LUGPA
Integrated Practices Comprehensive Care

October 31, 2024

875 N. Michigan
Avenue, Suite 3100
Chicago, IL 60611
www.lugpa.org

The Honorable Bill Cassidy
United States Senate
455 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Maggie Hassan
United States Senate
324 Hart Senate Office Building
Washington, D.C. 20510

Dear Senators Cassidy and Hassan:

Thank you for issuing your thoughtful white paper promoting site neutrality in Medicare. This issue has been a priority for the Large Urology Group Practice Association (LUGPA) for many years. LUGPA represents private practice urologists, about 40 percent of all urologists in the country, and is a leading advocate of independent medicine. The trends of hospital acquisition of physicians and the growing number of hospital-employed physicians are public policy concerns because they drive up costs to patients and the Medicare program by migrating care to the most expensive setting in healthcare: the hospital.

We wish to comment on the two site-neutral policies in your white paper:

1) **LUGPA supports your recommendation to establish site-neutral payments in off-campus hospital outpatient departments (HOPDs)**.

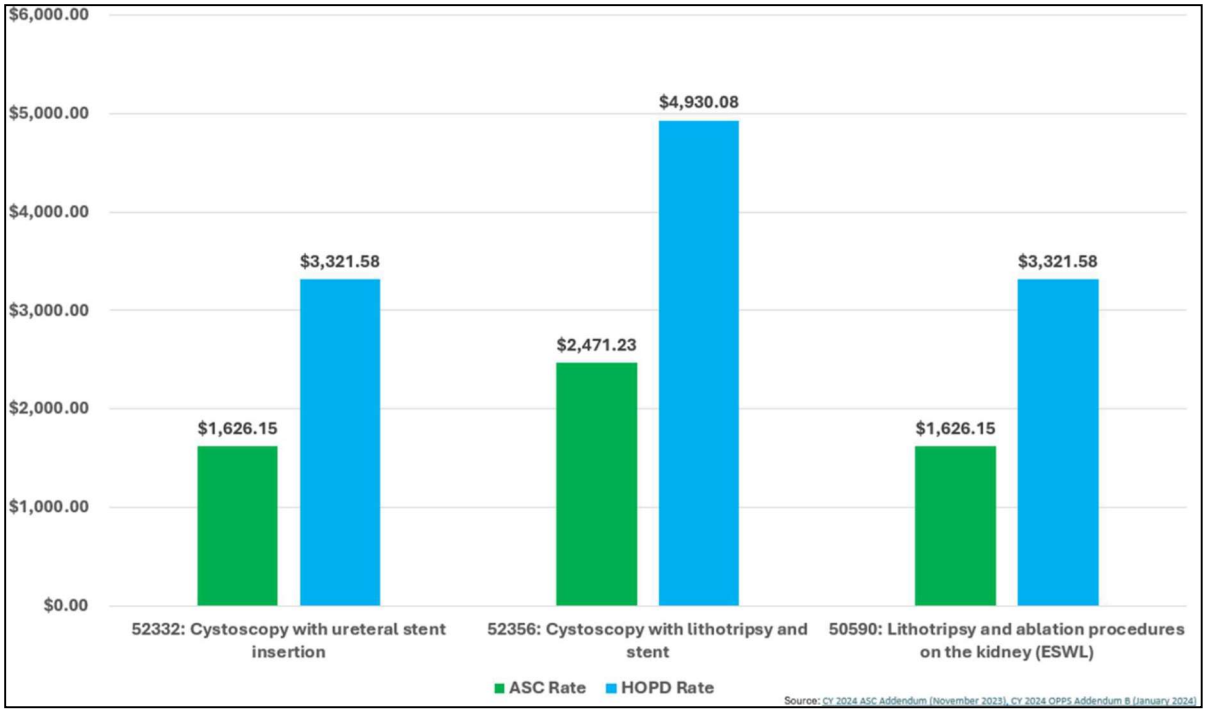
2) **Site-neutral policies for common outpatient procedures should be pursued by:**
   a. **Narrowing payment differentials between sites; and**
   b. **Adopting a majority volume rule for the triggering of site-neutral policies**

More details on our recommendations are provided after we underscore the need for site neutrality reform.

Need for Site Neutrality Legislation

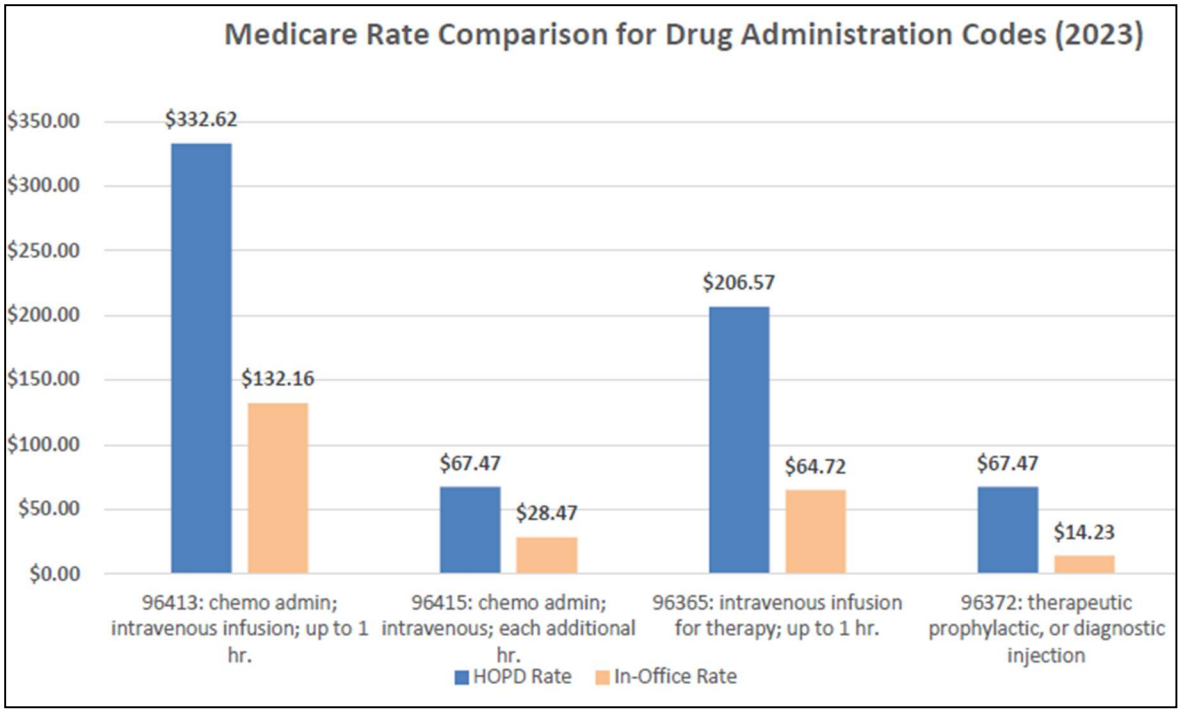
Independent physician practices provide high-quality, accessible care in the community yet are forced to compete with hospitals under payment models that favor these larger, more expensive sites of care. Site-of-service payment differentials are an artifact of historical views that did not anticipate the tremendous technological and clinical innovations that 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's office or ambulatory surgery center (ASC) paradoxically acts as a disincentive to pursuing innovations that could 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 patient treatment options.

As an example, Medicare pays hospitals more than twice the amount as physician offices for a cystoscopy with lithotripsy stent (CPT code 52356), even though this requires essentially the same staff, infrastructure, time, and technical training to perform. Hospitals are paid $4,390, while physician-owned ambulatory surgery centers are paid $2,471.23 for an identical procedure.



Similarly, Medicare pays more than twice as much to hospitals to infuse the same drugs that require the same nurse staff time and technical training compared to what Medicare pays in a physician office ($325.64 in the HOPD setting vs. $140.16 in the physician office).[1] [2] Even more concerning is that the patients are penalized for receiving their physician-administered Part B drug in the physician office because the law caps Medicare beneficiaries' out-of-pocket liability in the HOPD setting at $1,600, yet Medicare beneficiaries who receive their infused drugs in their own doctor's medical office face unlimited liability based on 20% of the total cost. (The IRA capped beneficiary liability for Part D drugs but did not enact a similar cap for Part B drugs, which are typically much more expensive.)

[1] CY 2024 ASC Addendum (November 2023)
[2] CY 2024 OPPS Addendum B (January 2024)



We wish to comment on the two site neutral policies in your white paper:

1. **LUGPA supports your recommendation to establish site neutral payments in off-campus hospital outpatient departments (HOPDs**). Most off-campus HOPDs are actually hospital-acquired physician practices, which enables hospitals to bill Medicare at the higher HOPD rate for providing the same services. We supported the provision in the Bipartisan Budget Act of 2015 to require hospitals to bill at the physician office rate for acquired physician practices, but that has not been properly enforced because CMS cannot track utilization from those sites. A provision in the House-passed "Lower Costs, More Transparency" legislation would resolve this issue and should be advanced to enactment without further delay. This policy should be expanded to apply to all off campus HOPDs – i.e the grandfathered locations. In addition, Congress should prohibit these acquired physician practices, which are now billing as HOPDs, from qualifying for 340B as that program only puts more resources into large hospital systems that is then used for further physician acquisitions and market consolidation.

2. **Site Neutral Policies for Common Outpatient Policies Should Be Pursued by:**

    1. **Narrowing Payment Differentials Between Sites;** Rather than simply cutting HOPD payments to the physician office/ASC level, we encourage you to consider narrowing payment differentials by modestly decreasing HOPD payments and modestly increasing physician office/ASC payments. Substantial net budget savings could still be achieved through this "carrot and stick" approach that both encourages more care in the physician office/ASC setting while deterring costly care in the hospital setting. For example, payments for complex drug administration could be increased in the physician office from $133 to $200 while payments to HOPD could be reduced from $332 to $250. This narrowing approach will better protect patient access and encourage physician offices to take on new patients that

may be turned away from the hospital. Additionally, adopting this policy makes the physician office setting more viable over the long-term and will encourage even greater migration, particularly since that payment system is confronting indefinite payment cuts while hospitals continue to receive robust, compounding payment updates. The savings created thereby could provide a direct and rational strategy to fund a more durable fix to the unsustainable ongoing cuts in MPFS reimbursement and the attendant annual crises that necessitate legislative doc 'fixes'.

2. **Adopting a Majority Volume Rule for the Triggering of Site Neutral Policies**

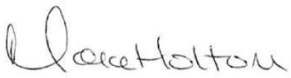
   LUGPA believes a policy to limit payments to the site-of-service that has the plurality of services (e.g. 35 percent), originally suggested by MedPAC, should be modified. We recommend retaining CMS's majority rule of physician office volume to trigger lower ASC payments, as is currently the case.

   The real opportunity for savings in Medicare are the higher cost procedures that could migrate from HOPD to ASC, where no current site-neutrality payment structure applies. A plurality policy could result in excessive payment cuts to the ASC setting could well result in many of those procedures reverting to the HOPD setting rather than diverting them to the physician office. Such an outcome would ironically increase costs to Medicare because savings that ASCs provide in comparison to HOPD would be lost as ASCs abandon these procedures.

Conclusion

We thank you for your leadership on bringing these site neutrality reforms to the table. We look forward to working with you to advance these ideas and bring greater efficiency and competition to the Medicare program and improved access to patients.

Thank you,



Evan R. Goldfischer, MD
President

Mara Holton, MD
Chair, Health Policy