United Specialists for Patient Access

September 6, 2022

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

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
Attention: CMS–1770–P
7500 Security Boulevard
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CY 2023 Physician Fee Schedule Proposed Rule

Dear Administrator Brooks-LaSure:

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 2023 Physician Fee Schedule (CMS-1770-P).[1] USPA represents a broad spectrum of office-based specialists such as anesthesiologists, cardiologists, dialysis vascular access providers, limb salvage specialists, phlebologists, physical therapists, radiation oncologists, radiologists, urologists, and vascular surgeons, as well as specialty societies and the device and equipment manufacturers that support them. In particular, USPA advocates on behalf of specialty providers in the office-based setting (place-of-service [POS] 11).[2]

USPA appreciates this opportunity to comment on the proposed regulations. As discussed in further detail below, USPA states at the outset that ongoing cuts to office-based specialists under the Physician Fee Schedule are contributing to office-based center closures, health system consolidation and, as a result, undermining this Administration's efforts on addressing health equity issues.

This letter will comment on the following issues:

- Ongoing Cuts to Office-Based Specialists Cause Center Closures
- 2023 PFS Proposed Rule Continues Historical Cuts to Office-Based Specialists
- Principles and Options for PFS Reform

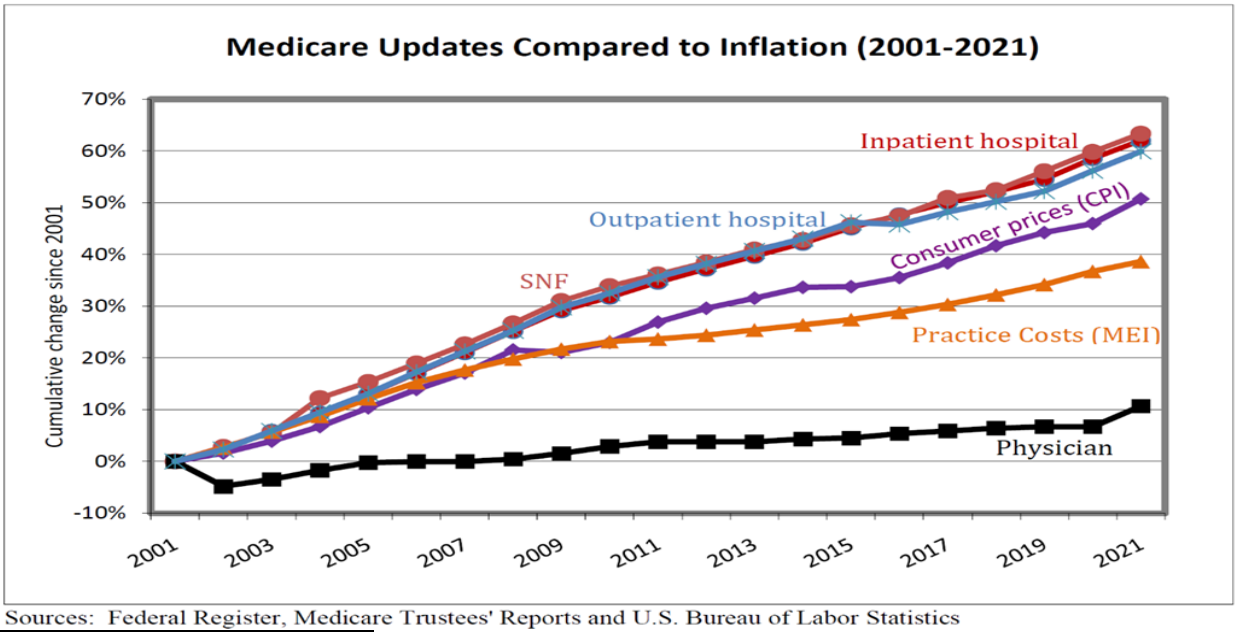
[1] Federal Register, 87 FR 45860 (July 29, 2022)
[2] For more information about USPA, please see https://www.uspaccess.org/

I. ONGOING CUTS TO OFFICE-BASED SPECIALISTS CAUSE CENTER CLOSURES

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 below).

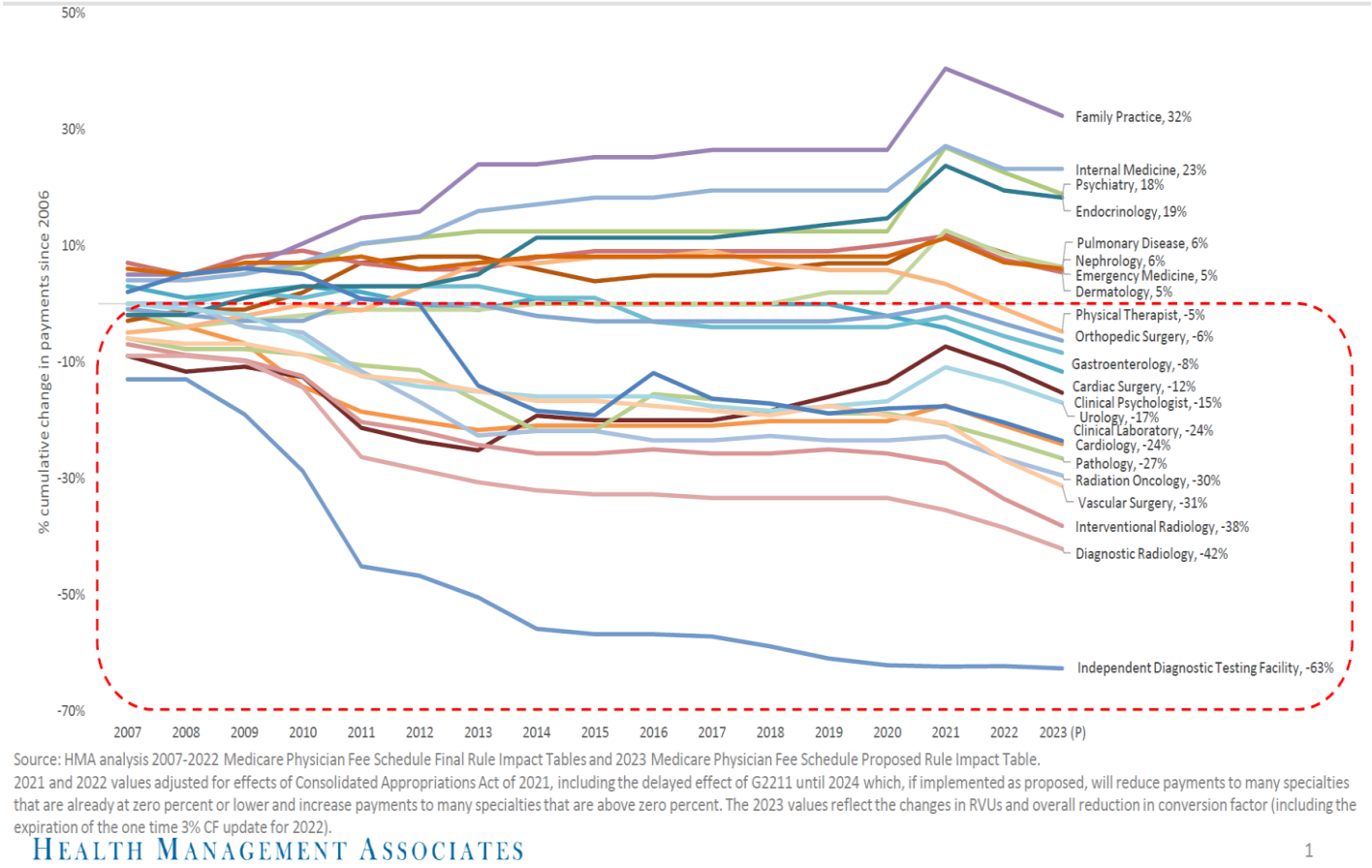
As a result of budget-neutralizing an underfunded system, the 2021 Physician Fee Schedule (PFS) Rule cut the conversion factor by 10% after an update to E/M data, which had a disproportionate impact on non-primary care providers. For example, physical therapists, who make on average roughly $89,000 per year, were cut 9% while primary care providers, who make $241,000 per year, saw a historic increase in reimbursement.[3] 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%).[4]

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 below).



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

[3] 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..
[4] Cuts were phased-in through H.R. 133 in 2020 and S. 610 in 2021.



Source: HMA analysis 2007-2022 Medicare Physician Fee Schedule Final Rule Impact Tables and 2023 Medicare Physician Fee Schedule Proposed Rule Impact Table.
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. The 2023 values reflect the changes in RVUs and overall reduction in conversion factor (including the expiration of the one time 3% CF update for 2022).

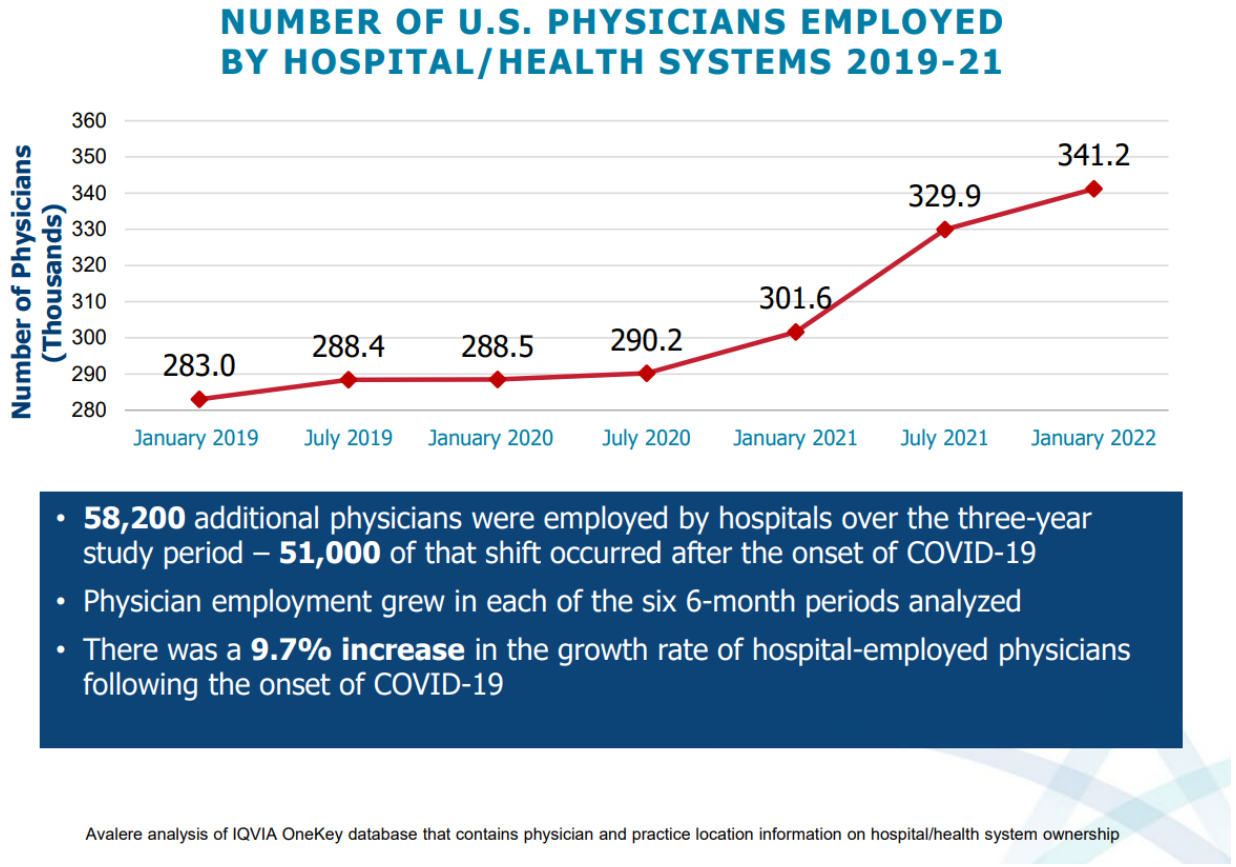
HEALTH MANAGEMENT ASSOCIATES 1

Ongoing Cuts to Office-Based Specialists as a Driver of Health System Consolidation

While President Biden's *Executive Order on Promoting Competition in the American Economy* makes it clear that this Administration is concerned with health system consolidation, the 2023 PFS Proposed Rule continues to undercut this initiative. **According to the American Medical Association, the share of physicians working for a hospital increased from 29.0 percent in 2012 to 39.8 percent in 2020.**[5] The ongoing pandemic also has accelerated these trends with hospitals and acquiring 58,200 additional physicians over the last three years (see chart on next page).[6] Given that the reimbursement for medical specialties is, on average, $178,000 more in a vertically integrated health system, the incentive is clear for beleaguered **PFS providers who may no longer be able to sustain further cuts in the 2023 PFS Proposed Rule to simply close their centers and continue the migration to large health systems.**[7] As noted by the Medicare Payment Advisory Commission (MedPAC), "the preponderance of evidence suggests that hospital consolidation leads to higher prices."[8]

[5] American Medical Association, *Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020*, Carol K. Kane, PhD, June 2021
[6] Physicians Advocacy Institute, *Covid-19's Impact on Acquisitions of Physician Practices and Physician Employment*, April 2022 [Prepared by Avalere, see link here.]
[7] Post, Brady PhD et al., *Hospital physician integration and Medicare's site-based outpatient payments*, Health Serv Res. 2021;56:7 15
[8] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2022

National Trends: Sharp Uptick in Physician Hospital Employment in Months Following Onset of Pandemic



Due to ongoing cuts under the Physician Fee Schedule, office-based providers are left with a limited set of options: (1) close their office, (2) join a hospital or (3) convert to an ASC. However, due to up-front costs, CON laws, business licensure, etc., setting up an ASC is impossible in many areas. For example, 35 states have certificate-of-need requirements for ASCs which often means a physician office alternative is the only possible non-hospital vascular access option in many states. As a result, (1) service migration to a hospital or (2) office-based center closure often are the only true options as office-based center closures continue.

Ongoing Cuts to Office-Based Specialists as a Driver of Health Inequities

The proposed cuts in the 2023 PFS Proposed Rule will have profoundly negative effects on health equity. While the Administration has launched a number of initiatives aimed at addressing health inequity through the elimination of disparities in health care, the 2023 PFS Proposed Rule actually threatens to undermine these initiatives in areas throughout the PFS by

continuing to phase in the 2022 PFS clinical labor cuts. The table below highlights code reductions contained in the 2022 PFS Proposed Rule. While CMS decided to phase-in these cuts over four years, this just delays the ultimate impact to these services until 2025.

Disease/Service	**Health Inequity**	**2022 PFS**
Venous Ulcer / Endovenous radiofrequency ablation	Black patients present with more advanced venous insufficiency than White patients[9]	Key Code (36475) Cut by 23%
ERSD / Dialysis Vascular Access	Black and Latino patients start dialysis with a fistula less frequently despite being younger[10]	Key Code (36902) Cut by18%
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[11]	Key Code (G6015) Cut by 15%
Peripheral Artery Disease / Revascularization	Black Medicare beneficiaries are three times more likely to receive an amputation[12] Latino are twice as likely[13]	Key Codes (37225-37221) Cut by 22%
Fibroid / Uterine Fibroid Embolization	Uterine fibroids are diagnosed roughly three times more frequently in Black women[14]	Key Code (37243) Cut by 21%

Ongoing Cuts to Office-Based Specialists Weaken Our Nation's Pandemic Response

Ongoing cuts to office-based specialists 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 is that it is critical that hospitals have sufficient resources to care for their sickest patients. Yet other patients dealing with cancer, end-stage renal disease, coronary disease, and other post-acute issues cannot wait for the cancer care, dialysis vascular access repair, imaging, physical therapy, etc. that is critical to keeping them alive or out of the hospital.[15][16] 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.

Historical Cuts to Office-Based Specialists Driven in Part By Faulty MedPAC Narrative

[9] Vascular and Endovascular Surgery, *Advanced Chronic Venous Insufficiency: Does Race Matter?*, 26 December 2016
[10] *Racial/Ethnic Disparities Associated With Initial Hemodialysis Access*. JAMA Surg.2015 Jun;150(6):529-36. doi: 10.1001/jamasurg.2015.0287
[11] Cure, *Cancer Sees Color: Investigating Racial Disparities in Cancer Care*, Katherine Malmo, 16 February 2021
[12] Dartmouth Atlas, *Variation in the Care of Surgical Conditions: Diabetes and Peripheral Arterial Disease*, 2014
[13] 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
[14] University of Michigan, *Understanding Racial Disparities for Women with Uterine Fibroids*, Beata Mostafavi, 12 August 2020
[15] 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.
[16] 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.

For years, the Medicare Payment and Advisory Commission (MedPAC) has suggested that the PFS is balanced away from primary care providers.[17] To support these claims, MedPAC often cites the SullivanCotter Survey which shows physician compensation differentials. However, there are several flaws with the SullivanCotter Survey and MedPAC's inferences from the survey, which include:

- **MEDPAC PROMOTES TAKING FROM LOWER REIMBURSED PROVIDERS TO PAY HIGHER REIMBURSED PROVIDERS MORE.** While the SullivanCotter Survey asserts that primary care physicians have the lowest median compensation, in fact, physical therapists are the lowest reimbursed PFS provider and primary care physicians are paid 170% more.[18][19]
    - As a result, MedPAC's strong promotion of the 2021 PFS policy to provide more funds to evaluation and management services in a budget neutral basis cut physical therapists by 9% to pay for providers who already were paid 170% more.[20]
- **MEDPAC USES PHYSICIAN REIMBURSEMENT DIFFERENTIALS TO SUPPORT CUTTING HIGHER PAID PROVIDERS, BUT DOES NOT KNOW WHAT APPROPRIATE REIMBURSEMENT DIFFERENTIALS SHOULD BE.** While the SullivanCotter survey explicitly notes that there *should* be physician reimbursement differentials due to different resources use requirements (such as high-tech supplies or equipment), MedPAC acknowledges that it does not know what appropriate physician reimbursement differentials are, nor does it think that such appropriate differentials are knowable.[21]
- **MEDPAC PROMOTES THE USE OF PFS BUDGET-NEUTRALITY TO ADDRESS ALLEGED IMBALANCES IN THE PFS, BUT ALSO ACKNOWLEDGES THAT SIGNIFICANT PHYSICIAN COMPENSATION OCCURS *OUTSIDE* OF THE PFS.** Specialty differentials highlighted in the SullivanCotter survey assert that other providers are compensated more than primary care when measured by differentials in total cash compensation [TCC], but PFS budget-neutrality policy is not an appropriate means for addressing asserted TCC differentials.[22]
    - But the SullivanCotter report notes that TCC includes significant payments that flow *outside* PFS RVUs, such as: (1) facility based technical payments in the IPPS and OPPS fee schedules (which MedPAC acknowledges often are paid at higher rates than the office) and (2) Part B drugs (which are not paid on the basis of RVUs).

[17] MedPAC, Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services, June 2018.
[18] Urban Institute and SullivanCotter, Analysis of Physician Compensation, January 2019. The report states that primary care provider compensation is $241,687 on average.
[19] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook , Physical Therapists. The report states that physical therapist compensation is $89,440
[20] MedPAC Comment to the 2021 PFS Final Rule (available here: http://www.medpac.gov/docs/default-source/comment-letters/10022020_partb_proposedrule2021_medpac_cms1734_comment_v2_sec.pdf?sfvrsn=0)
[21] Urban Institute and SullivanCotter, Analysis of Physician Compensation, January 2019.
[22] Total cash compensation includes base salary, incentive compensation, and other cash compensation (e.g. honoraria, longevity bonuses, retention bonuses, profit sharing, sign on bonuses, long term incentive payments).

- **MEDPAC POLICIES HAVE BEEN DRIVING SIGNIFICANT CUTS TO OFFICE-BASED SPECIALISTS, BUT ITS OWN DATA DOES NOT INCLUDE SUFFICIENT INFORMATION FROM OFFICE-BASED SPECIALISTS.** Independent physician practices are not even a significant source of SullivanCotter Survey data, which is extremely problematic given that the survey is being used by MedPAC to support ongoing cuts to office-based specialists.

II. 2023 PFS PROPOSED RULE CONTINUES HISTORICAL CUTS TO OFFICE-BASED SPECIALISTS

The 2023 PFS Proposed Rule continues these historical cuts to office-based specialists by reducing the 2023 Medicare conversion factor by about 4.5% from $34.6062 to $33.0775. This is largely a result of:

- The expiration of the 3% increase to the conversion factor at the end of calendar year 2022 pursuant to S. 610.
- Yet another round of budget neutrality related cuts from revaluations of EM codes families, including hospital, emergency medicine, nursing facility and home visits. These changes are estimated to require an additional reduction of about 1.5% to the 2023 Medicare conversion factor due to statutory budget neutrality requirements.

In addition, CMS is continuing with the second year of the 2022 clinical labor policy which adds additional cuts to certain providers of another 4.5% so that certain office-based specialists will be subject to cuts of more than 9% in 2023 alone.

We are pleased to note that CMS has begun to acknowledge the need to track the viability of office-based specialists. CMS stated in the 2023 PFS Proposed Rule:

- *We have received requests from interested parties for CMS to provide more granular information that separates the specialty-specific impacts by site of service. These interested parties have presented high-level information to CMS suggesting that Medicare payment policies are directly responsible for the consolidation of privately owned physician practices and free standing supplier facilities into larger health systems. Their concerns highlight a need to update the information under the PFS to account for current trends in the delivery of health care, especially concerning independent versus facility-based practices. In response to interested party feedback, we have recently improved our current suite of public use files (PUFs) by including a new file that shows estimated specialty payment impacts at a more granular level, specifically by showing ranges of impact for practitioners within a specialty.*

While an important first step, we note that there also are many shortcomings with the way the office-based (or "nonfacility") data has been presented, including 1) a lack of historical context and 2) missing data in Tables 139 and 148.

- **Lack of Historical Context.** As shown in the above chart, "Significant Specialty Variation in Estimated Payment Changes," some specialties could experience double digit reductions in payments under the PFS and still be well above the historical average

while other specialties already have experienced cuts of 20 to 40% or more. It's important to note that the specialty variation shown in the chart is by specialty and not by site-of-service (as CMS has not historically presented such data). It is likely if CMS had presented such data historically, it would have shown even worse impacts to office-based specialists.

- **Missing Data in Tables 139 and 148.** While Table 139 appears to show a fairly benign cut of -1% to nonfacility providers and increase of +2% to facility providers, in fact, the table leaves out the 3% cut to the conversion factor that occurs in 2023 due to the expiration of provisions in S. 610. As a result, cuts to office-based providers are closer to -4% overall and facility providers also will be subject to a -2% cut. Similarly, Table 148 appears to show a +2% increase to nonfacility providers and a -4% increase to facility providers, but does not include the third tranche of the 3% cuts to the conversion factor to occur in 2024 due to the implementation of G2211 or ongoing clinical labor cuts through 2025. Together these policies likely would result in still further cuts to office-based providers even with the inclusion of considered MEI rebasing and revising by CMS.

In the 2023 PFS Proposed Rule, CMS notes "In light of feedback from interested parties, CMS has prioritized stability and predictability over ongoing updates." However, the historical data and the experiences of the 2021 EM policy resulting in a 10% cut to the conversion factor and the 2022 clinical labor policy resulting in a 24% cut to the direct adjustment factor show that ongoing updates indeed are causing huge unrelated and undeserved cuts to office-based specialists.

REQUEST: We believe it would be best for CMS to truly "prioritize stability and predictability over ongoing updates" by temporarily freezing the implementation of further policy updates – including the clinical labor policy in 2023 through 2025, EM revisions in 2023 and the implementation of G2211 in 2024 – that will result in further significant redistributions to the Physician Fee Schedule. Instead, we urge CMS to focus on fundamental PFS reform.

III. 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"[23] 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).[24]

We believe PFS reform principles should promote stability, alignment and transparency as it relates to contemplated reforms of direct and indirect practice expenses as follows:

[23] https://www.cms.gov/medicare/physician-fee-schedule/practice-expense-data-methods
[24] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/Test.pdf

- **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.
- **Alignment Across Ambulatory Settings.**[25] 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).
- **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

In the 2023 PFS Proposed Rule, CMS notes that it believes, "Of the various PE data inputs, we believe that indirect PE data inputs, which reflect costs such as office rent, IT costs, and other non-clinical expenses, present the opportunity to build consistency, transparency, and predictability into our methodology to update PE data inputs" and notes that the primary source for indirect PE information – the Physician Practice Information Survey (PPIS) – reflects 2006 data. **We disagree and note that the last time the PPIS survey was conducted in 2007/2008, it resulted in yet another huge redistribution in the Physician Fee Schedule.**[26] **As noted above, we believe the *direct* PE portion of the Physician Fee Schedule presents the best opportunity for consistency, transparency, and predictability.**

Two distinct, mutually exclusive, PE related PFS reform options have been proposed in recent years: (1) using new HOPPS data for PERVUs or (2) removing PERVUs from the PFS:

- **Using HOPPS Data for PFS PERVUs.** In a 2021 report, Rand describes using data from the Hospital Outpatient Prospective Payment System (HOPPS) for PFS PERVUs.[27] 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. Given that direct costs should be equivalent across settings, we

[25] MedPAC explored this issue in an April 2022 briefing, "Aligning fee-for-service payment rates across ambulatory settings"
[26] 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.
[27] https://www.rand.org/pubs/research_reports/RRA1181-1.html

believe the use of HOPPS data should require using HOPPS data at 100% of its HOPPS value (likely requiring a new methodological process).

- **Removing PERVUs from the PFS.** At a 2020 RUC meeting, the AMA RUC recommended CMS separately identify and pay for high-cost disposable supplies.[28] 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, 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.

It's important to note that while the HOPPS and ASC Fee Schedules include only technical payments (e.g., the high-technology equipment, supplies and other interventions that have been a hallmark of the U.S. healthcare system) 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" office-based supplies and equipment to *dissimilar* items such as professional payments for physician work in the hospital. This dynamic is a significant contributor to the payment volatility within the PFS.

Included in PFS Budget Neutrality:

- Office Technical Component
- Office Professional Component
- Hospital Professional Component
- ASC Professional Component

Not Included in PFS Budget Neutrality:

- Hospital Technical Component
- ASC Technical Component

REQUEST: We agree with CMS' focus on practice expenses as the main source of volatility in the PFS, but urge CMS and Congress to focus on direct practice expenses in the Physician Fee Schedule as the best opportunity for PFS payment stability.

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 .

[28] https://www.ama-assn.org/system/files/oct-2020-ruc-recommendations.pdf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