The Endangered State of Medicare Reimbursement for Cardiothoracic Surgery: A Call to Action

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- This policy perspective reviews the enormous cuts facing cardiothoracic surgery, and what STS members can do to prevent them.

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<th>Strong, concerted effort by STS members is required to avoid these negative consequences</th>
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- Proposed cuts continue to threaten devastating consequences for our patients and profession
- Strong and sustained action by STS members is required

Strobel et al, 2022
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#VisualAbstract #AnnalsImages
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Running Head: CT Surgery Reimbursement at Risk

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Classifications: Health Policy, Reimbursement, Value-Based Care, Medicare, Pay Cuts

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The STS Executive Committee approved this document.
**Abbreviations**

STS: Society of Thoracic Surgeons

RVU: Relative Value Unit

AMA: American Medical Association

CMS: Centers for Medicare and Medicaid Services

RBRVS: Resource Based Relative Value Scale

RVS: Relative Value Scale

RUC: RVS Update Committee


PFS: Physician Fee Schedule

SGR: Sustainable Growth Rate

E/M: Evaluation and Management

MACRA: Medicare Access and Chip Reauthorization Act of 2015

ACS: American College of Surgeons

APM: Advanced Practice Model

MIPs: Merit-based Incentive Payment System

CMMI: Center for Medicare and Medicaid Innovation

ACOs: Accountable Care Organization
ABSTRACT

Reimbursement for cardiothoracic surgery continues to be threatened with enormous financial cuts, ranging from 5% to 10% in recent years. In this policy perspective, we describe the history of reimbursement for cardiothoracic surgery, highlight areas in need of urgent reform, propose possible solutions which Congress and the Executive Branch may enact, and call cardiothoracic surgeons to action on this critical issue. Meaningful engagement of STS members with their elected representatives is the only way to prevent these cuts.
ACCESS TO VALUE-BASED CARE IN CARDIOTHORACIC SURGERY IS AT-RISK.

Despite the life-saving work of cardiothoracic surgeons, reimbursement for cardiothoracic surgery continues to be threatened with enormous financial cuts. In recent years, several budgetary policies have called for annual cuts in Medicare reimbursement ranging from 5% to as high as 10%.1 Other existing policies intended to stabilize Medicare payments during the transition from fee-for-service to value-based care are set to expire. Additionally, there exist limited options for specialists to participate in alternative payment models, leaving many surgical specialists effectively being punished for continuing to operate in Medicare fee-for-service.2 While the Society of Thoracic Surgeons (STS) and its partners have been successful in delaying many of these cuts in years past, without permanent policy changes dramatic pay cuts across Medicare Part B (physician payment) and to cardiothoracic surgeons are inevitable. It is also noteworthy that 77% of non-Medicare payors, including private insurers, use the Medicare Fee Schedule as the basis for their individual fee schedules, and therefore the effects of changes to the Medicare Physician Fee Schedule extend far more widely than just Medicare reimbursement.3 Furthermore, it is a fact that the effects of changes to the Medicare Physician Fee Schedule impact not only the private practice surgeon who bills Medicare and private insurers directly, but also many employed physicians whose salaries are based on the number of RVUs that they generate. Meaningful STS member engagement with their members of Congress is the only way to prevent these cuts from compromising patient access to cardiothoracic surgical care and accelerating harmful consolidation in the healthcare industry.

In this policy perspective, we outline the history that has led to the present situation, identify areas in need of urgent reform, and propose policy changes Congress and the Executive Branch can make. Lastly, we propose three ways that each cardiothoracic surgeon can take action to help prevent these cuts:
1. Call or e-mail your legislators using the STS Legislative Action Center

   This easy-to-use web application includes pre-populated emails and phone scripts to facilitate focused advocacy efforts with your legislators which are linked to your account via your zip code. [www.sts.org/advocacy](http://www.sts.org/advocacy)

2. Attend the 2022 STS Legislative Advocacy Conference

   Join fellow STS members and staff for in-person advocacy and meetings with your elected representatives on September 13th-14th.

3. Share this article with your partners and colleagues

HISTORY OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) POLICIES AND THE DEVELOPMENT OF THE RESOURCE BASED RELATIVE VALUE SCALE (RBRVS)

RELATIVE VALUE UNITS (RVUS)

Medicare payments for physicians were originally based on a system known as “customary, prevailing, and reasonable” charges. However, a multitude of factors caused the costs of healthcare to skyrocket, making this system unsustainable. In January 1985, the American Medical Association (AMA) in consultation with multiple medical societies proposed to the CMS a Resource Based Relative Value Scale (RBRVS) reimbursement model. The AMA and CMS collectively decided the best method to develop this payment model would be to accept a Harvard University School of Public Health proposal for a “National Study of Resource-Based Relative Value Scales for Physician Services.” In 1988, the Harvard group reported the results of Phase I of this RBRVS study and created a system that converted physician work, regardless of specialty, into uniform units rather than charges for services rendered. With RBRVS, the values of different physician services are assigned relative value units (RVUs).
The total RVU for a physician service is the sum of three components, all of which are subject to geographical adjustment: 1) physician work RVU; 2) practice expense RVU; 3) malpractice RVU (Figure 1).

The initial physician work RVUs were based on the 1988 Harvard group RBVS study which relied on time for the physician to perform the service, the intensity of technical skill and effort, clinical judgment, and the stress caused by the potential risk of the service to the patient. In 1966, the AMA, in cooperation with multiple major medical specialty societies, developed a coding system for the description of medical procedures, and later medical services, using uniform language, the Current Procedural Terminology (CPT) system. In 1989, Congress authorized a new resource-based payment system. This new system required the linkage of RVUs to specific CPT codes. In 1992 the first Medicare Physician Fee Schedule was published.

By agreement between the AMA and CMS, the AMA Relative Value Scale (RVS) Update Committee (RUC), through its organized process including specialty society survey and debate, advises CMS on changes to work and practice expense RVUs, but the final decisions on the RVUs for each service (CPT code) rest with CMS. Over the last few years, CMS has frequently departed from RUC work RVU recommendations, arbitrarily using the phrase “we believe” in the Federal Register to justify their decisions without consistent methodology or explanation. Some studies have shown that CMS consistently over-emphasizes procedural time in their RVU calculations and, in many cases, ignores the intensity of the service provided by the physician. However, for cardiothoracic surgical procedures, the current RUC and CMS values for procedure time are significantly closer to actual real-world times based on the STS National Database and hospital anesthesia time datasets.
CONVERSION FACTOR (CF)

How are the RVUs converted to dollars? Medicare physician reimbursement is calculated by multiplying the total RVU’s for each CPT code by a conversion factor (CF) which is expressed as $/RVU. The conversion factor is the CMS-calculated physician payment rate multiplier that produces the actual amount of Medicare reimbursement for a service or procedure. Mathematically, Medicare payment for a physician service would be expressed as seen in Figure 2.

Each year, CMS publishes the Physician Fee Schedule (PFS) which includes updates where applicable to the relative value units assigned to individual service codes (CPTs), the CF for the PFS for the year that converts RVUs into a dollar payment amount, and other changes in payment policy for Medicare Part B (physician payment).

The calculation of the annual CF begins with the previous year’s CF and then is adjusted to comply with the statutory budget neutrality requirements. An excellent, in-depth summary of this process has previously been published by Dr. Jacobs and colleagues. The CF is medical specialty agnostic.

While the formula governing Medicare payment appears deceivingly simple, CMS has altered other policies related to the Physician Fee Schedule. These changes have further decreased payments for cardiothoracic surgical services.

POLICIES IMPACTING MEDICARE REIMBURSEMENT IN 2022

BUDGET NEUTRALITY
In the late 1980s, because of skyrocketing professional health care costs, Congress passed significant federal price controls in the form of the Sustainable Growth Rate Formula (SGR). Although Congress has now dispensed with the SGR, the RVU-based fee for service system is still able to control growth in physician payment costs through the budget neutrality mechanism.

Statute dictates that when CMS adjusts RVUs to account for “changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures” that result in a change of spending of more than $20 million, CMS must make a budget neutrality adjustment so that it does not result in an increase in overall CMS spending. This is often referred to as a “zero-sum game” in game theory (Figure 3). A crucial factor is that both the frequency of billing a specific code and increases in reimbursement for that code will result in overall cost increases. Particularly poignant is the impact of budget neutrality on evaluation and management (E/M) services. Outpatient E/M visits are among the most frequently billed CPT codes (e.g., CPT 99213: established patient office visit has >90 million Medicare occurrences per year). Therefore, even relatively small increases in reimbursement for these high frequency E/M services result in proportionately larger decreases in Medicare reimbursement for procedures and services that are performed less frequently.

E/M ADJUSTMENTS AND THE SURGICAL GLOBAL PERIOD

Unlike E/M visits that have specific values and payments per visit, Medicare currently pays surgeons and other specialists a single fee (global payment) for all care related to major or minor procedures. This single fee covers the costs of the procedure plus related care for 24 hours before the procedure and throughout the usual follow-up care over a 10- or 90-day timeframe. Many of the services provided during pre-and post-operative period and follow-up visits included in the global period are the same as the types of services that could be provided as “stand-alone” E/M visits. While some patients may
require more visits and some less, all CPT code valuations are based on the “typical patient” and the typical total number and individual complexity level of the E/M visits. This number and level of E/M visits is recommended by physician specialty survey and RUC recommendation and finalized by CMS.

In 2015, because CMS believed that the post-operative visits included in the global surgical reimbursement were not actually taking place or were being provided by non-surgeon physicians, they proposed changing all 10- and 90- day global surgery codes to 0-day globals (i.e., paying only for the procedure itself) and requiring surgeons to document and bill for each individual E/M service they provided both before and after the procedure. Not only did STS disagree with CMS’ assertion that postoperative visits were not occurring, but STS took the position that the requirement to file individual E&M claims for visits traditionally contained within the “global” periods would represent an administratively costly and unfair burden; the American Medical Association estimated the implementation of a 0-day global would result in at least 63 million additional new claims. Additionally, the 0-day global would undermine quality of patient care by deterring patient willingness to seek follow-up care by subjecting them to cost sharing for each medically necessary post-operative visit. In addition, CMS chose to disregard important reasons for the original concept underlying the global surgical period. One reason was to disincentivize “itinerant surgery”, where the surgeon is present in a community only the day of surgery, performs the operation, and leaves all post-operative care to someone else. The second reason was to disincentivize “fee-splitting”, where the surgeon agrees to give part of the procedural fee to the referring physician as payment for the referral and allows the referring physician to add to their revenue by billing for the post-operative care. Both of these practices violate the American College of Surgeons (ACS) code of ethics; the proposal to “unbundle” the global surgical payments would undermine these ethical principles.
As a result of STS advocacy, Congress passed legislation as a part of the Medicare Access and CHIP Reauthorization Act (MACRA) delaying the change to global surgical reimbursement until more data could be collected. Following the mandate from Congress, CMS contracted with the RAND Corporation to survey surgeons and collect data from 9 states on the incidence of post-operative visits following selected surgical procedures, including certain cardiothoracic surgical procedures. RAND required surgeons in these states to submit dummy/non-reimbursable “claims” for post-operative visits. RAND found CT surgery to be better at documenting post-operative visits (i.e., submitting “dummy” claims) than other surgical specialties, but still showed significant differences between the submitted “dummy” claims and the “expected” post-operative visits based on the “typical” visit pattern recorded in the AMA-RUC database. However, the study methodology showed the numbers of cases reported by the RAND investigators, which were based on administrative data from Medicare hospital claims, differed from the case numbers during the same time periods in the STS National Database for the same 9 states. This fact casts significant doubt on the RAND methodology as a whole. Cognizant of concerns about the validity of these reports, several years later CMS still claims to be studying this issue while continuing to publicly express doubt that all the post operative visits included in the global period valuation are being performed.

CMS has also made payment decisions based on their belief these visits may not be occurring:

Historically, each time stand-alone office visits’ (E/M) RVUs were increased since 1997, CMS also increased the values of the visits that are bundled into the surgical global period, thus increasing payment for surgical procedures. These increases occurred in 1997, 2007, and 2011. However, CMS did not make equitable changes when E/M values were updated in 2021.
Following their analysis of the 2021 Outpatient New and Established patient E/Ms, the RUC proposed new E/M payments, which included increases to global surgical reimbursement reflecting the number of E&M services included in the global surgical fees for each procedure. CMS proposed to increase payment for stand-alone office and outpatient E/M codes, but they did not apply the E/M payment adjustment to the corresponding outpatient E/M portion of the global codes (i.e., post-operative visits). CMS claimed that the MACRA statute prohibited them from making the change until the post-operative visit data-collection study, referenced above, was complete. However, STS and the surgical community have argued that updating the E/M codes without making analogous changes to global surgical payments actually constitutes a change to global surgical reimbursement prohibited by MACRA.

In addition, CMS also proposed creating an “add-on” code that could be used to increase reimbursement for certain E/M visits. Although CMS claimed any physician could use the add-on code, so as to avoid differential payment for certain specialties, it was clear in how the new code was implemented that CMS only intended to approve charges submitted by certain physicians. CMS actually estimated the financial impact of the add-on codes as though only physicians who do not perform procedures could use them. These E/M add-on codes would not be applicable to E/M visits incorporated in global period E/M codes. Despite protest from many surgical specialties, noting that arbitrarily adjusting some E/M services but not others, and creating add-on codes that only some could use, conflicts with laws governing the Medicare program, CMS has persisted. Those laws prohibit CMS from making Medicare payments at different levels to physicians for the same work (E/M code) because of the physician’s specialty.

Amidst the debate over these changes when they were proposed, the RUC reviewed and proposed to update E/M values, but also elected to make analogous changes to global surgical reimbursement. The
RUC proposal also eliminated the additional add-on code, stating that the magnitude of the 2021 E/M adjustments rendered the add-on code unnecessary. However, CMS ignored the RUC recommendations and increased E/M payments for outpatient office visits but did not increase the outpatient E/M visit global surgical fees and maintained the add-on code. The surgical community advocated against these changes and Congress acted, requiring CMS to postpone payment for the add-on code until at least 2024. However, reimbursement for surgical global periods without the upward outpatient E/M visit adjustment persists as a feature of the physician fee schedule.

It is important to remember that these E/M changes are still subject to budget neutrality requirements. Not only are cardiothoracic surgeons not getting a payment increase commensurate with the E/M adjustments and add-on payments, but under budget neutrality, procedural specialties and specialties that do not utilize E/M codes will suffer payment reductions to offset the increases for E/M services for non-proceduralists. Budget neutrality is controlled through the yearly changes to the CF which has decreased because of the increases in RVUs for the revised E/M codes and the quantitatively enormous volume of these E/M services. These actions by CMS negatively impact most procedural services as well as specialties that do not utilize many E/M codes.

Therefore, STS members are already suffering the impact of some of these changes, but the full weight of the cuts (the inequitable increase in the value of E/M services, the pending add-on code, and compounding budget neutrality adjustments) has not yet been felt.

**UPDATES TO THE CONVERSION FACTOR AND MACRA**
When MACRA was first passed, it provided base updates to the conversion factor through the 2019 payment year. This policy was intended to stabilize payments to allow providers to acclimate to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) programs. However, these were very small statutorily set numbers, and were not indexed to inflation.

After MACRA’s phase of small base updates, the legislation provides no increase to the conversion factor (through the 2025 payment year). Beginning in payment year 2026, MACRA provides small base updates to the conversion factor that will differ based on whether CMS views the physician as delivering the service under the jurisdiction of MIPS (0.25%) or under participation in an APM (0.75%). Again, these specific numbers are set and do not keep pace with inflation and/or budget neutrality adjustments.

**MIPS AND APMS**

In addition to RVUs, E/M codes and the overarching constraints due to budget neutrality, MIPS and APMs have their own performance-based bonus/penalty structure. In this zero-sum game within a game (budget neutral incentive payments and cuts that exist within the budget neutral fee schedule), performance-based cuts for some providers are then used to pay for increases for other providers.

MACRA was intended to incentivize a migration of Medicare providers from fee-for-service payment to value-based Alternative Payment Models. Over the past few years STS has been extremely active in this space, attempting to create an APM for cardiothoracic surgeons. STS staff and leaders met multiple times with staff from the Center for Medicare & Medicaid Innovation (CMMI) promoting a registry-based payment model. In addition, STS contributed to a payment model proposal created by the ACS and eventually negotiated with ACS to have the STS model included in a proposal that was considered by the Physician-focused Technical Advisory Committee, an organization designed to evaluate provider-
developed APMs and help see them implemented. While STS has been unsuccessful in establishing an APM (of note no other specialty has been successful either), the Society did recently negotiate to have STS quality measures included as alternative measure set reporting options in the largest CMMI APM, the Bundled Payment for Care Improvement – Advanced, to give STS members the option to choose to participate in an APM and have the registry data from the STS used to assess payments for quality. The STS’ online MACRA Toolkit for Cardiothoracic Surgeons provides an excellent discussion of MIPS and APMs.21

The recent CMMI Strategic Refresh indicates that CMS plans to have all their beneficiaries in an “accountable relationship” with a provider by 2030.21 This goal can only be accomplished by moving to mandatory APMs, which will involve Accountable Care Organizations (ACOs) providing the nexus for care and risk. With a foundation based on a primary care network, ACOs will largely be responsible for contracting with specialists, potentially eliminating direct physician-to-surgeon referrals.2

**INFLATION**

Medicare Part B reimbursement is not updated for inflation (Figure 4). This year, despite dramatic inflation, policy-based payment cuts are still anticipated.23 This is cause for additional alarm. The figure shows the historical and future impact of the conversion factor without inflationary updates.

**OTHER FEDERAL SPENDING POLICIES**

Last year, while advocating that Congress consider permanent reforms to the problems listed above, STS also vigorously opposed additional, unrelated cuts to Medicare reimbursement. Budgetary policies not specifically tied to Medicare Part B and the physician fee schedule were also scheduled to take effect.
When combined, those budgetary policies contributed to a proposed cut in payment to cardiothoracic surgeons exceeding 9.75% for 2022. Those cuts included:

- **3.75% Fee Schedule “Fix”** – Congress provided these funds to increase the 2021 conversion factor to offset large reimbursement cuts triggered by the significant budget neutrality impacts occurring due to the increase in RVUs for the Outpatient New and Established E/M codes. Additionally, these cuts were set to take place in the middle of the COVID pandemic. Last year, the surgical community asked Congress to continue that funding for another year. Congress agreed to a 3.0% “fix” in 2022, rather than the 3.75% the previous year. To continue receiving these offsets surgeons will have to go back to Congress every year, after CMS calculates the next year’s CF, and ask for more money. These one-year fixes are not sustainable.

- **2% Sequestration** – Sequestration is a budgetary tool used to distribute large amounts of spending across multiple programs (not necessarily healthcare related) and years by setting spending goals. If these spending goals are not achieved, a “sequester” is triggered with spending cuts implemented across specific federal programs. In this case, the Budget Control Act of 2011 called for Medicare spending cuts for Fiscal Year 2013 through Fiscal Year 2021 if certain parameters were not achieved. The sequestration policy has been used as a “slush fund” for Congress to use for funding non-healthcare related expenditures, and these sequesters and resulting payment reductions are now slated to continue through at least 2031.

- **4% Medicare PAYGO cuts** – PAYGO is a Congressional policy that requires recoupment of federal funding from other portions of the budget (not necessarily healthcare related) when legislation is enacted that is not fully “paid for.” This PAYGO “sequestration” to account for increased Federal spending in other areas is capped at 4% as it applies to Medicare.
Figure 5 depicts the proposed cuts for 2022 in the top panel and the actual cuts as they were implemented for 2022 in the bottom panel. Instead of a 9.75% cut, cardiothoracic surgeons, and all physicians, are experiencing a 2% reduction in pay averaged over 12 months. Cuts related to these budgetary policies will continue to be applied in 2023 and beyond.

**WHAT CAN YOU DO TO PROTECT PATIENT ACCESS AND MEDICARE REIMBURSEMENT TO CARDIOTHORACIC SURGERY?**

Reimbursement for cardiothoracic surgery is under immense pressure. Unabated, the planned cuts and changes detailed here will make it increasingly difficult for cardiothoracic surgeons to practice unless they are hospital or health system employees, and risk reducing patient access to lifesaving surgical care. Prior research has demonstrated that healthcare consolidation (i.e., hospital group or private equity-led acquisitions of hospitals/private practices/physician groups, closure of private practices, etc.) typically is associated with increased costs and in some cases worse outcomes.\(^{24}\) Similarly, studies have reported an association between increased Medicaid reimbursement and access to care – the inverse is also likely to be true for Medicare reimbursement.\(^{25}\) Only with a strong, concerted advocacy effort can cardiothoracic surgeons hope to avoid these negative consequences for our profession and our patients.

Although initially limited to Medicare reimbursement, private insurers traditionally mirror their reimbursement based on CMS policy. It is expected that these changes will ultimately result in lower surgeon reimbursement, regardless of patient mix (government insured vs. private) or employment structure (hospital-employed vs. private group practice).
The Society is committed to resolving the Medicare crisis by pursuing the following changes to payment policy:

1. Eliminate the Medicare Part B budget neutrality requirement;
2. Apply increased E/M adjustments to 10- and 90-day global codes to compensate all physicians for the same work;
3. Waive PAYGO and sequestration cuts for Medicare Part B; and
4. Work with clinician stakeholders to develop meaningful value-based payment models that result in increases in both quality and efficiency in the health care system

Only with concerted advocacy by all US-based STS members can cardiothoracic surgeons hope to avoid these specialty-altering cuts so that we can continue to innovate, improve quality of care, and provide value to the healthcare system.

Here are three, high-impact ways individual cardiothoracic surgeons to help to prevent these cuts:

1. Call or e-mail your legislators using the STS Legislative Action Center
   
   This easy-to-use web application includes pre-populated emails and phone scripts to facilitate focused advocacy efforts with your legislators which are linked to your account via your zip code. www.sts.org/advocacy

2. Attend the 2022 STS Legislative Advocacy Conference
   
   Join fellow STS members and staff for in-person advocacy and meetings with your elected representatives on September 13th-14th.

3. Share this article with your partners and colleagues
References
FIGURE LEGENDS

Figure 1. Components of Relative Value Units.

Figure 2. Calculation of Medicare Payment to Physicians based on Relative Value Units and Conversion Factor.

Figure 3. The Impact of Budget Neutrality on Changes in Specialty Reimbursement as % of total Medicare Physician Spending.

Figure 4. The Impact of Inflation on Reimbursement for Common Cardiothoracic Surgical Procedures.

Figure 5. The Impact of Society of Thoracic Surgeons’ Advocacy Efforts on Mitigating Budget Cuts in 2022.
<table>
<thead>
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<th>RELATIVE VALUE UNITS (RVUs)</th>
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Total RVUs x Conversion Factor = MEDICARE PAYMENT
### Cuts Proposed in 2022

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### Cuts Implemented in 2022

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<th>July – Dec (6 months)</th>
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