LUGPA
Integrated Practices Comprehensive Care

October 5, 2023

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Chicago, IL 60611
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Chairman Jason Smith
Ways and Means Committee
1139 Longworth
Washington, DC 20515

Dear Chairman Smith:

The Large Urology Group Practice Association (LUGPA) is pleased to provide these comments responding to the Committee's RFI on improving patient access in rural areas. 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. In addition, as advocates for patient access, care delivery and payment reform, and healthcare evolution and innovation, our public policy and advocacy efforts are impactful to providers and patients well outside of the scope of genitourinary (GU) care.

LUGPA practices provide all aspects of urological care and, as center(s) of excellence in urban, suburban, and rural communities across America, provide care for a variety of conditions, from the pre-natal evaluation of fetal kidney abnormalities seen on ultrasound to the treatment of female incontinence to advanced interventions for prostate cancer. Our providers enable patients to receive advanced diagnostic and treatment modalities in proximity to where they live, shop and work, offering accessible, convenient, and efficient care with offices and surgery centers. In stark contrast to disjointed care models where patients may travel from a specialist in one geography to another far away, LUGPA practices provide fully integrated comprehensive urologic care, from medical care to surgical treatment to the delivery of chemotherapy for cancer care, often in a single outpatient setting. Furthermore, it is typical for our physician practices to provide multiple sites of access throughout communities with a number of satellite locations, particularly in more rural areas where the presence of employed hospital specialists is typically sparse or nonexistent.

We believe there are concrete actions Congress can take to address the worsening rural healthcare access crisis:

1. **Establish a long-term payment solution that provides financial stability to physician practices to preserve Medicare patient access to care, especially for those in rural and underserved areas**; Two decades of minimal payment increases while practice costs escalate and competing providers receive compounding payment updates is unsustainable to independent practices.

2. **Reduce the payment rate disparities between independent practices** -- which operate physician offices and associated ambulatory surgery centers (ASCs) -- **and the higher cost hospital outpatient department (HOPD) setting** to incentivize delivery in lower cost sites of care, curtail provider consolidation, and, most importantly, to ensure physicians can financially support delivery of care in rural areas that need more providers.

3. **Increase payments in rural and underserved areas**. Make permanent the temporary floor for the Medicare Geographic Practice Cost Index (GPCI) and raise to 1.05 to improve access in rural communities. Additionally, increase the rural floor to 1.1 for rural localities that face provider shortages.

4. **Clarify the Stark Law so physician offices can deliver medicines and other medical supplies, particularly to rural patients, via mail, courier, or other methods**.
5. **Make Telehealth flexibilities permanent**.

There is a Urological Rural Access Problem

The challenge of providing adequate access to urological care in rural areas has grown in recent years and is on the trend to worsen significantly over the next decade. While the challenges that we face stem partly from the escalating physician shortage in the United States, several unique factors magnify the anticipated shortage within our specialty. Due to the number of retiring urologists, the workforce shortage is projected to become more severe over time, and a 2021 study published in *JAMA* estimated that there will be a continued decline in urologists per capita through 2060, based on the current growth of the profession[2]. Furthermore, the urological workforce is predominantly located in metropolitan areas, with only 0.5 percent of urologists in rural areas.[1] A staggering 62 percent of counties in the United States have no urology provider whatsoever. In addition, those urology providers who practice in rural locations are demographically older, white, and male, with nearly one-third of those over 55 years of age practicing in a rural area compared to only 17 percent of those less than 54 years of age.[1]

Additionally, there has been a marked trend towards job selection in an urban location. Since 2016, mean age and years in practice increased for rural urologists but remained stable for urban urologists, suggesting an influx of younger urologists to urban areas.[3] The AUA workforce survey (2020-2021) found that 96% of residents and >99% of fellows planned to practice in urban or suburban areas, with the predominance indication of urban preference.[4]

There are broad implications to reduced providers within rural communities, from access challenges for acute and emergent urologic care advanced interventions to the treatment of routine conditions and preventative care. In 2018, the Centers for Disease Control and Prevention (CDC) reported that prostate cancer incidence was higher in urban areas compared to rural areas, [two] and some hypothesize this may be related to reduced screening in rural communities. Using cancer registry data, Holmes et al. examined the association between distance to a urologist and delayed prostate cancer diagnosis.[3] The authors discovered that longer distances to a urologist were associated with increased rates of high-risk cancer diagnoses, the treatment of which almost inevitably requires more intervention, thus further increasing the burden on patients and families in coordinating more complex and intensive levels of care.

Rurality level[a]	No. practicing urologists	(%)
Metropolitan areas	12,360	89.6
Nonmetropolitan areas	1,430	10.4
Micropolitan	1,134	8.2
Small town	233	1.7
Rural	63	0.5
Total	13,790	100.0

Data sources: National Provider Identifier 09/2021 file, Rural-Urban Commuting Area Codes Data from RUCA3.10.
[a]An area was classified as a metropolitan area with a population size ≥50,000 or a nonmetropolitan area otherwise. The nonmetropolitan area was further classified as micropolitan area (population = 10,000-49,999), small town (population = 2,500-9,999), and rural area (population <2,500).

[1] Nam CS, Daignault-Newton S, Kraft KH, Herrel LA. Projected US Urology Workforce per Capita, 2020-2060. JAMA Netw Open. 2021 Nov 1;4(11):e2133864. doi: 10.1001/jamanetworkopen.2021.33864. PMID: 34783827; PMCID: PMC8596195.
[2] Stacy Jeong, et al. Cost-Effective and Readily Replicable Surgical Simulation Model Improves Trainee Performance in Benchtop Robotic Urethrovesical Anastomosis. American Urological Association Urology Practice Journal. Sep 1, 2022. https://www.auajournals.org/doi/epdf/10.1097/UPJ.0000000000000312
[3] American Urological Association, Urologists in Training-Residents and Fellows in the United States 2020-2021 Linthicum, Maryland, U.S.A., November 4, 2022)

Figure 1: Source

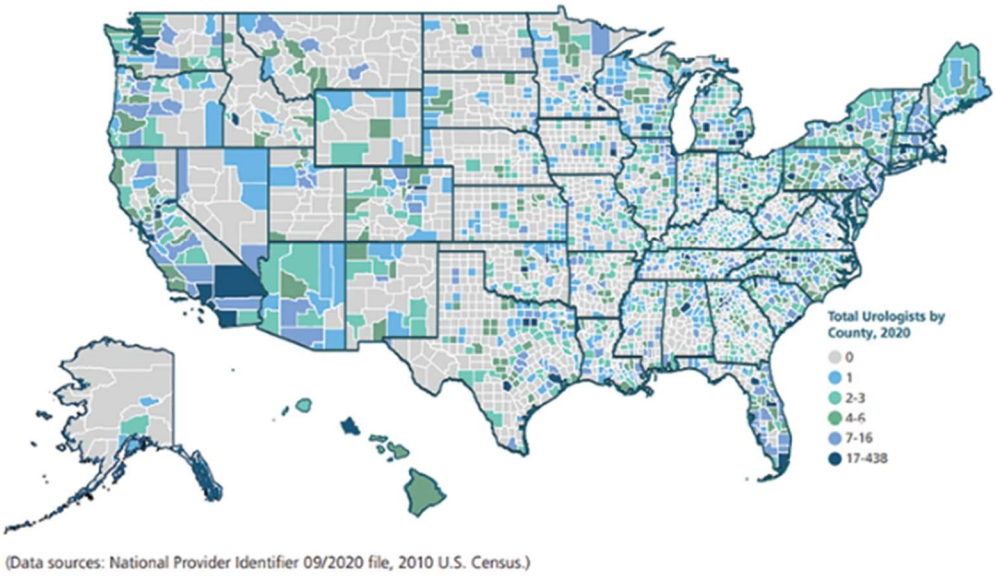


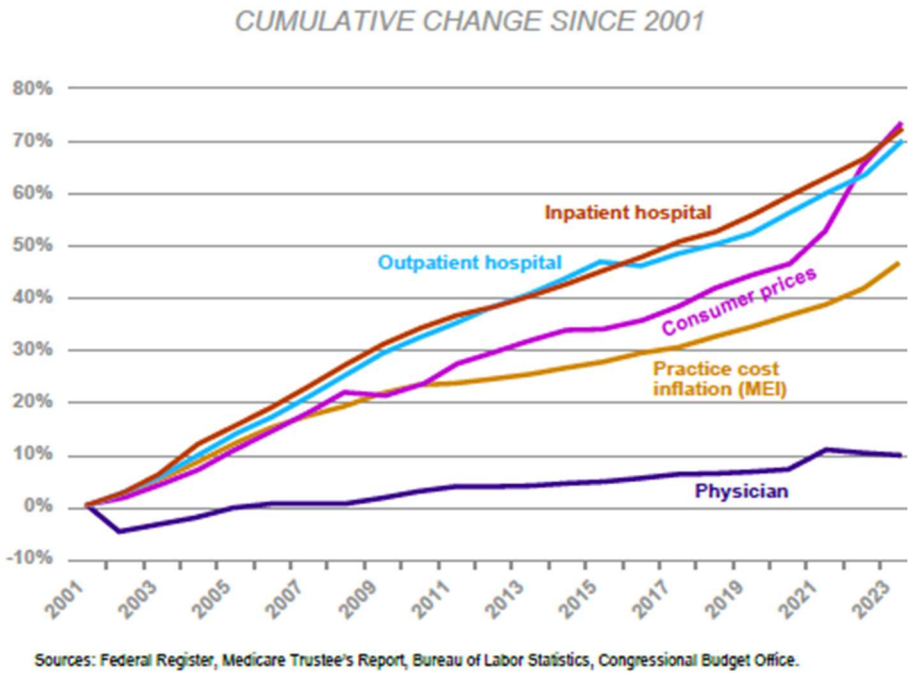
Figure 2: Source

The Need to Address the Current Untenable Physician Payment System

As the end of 2023 nears, physicians are once again facing payment cuts, followed by an indefinite payment freeze, yet still in the shadow of the lingering effects of a global pandemic, widespread inflationary pressures, ongoing supply chain crises, heal and healthcare workforce shortages, now in tandem with unparalleled rates of provider burnout. Over the last 20 years, physicians who participate in Medicare have faced negligible payment increases, freezes, and payment cuts while trying to provide increasingly complicated care to patients, who are frequently sicker and have more complicated health conditions. Meanwhile, competing hospital systems and other components of the healthcare infrastructure have received market basket or other adjustments designed to reflect rising costs of healthcare delivery. The graph below illustrates the inequity of the payment update system, as hospitals are projected to receive a 2.2 percent increase over the next decade while the physician update remains flat.[5] Despite not receiving payment updates, and facing a 3.4% payment cut at the end of 2023, independent practices must compete directly with hospitals for nurses, other staff and supplies in order to deliver care for the same patient needs and conditions in both rural and urban settings.

The impending 3.4% physician payment cut will intensify the provider shortages and healthcare access issues in rural and underserved areas. Physician practices in areas with a predominately public payor mix rely on Medicare reimbursement rates to keep their practices economically viable. Payment cuts will directly impact providers' ability to serve patients in rural and underserved areas as well as their important role as local employers for these communities. The "Strengthening Medicare for Patients and Providers Act" (H.R. 2474) would block the end-of-year cuts and would link payment rates to the Medicare Economic Index so that providers can receive appropriate payment adjustments in the future. LUGPA urges Congress to pass this bill into law and establish a long-term payment solution that will inject stability into physician practices, thus ensuring they can better serve all patients, and particularly those in rural and underserved beneficiaries.

5 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"



Recommendation: Enact The Strengthening Medicare for Patients and Providers Act (H.R. 2474)

The Need to Address Site-of-Service Reimbursement Disparities

Site of service payment differentials are an artefact of historical realities that simply could not have anticipated 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. Independent physician practices typically offer a variety of services and procedures at their offices and associated outpatient surgery centers. For example, many physician practices provide Part B drug infusions at their infusion suites and provide outpatient surgeries at an associated ambulatory surgery center. Yet, the policy of paying hospitals substantially more (in many cases twice as much) for the identical services provided in a physician office 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 provide 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 percent 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 2 acquired by hospitals. The trend is disturbing—with the proportion of independent physicians steadily dropping from 48.5 percent in 2012 to 31.4 percent in 2018.

At a macro level, hospital spending is growing much faster than physician spending, due to both price and utilization increases. The Medicare Payment Advisory Commission (MedPAC) March 2018 report found that from 2011 to 2016, program spending and beneficiary cost-sharing on services furnished in HOPDs increased by 51 percent, from $39.8 billion to $60 billion.3 MedPAC noted, ‘‘[a] large source of growth in spending on services furnished in hospital outpatient departments (HOPDs) appears to be the result of the unnecessary shift of services from (lower-cost) physician offices to (higher-cost) HOPDs.”[6]

[6] MedPAC March 2018 Report: Chapter 3 – Hospital Inpatient and Outpatient Services

Analogous results were observed on the commercial side: a University of California, Berkeley study that reviewed 4.5 million commercial HMO enrollees, found hospital-owned organizations incurred 19.8 percent higher expenditures than physician-owned organizations for professional, laboratory, and pharmacy services. [7]

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 on surgery and ancillary services. The revenue a physician generates for a hospital employer far surpasses the cost of the employed physician's salary. Hospitals receive three to four times the revenue they pay urologists and other specialists in salaries based on the ancillary services they capture when those urologists and other specialists become employed doctors.

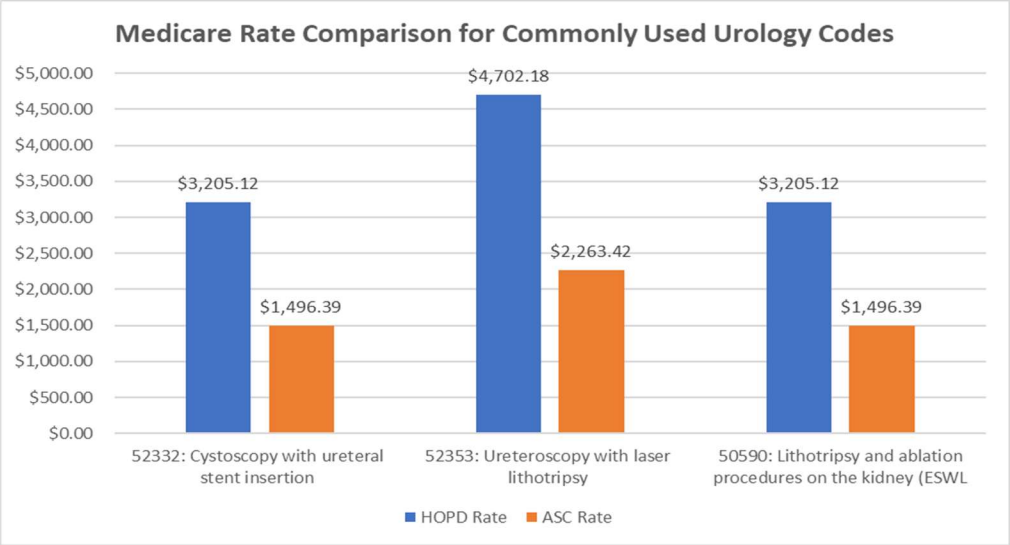
These site of service differences matter to patients in rural areas if they cannot access care at independent practices because the identical services are much more expensive in hospitals than independent practices and rural patients' income is generally lower than urban patients. Per capita income in urban America in 2021 was $66,440, while that in rural America was just $49,895.[8] And yet, rural patients who live remotely from a hospital setting are adversely impacted both by the time and cost associated with travel and pay comparatively more in copayments and deductibles when they receive care due to site of service differentials for equivalent services in a hospitals rather than an office of ASC location

Ongoing advances in technology and clinical innovation mean that increasingly complex care is delivered effectively and efficiently in an outpatient setting. Twenty years ago, it was inconceivable that cases such as ureteroscopy (endoscopic stone treatment) could or would ever be done in an ASC; however, in many regions, this is now a common site of delivery of this service. Yet, as illustrated below, reimbursement for ureteroscopy codes is typically less than half that reimbursed in the HOPD setting, despite the fact that the resources and staff required for the cases are essentially identical -- creating a perverse incentive for hospitals to drive care to their HOPD location.

Procedure	**ASC**	**HOPD**
Cystoscopy with ureteral stent insertion (CPT 52332)	$1,496.39	$3205.12
Ureteroscopy with laser lithotripsy (CPT 52353)	$2,263.42	$4,702.18
Lithotripsy and ablation procedures on the kidney (ESWL) (CPT 50590)	$1,496.39	$3,205.12
	Citation: CY 2023 OPPS Final Rule Addendum B	Citation: CY 2023 ASC Final Rule Addendum B

7 Robinson JC, Miller K. Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California. JAMA. 2014;312(16):1663–1669. doi:10.1001/jama.2014.14072

8 https://data.ers.usda.gov/reports.aspx?ID=17854



Similarly, as demonstrated below, the disparity in payment for services massively favoring hospital locations is pervasive. Outpatient drug infusions use analogous resources in an HOPD to those used in a truly outpatient setting, in this case, the physician office, but cost Medicare, beneficiaries and taxpayers

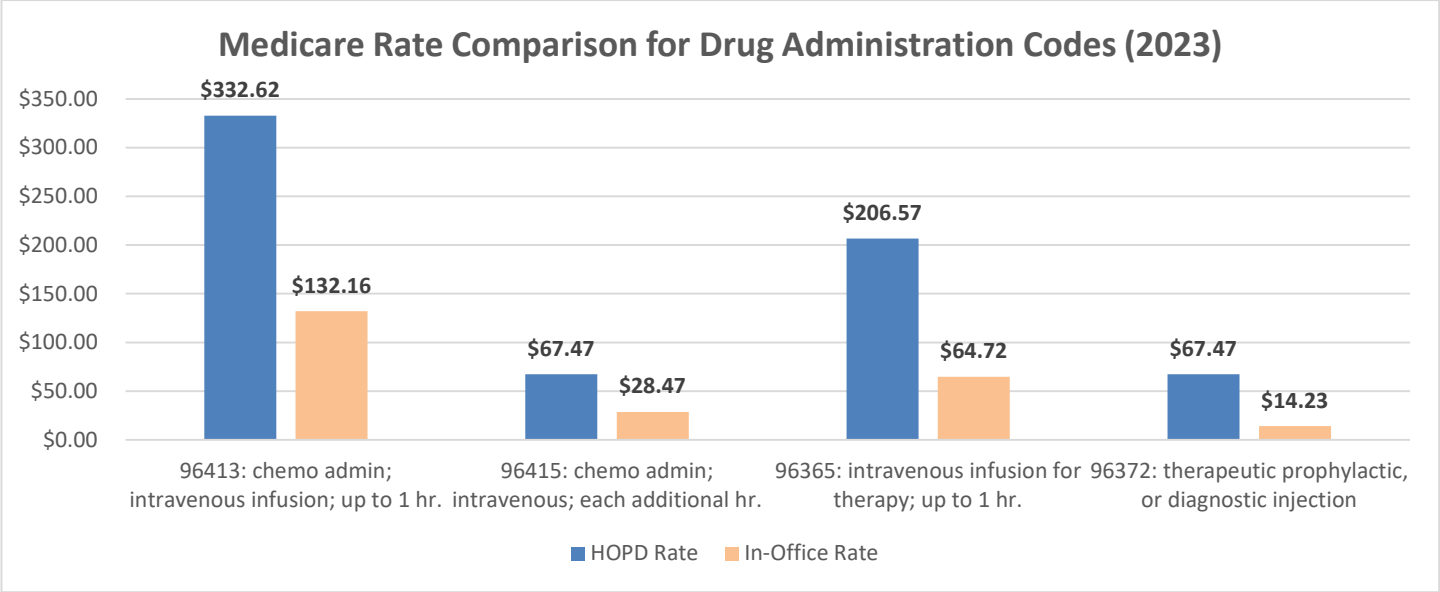


Figure 1: Citations: HOPD Rate = Hospital Outpatient PPS: Addendum B | In-Office Rate = PFS Search

vastly more in the HOPD setting. In an attempt to address this payment disparity, the Ways and Means Committee reported the "The Lower Costs, More Transparency Act" (H.R. 5378), which would phase-down drug administration payments to off-campus hospital outpatient departments (HOPDs) to the physician office setting over four years. We believe that proposal should be modified to apply to **all** HOPD-provided drug administration, not just those off-campus sites. We can find no compelling reason to limit application of this site neutrality payment reform only to off-campus HOPDs, since many large hospital stems are beneficiaries of steep 340B discounts but do not have different overhead costs than physician offices for inventory and provision of these Part B drugs.

Secondly, simply slashing payment rates to hospitals for services that can be provided at a lower price in physician offices or associated ambulatory surgery centers is not the most thoughtful approach. We recognize the differential investment challenges and inputs and believe that a measured approach which incentivizes care in less costly sites, ensuring the development of sufficient resources to protect and enhance patient access. As such, we suggest a different approach to site neutrality, whereby payments in physician offices and/or ASCs for high volume procedures such as drug administration and kidney stone treatments

could be modestly increased while payments to hospitals for those procedures could be modestly decreased. They need not end up at identical payments, but the differences in the sites of care should be narrowed. As an example, stone treatment with laser lithotripsy (52353), a procedure performed on CMS recipients 2,828 times in 2021. This would incentivize physician practices to increase volume and accept additional patients diverted from the HOPD and ensure access is maintained while rewarding the lower cost site of care. A compromise, which raised ASC rates by 25% while cutting HOPD by the same, would have provided massive cost savings greater than an estimated $1.5 million based on volume CPT 52353 cases done by location in 2021.

Recommendation: Narrow Site-of-Service Payment disparities for high volume procedures such as ureteroscopy, lithotripsy, and drug administration.

The Need to Permanently Increase the GPCI Floor in Rural and Shortage Areas

Medicare varies payments to different areas of the country to acknowledge the difference in input and labor 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.

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.[9] 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[10] 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 6.[11] 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.[12] The PW floor was intended to help providers in rural areas and prevent their reimbursement rates from being excessively deflated.[13]

[9] 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
[10] Section 1848(e)(1)(G) of the Social Security Act
[11] Section 1848(e)(1)(I) of the Social Security Act
[12] 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.
[13] American Medical Association, "Geographic Variation in the Payment Schedule." https://www.ama-assn.org/system/files/geographic-variation-in-the-payment-schedule.pdf

Congress should permanently increase the PW floor in rural areas (i.e., those counties that are NOT in a metropolitan statistical area) to 1.05. Simply extending the current policy, which has not solved the rural access problem is not sufficient. As PW comprises over 50 percent of physician compensation, this would provide substantial and permanent pay increase in rural areas indefinitely. It should further establish a PE and PW floor of 1.1 in rural areas that are designated as by the Health Resources Services & Administration (HRSA) as Health Professional Shortage Areas (HPSAs) and/or Medically Underserved Areas.

Recommendation: Permanently increase Physician Work 1.05 floor and increase Physician Work and Practice Expense floors to 1.1 in health professional shortage areas.

The Need to Modify the In-Office Ancillary Services (IOAS) so Providers Can Deliver Medications to Their Patients

Another important mechanism by which Congress can improve patient access in rural areas is to override antiquated "Stark law" regulations, which prohibit physician practices for delivering Part D drugs to patients' homes. For several years during the Public Health Emergency (PHE), physicians have been delivering oral cancer medications directly to their patients via mail, courier and other methods. However, recently CMS issued regulations, which state that such delivery of drugs to patient violates In-Office Ancillary Service IOAS exception.

Being able to utilize this exception to deliver medications directly to patients is extremely beneficial for patients in rural areas, where patients on average must travel more than twice the distance that urban patients do for medical care.[14] Patients in these areas often cannot afford to miss work to drive to their physician's office solely to pick up their medication and also often face challenges with securing reliable transportation in the first place. These travel and transportation factors contribute to reasons why rural patients often delay care, miss appointments, and fail to adhere to prescribed treatment regimens. Further, this issue extends beyond simply rural patients, as statistics reveal that 20-31% of prescribed medications remain unfilled and about 50% of patients do not adhere to their treatment plans.[15] In-office dispensing is a tool that can be used to improve patient adherence to treatment plans and allow for immediate medication adjustments when necessary.

CMS' interpretation of the IOAS exception is illogical, as there is no "referral" used as part of this process, the drug is simply delivered to the patient's address in lieu of being physically handed to them at the physician's office. These drugs are generally dispensed in cases where patients are receiving chronic cancer care and have routine office evaluations, treatment, and care. However, depending on their condition, delivery of some of the refills allows patients to have the flexibility to do remote check ins and telehealth visits instead of requiring travel to their provider's office. Additionally, during the COVID-19 public health emergency (PHE) a waiver was issued by CMS that temporarily lifted restrictions around delivering drugs to patients in this manner. Once the PHE ended, CMS issued two FAQs noting the expiration of the waiver granting the temporary exception. Unfortunately, patients who relied on this service during the pandemic have had their access to their medications compromised.

To address the distorted CMS interpretation of the Stark law, Reps. Harshbarger and Waasserman-Shultz introduced the Seniors' Access to Critical Medications Act (H.R. 5526). This bill would amend the Social Security Act to clarify that delivering medicines by mail, courier, or other methods of delivery, and that allow family members or a caregiver to pick up medicines on behalf of a patient, are not violations of the Stark law. The bill strengthens the IOAS exception by requiring CMS to revise its interpretation of the law and rescind the two FAQs issued by the Agency following the end of the PHE which restricted the physician practice's ability to mail or courier drugs and medical supplies to patients. LUGPA fully supports this bill

[14] Rural Health Information Hub, "Transportation to Support Rural Healthcare." https://www.ruralhealthinfo.org/topics/transportation#:~:text=Rural%20residents%20traveled%20more%20than,urban%20residents%20(25.5%20minutes).

[15] Centers for Disease Control and Prevention, "Factors Predicting Self-reported Medication Low Adherence in a Large Sample of Adults in the U.S. General Population: A Cross-sectional Study." June 2017. https://www.cdc.gov/dhdsp/pubs/docs/sib-Nov2017_508.pdf

and encourages Congress to advance the legislation so it can be used to improve access to care, particularly for rural populations.

Recommendation: Congress should enact HR 5526 to protect rural patient access to physician-practice delivered cancer drugs.

Extending Telehealth Flexibility

Telehealth reduces barriers to care for patients who reside 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. 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, loss and money saved due to less travel.[16] 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.[17]

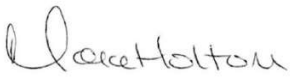
In conclusion, telehealth allows patients to avoid making the difficult decision of having to take significant time off work, incur additional expenses related to transportation and childcare while maintaining critical access to preventative care for chronic conditions, which if left untreated, could be both costly and harmful to their health. This flexibility is viable only if payment to physicians is maintained at the current E&M payment rates that have been in place since the PHE.

Recommendation: Promote telehealth adoption and expansion by allowing investment in infrastructure by making the telehealth flexibilities permanent and maintaining payment parity for office visits.

Conclusion:

LUGPA thanks the Committee for undertaking this examination of rural patient access challenges and soliciting concrete solutions to improve healthcare in rural communities. We hope our suggestions are useful and stand ready to work with you to advance these and other complementary solutions. Please feel free to contact Dr. Holton (mholton@aaurology.com), LUGPA's Chairman of Health Policy or LUGPA's Federal representative John McManus (jmcmanus@mcmanusgrp.com) if you have any questions or follow-up.

Sincerely,



Evan R. Goldfischer, MD
President

Mara Holton, MD
Chair, Health Policy

[16] 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

[17] 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.