

September 7, 2021

Meena Seshamani, M.D., Ph.D.
Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CY 2022 Payment Policies under the Physician Fee Schedule

Dear Deputy Administrator Seshamani:

On behalf of the sixteen (16) undersigned organizations, we are writing today in response to the Centers for Medicare & Medicaid Services' (CMS) 2022 Physician Fee Schedule (PFS) proposed rule, which was released on July 13, 2021. The proposed rule includes troubling cuts of more than 20 percent to specialties under the PFS as a direct result of the so-called "budget neutrality" policy, the same policy which drove drastic cuts in the 2021 PFS Final Rule. Successive, cumulative cuts to specialists under the PFS are resulting in reimbursement ever more out of touch with actual resource needs as well as increased healthcare consolidation and healthcare costs, greater health inequities, and a healthcare system unable to meet the challenges of an ongoing pandemic.

While some characterize the PFS "budget-neutrality" provision as a "sometimes you win, sometimes you lose" policy, in fact, over the last decade, cumulative PFS cuts clearly have negatively impacted certain providers. Specialties such as cardiology, interventional nephrology, interventional radiology, pathology, phlebology, radiation oncology, radiology, vascular surgery, and others have cumulatively faced PFS reductions of between 20 and 40 percent.¹ Other times, the PFS "budget-neutrality" provision is characterized as rebalancing the PFS away from higher-paid providers and towards lower paid providers. In fact, however, in the 2021 PFS, the lowest paid providers – physical therapists – received a 9% cut which was redistributed to other PFS providers making at least 171% more.²³

With the impact of cumulative cuts growing, we believe that the "budget neutrality" provision that underpins the cuts will continue to fuel the troubling trend of healthcare consolidation, office closures, and ultimately higher costs to the Medicare program at a time when President Biden is emphasizing his Administration's focus on addressing these challenges, including by issuing his recent *Executive Order on Promoting Competition in the American Economy*. Indeed, given the strong correlation between ongoing cuts and reimbursement volatility for PFS providers vis-à-vis the health system consolidation trend, we believe the best characterization of the so-called PFS "budget neutrality" provision is that it is a *driver* of PFS center closures and *increased* costs to the Medicare program.

¹ Health Management Associates, Analysis of the 2022 Physician Fee Schedule, 2021

² Urban Institute and SullivanCotter, *Analysis of Physician Compensation*, January 2019.

³ Bureau of Labor Statistics, *U.S. Department of Labor, Occupational Outlook Handbook, Physical Therapists*. 2021

The severe cuts proposed in the 2022 PFS Proposed Rule also threaten to exacerbate healthcare inequities. While the 2021 PFS budget-neutrality effect was due to the CMS policy of updating data for evaluation and management (E/M) services, the main driver of provider cuts in the 2022 PFS Proposed Rule relates to budget-neutrality effects of a CMS proposal to update clinical labor data. Like last year’s E/M proposal, as a first order effect, updating clinical labor data in the CMS database makes sense. However, because of second order effects of PFS “budget-neutrality,” the incorporation of new clinical labor data actually results in **massive cuts of more than 15 to 20 percent to critical services in the PFS.**⁴ These impacts also will have profoundly negative effects on health equity. While President Biden’s FY 2022 Budget contained many worthy provisions aimed at addressing health inequity through the elimination of disparities in health care, the 2022 PFS Proposed Rule actually threatens to undermine these initiatives in areas throughout the PFS as exemplified with several examples in the table below.

Disease/Service	Health Inequity	2022 PFS
Venous Ulcer / Endovenous radiofrequency ablation	Black patients present with more advanced venous insufficiency than White patients ⁵	Key Code (36475) Cut by 23%
ESRD / Dialysis Vascular Access	Black and Latino patients start dialysis with a fistula less frequently despite being younger ⁶	Key Code (36902) Cut by 18%
Cancer / Radiation oncology	Black men are 111 percent more likely to die of prostate cancer; Black women are 39 percent more likely to die of breast cancer ⁷	Key Code (G6015) Cut by 15%
Peripheral Artery Disease / Revascularization	Black Medicare beneficiaries are three times more likely to receive an amputation ⁸ Latino are twice as likely ⁹	Key Codes (37225-37221) Cut by 22%
Fibroid / Uterine Fibroid Embolization	Uterine fibroids are diagnosed roughly three times more frequently in Black women ¹⁰	Key Code (37243) Cut by 21%

Finally, these ongoing cuts to specialties under the PFS also are weakening our healthcare system’s ability to deal with the ongoing COVID-19 pandemic. A key lesson from the pandemic thus far is that it is critical that hospitals be able to focus on our sickest pandemic patients. However, many other issues such as cancer, dialysis vascular access for ESRD patients, cardiac patients with symptoms, the need for physical therapy to keep patient out of the hospital, etc. still must be addressed.^{11,12} Office-based care under the PFS provides a critical site-of-service outside of the hospital to deal with non-COVID cases so hospitals can focus on a resurging pandemic; ongoing cuts to PFS providers threaten the viability of the critical office-based setting during the COVID-19 pandemic.¹³

⁴ It is worth noting another area ripe for reform is the PFS “impact table,” which does not disaggregate specialty impact by site-of-service and, therefore, understates the negative impact to office-based specialists.

⁵ Vascular and Endovascular Surgery, *Advanced Chronic Venous Insufficiency: Does Race Matter?*, 26 December 2016

⁶ *Racial/Ethnic Disparities Associated With Initial Hemodialysis Access*. JAMA Surg.2015 Jun;150(6):529-36. doi: 10.1001/jamasurg.2015.0287

⁷ Cure, *Cancer Sees Color: Investigating Racial Disparities in Cancer Care*, Katherine Malmo, 16 February 2021

⁸ Dartmouth Atlas, *Variation in the Care of Surgical Conditions: Diabetes and Peripheral Arterial Disease*, 2014

⁹ J. A. Mustapha, *Explaining Racial Disparities in Amputation Rates for the Treatment of Peripheral Artery Disease (PAD) Using Decomposition Methods*, J. Racial and Ethnic Health Disparities (2017) 4:784–795

¹⁰ University of Michigan, *Understanding Racial Disparities for Women with Uterine Fibroids*, Beata Mostafavi, 12 August 2020

¹¹ See, for example, the March 2020 CMS “Adult Elective Surgery and Procedures Recommendations,” which listed several “do not postpone” procedures such as most cancers, cardiac patients with symptoms, limb threatening vascular surgery, etc.

¹² See also August 2020 CMS “Key Components for Continued COVID-19 Management for Dialysis Facilities,” which effectively lists dialysis vascular access as a “do not postpone” procedure.

¹³ Hospitals in two states where COVID-19 is surging already have begun to delay elective surgeries again. See Becker’s ASC Review, *Elective surgeries delayed at Florida, Louisiana hospitals amid COVID-19 surges*, 26 July 2021.

Taken together, the impacts of the proposed cuts on health system consolidation, healthcare costs, health inequity, and our ability to deal with a resurging pandemic far outweigh the merits of the clinical labor proposal. We strongly urge CMS not to finalize the clinical labor policy included in the 2022 PFS proposed rule at this time. In addition, we urge CMS to coordinate with Congress on fundamental reform to the PFS through legislation this year in light of the fact that the “budget neutrality” provision in the 2021 PFS Final Rule E/M policy is still causing negative impacts in the form of a scheduled 3.75 percent cut to the conversion factor in 2022.

Thank you for your consideration of our concerns.

Sincerely,

American College of Radiation Oncology
American Society of Diagnostic and Interventional Nephrology
American Vein & Lymphatic Society
American Venous Forum
Alliance for Physical Therapy Quality and Innovation
Association of Black Cardiologists
CardioVascular Coalition
Dialysis Vascular Access Coalition
The Fibroid Coalition
Outpatient Endovascular and Interventional Society
Preventive Cardiovascular Nurses Association
Renal Physicians Association
Society for Cardiovascular Angiography & Interventions
Society of Interventional Radiology
Society for Vascular Medicine
United Specialists for Patient Access