American Society for
Gastrointestinal Endoscopy

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January 22, 2025

The Honorable Bill Cassidy, M.D.
U.S. Senate
455 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Maggie Hassan
U.S. Senate
324 Hart Senate Office Building
Washington, D.C. 20510

Dear Senators Cassidy and Hassan:

On behalf of the American Society for Gastrointestinal Endoscopy (ASGE), I commend your commitments to lower health care costs for our nation's seniors and offer the ASGE's perspectives on your recently released framework that presents policy options for site-neutral payment reform.

Imposing the Lower Non-hospital Rate

Your framework proposes a site-neutral policy option that would impose the lower non-hospital rate (physician or ambulatory) for services that are "most commonly performed" in either a physician or ambulatory setting. Office-based procedures are services the Centers for Medicare and Medicaid Services (CMS) began paying for in ambulatory surgery centers (ASCs) in 2008 or later that are performed in physicians' offices at least 50 percent of the time. Current Medicare policy dictates that payment is the lower of the standard ASC rate or the practice expense portion of the physician fee schedule rate that applies when the service is furnished in a physician's office (this amount covers the equipment, supplies, non-physician staff, and overhead costs of a service). **CMS set a limit on the ASC rate for new, office-based services to mitigate financial incentives to shift services from physicians' offices to ASCs.[1] Given current policy, it is unnecessary to subject free-standing, independently owned ASCs to new site-neutral policies.**

In your framework overview, you write, "The Centers for Medicare & Medicaid Services, the Government Accountability Office (GAO), and the Medicare Payment Advisory Committee (MedPAC) have all found that for many low-acuity procedures, these different reimbursement rates do not reflect real differences in the quality of a procedure or the provider's cost of performing a procedure." In response, we point out that even for services deemed low-acuity, high-risk, or complicated, patients require additional resources, such as increased monitoring, specialized staff, or longer recovery times. While the actual procedural resources may remain consistent between an ASC and the hospital outpatient department (HOPD), the hospital provides a "safety net," including access to emergency backup if complications arise. This distinction can be important when evaluating resource utilization and reimbursement models.

Geographic Variability

The vast majority of gastrointestinal endoscopy procedures are provided in ASCs and HOPDs. Endoscopy procedures are also provided safely in physicians' offices; although, the prevalence of office-based endoscopy is dependent upon a number of external factors, including state licensing and regulatory requirements, as well as state certificate of need laws that may restrict the expansion of ASCs.

The effects of site-neutral payment policies are likely to vary by geography. For example, while certain endoscopy procedures are most commonly performed in ASCs, ASCs tend to be more geographically concentrated. Consequently, as MedPAC points out, beneficiaries could have difficulty accessing services subject to payment rate alignment,[ii] such as colorectal cancer screening colonoscopy, if hospitals reduce the provision of a service and the area lacks an ASC presence. **We recommend that in addition to reinvesting in rural and safety net hospitals that could face financial difficulties as a result of site-neutral payment policies, special consideration be given to geographic locations that lack sufficient alternatives to HOPDs for services otherwise most commonly performed in ASCs.**

HOPD and ASC Supply Acquisition Cost Variability

The HOPD and ASC share similar cost components, such as human resources; however, many endoscopy services that could be safely provided in the ASC are still scheduled in the HOPD because of the expense associated with capital equipment or disposable equipment (such as hemostatic clips, endoscopic ultrasound needles and endoscopic guide wires) involved with the procedure. Higher hospital outpatient payments better capture the cost of expensive medical equipment. Further, ASCs do not have the same purchasing leverage as hospitals to drive down the cost of these necessary endoscopic tools — costs that are rising as manufacturers move increasingly toward disposable equipment. For example, the volume of upper GI endoscopy procedures with guide wire insertion provided in ASCs remains low compared to the HOPD and actually fell from 2017 to 2022,[iii] which could be due to several factors, including the cost of the guide wire.

Site neutral payment should also recognize that certain services that could migrate to the ASC are not because of ASC payment *inadequacy*. Therefore, if a goal is to relieve Medicare beneficiaries from high out-of-pocket spending, including by obtaining care at ASCs where patient cost-sharing is lower, it is critical to understand the cost and reimbursement limitations faced by ASCs in providing certain services. Therefore, it would be beneficial for Congress to direct CMS to work with ASC and physician stakeholders to understand payment limitations that deter ASCs from providing certain otherwise ASC-approved services to Medicare beneficiaries.

Physician and ASC Practice Acquisition and Consolidation

The COVID-19 pandemic accelerated the loss of physicians from independent medical practices. Physicians are increasingly employed by hospitals, health systems and corporate entities, or have left the workforce entirely, exacerbating concerns about a mounting physician shortage. An estimated 333,942 health care providers exited the workforce in 2021, and 117,000 of these were physicians.[iv] The COVID-19 pandemic was a tipping point for physicians looking to escape

declining reimbursements, the inability to compete with hospitals in tight labor markets and increasing regulatory burden. Since 2016, Medicare payment for physician work has declined significantly for a number of key endoscopy codes and has coincided with the gradual disappearance of independent gastroenterology practices.

CPT code	Description	2016 Payment*	2016 Payment Adjusted for 2024 Inflation*	2024 Payment*	2024 Payment Variation	2024 Payment Variation Adjusted for Inflation
45378	Diagnostic Colonoscopy	$ 200.00	$ 262.00	$ 181.00	-10%	-31%
45380	Colonoscpy and biopsy	$ 217.00	$ 284.27	$ 197.00	-9%	-31%
45385	Lesion removal colonoscopy	$ 274.00	$ 358.94	$ 249.00	-9%	-31%
G0105	Screnning colonoscopy, high risk	$ 200.00	$ 262.00	$ 181.00	-10%	-31%
G0121	Screnning colonoscopy, low risk	$ 200.00	$ 262.00	$ 181.00	-10%	-31%
45330	Diagnostic sigmoidoscopy	$ 58.00	$ 75.98	$ 56.00	-3%	-26%
45331	Sigmoidoscopy and biopsy	$ 76.00	$ 99.56	$ 71.00	-7%	-29%
43235	EGD diagnostic	$ 135.00	$ 176.85	$ 120.00	-11%	-32%
43239	EGD with biopsy	$ 152.00	$ 199.12	$ 136.00	-11%	-32%
43255	EGD with control of bleeding	$ 217.00	$ 284.27	$ 197.00	-9%	-31%

Source: * https://www.cms.gov/medicare/physician-fee-schedule/search
** https://www.bls.gov/data/inflation_calculator.htm

At an April 11, 2024, hearing held by the Finance Committee, Sen. Elizabeth Warren asked what is motivating independent physician practices to sell their practices and work for big corporations, whether it is private equity, insurance companies or large health systems. The Senator also expressed concern about physician payment that is too low to cover primary care physician practice costs. Unfortunately, inadequate payments are a comprehensive problem and not isolated to primary care. It is well-understood that payment inadequacy and regulatory burden drive physicians away from independent practice and toward other models.

Today, four out of five physicians (77.6%) are employees of hospitals, health systems and other corporate entities.[v] It is indisputable that consolidation — vertical, horizontal, and cross-market — results in increased costs to the health care system which outweigh any suggestion that consolidation can lead to better care coordination and efficiency. Vertical consolidation leads to shifting care from a lower to a higher acuity setting and which has driven the calls for site-neutral Medicare payment policies that are often focused on driving rates down to levels that are unsustainable. It is time Congress acknowledge and address the root causes of consolidation, and the increasing number of physicians who are choosing to forego independent practice for employment — payment inadequacy and instability and regulatory burden. **We urge that Congress must not move foward with any site-neutral payment policies until much-needed Medicare physician fee schedule reform occurs, including providing physicians with an inflationary update tied to the Medicare Economic Index, revising budget neutrality requirements, and overhauling the Merit-based Incentive Payment Program to reduce practice burden. Further, any savings from site-neutral payment policies should be reinvested in the Medicare program, including to offset the cost of Medicare physician fee schedule reform, and not used to fund non-health care related policies.**

Thank you in advance for your consideration of ASGE's thoughts and concerns. ASGE physician leaders will be in Washington, D.C. on March 11 and would welcome an opportunity

to meet with you to discuss this and other issues. Camille Bonta, ASGE policy advisor, will follow up with your office to explore the possibility of a meeting. In the interim, should have questions, Ms. Bonta can be reached at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,

Prateek Sharma, MD, FASGE
ASGE President

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[i] Ambulatory Surgical Center Services Payment System, Payment Basics. Medicare Payment Advisory Commission. October 2024. https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_ASC_FINAL_SEC.pdf

[ii] Medicare Payment Advisory Commission, June 2022 Report to Congress on Medicare and the Health Care Delivery System, Page 162; https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/

[iii] Medicare Payment Advisory Commission, Ambulatory Surgical Center Services: Status Report. March 2024. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch10_MedPAC_Report_To_Congress_SEC.pdf

[iv] Physicians left their jobs by the hundreds of thousands in 2021: report. Modern Healthcare. Oct. 20, 2022. https://www.modernhealthcare.com/physicians/physicians-left-their-jobs-droves-2021-report?utm_source=modern-healthcare-daily-dose-thursday&utm_medium=email&utm_campaign=20221020&utm_content=article1-readmore

[v] Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023; Physicians Advocacy Institute. Prepared by Avalere Health, April 2024. https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023