Revision of Medicare Payment for Practice Expenses under the Physician Fee Schedule: Potential Impact on Freestanding Radiation Oncology Centers

While considerable attention has been paid to Medicare's proposal to reduce the Physician Fee Schedule (PFS) conversion factor in 2021, few have focused on an under-the-radar CMS initiative to revise the methodology and data used to determine Medicare payment for practice expense relative value units (PE-RVUs). Since Medicare payment for the technical component (TC) of radiation oncology services in freestanding centers is comprised virtually entirely of practice expense (PE) Relative Value Units (RVUs), this initiative has the potential to result in even greater changes to Medicare payment for freestanding facilities.

In the 2021 PFS Proposed Rule, CMS indicates that it is "interested in potentially refining the PE methodology and updating the data used to make payments under the PFS." In fact, CMS appears to be fairly far along in its thinking on this potential refinement: It has commissioned and received two reports from the RAND Corporation on this issue, and RAND has already drafted a model survey to gather new practice expense data.

Historically, practice expense surveys have raised formidable challenges for freestanding radiation oncology centers: Because the freestanding radiation oncology community is relatively small, it tends to be particularly underrepresented in surveys. Further, survey sponsors tend to merge practice expense data for freestanding centers with that of hospital- based radiation oncologists, whose practice expenses are relatively minor in comparison, resulting in a specialty average that significantly understates freestanding facility costs. Historically, AFROC has fought and won the battle to survey freestanding centers separately—but the need for such focused specialty surveys is not addressed in the RAND Report or in its model survey instrument.

In addition, the RAND Report puts forth two potential alternative PE methodologies, one of which would result in unsustainable payment reductions for radiation oncology technical component services. Under this alternative approach, hospital cost data is used to derive PE RVUs. Essentially, RAND identifies a list of codes for which there is sufficient hospital outpatient data to value PE, and then makes a number of adjustments to account for differences between the PFS and the Hospital Outpatient Prospective Payment System (HOPPS). **This approach would result in an estimated 20% reduction in allowed charges for radiation oncology technical component services**.

Impact of Practice Expense Relative Value Unit Changes (Percentage Difference)

Type of Service	Allowed Charges (Millions)	Scenario 1	Scenario 2 [1]
Anesthesia	$2,632	0	0
Evaluation and Management—Inpatient/ED/OB	$17,336	<1	<1
Evaluation and Management—Office Visits	$23,429	8	9
Evaluation and Management—Other	$2,696	25	25
Medicine—Cardiovascular	$2,654	–6	–5
Medicine—Manipulative Treatment	$773	11	12
Medicine—Neurology	$698	–24	–24
Medicine—Other	$9,117	–1	–1
Medicine—Physical Medicine	$4,101	–1	–<1
Nuclear Medicine	$637	–26	–25
Pathology and Laboratory	$1,985	–28	–27
Radiology—Advanced Diagnostic Imaging	$3,518	–24	–23
Radiology—Diagnostic Ultrasound	$666	–14	–14
Radiology—Other	$350	8	9
Radiology—Radiation Oncology	$1,470	–20	–20
Radiology—Standard Diagnostic Imaging	$1,395	–2	–1
Surgery—Cardiovascular	$2,822	–32	–27
Surgery—Digestive System	$1,976	1	<1
Surgery—Eye	$2,368	14	10
Surgery—Musculoskeletal	$3,693	17	17
Surgery—Other	$6,927	1	–3
Surgery—Spine and Spinal Cord	$1,407	17	17
Total	$92,650	0	0

SOURCE: Authors' analysis of MPFS, OPPS, outpatient claims, and carrier claims data.
NOTES: ED = emergency department; OB = observation. The change in PE RVUs is relative to a CY 2019 MPFS baseline including fully transitioned market-based supply and equipment prices and adjustment to indirect PE for office-based services with very low direct PE expenses, and without imposing the OPPS caps on imaging services. Although the OPPS caps on imaging services could apply to a large number of services, only about 7 percent of those services have MPFS values that exceed the cap. Applying these caps reduces the baseline PE RVUs by approximately 1 percent for diagnostic testing facilities and physicians specializing in radiology, nuclear medicine, and vascular surgery.

RAND indicates that, in its future work, it "will focus on approaches for more-limited use of HOPPS information and for phasing in the use of the OPPS-based PE values"--a statement that makes it disturbingly clear that CMS is interested in this alternative approach to updating PE-RVUs.

AFROC will be submitting comments on the RAND report and will be monitoring this issue carefully. If a new practice expense survey is in the offing, we will be counting on you to help us ensure that CMS takes into account the unique costs involved in providing high quality radiation treatment in non-hospital settings.

[1] The difference between Scenario 1 and Scenario 2 is related to the type of adjustments made for pre and post service practice expenses. For example, Scenario 2 makes different adjustments to account for the PE involved in post operative visits during the global period and to account for packaging differences between the two payment systems.