AAMD
American Association of Medical Dosimetrists

September 13, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244-8016

Dear Administrator Brooks-LaSure:

The American Association of Medical Dosimetrists (AAMD) appreciates the opportunity to offer its comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule for the CY 2022 Physician Fee Schedule (CMS-1751-P). AAMD represents medical dosimetrists and has a current membership of over 3,000. AAMD is dedicated to fostering radiation oncology education and science, improving patient care services, and encouraging education in radiation oncology.

AAMD appreciates this opportunity to comment on the proposed regulations. The AAMD is concerned about the financial implications this proposed payment rule will have on access to care for Medicare beneficiaries and radiation oncology practices across the country. Specifically, the cuts associated with the updates to clinical labor pricing and the expiration of the 2021 3.75% conversion factor increase have an incredibly burdensome impact on community-based radiation oncology. The combined impact of these significant proposals means payment for some radiation oncology services will be cut by as much as 23%.

We do not understand how radiation oncology is expected to contribute to President Biden's important goal of "ending cancer as we know it" considering these cuts. Furthermore, our members cannot withstand such drastic cuts on top of the crushing revenue declines associated with the global pandemic. The COVID-19 public health emergency (PHE) reduced radiation oncology practice revenues by 8% in 2020, and another wave of COVID-19 infections is leading hospitals to cancel elective procedures and shift radiation oncology staff, which will again result in drops in patient volumes and revenue. During the PHE, radiation therapy treatments have been interrupted or truncated prior to completion due to COVID infection and/or local quarantine requirements for patients, family caregivers, or clinic staff. The full extent of these unanticipated disruptions on clinical care is impossible to determine, and the payment cuts in the proposed rule only add to this unprecedented challenge. If finalized, these newly proposed cuts will result in a 25% decline in radiation oncology allowed charges over the last decade.

Additionally, CMS is proposing to update the clinical labor pricing for CY 2022, in conjunction with the final year of the supply and equipment pricing update. CMS believes it is important to update the clinical

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labor pricing to maintain relativity with the recent supply and equipment pricing updates. However, the analysis shows updating the clinical labor rates is estimated to increase Medicare direct practice expense costs by 30%. Based on $11.5 billion in Medicare allowed practice expense direct costs, the anticipated "price tag" for updating the clinical labor rates in CY 2022 will be approximately $3.5 billion. By increasing the clinical labor pricing, physician services with high-cost supplies and equipment are disproportionately impacted by the budget neutrality component within the practice expense relative values. For example, the negative impact for radiation oncology could be at a -5% cut. In reality, the negative impact with many radiation oncology services seeing reductions between -10% and -20%.

The clinical labor rates were last updated in CY 2002 using Bureau of Labor Statistics (BLS) data and other supplementary sources where BLS data was not available. In the proposal, 12 of the 32 staff types used "other sources" instead of BLS data for pricing. These 2002 "other sources" data was not readily available for public review. For CY 2022, 14 of the 32 staff types are being updated using a BLS crosswalk because an exact match was not available. To maintain transparency, CMS should publish the 'other sources' wage data details. In addition, CMS should update specific clinical labor wage rates based on stakeholder comments and data.

The BLS data includes several data elements for consideration. In the clinical labor pricing update proposal, CMS utilizes the mean wage data to establish updated clinical labor rates, while the majority of the MPFS data inputs are based on the median. For example, when developing RUC recommendations (work and practice expense) the physician times, work RVUs, clinical staff times and clinical staff types all use medians (ie, "typical"). The BLS survey data also include wage rates for a variety of sites of service (eg, hospitals, physician offices, farms) and wage data from a variety of industries. We urge CMS to consider using the median wage data, instead of mean wage data, to capture typical wage rates more accurately and to be consistent with the median statistic used for clinical staff time.

The current clinical labor proposal requires additional analysis and modifications prior to implementation. There is further work to be done by both the Agency and stakeholders to ensure accurate data is used and appropriate methodological steps are taken for implementation. CMS should not implement this update for CY2022 and instead should consider comments and publish an updated clinical labor proposal. In addition, CMS has requested comment on whether to implement a four-year transition to the new clinical labor cost data. There is precedent for a phased transition for significant MPFS changes, across several calendar years. CMS utilized a 4-year transition for the market-based supply and equipment pricing update concluding in CY 2022. CMS also utilized a 4-year transition, starting in 2010, for the practice expense proposal.

Section 1848(c)(2)(B)(ii)(II) of the Act requires increases or decreases in RVUs may not cause the number of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS adjusts preserve budget neutrality. This $20 million "threshold" has been the same since the inception of the MPFS in 1992. No adjustments to this threshold have been made to account for new technology over 30 years. As stated previously, allowed charges would increase by approximately $3.5 billion if the clinical labor proposal was implemented in 2022 without any offsetting reduction to the direct practice expense scaling factor. CMS should analyze the effects of implementing the clinical labor rates as they have proposed, after no

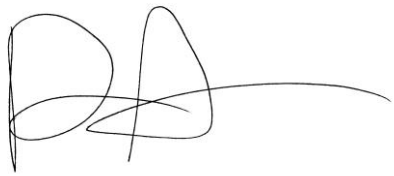
change for 20 years, versus having implemented those updates more regularly. CMS should publish how the annual $20 million restriction on changes to expenditures could have played a role in the clinical labor updates. CMS should also consider all the ways budget neutrality can be accounted for in the practice expense methodology, as there are several steps in the formula where budget neutrality is applied.

For CY 2021, the MPFS Conversion Factor was set at $33.63, a 10.2% reduction to account for the shift in payment across all medical specialties due to modifications in the valuation of the evaluation and management codes. As part of COVID-19 relief in the 2021 Consolidated Appropriations Act (CAA), Congress averted this significant cut by increasing the Conversion Factor by 3.75% to $34.89.

In the proposed rule, the CY 2022 Conversion Factor is set at $33.58, which represents a decrease of $1.31, or more than 3%, from the 2021 MPFS Conversion Factor rate update of $34.89. While the CAA prohibited CMS from using the updated figure in future Conversion Factor updates, the proposed CY 2022 Conversion Factor is still a decrease from the original figure for CY 2021 and an extremely negative impact to practices still amid the COVID-19 pandemic. Therefore, we urge CMS to press Congress to act and provide a positive update to the Medicare Conversion Factor in 2022 and all future years.

The AAMD's comments on the Physician Fee Schedule regulations seek to ensure ongoing access to high-quality, state-of-the-art radiation oncology services. Maintaining patient access is crucial to quality healthcare delivery since most of our patients require services five days a week for many weeks of life-saving therapy. Patient accessibility and continuity through a complete course of therapy are key components of the care continuum. We hope our comments highlight our sincere interest in making radiation oncology services cost-effective, fairly reimbursed, and readily accessible to cancer patients. We look forward to continuing to work with CMS to guarantee quality oncology services can be provided by our specialty to every Medicare patient. If you have any questions, please contact AAMD Executive Director Stacey Wilson at 703.677.8071 x 103 or swilson@medicaldosimetry.org.

Respectfully,



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