

February 10, 2020

Carol Blackford
Director, Hospital and Ambulatory Policy Group
Centers for Medicare & Medicaid Services
Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically

RE: CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies Proposed Rule

Dear Director Blackford:

On behalf of the undersigned organizations, we write to urge the Centers for Medicare & Medicaid Services (CMS) to consider alternative options to address the projected reimbursement cuts to services furnished by our health care professionals in 2021. We understand that these adjustments are proposed to offset implementation of higher relative value units (RVUs) for the office/outpatient evaluation and management (E/M) services and maintain the budget neutrality of the calendar year (CY) 2021 physician fee schedule (PFS). However, if adopted as proposed, our providers will incur deep reductions in reimbursement when furnishing services to Medicare beneficiaries, which will impede access to the essential and vital services that our members provide for seniors and individuals with disabilities. We thank you for meeting with our organizations on Monday, January 13, 2020, to hear our concerns and, as requested at the in-person meeting, we offer feedback and possible options to eliminate or alleviate this impact on our providers and the Medicare beneficiaries they serve.

In the 2020 PFS Final Rule, CMS increased payment for the office/outpatient evaluation and management (E/M) *Current Procedural Terminology* (CPT®) codes effective January 1, 2021. **We understand and support the policy goal of increasing payment for office/outpatient E/M codes for 2021.** Our concern rests on the fact that, to account for these increases and in an effort to maintain budget neutrality, providers who are statutorily ineligible to report E/M services and/or who provide the majority or all of their services outside of the office/outpatient E/M code set are expected to incur significant, and what we consider to be unjustified, decreases in Medicare reimbursement in 2021. These cuts compound numerous existing reductions already experienced by these providers, including the 2% sequestration reductions implemented in 2013 and the multiple procedure payment reduction (MPPR) applied to several categories of services, such as physical therapy, occupational therapy, and speech-language pathology. In combination with existing reductions, these cuts may prove unsustainable, especially for many small and rural providers.

We are concerned that the practical impact of reducing payment to 37 different provider specialties—the majority of whom are not eligible to report E/M CPT codes to Medicare—will not meet Congress’ and the Department of Health & Human Services’ (HHS) goal related to the delivery of coordinated, efficient, and cost-effective care that achieve patients’ desired outcomes and, whenever possible, reduce downstream costs. With significantly lower reimbursement, Medicare beneficiaries may consequently face reduced access to medically necessary care, as our providers have few options to mitigate their losses. At a time of significant increases in the

Medicare eligible population, we suggest that this loss of access to essential services due to the proposed cuts does not advance Congress', HHS', or CMS' policy goals and must be carefully weighed.

With these considerations, the undersigned organizations offer the following detailed recommendations and comments as CMS undertakes development of the CY 2021 PFS Proposed Rule.

Review impact of budget neutrality and the conversion factor adjustment on specialty providers

Section 1848(c)(2)(A) of the Social Security Act (SSA or the Act) authorizes the Secretary to establish RVUs for the PFS after considering recommendations of the Physician Payment Review Commission and consulting with organizations representing physicians. CMS published a final rule on November 25, 1991 (56 FR 59502) to implement section 1848 of the Act by establishing a fee schedule for physicians' services furnished on or after January 1, 1992.

Section 1848(c)(2)(b)(ii)(II) of the Act also provides that adjustments in RVUs may not cause total PFS payments to differ by more than \$20 million from what they would have been had the adjustments not been made. In response to concerns that the \$20 million budget neutrality provision may impose a “chilling” effect on consideration of legitimate changes on physician work, practice expense, and malpractice RVUs, CMS stated in the 1991 PFS Final Rule that “*We will carefully consider this comment as we do future updates of the RVS. It is certainly not our intention to use the \$20 million limitation on RVS adjustment to achieve budget savings or to impede the advancement of medical practice.*” [emphasis added]¹ While we recognize budget neutrality is statutorily mandated, we strongly urge CMS to consider how it might achieve the goal of increasing E/M values and its charge to maintain budget neutrality without placing the burden of paying for these changes on providers who provide limited or no E/M services under the Medicare program.

Table 120 in the 2020 PFS Final Rule (84 FR 63156 through 63157) illustrates the specialty payment impacts if CMS finalizes the proposal for the office/outpatient E/M code value increases without modification. Of primary concern to the undersigned are the reimbursement cuts to services furnished by our provider members due to the redistribution of the E/M code value increases through the budget neutrality adjustment to the conversion factor (CF). Rising debt and shrinking reimbursement provide the perfect storm for discouraging individuals from choosing to enter these health care professions in the future and may pose challenges to the financial viability of current providers. Such shortages would be particularly detrimental as more baby boomers reach Medicare age and more individuals across the lifespan and payer types seek access to services as health care reform provisions become effective.

In applying budget neutrality adjustments to the CF for 2021, professions that do not report any of the E/M CPT codes with increased values will be more significantly impacted than those that can mitigate the CF reduction through utilization of the increased E/M codes. Modifications in payment and policy should be fair and balanced, ensuring equitable impacts across all specialty types. Accordingly, the undersigned urge CMS to consider whether there is a mechanism to further adjust the CF to more evenly spread the impact of the coding and payment changes for

¹ 1991 Physician Fee Schedule Final Rule. Page 59573: <https://www.govinfo.gov/content/pkg/FR-1991-11-25/pdf/FR-1991-11-25.pdf>.

the office/outpatient E/M services while maintaining budget neutrality. However, in response to speculation that CMS may seek to reduce RVUs or apply a work adjuster to CPT codes as a mechanism for achieving budget neutrality, the undersigned express their strenuous opposition to any such possibility.

Recommendations:

- (1) CMS must explore alternative approaches to achieve budget neutrality without forcing providers who furnish little or no E/M services to pay for the E/M coding and payment changes. The undersigned recommend that CMS closely examine how the budget neutrality calculation was applied and look directly at areas most dramatically impacted, in regard to both increases and decreases incurred. CMS should consider how it can implement any necessary adjustments so that they are distributed across a broader cross-section of services to avoid undue burden to specific provider groups and patient populations.
- (2) Additionally, we urge CMS to conduct a code-by-code impact analysis to confirm that any proposed actions do not have an undue burden on a particular provider group or negatively impact beneficiary access. Accordingly, CMS should delay implementation of any reductions until such analyses are completed and CMS can ensure continued access to the high-quality, cost-effective services our providers deliver to Medicare beneficiaries.
- (3) CMS should implement a transparent decision-making process that evaluates the specific impacts on codes and procedures, and yields a result that allows all provider specialties to continue to meet program and beneficiary needs. This process should include replacement of the “Other” category in Table 120 of the CY 2020 final rule with individual specialty-level line items to ensure equitable access to impact information for all Medicare providers.

Defer or cancel implementation of add-on code GPC1X until new policy is authorized by Congress to cover new (currently unreimbursed) services under the Medicare program

The undersigned request that CMS reconsider whether it is an appropriate time to introduce the add-on Healthcare Common Procedure Coding System (HCPCS) code GPC1X in 2021, as described in the CY 2020 PFS final rule.

First, we note that the CY 2020 PFS final rule discussion reveals that there were numerous stakeholders that voiced concern about whether the HCPCS code GPC1X should be implemented at all, or at a minimum, deferred pending further evaluation, particularly due to concerns about potential overlap with existing codes and disproportionate impact on provider specialty payments. It is notable that Table 120 (84 FR 63156) demonstrates that the concurrent implementation of the E/M code changes and use of HCPCS codes GPC0X and GPC1X would result in a change in provider specialty payments ranging 26 percentage points from +16 percent to -10 percent. In contrast, Table 124 (84 FR 63178), reveals that the E/M code payment changes without the introduction of the two G-codes would reduce the variance in change of provider specialty payments to 17 percentage points from +10 percent to -7 percent.

Recommendations:

- (1) As CMS undertakes the development of the 2021 PFS Proposed Rule, we recommend that CMS fully consider deferring or cancelling the implementation of HCPCS code GPC1X until further analysis is conducted that utilizes all relevant sources of information as it evaluates any overlap with existing codes and further refines the work and PE RVUs appropriate for

this code. Furthermore, authorization of new services by Congress would allow the addition of GPC1X without having to apply budget neutrality, as it represents new, currently unreimbursed services.

- (2) If CMS elects to proceed with the use of HCPCS code GPC1X, we note that CMS provides a financial impact estimate assumption that **21 specialties** that bill E/M codes “*would bill HCPCS code GPC1X with 100 percent of their office/outpatient E/M visit codes*” (84 FR 63157). This assumption is concerning, as it seems implausible that all 21 specialties listed would always furnish services to beneficiaries meeting the clinical complexity and work effort included in the description of this code. In fact, on the same page of the Final Rule, CMS undermines the 100 percent assumption by stating that the estimated use of the HCPCS code GPC1X “*is not meant to be prescriptive*”, which we interpret to mean that CMS does not believe the 21 specialties would concurrently report the code 100 percent of the time with E/M codes. If CMS moves forward with the GPC1X code, the assumptions should be revisited and reduced to better reflect the true impacts by specialty.
- (3) At a minimum, we recommend that CMS revisit the assumptions related to the percentage of time the 21 listed specialties would bill GPC1X along with an E/M code. That effort should include working with impacted stakeholders to obtain realistic usage estimates and share the evaluation of the revised estimated impacts in a transparent manner before implementing the use of this add-on code at a later date.

Phase-in payment decreases to minimize the immediate impact on affected providers

While the undersigned organizations feel strongly that substantive changes are needed to definitively remedy the inequitable impacts of the 2021 payment reductions, we also believe that in the interest of time, more immediate action should also be taken. As such, the undersigned request that CMS phase-in any changes in reimbursement rates over multiple years to minimize the immediate negative impact on our member providers who are not eligible to report E/M services under the Medicare program and have few, if any, other means to mitigate the negative payment adjustments. As recommended by the Medicare Payment Advisory Commission (MedPAC) in Chapter 3 of the Commission’s June 2018 Report to Congress, adjustments to the fee schedule to address devaluation of E/M services could be phased in over multiple years to reduce the impact on other services.² We also note that there is precedent for phase-in when a proposal results in large-scale changes and shifts in payment. For example, CMS finalized a CY 2019 proposal to phase-in market-based supply and equipment pricing practice expense updates over a 4-year period “*to minimize any potential disruptive effects during the proposed transition period that could be caused by other sudden shifts in RVUs due to the high number of services that make use of these very common supply and equipment items.*”³

Recommendation: Until a permanent solution is realized, the undersigned strongly urge CMS to adopt a phase-in period in order to mitigate any volatility caused by the significant estimated redistribution of payment. This is especially important for specialties that have limited or no

² Medicare Payment Advisory Commission Report to the Congress: Medicare and the Health Care Delivery System (June 2018). http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf

³ 2019 Physician Fee Schedule Final Rule (pg. 59475). <https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>

ability to report E/M CPT codes to Medicare. Additionally, we urge CMS to make every effort to equitably balance the payment adjustments during the phase-in to avoid the wide variance among the positive and negative payment changes, as previously outlined in our discussion regarding GPC1X. Implementing a phase-in will help accomplish the agency's desired goal to minimize the potentially disruptive impact of far-reaching policy and payment changes and allow providers to adequately prepare for the decreases.

Conclusion

We urge CMS to be mindful of the impact of well-intentioned policy changes, as such proposals often result in inappropriate redistributions of Medicare outlays that significantly affect the broader provider community and the patients they treat. The undersigned greatly appreciate the opportunity to offer further comments and insight as CMS enters the 2021 PFS rulemaking cycle. We are eager to continue engaging in meaningful dialogue and working with CMS to advance and support Medicare beneficiary access to medically necessary services.

Thank you for your consideration.

Sincerely,

Academy of Nutrition and Dietetics
Alliance for Physical Therapy Quality and Innovation
American Academy of Audiology
American Chiropractic Association
American Health Care Association
American Occupational Therapy Association
American Physical Therapy Association
American Psychological Association
American Speech-Language-Hearing Association
National Association for the Support of Long Term Care
National Association of Rehabilitation Providers and Agencies
National Association of Social Workers
Private Practice Section of the American Physical Therapy Association

cc:

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