MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, NW • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert A. Berenson, M.D., F.A.C.P., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

August 30, 2011

Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1524–P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: File code CMS-1524-P

Dear Dr. Berwick:

The Medicare Payment Advisory Commission welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed notice entitled Medicare Program; Payment policies under the physician fee schedule and other revisions to Part B for CY 2012, published in the *Federal Register*, vol. 76, no. 138, pages 42772 to 42947. We appreciate your staff's ongoing efforts to administer and improve payment systems for physician and other services, particularly considering the agency's competing demands.

Our comments address the following provisions in the proposed rule:

- Changes to direct practice expense inputs
- Potentially misvalued services under the physician fee schedule
- Expanding the multiple procedure payment reduction policy
- Establishment of the value-based payment modifier
- Hospital discharge care coordination

Changes to direct practice expense inputs

Direct practice expense (PE) RVUs include the cost of nonphysician clinical staff, medical equipment, and medical supplies used to furnish a service. As we noted in our June 2006 report to the Congress, the Commission believes that Medicare needs a recurring and accurate source of data to keep PE RVUs up to date. Such data source(s) should capture the prices of supplies and equipment, specialties' practice costs, and the types and quantities of direct PE inputs.[1] CMS maintains a database of direct PE inputs that includes estimated prices for supplies and equipment,

[1]Medicare Payment Advisory Commission. 2006. *Report to the Congress: Increasing the value of Medicare.* Washington, DC: MedPAC.

but these prices have not been kept up to date. Inaccurate prices for supplies and equipment could lead to distortions in PE RVUs.

In last year's Part B final rule, CMS established an annual process for considering public requests for changes to the prices of medical supplies and equipment. Under this process, the public may submit requests to CMS to update prices; these requests should be supported by multiple invoices from different manufacturers that show market prices net of discounts and rebates. During 2010, CMS received a request to increase the price of a tray used for bone marrow biopsy-aspiration from $24.27 to $34.47. CMS proposes to accept this request for 2012.

We are concerned that this process for updating prices, which relies on voluntary requests from specialty societies, practitioners, and suppliers, might not result in objective and accurate prices because each group has a financial stake in the process. Specialty societies and practitioners are unlikely to provide CMS with evidence that prices for supplies and equipment have declined because this could lead to lower RVUs for services they provide.

CMS should establish an objective process to regularly update the prices of medical supplies and equipment to reflect market prices, with a particular focus on expensive items. As an initial step, CMS should use the General Services Administration (GSA) medical supply schedule as a data source for the prices of high-cost supply items and to reduce the prices of expensive items not on the GSA schedule by the average difference between the GSA prices and the prices in CMS's PE database for similar supplies. In addition, the agency should explore using the GSA schedule for all medical supplies and examine whether there is a similar data source for medical equipment. Although the GSA schedule may overestimate actual transaction prices because it does not include rebates or volume discounts, it is an independent source of data and is readily available to the public.

This year's proposed rule does not discuss establishing an objective process to regularly update the prices of medical equipment and supplies. In last year's Part B proposed rule, CMS proposed a process that would have used the GSA schedule to regularly update the prices of medical supplies with prices of $150 or more every 2 years beginning in 2013. In last year's final rule, the agency stated that it would continue to study the issue of how to update the prices of expensive supplies.

Potentially misvalued services under the physician fee schedule

On the issue of misvalued services in the physician fee schedule, the proposed rule includes requests for comments and proposals on three topics: validating the RVUs of potentially misvalued services, consolidating reviews of potentially misvalued services, and identification and review of potentially misvalued services.

Validating RVUs of potentially misvalued services

With the proposed rule, CMS is seeking comments on the requirement in PPACA that the Secretary establish a formal process to validate the fee schedule's RVUs. In particular, CMS is interested in comments on an approach to validating RVUs that was discussed in the Commission's comments last year on the Part B proposed rule for 2011: collecting data from a cohort of physician offices and other settings where physicians and other health professionals work.

Since submitting comments on the proposed rule for 2011, the Commission has considered this issue further. In our June 2011 Report to the Congress, we expressed deep concern in particular about the accuracy of the fee schedule's time estimates—estimates of the time that physicians and other health professionals spend furnishing services. These estimates are an important factor in determining the RVUs for practitioner work. However, research for CMS and for the Assistant Secretary for Planning and Evaluation has shown that the time estimates are likely too high for some services. In addition, anecdotal evidence and the experience of clinicians on the Commission raises questions about the time estimates. And the time estimates for a number of services have been revised under CMS's recent potentially misvalued services initiative. The concern is that the estimates rely on surveys conducted by physician specialty societies. Those societies and their members have a financial stake in the RVUs assigned to services, an inherent conflict that even affects the reviews conducted under the potentially misvalued services initiative.

We made two further points in the June 2011 report that are especially relevant to the request for comments in the proposed rule. First, the process for collecting data could be designed to ensure collection of data that are more consistent and accurate than the current time estimates. For instance, participating practices and other settings could be recruited through a process that would require participation in data reporting among those selected. The cohort would consist of practices with a range of specialties, practitioner types, and services furnished. Further, the cohort could consist of practices with features that make them more efficient than others (e.g., economies of scale, reorganized delivery systems). If necessary, practices could be paid to participate. As to the feasibility of this approach to collecting time data, the Commission is working with contractors and will have more on the issue in the near future. We have concerns, however, that two other alternatives have problems. One alternative—surveys—is always hampered by low response rates. A second alternative—a requirement that all practitioners' offices submit data—will no doubt give rise to complaints about administrative burden.

Second, if CMS were to collect data from a cohort of practices, it could be an opportunity to collect data not just for work RVUs but also for practice expense RVUs. Similar to data for work RVUs, practice expense RVUs are partly a function of estimates of the time that nonphysician clinical staff spend in furnishing services in nonfacility settings such as practitioner offices. Practice expense RVUs also rely on other information—such as the prices paid for equipment and supplies—that should be available from the cohort of practices.

Consolidating reviews of potentially misvalued services

As required by statute, CMS reviews the physician fee schedule's RVUs no less often than every 5 years. Currently, the agency fulfills this requirement by conducting two types of reviews.

One type of review is known as the five-year review: the periodic reviews of RVUs for work, practice expense, and professional liability insurance (PLI). The five-year review is a long-standing process. For instance, the first five-year review of work RVUs was initiated in 1994 and was effective for services furnished in 1997. To conduct the five-year review, CMS solicits public comment on potentially misvalued services. Specialty groups, organizations, and individuals respond with requests for review of specific services. In addition, contractor medical directors submit services. And CMS identifies services in need of review.

The other type of review—the annual review of potentially misvalued services—is newer. The first of these reviews was conducted for services furnished in 2009. For these reviews, CMS and the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) use various screening criteria to identify services that may be misvalued. The criteria identify services such as those with high volume growth or ones that were valued as inpatient services but that are now predominately furnished as outpatient services.

In the proposed rule, CMS proposes to consolidate the five-year review and the annual review of potentially misvalued services. Reviews of work and practice expense RVUs would occur annually rather than once every 5 years.[2] Further, the scope of the annual review process would be expanded. No longer limited to services identified according to screening criteria, the process would include provision for public comment.

The Commission agrees that the five-year review should be consolidated with the annual review of potentially misvalued services. As explained in the proposed rule, the PPACA directs the Secretary to examine services that are potentially misvalued based on certain criteria such as those CMS and the RUC have been using for this purpose. CMS is fulfilling this requirement with annual reviews of potentially misvalued services. A separate five-year review could be redundant.

We agree also with the point made in the proposed rule that—when reviewing the RVUs for a service—it is important to review both the work RVUs and the practice expense RVUs. For instance, an increase in the practice expenses incurred when furnishing a service may mean that the amount of practitioner work required has decreased. However, the policy for the five-year review has been to limit the review to either work or practice expense but not to consider more than one type of RVU simultaneously. Review of a service's work and practice expense RVUs together would account for any substitution that has occurred between the practice expense inputs used to furnish the service and the work of the practitioner.

---

[2] The policy of five-year reviews has included the RVUs for professional liability insurance. Those RVUs were reviewed most recently for 2010. CMS is not proposing to consolidate five-year review of PLI RVUs with the annual review of work and practice expense RVUs. Review of the PLI RVUs requires data on the premiums paid by practitioners for their PLI coverage. The agency believes it is not feasible to collect such data annually.

Identification and review of potentially misvalued services

Consistent with recent efforts to annually identify and review potentially misvalued services, CMS uses the proposed rule to identify additional services for review. First, the agency is proposing review of high-expenditure procedural services. As explained in the proposed rule, stakeholders have noted that many of the services previously identified under the potentially misvalued services initiative were concentrated in certain specialties. With the aim stated in the rule of developing a robust and representative list of services for review, CMS examined the highest-expenditure services by specialty. The agency then narrowed the list to include services that have not been reviewed since 2006, when the third five-year review of work RVUs was completed. The result was a list of 70 high-expenditure procedural services that are now proposed for review.

Second, the agency is proposing a review of all (91) evaluation and management (E&M) services. As discussed in the rule, one rationale for review of E&M services is that the focus of primary care has evolved from an episodic treatment-based orientation to a focus on comprehensive patient-centered care management to meet the challenges of preventing and managing chronic disease. Meanwhile, most E&M services have not been reviewed since the third five-year review, completed in 2006. In addition, E&M services consistently appear among the top 20 high-expenditure services for each specialty.

For review of the high-expenditure and E&M services, CMS would refer the services to the RUC. Further, the proposed rule notes that the agency would like the RUC to review at least half of the high-expenditure services and half of the E&M services by July 2012. Any revised RVUs could then be used to determine payments in 2013. CMS expects that the RUC would review the remaining E&M services by July 2013, in time for payments in 2014.

The Commission agrees that it is important to review certain high-expenditure procedural services, especially imaging, tests, and procedures other than major procedures. However, from the points made in the proposed rule about when CMS would like the RUC to conduct its reviews, it is clear that resources—including the RUC's time—are limited and that priorities for the review process are important, as we discuss below. The Commission has views also on issues concerning E&M services. We provide comments on E&M services with our comments below on hospital discharge care coordination.

One reason for focusing the review on high-expenditure services is that doing so can improve the balance of payments between primary care and services such as imaging, tests, and other procedures. As discussed in our comments on the five-year review of work RVUs for 2012, the Commission remains concerned that the fee schedule still lacks such balance. First, based on our review and analysis over a number of years, there is evidence that payment rates for some procedural services are too high relative to primary care services. Prices that are too high mean that Medicare is paying more than it should, a waste of resources. In addition, high prices make services profitable, creating an incentive for excessive volume growth. Trends in the volume of

procedural services suggest that such growth has occurred. Over the past decade, imaging, tests, and procedures other than major surgical procedures have all grown at rates 2 to 3 times that of other services. By contrast, primary care practitioners have limited opportunity to increase the number of services they furnish. The main component of their services is face-to-face time with patients, making it difficult to fit more services into a day's schedule. Thus, we see two risks for Medicare: distorted prices and unnecessary increases in volume, exacerbated by distorted prices. Review of imaging, tests, and other procedures should reduce the RVUs of overpriced services.

A review focused on high-expenditure services can also have a larger impact on spending than previous reviews of misvalued services. For example, the high-expenditure procedural services listed in the rule account for about 12 percent of fee schedule spending. By contrast, the services for which the RUC made work RVU recommendations for 2011 account for only 6 percent of fee schedule spending. The services in the recent fourth five-year review of work RVUs account for only 1 percent of fee schedule spending.

Our concern about priorities arises from the current pace of the review process. About 500 services account for over 90 percent of fee schedule spending. Of these, about 50 are E&M services, for which CMS will request RUC review by July 2013. Then there are the 70 high-expenditure services listed in the proposed rule. The proposal is that the RUC would review at least half of these services by July 2012. No date is proposed for when the remaining services on the high-expenditure list would be reviewed. We understand that a number of high-expenditure services were included in previous reviews or are otherwise in process. The fourth five-year review included 18 services that are among the 500 services with the highest spending. The services with RUC recommendations for 2011 included another 46 of these services. Nonetheless, many high-expenditure procedural services will remain unreviewed at least through 2013. Our concern is that a review process focused on high-expenditure procedural services, identified by specialty, could divert the process from the more important priority: imaging, tests, and other procedures regardless of specialty. As you know, the Commission has recommended an expert panel other than the RUC to assist with the review of misvalued services. One function of the panel could be to give advice on such matters of priority-setting.

Expanding the multiple procedure payment reduction policy

When outpatient therapy or surgical services are furnished to the same patient on the same day, Medicare reduces payments for the second and subsequent procedure to account for efficiencies in practice expense and pre- and post-surgical physician work. Similarly, Medicare reduces payments for the technical component of multiple imaging studies that are performed in the same session (the technical component includes the cost of the nonphysician staff who perform the test, medical equipment, medical supplies, and overhead expenses). CMS proposes to expand this policy—called the multiple procedure payment reduction (MPPR)—to the professional component of certain imaging services (the professional component includes the physician's work involved in interpreting the study's results and writing a report). When multiple computed tomography (CT), MRI, or ultrasound services are performed in the same session, CMS would reduce payment for

the professional component of the second and subsequent services by 50 percent. This proposal is based on the expected efficiencies in physician work that occur (primarily in the pre- and post-service periods) when multiple services are performed in the same session. This policy would be consistent with the current MPPR that applies to the TC of multiple imaging services.

The Commission supports CMS's proposal, which is consistent with a recommendation from our June 2011 Report to the Congress. We recommended that the Congress direct the Secretary to apply a MPPR to the professional component of diagnostic imaging services provided by the same practitioner in the same session. According to a study by the Government Accountability Office, when two or more imaging services are furnished together, certain physician activities are not done twice, such as reviewing the patient's medical history, reviewing the final report, and following up with the referring physician after the test.[3] Recent recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) offer additional support for CMS's proposal. The RUC recently valued new comprehensive codes that include two component codes (CT of the abdomen and CT of the pelvis) and recommended that the physician work RVU for the second component code be reduced by 50 percent to account for efficiencies in work that occur when services are performed together. We agree with CMS that this proposal would align the MPPR policy for the two portions of an imaging service: the technical component and the professional component.

This policy should apply across settings (e.g., hospitals and physicians' offices) because there are likely to be efficiencies in physician work regardless of the setting. When the RUC values additional comprehensive codes that contain multiple imaging services, these new codes should not be subject to the MPPR because they should already account for efficiencies in physician work associated with multiple services.

CMS also states that it will consider expanding the MPPR in the future to additional services. CMS asks for comment on the following options for expanding the MPPR:

- Applying the MPPR to the TC of *all* imaging services based on expected efficiencies in nonphysician activities, supplies, and equipment (the MPPR currently applies to the TC of CT, MRI, certain ultrasound, and nuclear medicine studies);
- Applying the MPPR to the professional component of *all* imaging services based on expected efficiencies in physician work (CMS proposes to apply the MPPR to the professional component of CT, MRI, certain ultrasound, and nuclear medicine studies for 2012); and
- Applying the MPPR to the TC of *all diagnostic tests* (the MPPR does not currently apply to diagnostic tests other than the imaging studies noted above).

The Commission supports expanding the MPPR to both the TC and professional component of all imaging services to account for efficiencies in practice expense and work that occur when multiple

[3] Government Accountability Office. 2009. *Medicare physician payments: Fees could better reflect efficiencies achieved when services are provided together*. GAO–09–647. Washington, DC: GAO.

studies are performed in the same session. Our recommendations to apply the MPPR to the TC and professional component of imaging services performed in the same session were not limited to specific imaging codes. Given that there are efficiencies when CT, MRI, certain ultrasound, and nuclear medicine studies are provided together, it is reasonable to expect that similar efficiencies occur when other imaging services (e.g., other ultrasound, X-rays, and fluoroscopy) are furnished in the same session. If CMS decides to expand the MPPR to additional imaging services, it should apply this policy to both the TC and professional components to maintain consistency between the two portions of an imaging study. The Commission also encourages CMS to explore applying the MPPR to the TC of diagnostic tests other than imaging (e.g., electrocardiograms, cardiovascular stress tests, and anatomic pathology tests). It is quite possible that there are efficiencies in practice expense when multiple diagnostic tests are provided together.

Establishment of the value-based payment modifier

Section 1848(p) of the Social Security Act (as added by section 3007 of PPACA) requires that the Secretary establish a budget-neutral payment modifier under the physician fee schedule that will provide for differential payment to a physician or a group of physicians based on cost and quality. The provision establishes the timeframe for implementation of this value-based payment modifier, requiring the Secretary to apply the modifier beginning January 1, 2015 to specific physicians and groups of physicians as the Secretary determines appropriate. The Secretary must apply the modifier with respect to all physicians and groups of physicians beginning not later than January 1, 2017.

The Commission is concerned that CMS's proposed rule for the value modifier incorporates too many quality measures (62 measures in the draft rule). We are concerned that consistently and accurately gathering and processing the data needed for such a large number of measures would be administratively burdensome for CMS as well as providers. The use of a large number of measures in the value modifier could increase the year-to-year statistical variability, and therefore uncertainty, into the annual calculation of each physician's or physician group's value modifier. Further, many of the proposed process measures run the risk of crediting physicians for providing the type of routine care that the Medicare program should expect as a standard of care from all practitioners serving its beneficiaries.

As detailed in our March 2005 and March 2010 reports to the Congress, one of the Commission's overarching principles of quality measurement is that Medicare should focus on tracking a few key population-based outcome, patient experience, and clinical process measures. For example, the value modifier could incorporate a set of measures focused on potentially preventable hospital admissions and emergency department visits. As measures are established that capture avoidable complications, care coordination, and the efficacy of care transitions, these types of measures could be added to the measure set. To address concerns about sample size when measuring outcomes for individual and small groups of physicians, CMS could explore using a two-step process that first would calculate quality measure results for all applicable physicians in a referral

region or other appropriately defined area, and then apply the resulting quality values (via the value modifier) to all physicians in the measurement area.

CMS also asks for comments on rolling out the value-based payment modifier in the initial years (2015 and 2016) to outlier physicians. The Commission recognizes that there are challenges in measuring resource use and quality at the individual physician level. However, for resource use measurement, the Commission and others have shown that physicians who deliver care with significantly higher resource use than their peers year after year can be reliably identified, irrespective of the methodology used.[4,5] If CMS determines that it is consistent with the statutory language and intent of the value-based payment modifier, it may be most appropriate at this time for the Medicare program to focus on physicians who persistently and reliably have higher resource use than their peers (i.e., outliers), instead of trying to develop a payment modifier that would apply to *all* physicians. When there is a valid, reliable method of measuring all physicians, CMS could then expand the value-based payment modifier to the entire pool of physicians.

Finally, the Commission continues to reiterate the importance of developing an episode-based resource use measure as well as per-capita measures of resource use. The Commission believes that Medicare should have the ability to measure both episode-based resource use and per-capita resource use in robustly identifying high or low-resource use physicians, particularly if the results are used for Medicare payment. The other measures proposed by CMS to capture resource use (such as measuring per-capita spending for acute inpatient hospital stays and 30 days after discharge) could work as a stopgap until the Medicare episode grouper is developed and CMS settles on the final design of the value-based payment modifier.

Hospital discharge care coordination

CMS has requested comments on physician delivery of effective care coordination surrounding a hospital discharge. The Commission strongly believes that the incentives in fee for service medicine do not properly recognize the importance of care coordination, and that effective care coordination across providers and settings is a key feature of a well-functioning health care delivery system. A few models of care coordination have been shown to improve outcomes for individuals with multiple chronic health conditions.

The Commission plans to review the utility of care coordination efforts in fee for service Medicare and can provide comments regarding the appropriate valuation and measurement of care coordination activities when completed. Policies considered could range from more straightforward approaches—such as new codes for care coordination—to more complex policies—such as packaging or bundling of services. Others have also raised concerns about whether current definitions of E&M services and documentation guidelines for those services are adequately oriented toward care coordination.

---

[4] Miller, M., J. M. Richardson, and K. Bloniarz. 2010. Correspondence: More on physician cost profiling. *The New England Journal of Medicine* 363: 2075-2076 (November 18).

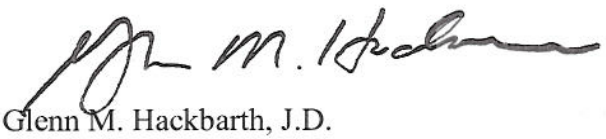
[5] Boccuti, C., K. Hayes, and K. Bloniarz. 2011. The sustainable growth rate system: Policy considerations for adjustments and alternatives. Presentation at February 23 MedPAC meeting.

Conclusion

The Commission appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. We also value the ongoing cooperation and collaboration between CMS and Commission staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, the Commission's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

GMH/kh/w