

THE SOCIETY OF THORACIC SURGEONS

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Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Dr. McClellan:

On behalf of The Society of Thoracic Surgeons, and the patients we serve we are writing to provide comments on the proposed revision of the practice expense (PE) component of the Medicare physician fee schedule. The STS represents the vast majority of board certified cardiac and thoracic surgeons nationwide, and our mission is to help cardiothoracic surgeons serve patients better.

The STS believes that the goal of PE payments should be accurate valuation of physician practice costs based on the statutory guidance that these payments should approximate actual costs. STS is committed to a pathway of evidence-based determination of practice expense, just as we have been with physician work. We believe that the most accurate data and sound methodology must be utilized without regard to the impacts and outcomes caused by those data.

We have analyzed the data provided at the February 15, town hall meeting, and considered the four methodologies offered not in terms of their impact, but on the rationale and soundness of their methodology. While method four would most minimize disruptive impacts and help assure more payment stability, we believe the methodology used to arrive at these values was developed by backing out of intended impact. Similarly, the methodology in examples 1 through 3 appear somewhat arbitrary, and seem to have been chosen for the purpose of seeking an outcome, rather than on the principle of accurate reflection of actual costs. We appreciate the CMS sensitivity to impact in this important policy area as well as the difficulty in obtaining accurate cost data, but believe that fitting formula to impact is, in large part, the reason we have a system today that has little correlation to actual costs incurred by various physician specialists, and is insensitive to changes in physician practice costs.

To provide an example of this, we have calculated the amount of annual payment to a cardiothoracic surgeon for practice expense based upon a reconstruction of annual PE payments, and then compared it to average practice costs for cardiothoracic surgeons. The results well illustrate the amount by which manipulated PE methodologies have evolved to shortchange practitioners of cardiothoracic surgery. Formula changes – such as removing payment for some

clinical staff but not others, the manipulation of scaling factors, and the acceptance of supplemental data for some but not other specialties – has created a PE payment policy whereby actual costs have little bearing on payment received.

Based upon the Medicare data, we determined a “typical” case mix distribution for a thoracic surgeon treating only Medicare patients. This analysis includes the entire fee schedule for CT surgeons, includes appropriate facility/non-facility PE payment according to the Medicare utilization file, and includes all assistant billing, co-surgery, E&M, diagnostic tests, and other appropriate services.

It is our assumption that perfect practice expense and malpractice RVUs would be equal to costs in those areas as they were intended to reflect actual costs similar to a pass-through system.

Our analysis determined that this typical case distribution yielded the following payments on average per physician using the current conversion factor:

2006 PE	\$122,813
2006 PLI	\$23,129

According to the 2005 MGMA Cost Survey for Cardiovascular/Thoracic Surgery, the mean PE costs for cardiovascular/thoracic surgeons were \$235,214 per FTE physician (excluding malpractice costs). The amount of PE payment for a typical distribution of all Medicare patients for 2006 is now nearly 50% of the average practice expense costs for cardiothoracic surgeons.

This comparison of actual payment to actual cost is similar for PLI, which should also be a direct pass-through. The disparity here is likely similar to all specialties, as evidenced by their general consternation, and reflects the difficulty of keeping a pass through component of the relative value system within the SGR.

Under the 4 methods proposed at the CMS town hall meeting, the average PE payment for cardiothoracic surgeons would further decrease by amounts ranging from a minimum of over \$8,000 to a maximum of \$14,750. All of these methods move our practice expense payments further from the actual costs basis and prove that the current and proposed formulas are inadequate to predict or approximate real world costs.

To return our PE payment policy to a rational system that is grounded in actual costs as Congress intended, we have several suggestions.

1. Perform an all-specialty survey of both direct and indirect costs. This is the only fair way to level the playing field and set a current cost basis for future payments. The Society of Thoracic Surgeons is ready to assist CMS and AMA in this effort.
2. Require all physicians, or an adequate sample thereof, to submit cost reports to CMS which could be audited and serve as a new baseline for PE calculations.

3. Delay implementation of the proposed PE changes including acceptance of the supplemental surveys and elimination of the zero work pool until RUC, E&M, SGR, imaging, and numerous other payment changes go into effect in 2007. This will provide a more stable platform from which to judge reimbursement adequacy and equity.

Clinical Staff Costs

We continue to suffer from the arbitrary decision to exclude the costs of clinical staff employed by physicians if they happen to work even part of the time in a hospital setting. The language and intent of BBA '97 is as clear today as it was in 1998, that CMS should “*include all costs for clinical staff*”. A recent analysis of the implementation of the resource based PE payments by the Urban Institute performed at the request of MedPAC showed that the specialty of thoracic surgery was disproportionately hurt by this decision stating, “This specialty lost the most payments per service as a result of the new PE RVUs (4.3% annually) while their RVU volume per beneficiary increased only 0.2% annually. With the possible exception of thoracic surgery (and their near-zero annual increases in service use and total RVU volume), the increases in volume seen suggest that access problems are not apparent at the national level...”

Additionally, CMS staff has maintained that under the bottom-up methodology, exclusion of clinical staff would have been in violation of the BBA statute, but that this BBA language does not apply to the (current) top-down methodology. Now that CMS is proposing a return to a bottom-up methodology, we certainly anticipate that the CPEP data on use of clinical staff in the hospital will be restored to our PE inputs. We further believe the previous contentions that it was not typical practice for CT surgeons to employ and bring staff to assist, and that the hospitals were paying these costs have been soundly refuted by the HHS OIG, GAO, and MedPAC studies. We would like CMS to consider the inequity in the fact that clinical staff in the office are included (regardless of their ability to bill directly), yet if those same staff assist even part time in the hospital, where team care has been shown to improve quality, they have been excluded.

The reality is that Thoracic Surgeons are paying the salary for non-physician extenders, and that this salary expense cannot be sufficiently offset by allowable billing or by hospital contributions from Part A dollars. Additionally, since a very significant proportion of our members practice in academic settings, the restrictions placed on assistant surgeon billing in the teaching setting (whether or not the resident salaries are **actually** paid for) also severely limit the ability to recover the cost of these physician extenders.

Without direct inputs for the cost of these staff, it is imperative that their cost be partially accounted for through the incorporation of actual practice cost by survey through the indirect cost allocation methodology. Proposed methods that reduce the indirect cost allocation, while systematically failing to recognize and incorporate legitimate direct costs, will result in a flawed resource-based practice expense model for our specialty. The simultaneous incorporation of other methods that may result in a discount of indirect payment, such as arbitrarily assigning low utilization rates to expensive equipment while increasing the relative contribution of direct inputs

to PE calculation, would further limit the ability of our specialty to recover its true practice expense.

Lastly on this topic, we urge CMS to recognize that the funds derived from the costs of our clinical staff continue to be paid-out through Medicare payments year after year – they are now going to physicians who never incurred these costs – through inflated E&M payments as a result of the pool leakage phenomenon. This formulaic error adds about \$.05 to each E&M visit, yet bleeds an estimated \$75,000,000 away from CT surgery each year.

We urge you to address the inequitable error of pool leakage and return the payments for the costs of employed clinical staff to those physicians who incur them in the treatment of Medicare beneficiaries, regardless of the setting in which they work.

Response to Questions Posed at CMS Town Hall Meeting

Direct Expense

The review and refinement of direct practice expense inputs through the RUC's Practice Expense Advisory Committee (PEAC) have resulted in updated and improved inputs that were identified through the CPEP process. CMS staff has referred to these refined direct PE inputs as the best micro-costed data available for a Medicare payment system. We must take only one exception to this claim. The PEAC from its inception was instructed by CMS not to consider the above-referenced question of payment for physician-employed clinical staff if they work part of the time in the hospital. Other than this directed exception, we believe the PEAC has appropriately updated direct costs. We must continue to object however that the one avenue for reconsideration of this question was removed by CMS.

Disposable Medical Supplies

The STS recommends that disposable medical supplies priced above \$200 should be re-priced on an annual basis beginning with the 2007 physician payment schedule.

Medical Equipment Interest Rate

The STS believes that the current cost of capital assumption of an 11% interest rate on medical equipment purchases is well above market rates, and that an assumption based upon the prime rate would be both fair and variable to account for future fluctuations. We further believe that an artificially high assumed interest rate subsidizes those who purchase equipment, which in turn drives the utilization growth in those areas at the expense of those who do not.

Medical Equipment Utilization Rates

In the original implementation of the resource-based practice expense methodology, an equipment utilization rate of 70% was established on the recommendation of Abt Associates. In 1998, in response to comments, CMS modified this rate to 50%. The STS believes that utilization rates can be consistently above or below, the 50% assumed rate depending on the type of equipment in question. We believe that some very expensive equipment is utilized at a rate closer to 80% while other equipment may be utilized less than 20% of the time. We believe that a review of a sample of each type of equipment would yield appropriate utilization rates for each, and that a single rate will not be adequate to avoid over paying for some, and under payment for others. Such a single utilization rate policy has had the effect of creating incentives for certain equipment purchases and use. The STS suggests that CMS may wish to consider a sliding scale that links equipment price to utilization assumption. We believe such a policy may have beneficial effects of removing artificial incentive to purchase high-cost equipment unless there is a demonstrable need. Thus, and high-cost piece of equipment would also carry a high assumed utilization rate.

Indirect Costs

Multispecialty Survey

The STS firmly supports the undertaking of a new all-specialty survey to appropriately identify accurate practice expense costs for both direct and indirect costs. The STS firmly supports the undertaking of a new all-specialty survey to appropriately identify accurate practice expense costs for both direct and indirect costs. We have no idea what the impact of such a survey would be upon our specialty, but if the methodology are robust and statistically sound, and the data collected are accurate, it will then be possible to set practice expenses in relative values that approximate real world costs. Also, if all physician costs are set under one methodology, the clear inequities that come from accepting some supplemental surveys at the expense of those who did not choose to perform them will be avoided.

This position is consistent with the opinion of the Lewin group, which while verifying the accuracy of the supplemental surveys, stated

“As we discuss elsewhere in this paper, the increase in total practice expense per hour value for urology is consistent with increases observed in other supplemental practice expense data. This suggests a broad trend in rising physician practice expenses and suggests the need for a multi-specialty practice expense survey, similar to the AMA’s SMS survey. “

In the interim time prior to the anticipated 2009 ability to implement new all-specialty survey data, there may be a way to accept the supplemental surveys without penalizing those who were unable to perform surveys. The STS suggests applying the assumptions made in these new surveys that generated the increased PE values to all specialties to arrive at an even impact. A methodology could be developed that relates the “broad trend” noted by Lewin in the new

supplemental data to the old SMS data, then applies an interim change to all specialties. We would recommend that this be done with a phase-in to 2009 when new, more accurate data might be available.

Indirect Expense Allocation

The STS recommends that overhead costs such as supplies and equipment have little or no impact on indirects. The attribution of such costs to each service is arbitrary by nature, and should not be part of the allocation method.

Indirect PE Pool Creation

The STS recommends that CMS should continue to use PE/Hr to create indirect PE pools.

Weights for Indirect Allocation

The STS recommends that CMS not vary the weights used in allocation of indirect costs. We strongly recommend that CMS continue to include work RVUs as a weight for allocation.

Use of Specialty-specific Indirect Percentage from SMS

The STS recommends that you do not use the indirect percentage from the SMS. We believe that the SMS was based on data from 1995 & 1996, and that it is no longer the best available data. We recommend that data be collected through the all-specialty survey to create accurate and up-to date info.

Use of the Maximum (greater) of Current or New Indirects

The STS does not recommend a methodology that varies based upon the result it would generate. While this method might minimize losses, if the goal is to more closely approximate actual practice expenses, this variable method is not consistent with that goal. We appreciate CMS looking to minimize underpayments, but in a system that is built upon budget-neutrality for all internal adjustments and a cumulative reduction in the total funds due to the SGR, the real impact of this approach is unpredictable.

Proxy Work RVUs for non-physician Practitioners

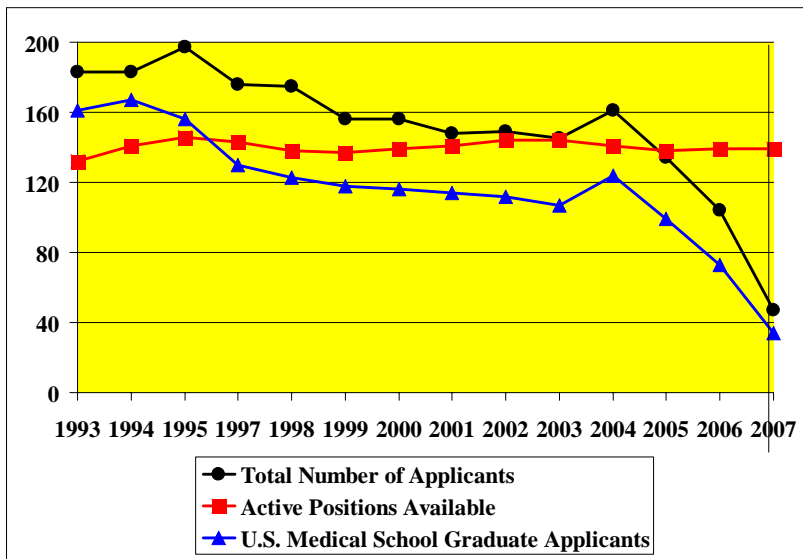
The STS does not recommend use of proxy RVUs. We understand the problem that occurs when work equals zero, and multiplication of any value by that work will result in zero. A new all-specialty survey could result in better information on non-physician work which could be the basis for new values, and would have the added benefit of using real data as the statute requires.

Conclusion

As a result of the chronic underpayment for costs of practice including both PE and professional liability insurance (which currently pays less than half of the average annual rate), coupled with the largest payment reductions of any specialty (nearly 50% cut over the past 20 years), the specialty of cardiothoracic surgery is failing. It is clearly no longer economically viable for potential doctors to spend the 12 years of medical school and residency, training for a profession that is paid far less than specialties that are not as difficult or stressful and that have far shorter training requirements.

The attached graph shows the continued decline in applications to thoracic surgeon residency programs. With an 8 year residency requirement, the access problem will not become apparent until 2013 when it will be too late to correct for another 8 years.

**Applications To Thoracic Surgery Resident Programs
1993-2007 (as of 1/31/06)**



The Society of Thoracic Surgeons appreciates the deliberate manner in which CMS has conducted this practice expense review. Our specialty knows as well as any the impact that one error could make in valuation of an entire specialty's services.

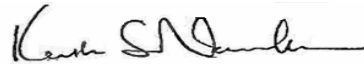
We would ask that CMS be equally forthcoming in the detailed explanation of the PE recommendations that will be made in the proposed rule. This explanation should be accompanied by examples and files that contain explicit information on the change and basis of change for each CPT code. This will be particularly important, as there will be combined effects of the 5-year review recommendations for both physician work and time. Although we have been provided with detailed information on a variety of proposed methods for changing PE determination, we have not been provided with the same information for the PE calculation as currently determined, at the code level.

We will be pleased to continue to work with CMS to arrive at the most accurate and equitable methodology for determining physician practice expense values in the future. It is our hope that these comments will illustrate the dire circumstance of our specialty and will elicit an era of cooperation to address these urgent problems together.

Sincerely yours,

Handwritten signature of Peter K. Smith in black ink.

Peter K. Smith, MD
Chairman
STS Workforce on Nomenclature and Coding

Handwritten signature of Keith S. Naunheim in black ink.

Keith S. Naunheim, MD
Chairman
STS Council on Health Policy &
Relationships