

October 2, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (the “PFS Proposed Rule”); file code CMS-1734-P.

Dear Administrator Verma:

On behalf of the American Society of Transplant Surgeons (ASTS), I am pleased to have the opportunity to comment on the PFS Proposed Rule. ASTS is a medical specialty society representing over 1,800 professionals dedicated to excellence in transplantation surgery. Our mission is to advance the art and science of transplant surgery through patient care, research, education, and advocacy. While ASTS supports CMS’ efforts to reduce the administrative burden associated with billing for Evaluation and Management (E&M) services, as recommended by the AMA’s Relative Value Update Committee, we strongly object to the sweeping Medicare payment reduction for specialty services, including transplant surgery, set forth in the PFS Proposed Rule.

A little over a year ago, the Administration launched the *Advancing American Kidney Health Initiative*, a bold new initiative to improve the lives of Americans suffering from kidney disease, expand options for American patients, and reduce healthcare costs. One of the primary goals of this initiative is to have 80 percent of new ESRD patients in 2025 either receiving dialysis at home or receiving a transplant. Since the time this initiative was launched, CMS has taken a number of bold steps towards this objective by, for example, removing the inadvertent disincentives to transplantation previously imposed by the Medicare certification requirements for Transplant Centers and launching a number of new demonstrations that aim to increase the rate of transplantation.

Unfortunately, the COVID-19 pandemic has set back progress significantly. As a result of the pandemic, many Transplant Centers ceased providing transplants or significantly reduced their operations and available resources were directed

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Marwan S. Abouljoud, MD, CPE, MM
Henry Ford Transplant Institute

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Devin E. Eckhoff, MD
Irene K. Kim, MD
Ashley H. Seawright, DNP, ACNP-BC

Executive Director

Daniel D. Garrett, CAE
daniel.garrett@asts.org

National Office

1401 S. Clark St.
Suite 1120
Arlington, VA 22202
703-414-7870
asts@asts.org
ASTS.org

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toward the treatment of COVID patients. As a result, many programs are currently facing unprecedented operational and financial challenges. Now is simply not the time to augment those challenges by slashing Medicare payment for transplant surgery by 11%, as set forth in the PFS Proposed Rule.

Nor do we believe this extraordinary reduction is mandated by the budget neutrality provisions applicable to the Physician Fee Schedule (PFS) under the Medicare Act.¹ While we recognize the Medicare Act does require adjustments be made to ensure modifications in coding and valuation do not result in higher PFS expenditures than those that would be made in the absence of such modifications, CMS has sufficient administrative discretion under the applicable law to eliminate or substantially moderate the budget neutrality adjustment proposed for 2021. The measures that could be taken to mitigate the Proposed Rule's extraordinary reduction are set forth at length in comments filed by the American Medical Association and by the E/M Coalition, which are incorporated by reference and which will not be repeated in their entirety here.

We do note, though, when it comes to mitigating the impact of the budget neutrality adjustment, CMS' hands are hardly tied by the governing statute: It is our understanding that, of the \$10.2 billion in additional spending attributable to changes described in the PFS Proposed Rule, only about half are attributable to modifications of E/M coding and valuation on which there is broad consensus in the medical community (CPT codes 99202-99215; 99XXX). More than half of the remaining spending is attributable to CMS' proposal to adopt a new primary care add-on code (HCPCS GPC1X) to reflect the medical complexity of certain primary care services. That code's descriptor is so vague it could not be valued by the RUC and so expansive CMS actuaries project it will be billed by almost every medical specialty for every E/M service, resulting in virtually unlimited exposure for the Medicare Trust Funds, hundreds of millions of dollars in additional copayment for Medicare beneficiaries, and incalculable financial exposure for third party payers (including Medicare Advantage Plans) that are legally obligated to provide coverage consistent with that provided under the Medicare PFS. Finally, the remaining spending that ostensibly supports the extraordinary conversion factor reduction proposed by CMS consists of increased valuation for certain selected services that CMS has identified as closely analogous to E/M services. Thus, about half of the proposed payment reduction could be eliminated if CMS were to simply (a) delay for a year implementation of the new controversial and budget-busting add-on code GPC1X; and (b) request the RUC to determine whether and to what extent revaluation of other services is necessary to maintain relativity with the newly revalued E/M services, rather than implementing these increases for arbitrarily selected physician visits in 2021.

Even the (roughly) half of the conversion factor reduction attributable to the E/M coding and valuation changes recommended by the RUC could be mitigated significantly by recalculating the budget neutrality adjustment in a manner that more reasonably projects utilization of E/M and other outpatient services in 2021. At this stage, it is clear the pandemic will continue to impact utilization of physicians' services well into next year. Budget neutrality calculations that use 2019 as the utilization base year (as proposed) will substantially overstate the number of office and outpatient visits (and other PFS services) likely to occur next year. Basing the budget neutrality projection on more realistic E/M and other utilization projections has the potential to substantially mitigate the need for the payment reductions

¹ Social Security Act, Section 1848(c)(2)(B(ii)).

set forth in the PFS Proposed Rule,² and correction of those calculations to account for E/M policy changes that will become effective in 2021 may further blunt the reductions.³

Finally, for the reasons set forth in comments filed by the American College of Surgeons, we strongly urge CMS to ensure the PFS continues to accurately reflect the relative resources of PFS services by applying the office visit increases to the global surgery packages. While we recognize the impact of this proposal may increase the budget neutrality adjustment, surgical specialties participated fully in AMA processes conducted to revalue office and outpatient visit codes, and CMS' proposal to retain current valuation of office and outpatient visits provided by surgeons during the global period is inconsistent with the governing statute's prohibition on specialty differentials.

In conclusion, then, ASTS stands with the rest of the house of medicine in opposing the draconian payment reductions set forth in the PFS Proposed Rule. We believe implementing the PFS Proposed Rule without change will undermine the recovery of the Nation's health care system and will, in the case of transplant surgery, exacerbate revenue shortfalls that threaten attainment of the objectives established by the Administration last year in the Kidney Health Initiative. Especially in light of the unprecedented conditions created by the pandemic, we urge CMS to utilize the full breadth of its administrative discretion to prevent the extraordinary disruption that would follow in the wake of the reductions described in the PFS Proposed Rule.

Sincerely,



Marwan Abouljoud, MD, FACS, CPE, MMM
President
American Society of Transplant Surgeons

² The Commonwealth Fund, [“The Impact of the COVID-19 Pandemic on Outpatient Visits: Changing Patterns of Care in the Newest COVID-19 Hot Spots August 13, 2020.”](#)

³ For example, in last year's PFS Final Rule, CMS finalized a policy under which CPT codes 99358–99359 generally will not be payable in association with office/outpatient E/M visits beginning in CY 2021; yet the proposed budget neutrality adjustment appears to be based on the assumption that several hundreds of thousands of claims for these services will be separately payable in 2021.