United Specialists for Patient Access

October 5, 2020

Submitted electronically via: http://www.regulations.gov

The Honorable Seema Verma Administrator
Centers for Medicare and Medicaid Services
Attention: CMS–1734–P
7500 Security Boulevard
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CY 2021 Physician Fee Schedule Proposed Rule

Dear Administrator Verma:

The United Specialists for Patient Access (USPA) appreciates the opportunity to offer its comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule for the CY 2021 Physician Fee Schedule (CMS-1734-P).[1] USPA represents a broad spectrum of office-based specialists such as anesthesiologists, cardiologists, dialysis vascular access providers, limb salvage specialists, general surgeons, physical therapists, radiation oncologists, radiologists, vascular surgeons and vein specialists, as well as specialty societies and the device and equipment manufacturers that support them.

USPA appreciates this opportunity to comment on the proposed regulations. This letter will comment on the following issues:

- Impact of the PFS Rule on Office-Based Specialists
- Critical Need for Stability for Office-Based Specialists

I. IMPACT OF THE PFS RULE ON OFFICE-BASED SPECIALISTS

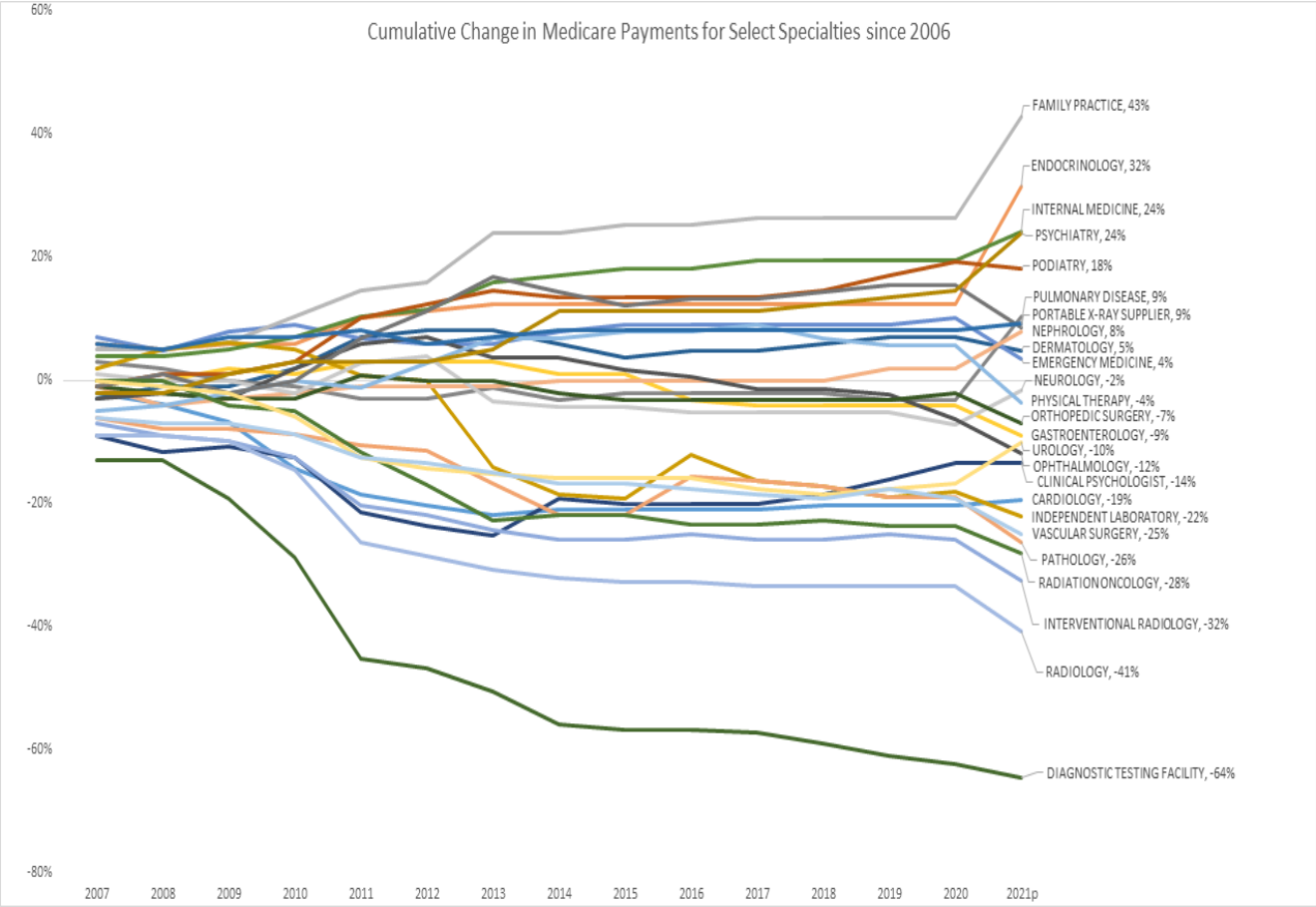
In the CY 2020 PFS Final Rule, CMS finalized its proposal to increase payments starting in 2021 for office & outpatient E&M services (CPTs 99202-99215) in-line with recommendations from the American Medical Association (AMA) Relative Value Scale Update Committee (RUC). CMS also finalized its proposal to introduce a new add-on code (HCPCS GPC1X) for complex care associated with E&M services and adjusted "E&M-like" services codes to maintain relativity to new and existing E&M services. In large part due to these changes the 2021 PFS Proposed Rule would implement, 16 specialties would see a decrease of 7 percent or more in

[1] Federal Register, 85 FR 48772 (August 12, 2020)

payments, while another 13 specialties could see an increase of 7 percent or more, **resulting in one of the most significant redistributions of Medicare physician payments ever implemented by CMS.**

Cumulative Impact of PFS Redistributions Since 2006

Unfortunately, this redistribution of Medicare physician payments away from certain office-based specialists is not a new occurrence. Many of these office-based specialists have seen significant redistributions under the PFS away from their services since 2006 with such redistributions growing over time. The chart below shows the results of PFS impact tables since 2006 with specialties highlighted that have had significant changes over the last 14 years amounting to at least $10 billion.[2]



These cumulative changes derive in large part from the outmoded "budget neutrality" provisions under Section 1848 of the Social Security Act which aims to keep spending within the Physician Fee Schedule "budget neutral" to itself. As history has shown, however, this siloed,

[2] Health Management Associates, "HMA analysis of 2006-2021 Medicare Physician Fee Schedule Proposed and Final Rule Impact Tables."

anachronistic approach to Medicare policy ignores the effects of the volatility and sustained cuts to office-based specialists stemming from the policy. When office-based specialists are forced to close their centers and such care moves to higher cost sites-of-service, "budget neutrality" is not the outcome. **The outcome is higher costs to the Medicare program and its beneficiaries, upheaval to patients' healthcare continuum, and an overall diminution in patient access.**

This situation is only exacerbated by the ongoing COVID-19 pandemic. At a time when CMS has stated that many of these interventions should not be postponed[3] and, in the case of physical therapy, are keeping patients out of the hospital, such proposed cuts are simply unconscionable.

RECOMMENDATION: USPA urges in the strongest possible terms that CMS waive budget neutrality under the PFS for 2021 and spare vulnerable patients – and the office-based specialists who treat them – from huge cuts during a pandemic.

In addition, USPA urges CMS to take steps to address more fundamental issues with the so-called "budget neutrality" provision in the Physician Fee Schedule. Put simply, "budget neutrality" is a misnomer, which often results in *reduced* Medicare beneficiary access to office-based specialists and can force such patients to receive necessary care at a *higher* cost site of service. While we realize that fundamental changes to budget neutrality may require Congressional intervention to allow for long-term reform, we urge the Agency to begin working now with stakeholders on options to address this issue.

II. CRITICAL NEED FOR STABILITY FOR OFFICE-BASED SPECIALTIES

In the 2021 PFS Proposed Rule, CMS highlights the age of the data currently used for indirect practice expenses in the CMS database ("our current system for setting PE RVUs relies in part on data collected in the Physician Practice Information Survey (PPIS), which was administered by the AMA in CY 2007 and 2008."). The Agency also notes it is "interested in potentially refining the PE methodology and updating the data used to make payments under the PFS …. as soon as practicable." Approaches to updating the indirect practice expense data – and potentially the practice expense data overall – appear to break down along three general approaches:

- **Use of OPPS Data.** This approach appears to be favored by the RAND Corporation. In a 2018 report to CMS, Rand describes how macro-level hospital charge data could be used to set overall practice expenses under the Physician Fee Schedule.[4] While such an approach could result in better price transparency and stability for office-based stakeholders, a key consideration would be setting the percent of OPPS rates per specialty in a way that promoted the viability and stability of services in the office setting. For example, freestanding radiation oncology centers likely incur practice expenses approaching 100% of a hospital outpatient departments costs and other office-based specialties similarly use the same high-cost supplies as a hospital.

[3] https://www.cms.gov/files/document/covid-elective-surgery-recommendations.pdf

[4] Rand Corporation, Practice Expense Methodology and Data Collection Research and Analysis, 2018

- **Use of AMA Data.** This approach appears to be favored by the AMA and would involve the use of micro-level physician data compiled through a physician survey. The previous 2007 / 2008 AMA survey resulted in significant cuts to office-based specialties (e.g. cardiology [-13%], interventional radiology [-10%], radiation oncology [-5%]) when incorporated in the 2009 Physician Fee Schedule. Moreover, it's worth noting that these data pulled from the 2009 Physician Fee Schedule impact table likely masked an even greater negative impact on office-based specialties given that the Medicare impact tables include both office-based and hospital-based physicians. In addition, any new indirect practice expense data would be fed into CMS' complicated 19 step Practice Expense Methodology ultimately making any new rate-setting for office-based specialty PERVUs a mystery beyond the actual dollar impact to a given office-based specialty.

- **Use of Market Data.** This approach, among others, is contemplated by CMS in the 2021 PFS Proposed Rule and would involve the use of "market-based information" similar to the market research conducted to update equipment and supply data through rulemaking in 2018 for the 2019 Physician Fee Schedule. CMS' approach in 2018 to derive direct practice expense data for supplies and equipment was grounded in the Agency's use of a contractor, StrategyGen, to arrive at such pricing. Unfortunately, this approach – sometimes referred to as a "secret shopper" methodology – suffers from a lack of transparency on exactly what kind of invoice data (e.g. manufacturer(s), setting, year, aggregation methodology) ultimately was used to arrive at the equipment and supply pricing currently included in the CMS database.

We believe there are two key principles to which CMS must adhere before choosing any new methodology to update the PFS practice expense methodology. **First, CMS must be transparent and provide stakeholders the tools to understand how any proposed approach to update the PFS practice expense methodology will impact reimbursement *before* implementing a new PE methodology.** This principle is critical as many office-based specialists focus on discrete service lines. While this means that office-based specialists often can realize optimal patient outcomes as "centers of excellence," they are much more susceptible to reimbursement volatility than, for example, hospitals, which often provide a broad array of services.

The second principle, which builds off the first principle, is that CMS must publicly certify that any new Agency action that results in more than a 1 percent reduction to a given office-based specialty will not result in a migration of services to a higher cost site-of-service or significant reduction in patient access to specialty care. For years, office-based specialists have suffered under significant payment volatility under the PFS and have been forced to make perennial entreaties for relief to the Agency and Congress based on concerns that cuts to office-based specialists would cause center closures, a reduction in patient access, and likely increases to the Medicare program due to migration of services to other settings. In some cases, the Agency and Congress have responded – after the fact – to mitigate or reverse proposed cuts. Too often, however, actual cuts, or the simple volatility caused by proposed cuts, have

caused the very center closures, migration of services, and reduction in patient access that USPA profoundly hopes to avoid in the future.

As noted in a 2019 American Medical Association (AMA) report, 2016 was the first year in which less than half of practicing physicians (47.1 percent) had an ownership stake in their practice and 2018 marked the first year in which there were fewer physician owners (45.9 percent) than employees (47.4 percent). The report also noted that between 2012 and 2018 the percentage of physicians in practices with 10 or fewer physicians dropped from 61.4 percent to 56.5 percent with much of that change driven by a shift away from solo practice.[5]

The COVID-19 pandemic only has accelerated these trends. An April 2020 survey by the Medical Group Management Association (MGMA) found that "a significant number of medical practices have already been forced to layoff and furlough staff in response to the financial challenges of COVID-19."[6] A more recent survey completed by The Physicians Foundation completed in August 2020, found:

- 8% of respondents have closed their practices, with more than three-quarters of this group being specialists, equating to as many as 16,000 practices nationally based on SK&A market research data.[7]

- Another 4% said they plan to close their practices within 12 months as a result of COVID-19.[8]

RECOMMENDATION: USPA urges that any new approach by CMS to update the practice expense methodology be transparent and provide stakeholders the tools to understand – before implementation – how such changes will impact stakeholder reimbursement. Second, USPA urges that any new significant regulatory action that by CMS that results in more than a 1 percent reduction to an office-based specialty under the Physician Fee Schedule must be accompanied by a public certification by the Agency, after consultation with affected specialties and other stakeholders, that such action will not cause a migration of services to a higher cost site-of-service.

Conclusion

We look forward to continuing to work with CMS to reform the Physician Fee Schedule to ensure the viability of office-based specialists. If you have additional questions regarding these matters and the views of the USPA, please contact Jason McKitrick at (202) 465-8711 or by email at jmckitrick@libertypartnersgroup.com .

[5] American Medical Association, *Policy Research Perspectives Updated Data on Physician Practice Arrangements: For the First Time*, Fewer Physicians are Owners Than Employees, 2019
[6] Medical Group Management Association, *Covid-19 Financial Impact on Medical Practices*, 2020
[7] American Hospital Association, *Specialist and Private Practices Take Severe Blow During Pandemic*, 2020
[8] The Physicians Foundation, *2020 Survey of America's Physicians: COVID-19 Impact Edition*, 2020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