MEDPAC Medicare Payment Advisory Commission

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July 22, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1582–PN
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: File code CMS-1582-PN

Dear Dr. Berwick:

The Medicare Payment Advisory Commission welcomes the opportunity to comment on the Center for Medicare and Medicaid Services (CMS) proposed notice entitled Medicare Program; Five-year review of work relative value units under the physician fee schedule, published in the *Federal Register*, vol. 76, no. 108, pages 32410 to 32813. We are particularly interested in the results of this five-year review because it is the first such review to have been initiated since the Commission made recommendations on the subject in March of 2006. Further, 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.

CMS initiated this five-year review in November 2009 by soliciting public comment on potentially misvalued services. Specialty groups, organizations, and individuals responded with requests for review of 113 services. Contractor medical directors (CMDs) submitted another 10 services. And CMS identified 96 services in two categories: 1) services meeting a utilization threshold but still with work RVUs from the 1980s Harvard study on the fee schedule, and 2) services initially valued as performed in the inpatient setting but that are now predominantly performed in the outpatient setting. CMS then compiled the list of potentially misvalued services and submitted it to the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) for recommendations. The RUC conducted its review and developed RVU recommendations for 173 services.[1] As discussed below, CMS agreed with some of the RUC's

[1] Services added and deleted over the course of the review led to the difference between the number of services initially identified by the public, CMDs, and CMS (219 services) and the number of services in the review at the end of the process (173 services). The services added (71) were all similar enough to services already in the review to warrant consideration to ensure continued relativity of payments within "families" of services. Some of the services deleted were sent to the CPT Editorial Panel for coding changes (53), some were withdrawn by the specialty society

recommendations and disagreed with others. The proposed RVUs in the notice—either recommended by the RUC or recommended by the RUC but revised by CMS—would be effective beginning January 1, 2012.

This five-year review—the fourth such review of the fee schedule's relative value units (RVUs) for practitioner work—is the first review initiated since the Commission made its recommendations about the five-year review in March 2006.[2] Our concern then was that the review process appeared to have a bias that was leading to substantially more recommendations for increases than decreases in RVUs, even though many services are likely to become overvalued as time passes. In response, the Commission recommended that CMS establish a standing panel of experts to help identify overvalued services and to review recommendations from the RUC. We anticipated that this panel would help CMS reduce its reliance on physician specialty societies and take a more central role in identifying potentially misvalued services. While CMS has not established the panel the Commission recommended, the agency has taken other steps to better identify overvalued services. For instance, there is now an annual process for review of potentially misvalued services. Since 2009, CMS has used this new process to review over 700 services.

Subsequent to publication of this proposed notice, CMS issued the proposed rule on the physician fee schedule for 2012. With that rule, the agency proposes to consolidate the five-year review with the annual review process. While we will comment on the consolidation proposal as part of our comments on the proposed rule for 2012, in this comment letter we state our views on the five-year review of work RVUs for the 173 services and, more broadly, on the issue of mispricing of physician services.

Advice to CMS on overpriced services

We reassert our recommendation that, with the five-year review and other reviews of mispriced services, CMS should seek advice independent of the RUC. For this review, the CMDs—a potential source of independent advice—offered some advice, but they submitted only 10 services. CMS needs a regular source of expertise available to assist with the highly complex process of valuing practitioner services, expertise that is not solely in the domain of the RUC. In addition to the RUC, the CMS should convene a panel comprised of CMDs but also experts in medical economics and technology diffusion, private plan representatives, and a mix of practitioners, such as hospital and medical group chief medical officers, as long as they do not have a financial interest in changes to the fee schedule. We believe such a panel could have identified more overpriced services than those considered in this review and could have recommended decreases in RVUs larger than those recommended by the RUC.

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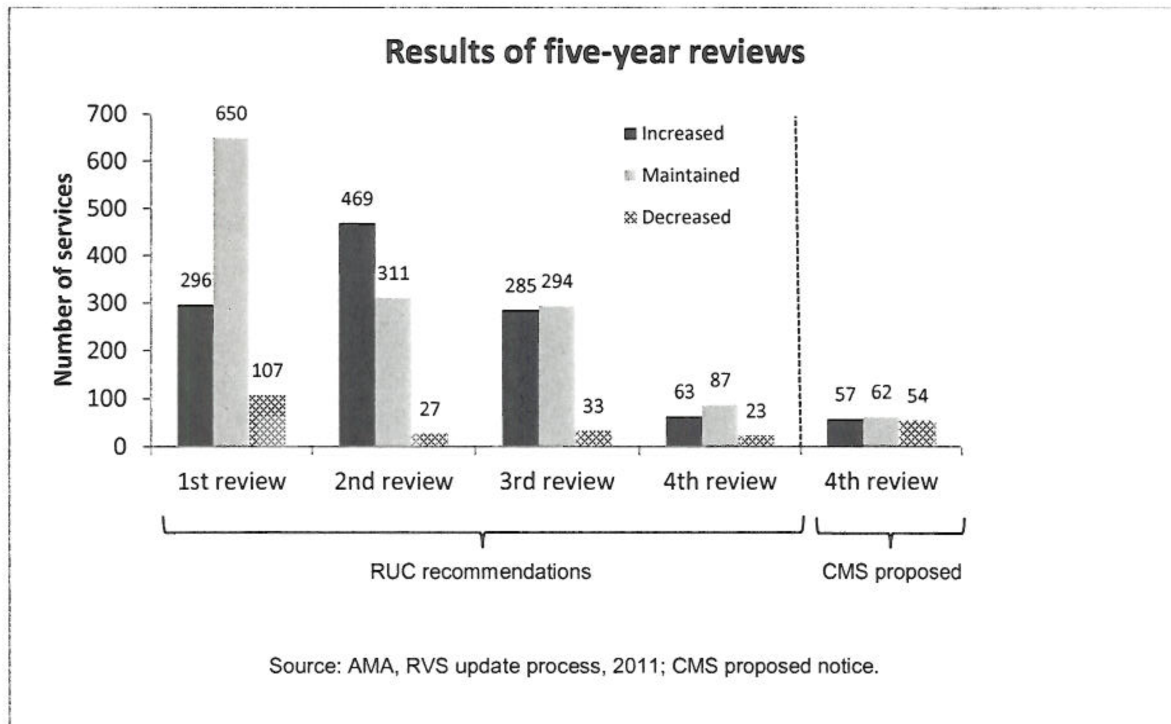
initially requesting their review (14), some had RVUs that were only interim (36), and the remainder were noncovered services (14).

[2] Previous reviews were conducted in 1997, 2002, and 2007.

Aggressive review of overpriced services

The previous five-year reviews showed the limitations of a review process dominated by physician specialty societies: large numbers of services were identified for review, and the majority of those services were recommended for RVU increases. For instance, during the first two reviews, the RUC recommended increases in work RVUs for 765 services but decreases for only 134 services. The third five-year review produced similar results, with recommendations for increases in the work RVUs for another 285 services but decreases for only 33. Clearly, specialty societies have an incentive to propose RVU increases.

However, this five-year review shows that it is possible to reorient the process so it is focused less on underpriced services and more on services that are overpriced (see figure). First, specialty societies proposed fewer services for the review, so the potential for RVU increases was lower than in previous reviews. Second, CMS accepted fewer of the RUC's recommendations. During previous five-year reviews, CMS agreed with over 90 percent of the RUC's recommendations. For this review, the acceptance rate was 51 percent. Third, CMS was less willing than the RUC to maintain RVUs at current levels. Instead, where the RUC recommended decreases for 23 services, CMS is proposing to reduce the RVUs for 54 services, with most of the difference coming from services that the RUC had recommended for no change in RVUs.



Source: AMA, RVS update process, 2011; CMS proposed notice.

Nonetheless, we see potential for the review process to have a bigger impact. CMS indicates in the notice that this five-year review's net effect on fee schedule spending would be under $20 million.[3] Another way to assess impact is to consider total work RVUs for the services in the review (work RVUs per service times units of service in 2009). While it is true that CMS has proposed RVU reductions for nearly a third of the services reviewed, the changes would result in work RVUs that are only 2 percent lower than the total using pre-review (2011) work RVUs. Regardless of how the impact is calculated, however, one reason for the relatively small impact is clear: the services included in the review do not account for a large share of spending. Of the 173 services, only 18 are among the 500 services that account for over 90 percent of spending. These 18 services account for only 0.6 percent of allowed charges. A more aggressive review process would focus attention on overpriced services and services that have a larger impact on spending.

Balance of payments between primary care and procedural services

The Commission remains concerned about the balance of payments between primary care and procedural services, including tests. First, based on our review and analysis over a number of years, we believe the fee schedule's payment rates for 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.

This five-year review did little to rebalance payment rates for primary care relative to procedural services. Only 2 of the 173 services in the review were primary care services. And, as noted above, the services in the review have a small impact on spending. We urge CMS to use the process of validation of the fee schedule's RVUs—a requirement of Section 3134 of the Patient Protection and Affordable Care Act—to review the valuation of primary care services and to correct distortions in prices and ensure that growth in high-volume of procedural services is not due to overpricing. We acknowledge and support CMS's efforts in this area that are underway.

Better data for setting accurate RVUs

As discussed in the Commission's June 2011 report to the Congress, CMS needs better data to set accurate RVUs. The fee schedule's time estimates are an example. The RVUs for practitioner work are largely a function of estimates of how long it takes a practitioner to perform each service. According to research for CMS and the HHS Assistant Secretary for Planning and Evaluation, the

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[3] The Commission's analysis is that the net effect of the changes in work RVUs would be a reduction in payments of about $8 million.

estimates for some services at least are likely too high. The Commission is concerned that the current process for addressing inaccuracies in the fee schedule is flawed because the process for developing the time estimates relies on surveys conducted by physician specialty societies and that those societies and their members have a financial stake in the process.

Better data are also needed for the fee schedule's practice expense RVUs. CMS's methodology for determining these RVUs relies on various types of data: time estimates for clinical employees who work in practitioners' offices, prices for equipment and supplies used in practitioners' offices, and total practice costs for each physician specialty. The Commission has concerns about the accuracy and timeliness of these data.

To collect better data, CMS could consider surveys, but response rates are likely to be low. Alternatively, there could be a requirement that all practitioners' offices submit data, similar to the requirement that institutional providers submit cost reports. However, this option would no doubt give rise to concerns about administrative burden. As discussed in the Commission's June 2011 report, another alternative is to collect data from a cohort of practitioner offices and other settings where practitioners work. Data could be collected for both the work RVUs and the practice expense RVUs. The Commission is working on the feasibility of this option and will be discussing it further in the near future.

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/cw