Texas Hospital Association

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Via electronic submission
http://www.regulations.gov

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1734-P,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850

RE: CMS-1734-P, Medicare Program: CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment

Dear Ms. Verma:

On behalf of our more than 465 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to provide comments on the above-referenced proposed rule for the Physician Fee Schedule.

We strongly *oppose* CMS' proposal to reduce the conversion rate by 10.6 percent. We recommend a longer phase-in period be implemented as well as a cap be placed on any increase/decreases. These reductions will not only directly impact a hospital's bottom line but will adversely impact other payer reimbursements if they utilize reference pricing.

Background:

Given that outpatient E/M visits comprise 20 percent of allowed charges for Medicare Physician Fee Schedule services, the impact of these changes is significant. This rule proposes reducing the conversion factor from $36.09 to $32.26. If the same number of RVUs are performed in 2021, the reimbursement would be 10.61 percent less than in 2020. By comparison the change in the conversion factor from 2019 to 2020 was $0.05.

The impact of these changes would vary significantly by specialty. Medical specialists will see significant increases in Medicare reimbursement while hospital-based physicians and proceduralist will see nearly as dramatic reductions. If adopted the practitioners in 18 specialties would see two percent or more increase. These include endocrinology (+17 percent), rheumatology (+16 percent), family practice (+13 percent) and hematology (+14 percent). By contrast those in 34 specialties would receive two percent or more reduction. Those

experiencing the most significant reductions include numerous hospital-based specialists such as radiology (-11 percent), interventional radiology (-9 percent), and anesthesiology (-8 percent).

By comparison, in 2020, the highest increase by specialty was four percent (clinical social workers) and the greatest reduction was four percent for ophthalmology. Only 9 specialties saw more than a one percent change.

Hospitals are particularly hard hit as the contractual conversion factor does **not** change unless the contract is subsequently amended or renegotiated. In addition, the conversion factor for anesthesiology is proposed to decline from $22.20 per ASA unit to $19.96 per ASA unit.

CMS value-based strategy drove its decision last year to increase fee-for-service reimbursement for medical specialist by increasing the RVUs for the services they provide. Now faced with paying for those increases in 2021 absent any "new money", CMS' only option was to cut reimbursement for all other services, negatively impacting proceduralist and hospital-based physicians.

The impact on physicians employed by hospitals or compensated under professional services arrangements is more complicated. Today, most employment contracts and PSAs tie compensation to productivity, using personally performed work RVUs as the measure of productivity. Under such an agreement, a physician's total work RVUs in a specified time period is multiplied by a conversion factor (i.e. contracted conversion factor) the amount of which is specified in the agreement. In most cases, this conversion factor is based on historical benchmark survey data for compensation per work RVU for the physician's specialty.

Because the contracted conversion factor is specified in the physician employment agreement, it will not change if CMS' proposal is finalized. The hospital would remain obligated to compensate physicians based on contracted terms. However, there will be a material impact on the resulting compensation due to the work RVU changes.

Hospital-based physicians would see some increase in their total wRVUs due to an increase in the RVUs for office/outpatient E/M codes, but far less than the medical specialist who provide these services more regularly. The hospital would receive lower Medicare reimbursement in 2021 than it did when the same services were performed in 2020. The same would be true for commercial contracts with fee schedules tied to current Medicare rates.

Some hospital employment agreements and/or PSAs include provisions permitting changes to the contracted conversion factor to maintain fair market value compensation. Depending on the contract's language and the specific facts and circumstances, a hospital may need to revisit existing physician compensation arrangements. This will not be without challenges. The benchmark survey data to which this compensation conversion factor is often tied will not fully reflect these impacts for another 2-3 years given normal timing lags in survey data and the

varied rate with which contract modifications occur. It may be 2023 (based on 2022 data) before benchmark surveys have stabilized from the impact.

Hospital-owned physician practices are already struggling with narrow or negative operating margins. They will continue to struggle and potentially see greater losses without any cost mitigation.

Thank you for your consideration of these comments. We look forward to working with you on these issues. Should you have any questions or comments, please email me at rschirmer@tha.org.

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