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Dear Drs. Chernew and Mathews:

The undersigned organizations appreciate MedPAC's work in advising Congress on issues affecting the Medicare program and the opportunity to comment on MedPAC's June 2022 Report to the Congress: Medicare and the Health Care Delivery System (Report). We write to share our concerns regarding the Commission's recommendation that there be an alignment of fee-for-service payment rates across ambulatory settings. While we are generally supportive of site-neutral payments, simply setting payment rates for a certain service equal to the setting with the lowest payment is not the solution. Slashing all payments to the lowest amount in any setting will create instability in the market and may lead to situations where services are no longer provided due to such a significant reduction in reimbursement, particularly in underserved areas.

In Chapter 6 of the Report, it states that varying Medicare payment rates across different settings "encourage[s] arrangements among providers—such as the consolidation of physician practices with hospitals—that result in care being billed at the payment rates of the provider with the highest rates, increasing program and beneficiary spending without meaningful changes in patient care." As discussed in the Report, to remedy this, Congress passed the Bipartisan Budget Act of 2015 (BBA), which directed CMS to develop a limited payment system that more closely aligned payment rates between hospital outpatient departments (HOPDs) and freestanding facilities.

In the 2017 Hospital Outpatient Prospective Payment System (HOPPS) final rule, CMS finalized new Medicare Physician Fee Schedule (MPFS) payment amounts for nonexcepted items and services furnished by nonexcepted provider-based departments (PBDs) that bill under the HOPPS. Nonexcepted items and services, as well as nonexcepted providers, were those items and services that were rendered by providers in PBDs, that were billed under the HOPPS after the BBA. The Agency adopted payment rates for these items and services that were based on a 50% reduction, also known as the Physician Fee Schedule Relativity Adjuster, to the OPSS payment rates for 2017. At the time, CMS stated that the application of the adjuster would be a transitional policy until more precise data became available. Then, in 2019, CMS went further and reduced the HOPPS payment rates to more closely align with the MPFS rate for office visits that take place in any off-campus PBD.

MedPAC analyzed HOPPS ambulatory payment classifications (APCs) to determine if an ambulatory service should continue to have different payment rates across the three settings, and determined that, "The services in many of the 57 APCs suitable for payment rate alignment are overwhelmingly provided in physician offices...suggesting that, for these APCs, the PFS payment rates are adequate for patients of any complexity."

We disagree. It cannot be assumed that MPFS payment rates are adequate—there is a significant difference between what MPFS pays and what it costs to run a modern medical practice. What’s more, the MPFS does not take into account annual inflation (HOPPS does), so the contrast between HOPPS and MPFS rates cannot be chalked up to overpayments in HOPPS. When adjusted for inflation, Medicare physician pay has declined 19% from 2001 to 2018, while the cost of running a medical practice has increased 32% in the same period.¹ Yet, in MedPAC’s March 2022 Report, it recommended a continued freeze on Medicare physician payment rates under current law.

The steady declines over the years in MPFS reimbursement rates have been untenable for many practices across the country, particularly in rural and underserved areas. Aligning payment rates across all settings to the lowest common denominator would not allow for high-quality health care in many parts of the country, and that is why we support Medicare payment parity policies that do not lower total Medicare payments. At a minimum, any payment alignment should be implemented in a budget neutral manner, and the savings should be reinvested into the MPFS to adequately compensate physician practices.

Additionally, payments should be based on the service itself rather than where it is provided, which requires accurate and reliable data. Here we note the significant differences between how resource costs are determined for the HOPPS versus the MPFS. HOPPS rates are calculated using a geometric mean of the costs of services in the same APC, whereas MPFS rates are determined using recommendations from the Resource-Based Relative Value Scale (RBRVS) Update Committee (RUC). The RUC process uses a “bottom-up” methodology where the resource costs of a particular service are added line-by-line to calculate the actual costs of providing that service.

Further, a portion of the payment for a service provided in a freestanding facility typically has a higher practice expense component to reflect the cost of clinical staff, medical supplies and equipment, and overhead incurred by the physician, while a service provided in an ASC or HOPD receives a separate payment to cover these same expenses, which are incurred by the facility. To equate these methodologies fails to recognize the intrinsic differences in providing a service in different settings.

We urge MedPAC to consider reasonable alternatives that take into account these distinctions rather than pursuing a methodology that will jeopardize practice viability and create access to care issues. Thank you for the opportunity to comment on this report. If you have any questions, please contact Adam Greathouse, Senior Manager of Health Policy, at 703-839-7376 or Adam.Greathouse@astro.org.

Respectfully,

Alliance of Wound Care Stakeholders

¹ <https://www.ama-assn.org/system/files/2019-05/issue-brief-pay-variations-outpatient-sites.pdf>

American College of Radiation Oncology
American College of Radiology
American Society for Diagnostic and Interventional Nephrology
American Society for Radiation Oncology
American Society of Nephrology
American Vein & Lymphatic Society
American Venous Forum
CardioVascular Coalition
Dialysis Vascular Access Coalition
Outpatient Endovascular and Interventional Society
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
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