

September 7, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1751-P; Medicare Program; CY 2022 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (July 23, 2021)

Dear Administrator Brooks-LaSure:

The undersigned organizations, representing a broad range of physicians offer the following comments on the Centers for Medicare and Medicaid Services (CMS) Notice of Proposed Rule Making (Proposed Rule) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year (CY) 2022, published in the July 23, 2021, *Federal Register (Vol. 86, No. 139 FR, pages 39104-39907)*.

CMS is proposing to update the clinical labor pricing for CY 2022, in conjunction with the final year of the supply and equipment pricing update. CMS believes it is important to update the clinical labor pricing to maintain relativity with the recent supply and equipment pricing updates. The clinical labor rates were last updated in CY 2002. The undersigned organizations agree that the 20+ year-old Medicare physician fee schedule (MPFS) clinical labor rates should be updated. However, our initial analysis shows updating the clinical labor rates is estimated to increase Medicare direct practice expense costs by 30%. Based on \$11.5 billion in Medicare allowed practice expense direct costs, we estimate the “price tag” for updating the clinical labor rates in CY 2022 will be approximately \$3.5 billion. Due to budget neutrality constraints, the CY2022 scaling factor to account for this dramatic rise in direct practice expense costs is proposed to fall drastically to 0.44, from 0.59, an unprecedented rate. The result is that the burden of the pay-for is disproportionately distributed within the MPFS and rests squarely on the services performed in the non-facility office setting for services with high supply and equipment costs. If the CMS proposal goes into effect, as written, many of these non-facility offices will fail. This will limit access to care for Medicare patients and force many of those patients into the facility-based system.

Scaling Factors

The direct scaling factor is proposed to decrease -24% from 0.5916 in 2021 to 0.4468 in 2022. The practice expense component of the MPFS comprises approximately 45% of the total physician payment and that percentage is fixed. Therefore, an increase in the clinical labor rates results in a shift of RVUs that were previously directed to supplies and equipment. Stated another way, Medicare will now reimburse 44 cents on the dollar instead of 59 cents on the dollar for supply and equipment costs. This is an unsustainable payment rate for any business. The services performed by the undersigned specialties often require the use of expensive supplies that need to be stocked and readily available. The services also often require considerable capital costs to purchase and maintain equipment. CMS' proposed policy would result in wildly fluctuating shifts in reimbursement, violating a core principle of the resource-based relative value system which is to stabilize RVUs and

reduce fluctuations in year-to-year payments. The Medicare system should provide stable and predictable reimbursement for care rendered to their beneficiaries. **CMS should explore options to adjust the scaling factor(s) in order to more appropriately reimburse for expenses incurred to treat their beneficiaries.**

Budget Neutrality

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than \$20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS makes adjustments to preserve budget neutrality. This \$20 million "threshold" has been the same since the inception of the MPFS in 1992. No adjustments to this threshold have been made to account for new technology over 30 years. As stated previously, allowed charges would increase by approximately \$3.5 billion if the clinical labor proposal was implemented in 2022 without any offsetting reduction to the direct practice expense scaling factor. **CMS should analyze the effects of implementing the clinical labor rates as they have proposed, after no change for 20 years, versus having implemented those updates more regularly. CMS should publish how the annual \$20 million restriction on changes to expenditures could have played a role in the clinical labor updates. CMS should also consider all the ways budget neutrality can be accounted for in the practice expense methodology, as there are several steps in the formula where budget neutrality is applied.**

Impact

By increasing the clinical labor pricing, physician services with high cost supplies and equipment are disproportionately impacted by the budget neutrality component within the practice expense relative values. In the proposed rule, CMS displayed the isolated anticipated effects of the clinical labor pricing update on specialty payment impacts in Table 6. CMS highlights in the text that specialties with a substantially lower or higher than average share of direct costs attributable to labor would experience significant declines or increases, respectively, if this proposal is finalized. They go on to say that the Table 6 impacts do not include complete impacts of all the policies the Agency is proposing for CY 2022, only the anticipated effect of the isolated clinical labor pricing update. The impacts published in Table 6 and Table 123 are misleading. For example, the highest negative impact in Table 123 is -9% and in table 6 is -10%. In reality, the negative impact is much greater. As described above, this proposal disproportionately hits those services that are incurring the most direct practice expense. More specifically, groups of similar services in the nonfacility setting are projected to incur **reductions greater than -20%** for the majority of their services. While the undersigned organizations understand the impact tables are for illustrative purposes for aggregate impacts on specialties, and not meant to be code specific,

it would be more transparent to share actual impacts when they are so devastating to providers of office-based procedures with high supply and equipment costs. **CMS should publish a cost estimate for the clinical labor proposal as well as impacts to illustrate how the proposal is actually impacting non-facility reimbursement rates for highly affected code families.**

Clinical Labor Rates – BLS Data

CMS believes it is important to update the clinical labor pricing to maintain relativity with the recent supply and equipment pricing updates. CMS is proposing to use the methodology outlined in the CY 2002 PFS final rule, which draws primarily from United States Bureau of Labor

Statistics (BLS) wage data. CMS believes that the BLS wage data continues to be the most accurate source to use as a basis for clinical labor pricing and this data will appropriately reflect changes in clinical labor resource inputs for purposes of setting PE RVUs under the PFS.

The clinical labor rates were last updated in CY 2002 using BLS data and other supplementary sources where BLS data were not available. In the proposal, 12 of the 32 staff types used “other sources” instead of BLS data for pricing. These 2002 “other sources” data were not readily available for public review. For CY 2022, 14 of the 32 staff types are being updated using a BLS crosswalk because an exact match was not available. To maintain transparency, **CMS should publish the ‘other sources’ wage data details. In addition, CMS should update specific clinical labor wage rates based on stakeholder comments and data.**

Data Elements in Wage Rates

The BLS data includes several data elements for consideration. In the clinical labor pricing update proposal, CMS utilizes the mean wage data to establish updated clinical labor rates, while the majority of the MPFS data inputs are based on the median. For example, when developing RUC recommendations (work and practice expense) the physician times, work RVUs, clinical staff times and clinical staff types all use medians (ie, "typical"). The BLS survey data also include wage rates for a variety of sites of service (eg, hospitals, physician offices, farms) and wage data from a variety of industries. **We urge CMS to consider using the median wage data, instead of mean wage data, to more accurately capture typical wage rates and to be consistent with the median statistic used for clinical staff time.**

Fringe Benefit Multiplier

To account for employers’ cost of providing fringe benefits, such as sick leave, CMS proposes to use the same benefits multiplier of 1.366 that was utilized in CY 2002. Using the fringe benefits multiplier rate from 20 years ago (2002) is not consistent with CMS’ premise for updating the clinical labor pricing which was to “maintain relativity with the recent supply and equipment pricing updates.” BLS publishes benefits data routinely. **CMS should use a current fringe benefits multiplier ([1.296 BLS](#)).**

Timeline

The current clinical labor proposal requires additional analysis and modifications prior to implementation. There is further work to be done by both the Agency and stakeholders to ensure accurate data is used and appropriate methodological steps are taken for implementation. It is important to note that CY2022 will be the 4th and final transition year of the update to supply and equipment items—a proposal that also yielded significant shifts in payment rates. **CMS should not implement this update for CY2022 and instead should consider comments and publish an updated clinical labor proposal.**

In addition, CMS has requested comment on whether to implement a four-year transition to the new clinical labor cost data. There is precedent for a phased transition for significant MPFS changes, across several calendar years. CMS utilized a 4-year transition for the market-based supply and equipment pricing update concluding in CY 2022. CMS also utilized a 4-year transition, starting in 2010, for the practice expense proposal.

Summary of Recommendations

The undersigned organizations are advocates for cost effective, efficient and safe healthcare. The clinical labor proposal, as written, if implemented, will jeopardize the delivery of care to Medicare beneficiaries. We recommend CMS take the following steps regarding the clinical labor proposal:

1. Explore adjustments to the scaling factor(s)
2. Analyze the budget neutrality options
3. Publish non-BLS 'other sources' wage data
4. Update specific clinical labor wage rates based on stakeholder comments and data
5. Consider the use of median wage rates
6. Apply a more current fringe benefits multiplier
7. Analyze and publish codes with the most significant impacts

If you have any questions or comments related to this letter, please contact Trisha Crishock (SVS trishacrishock@gmail.com),

Sincerely,

The Alliance of Wound Care Stakeholders
The American College of Cardiology (ACC)
The American College of Radiology (ACR)
The American College of Surgeons (ACS)
The American Rhinologic Society (ARS)
The American Society for Radiation Oncology (ASTRO)
The American Urological Association (AUA)
The American Vein and Lymphatic Society (AVLS)
The American Venous Forum (AVF)
The Renal Physicians Association (RPA)
The Society for Cardiovascular Angiography and Interventions (SCAI)
The Society for Vascular Surgery (SVS)
The Society of Interventional Radiology (SIR)

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