



AMERICAN COLLEGE OF GASTROENTEROLOGY

11333 Woodglenn Drive, Suite 100, North Bethesda, Maryland, 20852-3071
P: 301-263-9000; F: 301-263-9025; Website: www.gi.org

June 14, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Wyden and Ranking Member Crapo:

The American College of Gastroenterology (ACG) appreciates the opportunity to comment on the Senate Committee on Finance's white paper entitled, *Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B*. We applaud the Committee for taking steps to address the financial and regulatory burdens that independent medical providers experience, which also would improve access to patient care.

ACG is a physician organization representing gastroenterologists and other gastrointestinal (GI) specialists. Founded in 1932, and representing nearly 20,000 GI clinicians, ACG's mission is to enhance the ability of our members to provide world class care to patients with digestive disorders and advance the profession through excellence and innovation based upon the pillars of patient care, education, scientific investigation, advocacy, and practice management.

Our top policy priorities are to increase access to patient care and preserve the sanctity of the patient-provider relationship. Specifically, ACG believes that:

1. Medicare physician reimbursement impacts patient care and access to health care services.
2. The lack of Medicare physician reimbursement reform contributes to physician practice consolidation and provider burnout and slows down healthcare innovation and the development of new technologies in patient care.
3. Medicare physician reimbursement must, at a minimum, keep up with inflation and the rising costs of providing healthcare services.
4. The Medicare "budget neutrality" statutory requirement is unfair, unwarranted, and is a leading cause of annual Medicare reimbursement temporary fixes and legislative emergencies.
5. Any quality reporting program tied to Medicare reimbursement must be carefully implemented, including an accurate assessment of the time, practice burdens, and costs associated with these quality reporting programs.
6. Prior authorization and step therapy protocols should be eliminated or meaningfully restricted to preserve patient care and prevent avoidable adverse events.

Physician Payment Reform

The U.S. is experiencing one of the greatest crises in the healthcare workforce today. GI practices cannot compete with staffing shortages in a time of declining reimbursement. The annual “doc fix”—legislation passed by Congress to decrease cuts to provider reimbursement—is due to an antiquated Medicare reimbursement system and overdue need for reform. This is a larger, systemic problem that impacts patient care and the practice of medicine.

Addressing Concerns regarding Budget Neutrality in the Medicare Physician Fee Schedule (PFS)

Should the Committee consider additional parameters to align the statute’s budget neutrality provisions with the goal of maintaining fiscal integrity, as well as to avert or mitigate substantial payment fluctuations and volatility resulting from regulatory policy changes?

Congressional action is the only solution to address Medicare reimbursement reform. Budget neutrality and lack of inflationary updates are the root causes of inadequate Medicare physician payment. The *Social Security Act* (the Act) provides that overall Medicare reimbursement spending cannot be higher than the total spending of the baseline year or starting point. Based on ACG’s review of the Medicare provisions in the Act, the “base year” is 1994. Due to budget neutrality requirements, increases to one specialty’s reimbursement requires cuts to another. Specifically, changes in relative value units (RVUs) over \$20 million require a decrease in overall reimbursement applied via a conversion factor (CF) reduction to preserve budget neutrality. This is problematic given the \$20 million threshold is in statute and has neither changed nor been adjusted for inflation since it was established in 1994. Congressional action is critical to fix this system, given Congress is the only branch of government that can make these permanent reforms.

We also urge Congress to remain mindful of its actions that may exacerbate reimbursement issues. Specifically, Congress should not pass legislation that results in incremental cuts to Medicare reimbursement, such as laws with corresponding impacts due to pay-as-you-go (PAYGO) requirements and/or sequestration. These provisions (and the budget neutrality requirements) adversely impact overall reimbursement.

Conversion Factor Fluctuations and Constraints

As an alternative to the current-law updates, how should the conversion factor (CF) be updated to provide greater certainty for clinicians moving forward, including in light of inflationary dynamics?

The calculations under the PFS are simply antiquated and failing. They also include limited transparency for providers to fully understand or recreate the calculations. Congress has repeatedly had to step in for what has now become an annual routine of temporary corrections to forgo cuts to providers. Of note, under current law, *there is no administrative or judicial review of Medicare reimbursement changes*. We urge Congress to ensure that the Centers for Medicare & Medicaid (CMS) follow the law when establishing regulations. Only Congress has the oversight, jurisdiction, and authority to make any changes. The lack of administrative and judicial review significantly impacts physicians’ ability to understand both why and

how their reimbursement is changing on an annual basis and to take steps to hold the agency accountable for these changes.

In its March 2024 report¹, the Medicare Payment Advisory Commission (MedPAC) recommended an increase for physician payment that is 50 percent of the projected Medicare Economic Index (MEI) increase (for 2024, this would be an additional 1.3 percent increase). MedPAC also recommended a permanent update to physician payments, as opposed to the annual “doc fix” that has occurred in recent years. While ACG is encouraged to see MedPAC’s recommendation tying reimbursement to the MEI, doing so at only 50 percent would still result in Medicare payment reimbursement lagging behind inflation given the ever-increasing costs of running a practice. Furthermore, unlike Congress, MedPAC recommendations are just that – non-binding recommendations.

The discrepancy between the cost of running a practice and payment, illustrated by the two charts below, is a leading contributor to patient access challenges, consolidation, and provider burnout. The administrative burden of participating in Medicare and the Merit-based Incentive Payment System (MIPS) also exacerbates these issues.

Chart One includes analysis from the American Medical Association (AMA) which highlights that from 2001 to 2024 cumulative Medicare physician payment updates are 46 percent less than cumulative practice cost inflation.

Chart One
Medicare updates compared to inflation in practice costs (2001-2024)

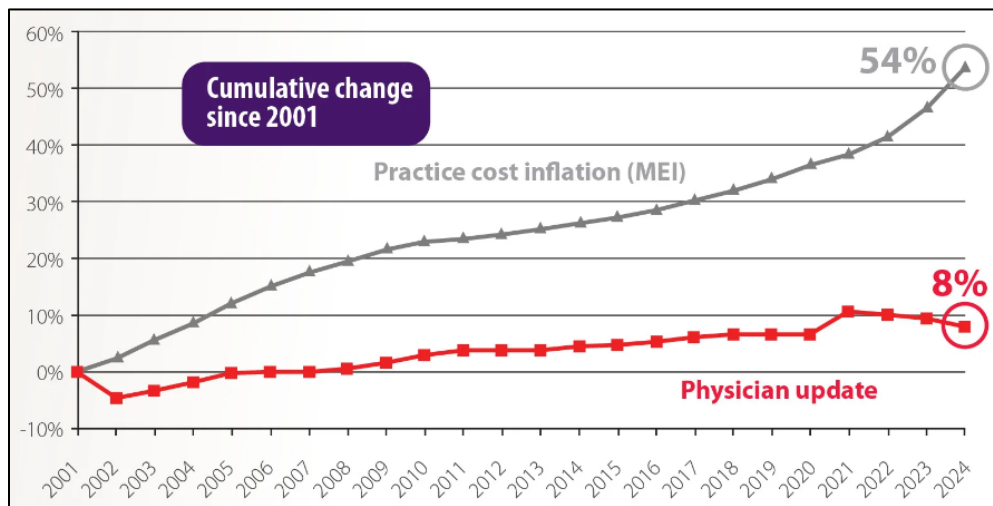
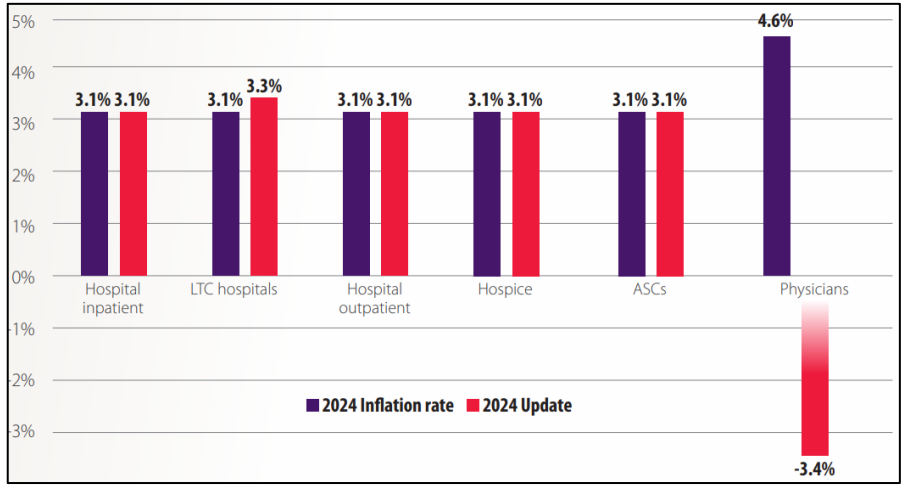


Chart Two illustrates a comparative analysis from AMA on Medicare physician reimbursement across various facilities. Of note, in 2024, Medicare payment updates are scheduled for all providers *except for* physicians.

¹ See https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf.

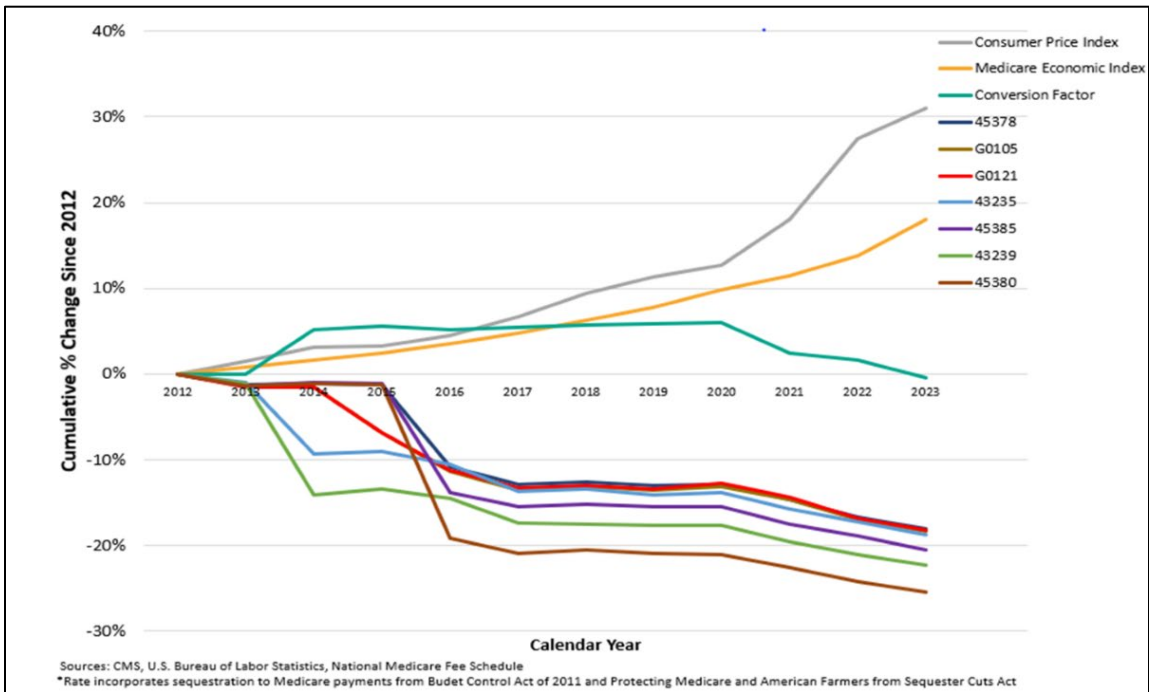
Chart Two
Medicare payment updates for providers in 2024



Physicians, unlike hospitals and outpatient facilities, do not receive an annual inflationary adjustment to Medicare payment. ACG continues to support policies which would provide an annual PFS update tied to inflation (measured by the MEI, ACG’s best estimate of the cost of running a practice). This is compounded by Medicare’s budget neutrality provision, which is detailed above.

Chart Three further illustrates how payment for GI services has decreased, given inflation is not considered when establishing physician payment.

Chart Three



Congress passed the *Omnibus Budget Reconciliation Act of 1989*, which established the components of the CF and annual update. The CF is a dollar amount that reflects the legislative, regulatory, and reimbursement policy changes for that year. Prior to 2015, the MEI, in combination with the sustainable growth rate (SGR) formula, was used to annually update the CF. Today, the CF is CMS’s primary tool to comply with budget neutrality requirements, creating a “robbing Peter to pay Paul” paradox. These constraints must be removed or the downward payment spiral will continue in perpetuity.

Protecting Patient Access to Community-Based Care

The community doctor, whether it is a family medicine physician or gastroenterologist, is the lifeblood of local communities. A vibrant community needs access to healthcare services. Yet, it is estimated that it requires roughly \$100,000 just to start an independent medical practice.² More than 100,000 doctors have left private practice and become employees of hospitals and other corporate entities since 2019.³ Nearly three in four physicians are employees of larger health care entities or other corporations.⁴ The spike in the cost of managing a medical practice—whether in primary care or other specialty— has played a significant role per surges in costs for labor, rent, and premiums for malpractice insurance.⁵ Furthermore, physicians have had to make significant investments in information technology, cybersecurity, and electronic health records (EHRs).

According to a new analysis, in the past 10 years, there has been a dramatic shift in physician practice ownership as less than half of doctors now work in private practices. Doctors are continuing to abandon private practice in favor of direct or indirect hospital employment, according to an AMA study of physician practice arrangements.⁶ Between 2012 and 2022 the share of physicians working in private practices fell by 13 percent, from 60.1 percent to 46.7 percent. In contrast, the share of physicians working in hospitals as direct employees or contractors increased from 5.6 percent to 9.6 percent in the same 10-year time period and the share of physicians working in practices at least partially owned by a hospital or health system increased from 23.4 percent to 31.3 percent, according to a benchmark analysis from the AMA.⁷

In addition, the “Physician Practice Benchmark Survey” found that, in 2022, 46.7 percent of doctors worked in wholly-owned physician practices, down from 49 percent in 2020 and 60 percent in 2012, the first year of the survey. Conversely, 31.3 percent of doctors worked in practices that were wholly or partially hospital-owned, up from 30.5 percent in 2020 and 23.4 percent in 2012.⁸ The percentage of doctors employed directly by hospitals or working as contractors rose to 9.6 percent from 9.3 percent in 2020 and 5.6 percent in 2012. Respondents cited the ability to negotiate higher payment rates as the

² See <https://www.businessnewsdaily.com/8910-opening-a-medical-practice.html>.

³ See <https://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21>.

⁴ See <https://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21>.

⁵ See <https://www.mgma.com/mgma-stats/mgma-poll-an-almost-universal-financial-pinch-on-medical-practices-as-inflation-rises>.

⁶ See <https://www.medicaleconomics.com/view/ama-analysis-private-practice-dwindling>; <https://www.medicaleconomics.com/view/employed-physicians-outnumber-independent-physicians-first-time-ever>.

⁷ See <https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf>.

⁸ See <https://www.medicaleconomics.com/view/pay-productivity-up-for-doctors-in-hospital-owned-practices>.

biggest reason for joining a hospital, with 79.5 percent calling it “important” or “very important.” That was followed by the need to better manage payers’ regulatory and administrative requirements (71.4 percent) and wanting to obtain better access to costly resources (69 percent).⁹ While practice ownership has declined among physicians of all ages, the sharpest drop—from 44.3 percent to 31.7 percent—occurred among doctors under age 45. The smallest decrease, from 54 percent to 49.7 percent, was among those age 55 to 64.¹⁰

Unfortunately, the days of the trusted community doctors – like many of ACG’s members – are changing. Data illustrates that the costs and quality of care provided in independent practice versus larger, integrated practice and health systems impact patient care differ.¹¹ In short, the independent physician has direct control over the quality of patient care. This is not to disparage in any way the quality of care in other settings – but it should never be forgotten that it is only in an independent practice in which the physician is the direct and final arbiter of such decisions and actions. This is a matter of great pride among gastroenterologists and, historically speaking, all physicians.

While different practices and markets have unique challenges, Congress must address the antiquated requirements of the Medicare physician payment system and unnecessary regulatory burdens that have and will continue to lead to barriers to health care access and physician burnout.

Reducing Physician Burnout & Administrative and Financial Burden

Physician burnout is a major threat to health care quality, patient outcomes, and the vitality of the medical workforce. More than half of U.S. physicians report at least one symptom of burnout—nearly twice the rate of the general working population—and many also experience depression, anxiety, or suicidal ideation. Burnout is estimated to cost the health care system at least \$4.6 billion annually, with the greatest burden attributable to turnover and work-hour reductions among primary care physicians.¹²

According to *Medscape’s* 2024 “Physician Burnout and Depression Report,” published in January 2024, gastroenterology has among the highest percentage of burn-out practitioners at 50 percent.¹³ The top factors contributing to physician burnout include, in part: too many bureaucratic tasks (62 percent); too many hours at work (41 percent); insufficient compensation (38 percent); lack of control/autonomy (32 percent); and government regulations (13 percent).¹⁴ The forces that are driving burnout are the pressure to care for too many patients with little time and few resources as well as reimbursement and administrative burdens.

ACG is committed to addressing provider wellness and physician burnout. We have published various articles and educational materials on methods to improve the mental well-being of our membership and colleagues. ACG is making every effort to support clinical gastroenterology and our communities.

⁹ See <https://www.medicaleconomics.com/view/top-8-worst-administrative-hassles-according-physicians>.

¹⁰ See <https://www.ama-assn.org/press-center/press-releases/ama-examines-decade-change-physician-practice-ownership-and>.

¹¹ See <https://hms.harvard.edu/news/what-happens-when-private-equity-takes-over-hospital#:~:text=National%20study%20of%20quality%20of,younger%20and%20less%20disadvantaged%20patients>.

¹² See <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2802872>.

¹³ See <https://www.beckersasc.com/asc-news/physician-specialties-with-the-highest-burnout-rates.html#3>.

¹⁴ See <https://www.beckersasc.com/asc-news/the-factors-contributing-to-physician-burnout.html>.

However, we need Congress's help. Independent practices are stretched and stressed, and the system is breaking.

Reducing Physician Reporting Burden Related to MIPS

Most notably, providers experience administrative and financial burden associated with participation in MIPS. For 2024, CMS estimated roughly 38 hours of work per clinician was required, at a cost of nearly \$7,800. Recent research published in JAMA suggests those figures are woefully low, where an average of \$12,811 per physician was spent to participate in MIPS in 2019.¹⁵ In addition, clinicians and administrators spent more than 200 hours per physician on MIPS-related activities. It is critical that Congress act to reduce these burdens.

Conclusion

ACG appreciates your leadership in addressing the many challenges providers, especially GIs, face in the U.S. healthcare system. We urge your continued commitment to addressing the financial and regulatory burdens that independent medical providers experience through enacting legislation reforming physician payment and decreasing administrative burden. We look forward to working with the Committee to ensure increased access to care for patients.

¹⁵ See <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947>.