of 2020. The OIG administrative changes created three new safe harbors to encourage value-based care models: (1) care coordination arrangements without requiring the parties to assume risk; (2) value-based arrangements with substantial downside financial risk; and (3) value-based arrangements with full financial risk. Essentially simultaneously, CMS adopted revisions to the Medicare self-referral statute also designed to support value-based payment arrangements in the Medicare program. Although these regulatory changes were helpful in advancing the adoption of payment

arrangements that reward value over volume, they remain constrained by the underlying statutes and furthermore, these regulations are complex and hard to understand by providers. As a result, practitioners have been reluctant to enter new or innovative payment arrangements for fear of triggering inadvertent violations of the underlying statutes or investigations by overzealous prosecutors. In addition, adoption of these programs is hampered by logistical challenges for practices remain as compliance is carried out while dealing with real-time patient pressures and practice resource constraints.

LUGPA looks forward to working with the Committee to help improve access, enhance quality and reduce costs for our patients. please feel free to contact Dr. Mara Holton (mholton@aaurology.com) if LUGPA can provide additional information to assist the committee as it considers these issues.

Respectfully submitted,



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[1]OECD Out-of-pocket Health Spending, 1990-2021, accessed at: https://data.oecd.org/healthres/health-spending.html
[2]Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills. Accessed at: https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/
[3] Rabbani M. Non-profit hospital mergers: the effect on healthcare costs and utilization. Int J Health Econ Manag. 2021 Dec;21(4):427-455.
[4] Whaley CM, Zhao X, Richards M, et al. Higher Medicare Spending on Imaging and Lab Services After Primary Care Physician Group Vertical Integration. Health Aff (Millwood). 2021 May;40(5):702-709.
[5] Carlin CS, Feldman R, Dowd B. The impact of hospital acquisition of physician practices on referral patterns. Health economics. 2016 Apr;25(4):439-54.
[6] Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey
[7] Hayes J, Hoverman JR, Brow ME, et. al. Cost differential by site of service for cancer patients receiving chemotherapy. Am J Manag Care. 2015 Mar 1;21(3):e189-96.
[8] Kaiser Family Foundation, "Hospital Charity Care: How It Works and Why It Matters," Zachary Levinson, Scott Hulver, and Tricia Neuman, https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and why-it-matters/.
[9] American Hospital Association, "Fast Facts on U.S. Hospitals, 2022," https://www.aha.org/statistics/fast-facts-us-hospitals.
[10] How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits, Sep. 27, 2022, at https://www.nytimes.com/2022/09/24/health/bon-secours-mercy-health-profit-poor-neighborhood.html?smid=tw-share
[11] Many Hospitals Get Big Drug Discounts. That Doesn't Mean Markdowns for Patients. *The Wall Street Journal.* Available at https://www.wsj.com/articles/340b-drug-discounts-hospitals-low-income-federal-program-11671553899
[12]They Were Entitled to Free Care. Hospitals Hounded Them to Pay. The New York Times. Available at https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html
[13] See Senator Baldwin's letter to Ascension, citing its 10-year partnership with a debt collection company that had to cease operations in Minnesota following a state investigation that found it embedded debt collectors among hospital staff and assigned patient scores based on their ability to pay, according to the letter. Senator Baldwin also noted that the partnership is still ongoing and particularly unusual given that nonprofit health systems are held to strict standards that bar aggressive billing and debt collection practices. A STAT news article analyzing Ascension's private equity operations, suggests many investments did not align the nonprofit's mission of providing charitable benefits to the community. Available at https://www.baldwin.senate.gov/download/ascension-financial-letter_final
[14] See Letter from Senators Warren and Wyden to McKinsey. A recent investigation by the *New York Times* uncovered a deal between Providence and McKinsey that resulted in a plan to use predatory tactics to pressure patients into paying for their care, no matter their income or ability to pay. As a result, more than 55,000 patients were pursued by debt collectors when they should have been offered discounts due to their socioeconomic status. Available at https://www.warren.senate.gov/download/20230220-letter-to-mckinsey-re-nonprofit-hospitals
[15] Patients Rights Advocates. Fourth Semi-Annual Hospital Price Transparency Report, Feb. 2023, available at https://www.patientrightsadvocate.org/february-semi-annual-compliance-report-2023
[16] *JAMA Health Forum.* 2021;2(3):e210316. doi:10.1001/jamahealthforum.2021.0316
[17] Associate Secretary for Planning & Evaluation, HHS, available at https://aspe.hhs.gov/sites/default/files/documents/0d2c04fec395bc8c573c5b20c189cdd0/enviromental-scan- consolidation-hcm.pdf. *See also* https://www.vox.com/policy-and-politics/2023/1/20/23560762/hospital-mergers- uk-study-deaths-readmissions. (According to VOX, in 2005, about half of US hospitals were part of a larger system. By 2017, two-thirds were. Most places in the US have what is considered a highly concentrated hospital market, which means one company operates most of the hospital facilities in the area.)
[18] *See ASPE* report.
[19] https://www.medpagetoday.com/special-reports/features/103127 (Focused on NC hospitals, this report noted that CEOs and top executives at North Carolina's nonprofit hospitals made over $1.75B between 2010 and 2020, as worker wages were stymied, medical debt mounted, and a lack of transparency persisted.)
[20] Bai, et al. "Analysis Suggests Government and Nonprofit Hospitals' Charity Care is Not Aligned with Their Favorable Tax Treatment". Health Affairs, April 2021
[21] Gaynor M, Moreno-Serra R, Propper C. Death by market power: reform, competition, and patient outcomes in the National Health Service. American Economic Journal: Economic Policy. 2013 Nov 1;5(4):134-66.
[22] Brian Miller et al. "Reversing Hospital Consolidation: the Promise of Physician-Owned Hospitals" Health Affairs Blog April 2021