SVS | Society for Vascular Surgery

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June 23, 2021

The Centers for Medicare and Medicaid Services (CMS)
200 Independence Avenue, SW
Washington, DC 20201
Sent electronically via: CMSPETownHall@rand.org

Re: Improving Data and Methods Relate to the Indirect Practice Expense in the Medicare Physician Payment Schedule

To Whom It May Concern:

The Society for Vascular Surgery (SVS) appreciates the opportunity to provide written feedback in response to the "Improving Data and Methods Related to Indirect Practice Expense in the Medicare Physician Fee Schedule" virtual Town Hall meeting on June 16, 2021. The SVS is concerned that Rand allowed only one week for feedback after the virtual Town Hall. It will be important moving forward that CMS and contractors allow enough time for thoughtful comments and engage in continued dialogue as new information is obtained. Below, we provide feedback on the three topics addressed during the virtual Town Hall.

1. Establishing a System of Ongoing Data Collection
SVS appreciate CMS' interest in identifying potential new Medicare practice expense methodologies and approaches for ongoing collection of accurate practice cost data. SVS believes that a review every five years would provide adequate update to practice cost data. A schedule that is more frequent would be burdensome. We also strongly urge CMS to use the expertise of the American Medical Association's (AMA) prior and continuing data collection activities to develop a data collection methodology.

We also urge exercising extreme caution while considering policies that would result in significant changes to the existing methodology. SVS agrees that timely and accurate practice cost information should be a priority for CMS. Physician practices, however, have suffered tremendously during the recent public health emergency and prior to pursuing collection of data, there must be confidence that physician practice costs have returned to "normal" in a relative sense. Engaging in any data collection prior to 2022 would likely result in data that is not accurate or relative.

With respect to survey data collection participation, SVS encourages offering incentives that compensate for time. There should be no punitive measures if a practice is randomly chosen and does not want to participate. Again, we strongly urge CMS to use the experience of the AMA prior data collections efforts.

2. Collecting PE Data By Specialty
We disagree with applying shortcuts for obtaining data (eg, consolidation of specialty cost structures). All efforts should be made to obtain and use representative data for all specialties. Recent use of crosswalking malpractice insurance for some specialties significantly distorted relativity between specialties. As a specific example, physical therapy malpractice insurance was crosswalked to an "all physician" category even though limited collected data for physical therapists showed insurance premiums were a fraction of the rate assigned to all physicians. The volume of services provided by physical therapists distorted (reduced) the premiums for physician categories with higher actual rates. We believe that "some data" is better than crosswalking—at a minimum the collected data should guide relativity.

It may also be helpful to understand why CMS has created new specialty categories. For example, each of the following specialty categories has a separate corresponding interventional category: pain medicine, radiology,

cardiology. It is unlikely that practices are 100% cardiology or 100% interventional cardiology. Consolidating these two categories may result in underpayment or overpayment of practice costs for services provided. Weight averaging data would not correct this discrepancy. This issue requires more investigation.

3. Improving Allocation
The Agency (and its contractors) should work closely with stakeholders to consider new expense types and/or adjusting current rules for practice expense rate setting. Those might include maintenance fees (adjusting the current 5%), electronic health record systems, "per click" fees, artificial intelligence expenses, and others. There should also be serious consideration to separately reporting disposable supplies that cost more than $500 by developing HCPCS codes rather than have items embedded as direct practice expense inputs for individual services. It has been shown many times that these high-priced disposable supplies distort relative payment for practice expense.

We are uncertain that alternative allocators would result in accurate data. For example, assigning a standard clerical staff cost per patient encounter dismisses the fact that patients require different amounts of work (eg, scheduling and billing for one service versus multiple services at a single encounter).

If stakeholders come to the conclusion that the relativity of the existing practice expense per hour data are misaligned and new data should be collected, the Agency should work with the AMA to collect update data. The AMA has experience working with specialty societies to collect such data, whereas the Agency (and its contractors) does not.

Using the Hospital OPPS to Determine Physician Cost Relativity
Although the virtual Town Hall did not discuss using the Hospital Outpatient Prospective Payment System (HOPPS) in Physician Fee Schedule (PFS) rate-setting, we would like to take this opportunity to provide comments on this topic. The Agency's regulatory language denotes a higher confidence level with Medicare's HOPPS data than Medicare's PFS practice expense level data, implying the HOPPS data is the gold standard. While the Agency might have access to hospital charge data, using that as a basis to conclude the data are more reliable is flawed. Hospital charge data are often based on existing Ambulatory Payment Classification (APC) Medicare payment amounts, reflecting a relativity of APC payment rather than actual cost relativity, which is circular. It is also important to acknowledge that hospital cost reporting is a black box, where hospitals are able to allocate costs to various departments at will. This is similar to assigning all costs related to vascular procedures to cardiac procedures because they want cardiac procedures to have higher APCs. The Agency (and its contractors) must immediately stop trying to use HOPPS cost data to set payments in the nonfacility setting.

To summarize, meaningful engagement with stakeholders will increase the likely success of improving the Medicare practice expense data. It will be important that CMS work with specialty societies and the AMA to ensure a thorough review of this complicated topic. Thank you for the opportunity to provide comments on the important issue of Medicare's practice expense methodology. If you have any questions, please contact Trisha Crishock at trishacrishock@gmail.com.

Sincerely,

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