



Testimony of Dr. Michael Weinstein

**President, Digestive Health Physicians Association
Before the Energy & Commerce Subcommittee on Health
“Examining Barriers to Expanding Innovative,
Value-Based Care in Medicare”**

September 13, 2018

Chairman Burgess and Ranking Member Green,

Thank you for inviting me to testify regarding the importance of removing barriers to value-based care in Medicare. I am Dr. Michael Weinstein, a practicing gastroenterologist and President of Capital Digestive Care, an independent physician practice with 65 GI doctors in 17 locations in the greater Washington DC metropolitan area. I am also President of the Digestive Health Physicians Association (DHPA), which represents 78 GI practices in 36 states with more than 1,800 gastroenterologists. DHPA’s member practices care for hundreds of thousands of Medicare beneficiaries each year.

Independent physician practices provide high quality, accessible care in the community at a much lower cost than identical services in the hospital setting, yet value-based arrangements are generally not available to them. Physician practices are facing increasing challenges competing with mega-hospital systems, in part, because antiquated Medicare law and regulations

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generally favor hospital systems. Congress and the Centers for Medicare and Medicaid Services (CMS) could do much to level the playing field, improve care coordination, cut costs and promote value-based delivery to patients by:

- 1) Promoting greater transparency for patients across sites of care;
- 2) Providing improved access to claims and utilization data in order to build innovative payment arrangements; and
- 3) Modernizing the Stark and associated fraud and abuse laws, which are an impediment to development and implementation of innovative alternative payment models (APMs), particularly for independent practices.

Together, hospital and physician services account for more than half of national health spending,¹ and their finances are increasingly intertwined. Hospitals recently embarked on a buying spree of physician practices, with the number of hospital-employed physicians increasing 50 percent from 2012 to 2015.² This has impacted costs, as hospitals seek to recoup these investments that typically far exceed the value of services the acquired physicians could possibly bill.³ Hospitals make up this loss by capturing highly profitable ancillary services – the very same “designated health services” regulated by the Stark self-referral law.

¹ CMS. National Health Expenditures 2016 Highlights, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

² Avalere and Physicians Advocacy Institute. Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012- 2016; <http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/2016-PAI-Physician-Employment-Study-Final.pdf>

³ According to the Medical Group Management Association, losses of \$200,000 per hospital-employed physician are not unusual. MGMA Cost Survey: 2013 Report Based on 2012 Data. <http://www.mgma.com/resources/products/mgma-2013-practice-operations> report.

Provider consolidation has clearly led to higher costs of care.^{4,5} Congress took a modest step in addressing consolidation in the Bipartisan Budget Act of 2015 by prohibiting a windfall of higher, hospital-based payments for future acquisitions of physician practices, yet significant payment disparities for high volume services persist.

For example, Medicare pays nearly twice as much for the two highest-volume colonoscopy procedures in the hospital outpatient department as the identical procedures in an ambulatory surgery center (ASC). There is no clinical reason that nearly half of the 2.7 million colonoscopies continue to be performed in the more expensive setting.

Policymakers should be doing more to encourage a robust, competitive market that allows independent practices to compete and deliver value-based care, which will improve patient care and lower costs.

⁴ A recent JAMA study that examined 7.4 million Medicare beneficiaries in 240 metropolitan areas from 2008 to 2012 concluded outpatient costs increased for hospital-acquired physician practices by \$500 million. Neprash, H., Chernew, M., Hicks, A., Gibson, T., and McWilliams, J. (2015). Association of financial integration between physicians and hospitals with commercial health care prices. *JAMA Internal Medicine*, 175(12):1932–1939; <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2463591>.

⁵Analogous 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, hospital, laboratory and pharmacy services. Robinson, J. and Miller, K. (2014). Total expenditures per patient in hospital-owned and physician organizations in California. *JAMA*, 312(6):1663–1669; available at <https://jamanetwork.com/journals/jama/fullarticle/1917439>.

First, patients need better and more accessible information about their treatment options. For example, under the law, a screening colonoscopy – regardless of where it is provided – has no copay and the patient is likely to have no idea that there is a substantial cost differential to Medicare (and consequently, their Part B premium) when provided in the hospital rather in a physician-owned ASC. Similarly, patients should be able to access uniform quality and patient outcome metrics across sites-of-service for identical procedures. Disparate quality measures for each site-of-service do not allow for digestible apple-to-apples comparisons by patients considering their treatment options.

Second, Congress and CMS must improve the system to develop, evaluate and approve APMs. A couple of years ago, CMS projected that 10 to 20 percent of physicians would be enrolled in an APM by 2017. Today, that number stands at a paltry 5 percent. Hospital-employed physicians are often participating in an APM through system-sponsored ACOs. If independent physicians are effectively shut out of APM participation, they have very little chance to move from fee-for-service to value-based care, improve care coordination and compete with mega-hospital systems. Moreover, it means that Medicare is not moving to value-based models for much of specialty-related care delivered outside of hospitals.

One challenge is ready and affordable access to utilization data needed to model and develop innovative payment arrangements. To gain access to complete Medicare claims (Limited Data Sets Standard Analytical Files), stakeholders must send a request to CMS, which CMS

states can take up to eight weeks to process and respond. Moreover, access to this data is costly: CMS charges \$4,500 for one year of data for the HOPD and ASC setting.⁶ Multiple years of data are typically needed for meaningful trend analysis, making access cost-prohibitive for many. This de-identified Medicare utilization information should be available to the public, researchers and stakeholders for free on a public website.

Under MACRA, Congress established the Physician-Focused Payment Model Technical Advisory Committee (PTAC), to facilitate, evaluate and recommend physician-developed APMs in Medicare. Unfortunately, *CMS has yet to implement a single APM recommended by PTAC* despite PTAC's review of 26 APM submissions, with five recommended for implementation and six for limited-scale testing. More troubling, even if the PTAC system were operational, a very small portion of the Medicare population would be enrolled in APMs because many stakeholders cannot know whether those models would work in the real world and have therefore refrained from submitting proposals.

The Medicare statute permits the Department of Health and Human Services to waive the Stark and other fraud and abuse laws on a case-by-case basis for approved APMs. It does not, however, allow providers to test a submitted APM while it is pending approval.

⁶ CMS, Standard Analytical Files (Medicare Claims), LDS Worksheet, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/StandardAnalyticalFiles.html>

For example, two years ago DHPA member practice Illinois Gastroenterology Group submitted “Project Sonar” – a care management program designed to improve the management of patients with high-beta chronic inflammatory bowel disease (IBD), where outcome and cost are highly variable – to the PTAC. Project Sonar shifts management and care of patients from a reactive to a proactive model, inducing the transformation of the practice from fee-for-service to a value-based payment model. Although PTAC approved Project Sonar on a pilot basis, practices were not able to test the project while awaiting a CMS decision. This is disappointing, as Project Sonar would have allowed physicians to assume risk for their patients with chronic diseases and conditions (that are not triggered by a surgical procedure on an inpatient or outpatient basis) as well as improve patient outcomes and create shared savings. Testing would have provided both clinicians and policymakers with critical information on whether the APM had merit worthy of approval and implementation.

At the same time, the Affordable Care Act granted the Secretary the authority to waive the Stark law, the Anti-kickback Statute and Civil Monetary Penalties for Medicare Shared Savings Program accountable care organizations (ACOs), creating an unlevel playing field that generally favors hospital systems. Not only did this fuel provider consolidation as specialists were often threatened with being frozen out of networks unless they joined an ACO, but the ACOs have failed to produce meaningful savings to the Medicare program.⁷ Independent

⁷ The Medicare Shared Savings Program (MSSP) increased federal spending by \$384 million from 2013 to 2016. Avalere Analysis on Medicare Accountable Care Organizations based on CMS data, available at <http://avalere.com/expertise/managed-care/insights/medicare-accountable-care-organizations-have-increased-federal-spending-con>

physicians are simply seeking the same waiver authority under MACRA that was afforded to ACOs under the ACA.

We do not advocate fundamentally amending the Stark self-referral law in the context of fee-for-service. But we do think the law needs to be modernized to encourage participation and success in APMs. Prohibitions on remuneration for “value or volume” make no sense under capitated or at-risk arrangements that seek to incentivize appropriate physician behavior for adherence to recognized treatment pathways. Medicare’s fiscal exposure is limited but practices cannot penalize or reward their physicians with designated health services revenue based on their ability to deliver value. How can Medicare promote value-based care if physicians are explicitly prohibited from remunerating based on value in the statute?

Solutions are available and achievable. DHPA was delighted to join 24 other physician organizations from across the house of medicine in endorsing “The Medicare Care Coordination Improvement Act” (H.R. 4206), authored by Reps. Bucshon and Ruiz, which would make several important and targeted modernizations to the Stark law. That bill would provide the Secretary the identical authority to waive statutory impediments for physician-focused APMs as provided to ACOs. It would also repeal the “volume and value” prohibitions for physicians participating in APMs.

Finally, it permits physicians to test formally submitted and recognized models while they are under review by CMS. Enacting such improvements would dramatically increase physician participation in value-based care.

We look forward to working with the Committee on these ideas to strengthen the Medicare program, improve patient care and conserve resources.