Join us in Urging CMS to Protect Medicare Reimbursement Rates for Specialty Providers

Sending Office: Honorable Bobby L. Rush
Sent By: William.Vogt@mail.house.gov

Request for Signature(s)

Dear Colleague:

We invite you join us in sending a letter to the Centers for Medicare and Medicaid Services (CMS) urging CMS not to finalize the clinical labor policy in the 2022 Physician Fee Schedule (PFS) proposed rule, which was released on July 13, 2021. As it stands, the proposed rule cuts critical services by up to 20 percent. Given the impact of the COVID-19 pandemic on the financial stability of providers, now is not the time for substantial cuts.

For the 2022 Physician Fee Schedule, the main driver of provider cuts relates to budget-neutrality effects of a CMS proposal to update clinical labor data. Like last year's E/M proposal, updating clinical labor data in the CMS database sounds reasonable. However, because of the PFS budget-neutrality requirements, the incorporation of new clinical labor data would necessitate massive cuts to critical services in the PFS.

Instead of implementing misguided and massive cuts, we urge CMS to work with Congress on fundamental reforms to the PFS. We invite you to join us in ensuring continued access to care for patients. If you have questions or would like to sign the letter, please contact Lauren Citron (Lauren.Citron@mail.house.gov) and William Vogt (William.Vogt@mail.house.gov) in Congressman Rush's office or Chris Jones (Chris.Jones@mail.house.gov) in Rep. Bilirakis's office. Alternatively, you can sign onto this letter via quill here.

Sincerely,

Bobby L. Rush
Member of Congress

Gus M. Bilirakis
Member of Congress

LETTER TEXT

Dear Deputy Administrator Seshamani:

We write regarding the Centers for Medicare & Medicaid Services' (CMS) 2022 Physician Fee Schedule (PFS) proposed rule, released on July 13, 2021, which cuts critical services under the PFS by up to 20 percent and exemplifies the need for fundamental PFS reform relating to the PFS "budget-neutrality" provision. The primary driver of drastic cuts to PFS providers under the 2022 PFS Proposed Rule, the "budget-neutrality" provision also was the driver of massive cuts in the 2021 PFS Final Rule.[1] These year-over-year "budget-neutral" cuts, being implemented during a pandemic, are causing significant disruption to

the healthcare system and are being implemented without regarding to patient outcomes, actual PFS provider resource needs, or any other rationale policy.

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 redistributions clearly have negatively impact certain providers. For example, cardiology, vascular surgery, radiation oncology, and radiology have endured cumulative cuts over the last decade in the PFS of between 20 and 40 percent.[2] 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 percent cut which was redistributed to other PFS providers making at least 170 percent more.[3][4] 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.

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 2022 PFS Proposed Rule serves 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 corporate entities acquiring 20,900 additional physician practices over the last two years.[6] Given that the reimbursement for all specialists is, on average, more than $100,000 in a vertically integrated health system than in a physician office, the incentive is clear for beleaguered **PFS providers who may no longer be able to sustain cuts in the 2022 PFS Proposed Rule to simply close their centers and continue the migration to large health systems.**[7]

While the 2021 PFS budget-neutrality effect was due to the CMS policy of putting more money into 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, on its face, updating clinical labor data in the CMS database makes sense. However, because of aforementioned PFS "budget-neutrality," the incorporation of new clinical labor data actually results in **massive cuts of up to 20 percent to critical services in the PFS**.[8] 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[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%

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 learned since the start of the pandemic is that it is critical that hospitals be able to focus on our sickest pandemic patients. Yet many 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.[17]

Considering that the second-order negative effects of PFS "budget neutrality" strongly outweigh incorporating new clinical labor data, **we strongly recommend CMS not finalize the clinical labor policy at this time in the 2022 PFS Final Rule**. Moreover, considering PFS "budget neutrality" effects from the 2021 PFS Final Rule E/M policy are still causing negative impacts in the form of a scheduled 3.75 percent cut to the conversion factor in 2022, **we urge you to work with Congress on fundamental reform to the PFS** in order that we may better address the upcoming 3.75 percent cut in legislation later this year.

Thank you for your consideration of our concerns.

Sincerely,

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[1] The significant provider cuts in the 2022 PFS Proposed Rule are compounded by the 2021 PFS Final Rule cuts, which, as a result of the Consolidated Appropriations Act of 2021 are being phased-in with a 3.75% overall PFS reduction slated for January 1, 2022, and another conversion factor cut of a similar magnitude slated for January 1, 2024.

[2] Health Management Associates, Analysis of the 2022 Physician Fee Schedule, 2021

[3] Urban Institute and SullivanCotter, *Analysis of Physician Compensation*, January 2019.

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

[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] Avalere, *Hospitals and Corporations Own Nearly Half of U.S. Physician Practices: Covid-19 Accelerated Ownership Trend*, June 2021

[7] Post, Brady PhD et al., *Hospital physician integration and Medicare's site-based outpatient payments*, Health Serv Res. 2021;56:7 15

[8] It is worth noting another area ripe for reform is the PFS "impact table," which does not disaggregate specialty impact by site-of-service nor include the 3.75% cut to the conversion factor, thereby masking the true impact of the PFS on office-based specialists in the 2022 PFS Proposed Rule.

[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.

[17] 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 2001.