



Saving and improving lives with transplantation.

American Society of Transplant Surgeons®

August 30, 2022

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare &
Medicaid Services
Department of Health
and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

RE: RIN 0938-AU81. Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, et seq. ("2023 PFS Proposed Rule" or the "Proposed Rule")

Dear Administrator Brooks-LaSure:

On behalf of the American Society of Transplant Surgeons (ASTS), I am pleased to have the opportunity to comment on the 2023 PFS Proposed Rule. ASTS is a medical specialty society representing approximately 1,900 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.

Our comments address the following provisions of the Proposed Rule:

- The Centers for Medicare and Medicaid Services' (CMS') proposal to provide Medicare coverage for dental evaluation and treatment performed in connection with organ transplantation;
- CMS' solicitation of information regarding refinement of global surgical package valuation; and
- CMS' proposal to update the Medicare Economic Index but to delay the update until 2024.

Preliminarily, we note that the Proposed Rule would substantially reduce Medicare payment for services paid under the PFS during a time when the health care community continues to struggle with the ongoing impact of COVID and of rampant inflation. Specifically, under the Proposed Rule, the conversion factor would be reduced by over 4%, without taking into account other reductions required under Congressional budgetary rules, such as PAYGO and sequestration reductions. While we understand that budget neutrality and other statutory constraints limit CMS' discretion to mitigate these reductions, we strongly urge the agency to do what it can to alleviate the impact of such payment reductions by, for example, postponing revaluations and other changes that contribute significantly to the proposed conversion factor reduction and implementing those changes that cannot be postponed over a longer transition period. We would hope that the agency will do what it can to ensure that our health care system is insulated from substantial shifts and payment reductions to the extent practicable during this fragile post-but-not-post COVID period.

President

William C. Chapman, MD
Washington University

President-Elect

Elizabeth A. Pomfret, MD, PhD
University of Colorado

Secretary

Ginny L. Bumgardner, MD, PhD
The Ohio State University

Treasurer

James F. Markmann, MD, PhD
Harvard Medical School

DEI Officer

Henry B. Randall, MD, MBA
SSM Health Saint Louis University

Immediate Past President

A. Osama Gaber, MD
Houston Methodist Hospital

Past President

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

Councilors-at-Large

Kenneth A. Andreoni, MD
Devin E. Eckhoff, MD
Irene K. Kim, MD
Linda C. Cendales, MD
Ty B. Dunn, MD, MS
Jayme E. Locke, MD, MPH
André A. S. Dick, MD
Majella B. Doyle, MD, MBA
Sunil K. Geevarghese, MD, MSCI
Ashley H. Seawright, DNP, ACNP-BC

Executive Director

Maggie Kebler-Bullock, CFRE

National Office

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

American Transplant Congress

June 3–7, 2023
San Diego, California

Expanded Medicare Coverage for Dental Evaluation and Treatment Performed as an Integral Component of Organ Transplantation

Section 1862(a)(12) of the Act generally precludes payment under Medicare Parts A or B for any expenses incurred for services “in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth.” However, the Proposed Rule observes that certain dental services that are inextricably linked to, and substantially related and integral to the clinical success of otherwise covered services may be covered despite this statutory prohibition. Along these lines, the Proposed Rule seeks comment on whether Medicare coverage should be extended to dental services, such as dental examination, including necessary treatment, performed as part of a comprehensive workup prior to organ transplant surgery.

As stated in the Proposed Rule, if a patient requiring an organ transplant has an oral infection, the success of that transplant could be compromised if the infection is not properly diagnosed and treated prior to the transplant surgery. If such an infection is not treated prior to transplant, and immunosuppressant therapy is initiated to preserve the transplant, then there is an increased likelihood for morbidity and mortality resulting from spreading of the local infection to sepsis.

ASTS Comment: *ASTS strongly supports CMS’ proposal to add regulatory language (42 CFR Section 411.15(i)(3)(A)) that authorizes Medicare coverage for the dental evaluation performed as part of a comprehensive transplant work up and medically necessary diagnostic and treatment services to eliminate dental infection prior to organ transplant.*

Global Surgical Package Valuation

The 2023 PFS Proposed Rule solicits comments on potential refinement of global surgical packages, including the 90-day global surgical package. Because all transplant procedures are 90-day global procedures, this issue is of significant importance for ASTS members.

ASTS strongly supports the comments on global surgical package valuation submitted by the American College of Surgeons, which are hereby incorporated by reference. In general:

- We strongly encourage CMS to disregard the RAND recommendations for revaluation of the global codes given that the RAND methodology is not only flawed but is based on numerous assumptions that are not transparent to the public. We encourage CMS to release the underlying data and assumptions used by RAND.
- We encourage CMS to reach out to EHR vendors and Medicare Administrative Contractors (MACs) to obtain data on the number of postoperative visits actually provided.
- We suggest that CMS consider eliminating the 10-day global period and review codes with that global period to determine if a 0-day or 90-day global period is most appropriate, but this must only be done by engaging stakeholders and reviewing the codes for relative valuation, not by using a formulaic building block valuation approach.

We encourage CMS to continue to work with specialty societies as it moves forward, so we can weigh in on the Agency’s policy considerations related to revaluation of global surgical packages.

Modification of Medicare Economic Index (MEI)

The changes in the MEI that CMS is proposing are almost entirely related to the category weights. A change in the price proxy is recommended for just one of the cost categories which accounts for only 2% of the index. CMS is not proposing a change to the productivity adjustment. The proposed changes in the category weights are primarily derived from the Census Bureau’s 2017 SAS for the “Offices of Physicians” industry, which was not designed with the purpose of updating the MEI. As a result, there are key areas (physician work, nonphysician compensation and medical supplies) where CMS must use data from other sources to work around this important gap.

Several of the flaws in utilizing the SAS data for this purpose, include:

- 7% of the revenue for “Offices of Physicians” on the 2017 SAS was from non-patient care sources (e.g., grants, investment income) and any expenses associated with these sources cannot be excluded.
- CMS used BLS data to split out the US Census SAS data using the NAICS 6211 “Offices of Physicians” category. However, only 64% of employed physicians are in this category in both the US Census SAS and BLS OEWS datasets. This analysis excludes 36% of physicians who are employed in other health care settings, such as hospitals. For example, the NAICS 6221 “General Medical and Surgical Hospitals” category was not included in CMS’ analysis and this category includes 158,880 employed physicians according to the 2017 BLS OEWS data. Hospital-based physicians have a higher proportion of physician earnings and PLI cost relative to other practice costs, as many of these other costs are the responsibility of the hospital or other facility. **The CMS proposal greatly underrepresents the cost share of physician work and PLI relative to practice expense due to this inappropriate exclusion.**
- In the current MEI, CMS excludes expenses for separately billable supplies and drugs. The 2017 SAS for “Offices of Physicians” has a single category for Medical Supplies without any breakout for the separately billable component. To estimate separately billable supply and drug expense, CMS proposes to age forward AMA-PPI results for these expenses and then compare the estimated total to Medical Supplies expense from the SAS (finding that 80% of Medical Supplies expense is for separately billable medical supplies or drugs). There are two problems with the CMS proposed approach: 1) The measures used to age expenses forward are not entirely appropriate (using growth in Medicare Part B drug spending when an all-payer measure would be better, and using measures of inflation (CPI and PPI from BLS) to age spending); and 2) totals estimated from two entirely different surveys are being compared when those surveys may have different populations and methods (for example, the wording of the questions and direction on what to include in the category could be entirely different).
- The dramatic decrease in the weight for PLI cost seems unrealistic. In 2021, the Medicare physician payment schedule allowed charges were \$91 billion. If PLI payment only represented 1.4% of this payment, total Medicare spending on its share of these premiums and self-insured actuarial costs would be \$1.274 billion. With more than one million physicians and other health care professionals billing Medicare, this would compute to Medicare paying an average of \$1,275 per individual. Assuming Medicare represents approximately 25% of physician payment, an understated \$5,100 in PLI premium cost results. This is in direct contradiction to the volume weighted PLI premium costs of \$21,700 computed by CMS elsewhere in the Proposed Rule. It appears that a 4-5% PLI weight is more appropriate than the proposed 1.4%.

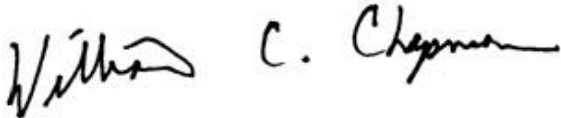
The result of modifying the MEI in the manner proposed would be to significantly reduce Medicare payment for physicians’ services provided in facility settings while increasing Medicare payment for those services provided in physicians’ offices. Based on the impact charts included in the Proposed Rule, the redistributive impact of making these MEI changes would be very substantial. In summary, this proposal redistributes physician payment from physician work to the business side of health care. This proposal is particularly unfortunate as physicians face uncertainty about the Medicare conversion factor and continue to suffer from burnout. The Administration should be doing more to emphasize the importance of physicians, rather than direct resources away from their individual contributions.

At the same time, the Proposed Rule makes it clear that CMS is on the brink of completely revising the practice expense methodology used to determine PFS allowances. In our view, it simply makes no sense to undertake changes that result in massive payment redistributions based on the current PE methodology, when radical change in the PE formula is on the horizon. For this reason, we urge CMS to reconsider its proposal to revise and rebase the MEI at this time. We also urge CMS to continue to collaborate with the American Medical Association on data collection efforts that ensure consistency and reliability in physician payment. Updates to MEI weights should be postponed until new survey data are available. It is anticipated that a new data collection effort will begin in 2023, and based on 2022 data.

If CMS does decide to proceed with the proposed MEI revisions, we concur that these changes should be delayed until 2024 in order to provide those affected the opportunity to study the changes in detail and to provide comments on potential refinements. Also, if the MEI revisions are ultimately adopted, we urge that they be phased in over a period of at least four years, in order to mitigate the potentially disruptive impact of such sizeable shifts in physician payment.

We appreciate the opportunity to comment on the 2023 PFS Proposed Rule. If you have any questions regarding these comments or if we can provide any further assistance, please do not hesitate to contact Emily Besser at Emily.Besser@ASTS.org.

Sincerely yours,

A handwritten signature in black ink that reads "William C. Chapman". The signature is written in a cursive style with a large initial "W" and a clear "C. Chapman" following.

William Chapman, MD, FACS

President

American Society of Transplant Surgeons