August 1, 2024

The Honorable Charles Schumer
Majority Leader
United States Senate
S-221, The Capitol
Washington, DC 20510

The Honorable Mike Johnson
Speaker
United States House of Representatives
H-232, The Capitol
Washington, DC 20515

The Honorable Mitch McConnell
Minority Leader
United States Senate
S-230, The Capitol
Washington, DC 20510

The Honorable Hakeem Jeffries
Minority Leader
United States House of Representatives
H-204, The Capitol
Washington, DC 20515

Dear Majority Leader Schumer, Minority Leader McConnell, Speaker Johnson, and Minority Leader Jeffries:

As members of the Community Practice Coalition, we are deeply concerned about the recently proposed CY 2025 Physician Fee Schedule, which includes a 2.8% cut to the Medicare Physician Fee Schedule (MPFS). Following years of reductions, these cuts highlight the urgent need for comprehensive reform. If implemented, these cuts will severely impact the financial viability and future survivability of community-based and independent healthcare providers.

The Impact of Payment Disparities

Our coalition, comprising a wide range of medical specialties, including oncology, rheumatology, urology, and women's health, is united in our commitment to serving hundreds of thousands of patients annually. This shared commitment is the driving force behind our advocacy for comprehensive reform.

As community healthcare providers, we have long been concerned about the disparities in payment between hospitals and community and independent practices. For example, Medicare pays hospitals more than twice the amount it pays physician offices for a cystoscopy with lithotripsy stent (CPT code 52356) despite requiring essentially the same staff, infrastructure,

time, and technical training. Hospitals are paid $4,390.00, while physician-owned ambulatory surgery centers receive $2,471.23 for the identical procedure.

Similarly, Medicare pays more than twice as much to hospitals for administering the same drugs that require the same nurse staff time and technical training compared to the amount Medicare pays for the same drug administration in a physician's office ($325.64 in the HOPD setting vs. $140.16 in the physician's office). This discrepancy strains community-based and independent practices and imposes higher costs on patients, who can face higher out-of-pocket liabilities for care furnished in a physician's office.

The Challenge Facing Community and Independent Healthcare: A Crisis

The costs of providing healthcare in our communities continue to escalate. CMS's announcement of generous payment updates for large hospital systems is equally troubling, as it worsens the historical disparity jeopardizing the survival of community-based and independent practices, and patients' access to care in rural and underserved areas.

These cuts echo the failures of the Sustainable Growth Rate (SGR) formula, which repeatedly pushed providers to fiscal cliffs. The cumulative effect will devastate community and independent practices, exacerbating the impacts of inflation and ongoing staffing and supply chain issues. Moreover, community-based practices and independent practitioners have been marginalized in alternative payment models (APMs), with insufficient support for specialty-care value arrangements.

Our Recommendations for Reform

To support our healthcare system, particularly for chronically ill patients, we urge Congress to take action by implementing the following recommendations:

I. Reform Payment Updates:

> **Eliminate Pending Cuts:** Eliminate the proposed Medicare Physician Fee Schedule cuts, including those resulting from reductions in the Medicare Conversion Factor. This is critical to maintaining the financial viability of community-based and independent practices.
>
> **Reflect Actual Costs:** To ensure reliable and predictable payment updates, replace the current payment system with a methodology that reflects the actual costs of care, such as at least the Medicare Economic Index (MEI). Temporary patches and minor updates are inadequate to address the financial realities faced by community-based and independent healthcare providers.

II. Promote Community-Focused Payment Models:

PTAC Reform: Reform the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to include meaningful input from community-based and independent healthcare providers in developing and reviewing alternative payment models.

CMS Pilot Programs: Mandate CMS to pilot PTAC-approved APMs and encourage the Center for Medicare and Medicaid Innovation (CMMI) to adopt community-focused payment models independently of the PTAC process. This will ensure that community-based and independent practices' unique needs are considered and addressed.

III. Revise MIPS and Quality Metrics:

Eliminate the Zero-Sum Game: Reform or repeal the zero-sum nature of the Merit-Based Incentive Payment System (MIPS) to meaningfully reward quality and value.

Incentivize High Performance: Eliminate the winner/loser system in MIPS and expand the $500 million bonus pool for exceptional performers. This will encourage higher standards of care and reward those who achieve them.

Meaningful Metrics: Direct CMS to develop clinically meaningful metrics, expanding the number of specialty-specific quality measures while minimizing provider documentation burdens. This will ensure that quality metrics are relevant and feasible for community-based and independent practices.

IV. Achieve Site-Neutral Payments:

Equalize Payments: Move toward true site-neutral payments for physician-administered drugs and outpatient surgical procedures. This will address the significant payment disparities between hospital and community-based/independent practice settings.

Adjust Reimbursement Rates: Modestly decrease hospital payments while increasing community-based/independent practice payments to ensure equitable reimbursement. This will help level the playing field and support the financial sustainability of community-based and independent practices.

V. Support Administrative Reforms:

Codify Reforms: Codify and build upon administrative reforms to the Stark and Anti-Kickback laws to incentivize innovative, integrated, value-based care models. This will support the development of more efficient and effective care delivery models.

Risk-Sharing Arrangements: Transition towards risk-sharing arrangements that align payments with outcomes and expenditures. This will further incentivize providers to focus on delivering high-quality, cost-effective care.

The Consequences of Inaction

If these payment cuts and disparities are not addressed, community-based and independent practices will continue to struggle to remain financially viable. The shift of healthcare services from community-based and independent practices to higher-cost hospital settings will accelerate, further increasing costs for Medicare and patients. This will undermine efforts to provide high-quality, accessible care in local communities and exacerbate healthcare access challenges in rural and underserved areas.

Conclusion

Congress must act swiftly to avert statutory payment cuts and address payment disparities threatening the viability of community-based and independent healthcare practices. By implementing the recommendations outlined above, we can ensure that community and independent practices have the financial stability they need to continue providing essential healthcare services. These reforms are critical to maintaining equitable access to high-quality care for all Americans.

Thank you for your attention to this critical matter. We look forward to working with you to achieve meaningful reforms that strengthen our healthcare system.

Sincerely,

Evan Goldfischer, MD
President
LUGPA

Jack Feltz, MD
President
U.S. Women's Health Alliance

Jeffrey Racca, MD
Advocacy Chair,
The OrthoForum

Madelaine A. Feldman, MD, FACR
VP, Advocacy & Government Affairs
Coalition of State Rheumatology Organizations