United Specialists for Patient Access

Physician Fee Schedule Reform Urgently Needed to Provide Payment Stability

The Problem: "Budget-Neutrality" Coupled with a PFS That Has Not Kept Up With Inflation

BUDGET-NEUTRALITY CUTS TO OFFICE-BASED SPECIALISTS MUST STOP

While "budget-neutrality" *sounds* like good policy, when it operates within a Physician Fee Schedule that has not kept up with inflation, it results in massive swings in reimbursement and punishes providers irrespective of the value they add to the healthcare system. This is because, while reimbursement under the overall Physician Fee Schedule has increased *11 percent* over the last two decades, the cost of running a medical practice has increased *39 percent* over that same period (see AMA's "Medicare Updates Compared to Inflation" chart on the last page).

As a result of budget-neutralizing an underfunded system, the 2021 Physician Fee Schedule (PFS) Rule cut the conversion factor by 10% after an update to E/M data, which had a disproportionate impact on non-primary care providers. For example, physical therapists, who make on average roughly $89,000 per year, were cut 9% while primary care providers, who make $241,000 per year, saw a historic increase in reimbursement.[1] Indeed, 2021 PFS cuts were so significant Congress phased them in with the first tranche occurring in 2021, the second tranche occurring in 2022 and the next tranches now set to occur in 2023 (3%) and 2024 (3%).[2]

The 2022 PFS cut office-based specialists still further due to a 24% cut to the PFS direct adjustment factor, again due to so-called "budget-neutrality" provisions relating to an update to clinical labor data. As a result of the 2022 PFS, office-based specialists providing care to patients with cancer, end-stage renal disease, fibroids, as well as limb salvage and venous ulcer needs, will see their reimbursement decreased in some cases by more than 20% through 2025 on top of other aforementioned cuts to the conversion factor. Moreover, it is critical to understand that for many office-based specialists, these cuts also come on top of still further cumulative cuts of up to 60% since 2006 (see HMA's "Significant Specialty Variation" chart on the last page).

STOP ONGOING PFS SPECIALTY CUTS AND WORK ON PFS REFORM

We urge Congress to stop (1) remaining PFS conversion factor cuts in 2023 and 2024 and (2) remaining clinical labor cuts through 2025.

In addition, **we urge Congress to respond to broad, bipartisan calls for PFS reform** by hearing the request of 247 Members of Congress who, in an October 2021 letter asked for "long-term reform … as soon as possible" and 96 physician stakeholder groups who, in a February 2022 letter, asked for "formal proceedings (hearing, roundtables, expert panels, etc.) to discuss potential reforms to the Medicare physician payment system."[3] In March 2022, Secretary Becerra also indicated an interest in working on PFS reform.[4] USPA welcomes the opportunity to be a part of formal proceedings relating to broad reform of the Physician Fee Schedule.

PRINCIPLES AND OPTIONS FOR PFS REFORM

Given significant funding gaps between practice costs and PFS reimbursement, CMS PFS reform concepts have focused on *practice expense* (PE) RVUs. In June 2021, CMS held a Town Hall on "Improving Practice Expense Data & Methods"[5] where the agency explained:

- PFS Reimbursement = (work RVUs + PE RVUs + MP RVUs) * conversion factor.
- PE RVUs = direct PE RVUs (supplies, equipment and labor) + indirect PE RVUs (administrative, overhead, nonclinical labor, rent, information technology).[6]

PFS Reform Principles Should Promote Stability, Alignment, and Transparency

1. Stability. Medicare providers should have stable reimbursement so they can focus their time on treating patients. Unfortunately, Medicare reimbursement has been particularly unstable in the Physician Fee Schedule for many years. Any new system should promote stability.

2. Alignment Across Ambulatory Settings.[7] Medicare should reimburse for *direct* practice expenses equally, regardless of setting (HOPD, ASC, or office): a stent used in an office is the same stent used in a hospital; a CT machine used in an ASC is the same machine used in a hospital; a nurse working in an office on Monday and a hospital on Thursday is the same nurse. For *indirect* practice expense, CMS should recognize differential overhead needs by setting (e.g. a typical hospital has more overhead than a typical primary care office).

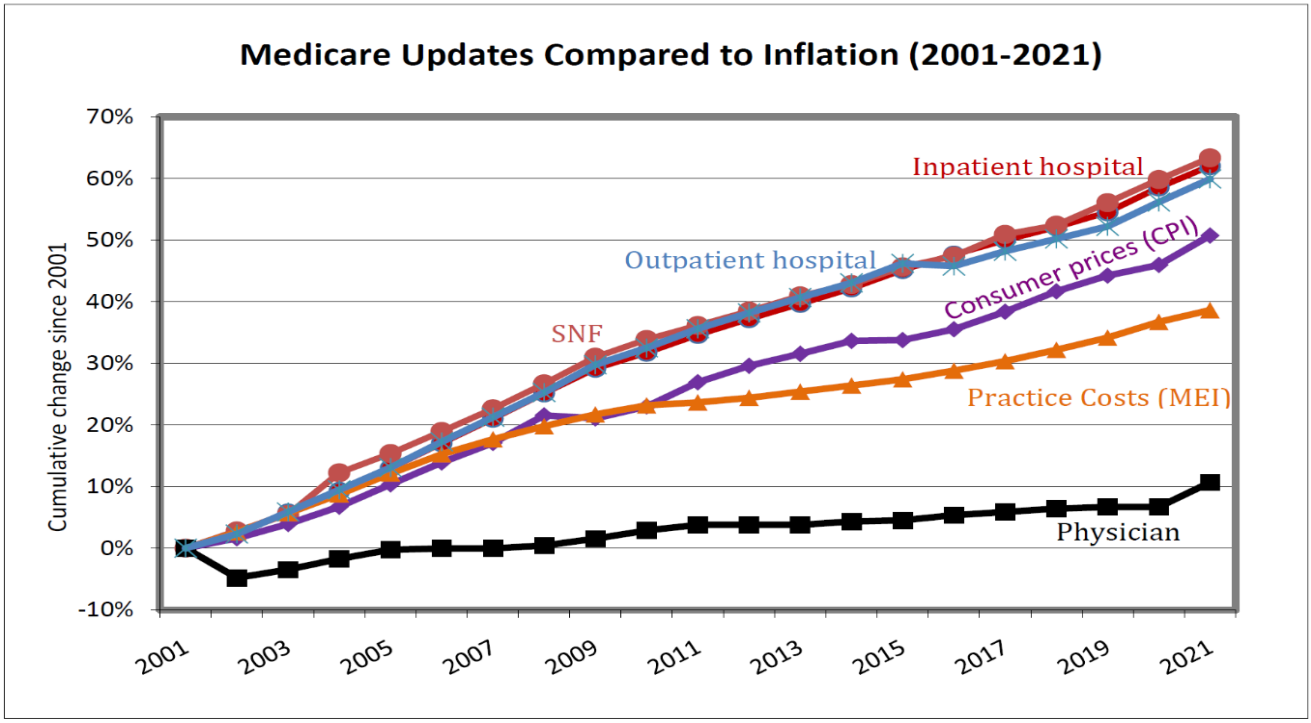
3. Transparency. The PFS PE methodology is a 19-step algorithm that is exceedingly complex and opaque and much of the data used in the methodology derives from an AMA RUC process which is not publicly accessible. CMS should promote transparency in any new PFS system.

Applying PFS Reform Principles to Two Distinct Options for PFS Reform

Two distinct PFS reform options have been proposed: (1) using new HOPPS data for PERVUs or (2) removing PERVUs from the PFS.

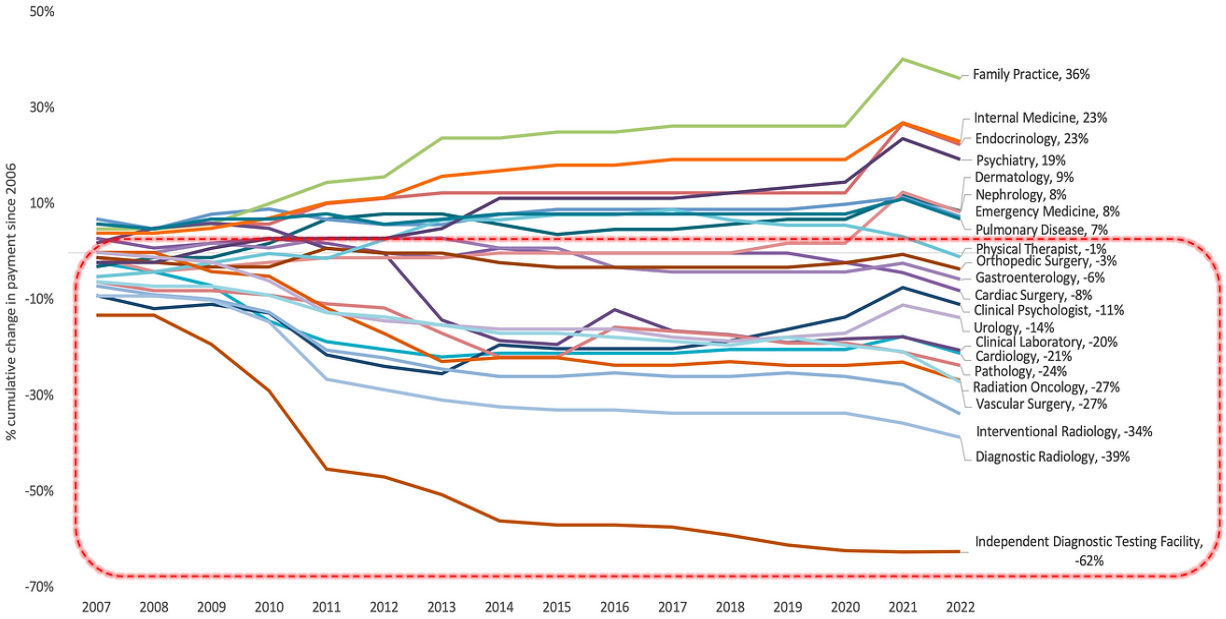
1. Using HOPPS Data for PERVUs. In a 2021 report, Rand describes using data from the Hospital Outpatient Prospective Payment System (HOPPS) for PFS PERVUs.[8] Due to OPPS "ancillary services," however, CMS either would overstate costs in the PFS if APC values are used or understate cost if CPT values are used. In order to promote reimbursement stability, alignment across ambulatory settings, and transparency, CMS should (1) derive direct costs from HOPPS data in a transparent manner for inclusion in the PFS on an equivalent basis through a new methodology which promotes alignment across settings and (2) exempt this new data from underlying budget-neutrality and other provisions in the PFS.

2. Removing PERVUs from the PFS. At a 2020 RUC meeting, the AMA RUC recommended CMS separately identify and pay for high-cost disposable supplies.[9] Since 2019, CMS has been using a contractor (StrategyGen) to provide equipment and supply pricing data for PFS direct costs. Removing PERVUs from the PFS could necessitate a new, technical fee schedule for all ambulatory settings and promote stability and alignment across settings[10], but CMS should strengthen transparency of the StrategyGen process through public comment on how exactly how CMS arrives at pricing data (GPO discounts, setting, etc.) for specific equipment and supplies.



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

Significant Specialty Variation in Estimated Payment Changes since 2006



Source: HMA analysis 2007-2022 Medicare Physician Fee Schedule Final Rule Impact Tables.
2021 and 2022 values adjusted for effects of Consolidated Appropriations Act of 2021, including the delayed effect of G2211 until 2024 which, if implemented as proposed, will reduce payments to many specialties that are already at zero percent or lower and increase payments to many specialties that are above zero percent.

[1] Primary care has kept up with practice costs (e.g. family practice has seen cumulative PFS increases of 36% since 2006). It is non-primary care providers, particularly those utilizing innovative technologies, which have been most impacted by the underfunding of practice costs in the PFS.
[2] Cuts were phased-in through H.R. 133 in 2020 and S. 610 in 2021.
[3] Reps. Bera-Bucshon and Medicare Payment Coalition letters to Congressional Leadership
[4] Inside Health Policy, Becerra Hopes To Work With Congress To Reform Medicare Doc Pay, 17 March 2022
[5] https://www.cms.gov/medicare/physician-fee-schedule/practice-expense-data-methods
[6] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/Test.pdf
[7] MedPAC explored this issue in an April 2022 briefing, "Aligning fee-for-service payment rates across ambulatory settings"
[8] https://www.rand.org/pubs/research_reports/RRA1181-1.html
[9] https://www.ama-assn.org/system/files/oct-2020-ruc-recommendations.pdf
[10] While the HOPPS and ASC Fee Schedules include only technical payments for HOPDs and ASCS, the PFS includes technical payments for office-based providers *plus professional payments for physicians in all settings (e.g. HOPD, ASC and office)*. As a result, PFS technical payments currently "budget-neutralize" to dissimilar professional payments like physician work. An alternative option would be for ambulatory (HOPD/ASC/Office) technical payments to be paid within a single fee schedule outside of the PFS.