MEDPAC Medicare Payment Advisory Commission

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August 29, 2008

Kerry Weems, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1403–P
P.O. Box 8013
Baltimore, Maryland 21244-8013

RE: File code CMS-1403-P

Dear Mr. Weems:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Center for Medicare and Medicaid Services (CMS) proposed rule entitled Medicare Program; Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2009; and revisions to the amendment of the e-prescribing exemption for computer generated facsimile transmissions, published in the *Federal Register*, vol. 73, no. 130, pages 38502 to 38881. 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.

Resource-based practice expense relative value units

In estimating the price of medical equipment, CMS uses several factors, including the cost of the equipment, its useful life, maintenance cost, how frequently it is used, and the interest rate. CMS assumes that almost all equipment is operated 50 percent of the time that practices are open for business. If these assumptions are inaccurate, then the payment rates for services that use costly equipment will also be inaccurate. In the final rule for 2008, CMS acknowledged that the 50 percent use assumption does not reflect the actual use rates of all equipment, but stated that there is not sufficient empirical evidence to justify an alternative assumption. The Commission believes there are two options for changing this assumption:

- collect data on equipment use through a survey of providers, or
- set a standard based on how frequently efficient providers are expected to use expensive equipment.

In 2006, MedPAC conducted a survey of a representative sample of imaging providers in six markets that demonstrated that a short, targeted questionnaire can be used to collect information on how often providers use medical equipment. Our survey results indicated that, on average,

providers in those markets use MRI machines more than 90 percent of the time and CT machines more than 70 percent of the time.[a] This survey, which had a 72 percent response rate, raised questions about whether CMS underestimates how frequently providers use MRI and CT equipment.

An alternative option is for CMS to base the assumption for expensive equipment on an expectation of how frequently efficient providers operate such equipment. CMS could retain the 50 percent assumption for less costly equipment. If providers buy expensive equipment and use it only half the time or less, this inflates the per service price of the equipment, which means that Medicare pays more for services performed with the equipment. Medicare should set its rates at a level that encourages providers to be efficient. For example, one could argue that a provider that purchases a $1 million machine should be expected to use it during all the hours it is open for business, with some allowance for downtime due to maintenance and patient cancellations. Indeed, the MedPAC survey discussed above found that several MRI providers operate their machines more than 90 percent of the time. Because changes to practice expense relative weights are budget neutral, any savings from adopting a higher equipment use assumption would be redistributed to other physician services.

In this proposed rule, CMS proposes to reduce the equipment use assumption for equipment used for two telephonic services:

- CPT code 93012: telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time; tracing only
- CPT code 93271: patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmissions, and analysis

Having previously determined that this equipment is used 24 hours a day and 7 days a week, CMS currently applies an equipment utilization rate of 100 percent to these codes. However, based on discussions with a provider group, CMS now believes that the equipment is not used 100 percent of the time during the year and proposes to lower the utilization rate for this equipment from 100 percent to 50 percent. This change would increase the practice expense relative weights for these two codes. CMS does not describe the nature of the evidence that would justify lowering the equipment use assumption for these codes. We oppose this change because it does not appear to be consistent with either of our suggested approaches for changing this assumption (collecting data through a survey of providers or setting an assumption based on an expectation of efficient use).

CAP Issues

The Commission supports efforts by the agency to improve the competitive acquisition program for Part B drugs or CAP program. The Congress mandated the establishment of the CAP program as an alternative way for providers to acquire physician-administered drugs. Under CAP, organizations like wholesalers or specialty pharmacies submit bids to become designated vendors

[a] For more details about this survey, see MedPAC's June 2006 Report to the Congress (Medicare Payment Advisory Commission. 2006. *Report to the Congress: Increasing the value of Medicare*. Washington, DC: MedPAC.).

for Part B drugs. Each year, physicians choose whether to continue to purchase and bill for Part B drugs or to receive these drugs through a Medicare-designated vendor. Medicare pays the vendor directly and the vendors bill patients for the required copayments. One goal of the program was to eliminate financial incentives for physicians to prefer one drug over another. Additionally, CAP provides an alternative way for small practices that are unable to purchase drugs at the Medicare payment rate to continue to acquire drugs and administer them in their offices.

Currently, regulations require that CAP drugs be delivered to the facility in which they will be administered. In the proposed rule, CMS proposes to permit transport of CAP drugs between a participating CAP physician's practice locations subject to voluntary agreements between the CAP vendor and the physician. The Commission supports this proposal. In our 2006 study on the effects of Medicare payment changes on the delivery of chemotherapy, the Commission recommended that the Secretary allow an exception to the CAP delivery rules. Particularly in rural areas, physicians may practice in a number of satellite offices that are only open on specific days. The practice cannot ensure that anyone will be at the satellite office to accept delivery of a drug shipment. In the case of chemotherapy, staff working in the satellite office may not be able to mix the drugs even if they do receive them. We recognize that safeguards are necessary to ensure that the safety and quality of the drugs are not compromised. We believe the proposed modification of the delivery rules will help facilitate physician participation in the CAP program and foster access to chemotherapy for beneficiaries, particularly those living in rural areas.

ESRD provisions

CMS proposes to not update the add-on payment to the composite rate, which would maintain the 2008 add-on payment of 15.5 percent in 2009. CMS based this proposal on its projections that the combined change in per patient utilization (–1 percent) and pricing for ESRD drugs (–1.9 percent) for 2009 would result in a negative update equal to –2.9 percent. The agency did not propose to reduce the add-on payment because the statutory language instructs the Secretary to annually *increase* the add-on payment based on the growth in expenditures for separately billable ESRD drugs.

The agency states that applying the –2.9 percent reduction to the add-on payment would result in decreasing the add-on payment from $20.33 to $19.74 per treatment. Such a change would decrease total add-on payments by about $19 million per year.

CMS's proposal is based on measuring the price changes of ESRD drugs using information from average sales price (ASP) pricing data for ESRD drugs. In previous years, CMS used the Producer Price Index (PPI), which includes all prescription drugs, as a proxy for ESRD drug prices. CMS states that if it had used the PPI instead of ASP drug pricing data, then the total add-on payment would have increased from 15.5 percent in 2008 to 15.9 percent in 2009. Such an update would result in increasing the add-on payment from $20.33 to $20.90 per session, or an increase in total add-on payments of about $19 million per year.

While we have recommended eliminating the add-on payment (and thus the need to update it), the Commission recognizes that CMS is required to do so under current law. Therefore, CMS should use drug pricing data from the most current and accurate data source available. The ASP drug

pricing data measures the change in the top 11 ESRD drugs that dialysis facilities furnished to beneficiaries. By contrast, the PPI includes many classes of drugs; it is a weighted average of some 47 separate indexes for individual therapeutic categories of drugs.[b] Because the ASP drug pricing data is limited to ESRD drugs, it more accurately tracks price changes than the PPI.

As we recommended in our June 2005 Report to the Congress, the Commission believes that the composite rate and the add-on payment should be combined. The add-on payment is complex and may not be the most appropriate way to pay for dialysis services. MedPAC and other researchers have noted that the pre-MMA drug payment policy promoted a less-than-efficient use of drugs by certain providers. The add-on adjustment continues to base payment on this policy. In addition, an increase in the add-on payment for dialysis drugs risks overpayment for use of the drugs. For these reasons, the Secretary should seek Congressional authority to combine the composite rate and the add-on payment.

CMS also requested comments on the application of the preventable hospital-acquired conditions payment provision for inpatient prospective payment system hospitals to other sectors, including the outpatient dialysis sector. MedPAC strongly supports using Medicare payment policy to reward improvements in quality, and the Secretary's effort to move Medicare toward value-based purchasing. MedPAC first recommended the adoption of a pay-for-performance program for facilities and physicians that treat dialysis patients in our March 2004 Report to the Congress. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) calls for the Secretary to modernize the outpatient dialysis payment system by broadening the payment bundle and implementing a pay-for-performance program starting in 2011. These changes should lead to improvements in quality and create incentives for providers to furnish services more efficiently.

Independent diagnostic testing facilities

CMS proposes to require that physician practices that provide diagnostic testing services enroll with Medicare as independent diagnostic testing facilities (IDTF) and comply with most IDTF performance standards, such as ensuring that the technical staff and supervising physicians are qualified and that the testing equipment is properly maintained. CMS contends that this enrollment rule is necessary to ensure that diagnostic tests are performed by qualified nonphysician staff, whether they are furnished in an IDTF or physician office. CMS asks for comment on whether this requirement should apply to all diagnostic testing services, only imaging services, or only advanced imaging services (such as MRI and CT).

In our March 2005 Report to the Congress, we described evidence of quality problems with some imaging providers and the lack of quality oversight for imaging tests provided in non-hospital settings. Consequently, the Commission recommended that the Congress direct the Secretary to set quality standards for providers who bill Medicare for performing and interpreting diagnostic imaging studies. We also recommended that, to reduce the burden on CMS, the Secretary should select private sector organizations to administer the standards. We encouraged CMS to set standards in at least the following areas: the imaging equipment, qualification of technicians,

[b] For more details, please see: http://www.bls.gov/ppi/ppidrug.htm.

qualifications and responsibilities of the supervising and interpreting physicians, quality of the images produced, and patient safety procedures.

Section 135 of MIPPA mandates that providers billing for the technical component of advanced imaging services under the physician fee schedule become accredited by an accreditation organization designated by the Secretary. Accreditation organizations selected by the Secretary must have standards for the qualifications of nonphysician staff and supervising physicians, imaging equipment, patient and staff safety, and quality assurance programs. This provision, which will become effective in 2012, applies to MRI, CT, and nuclear medicine services, but not X-ray, ultrasound, or fluoroscopy.

The Commission supports CMS's proposal to extend the IDTF performance standards to physician offices that perform any type of diagnostic imaging. However, the IDTF standards and the MIPPA accreditation requirement leave gaps in the oversight of imaging services provided outside of hospitals. CMS should strive to address these gaps.

Although the IDTF standards could be applied to all types of imaging services, they do not require that providers adopt quality assurance and patient safety programs, nor do they require that interpreting physicians demonstrate that they are qualified. Further, there have been problems with the enforcement of IDTF rules by Medicare contractors. For example, a 2006 report by the Office of Inspector General (OIG) found that many IDTFs were not complying with rules relating to technicians, supervising physicians, and testing equipment.[c] Instead of relying on contractors to oversee the quality of IDTFs, CMS should select private accreditation organizations to carry out this function. Because accreditation organizations support their operations by charging fees to providers, Medicare would be able to save the money it currently devotes to monitoring the quality of IDTFs.

By contrast, MIPPA would apply comprehensive quality standards to the technical component of advanced imaging services. Further, it requires the Secretary to use accreditation organizations to verify compliance with these standards. However, the MIPPA accreditation requirement also has gaps. It does not include standards for physicians who interpret imaging studies and bill for the professional component. In addition, MIPPA specifically excludes X-ray, ultrasound, and fluoroscopy services.

Based on the Commission's recommendations, an ideal quality assurance approach for diagnostic imaging would:

- apply to all types of diagnostic imaging services (although standards for advanced imaging should be adopted first),
- require that imaging providers have patient safety and quality assurance programs (in addition to having qualified technicians and supervising physicians, and using properly maintained equipment),

[c] Office of Inspector General, Department of Health and Human Services. 2006. *Review of claims billed by independent diagnostic testing facilities for services provided to Medicare beneficiaries during calendar year 2001*. Washington, DC: OIG. June.

- include standards for the interpreting physicians, and
- use private accreditation organizations to certify compliance.

CMS should seek to develop a robust quality assurance program for diagnostic imaging by addressing the gaps in the IDTF standards and the MIPPA accreditation program. If possible, the agency should do this through its existing statutory authority. However, if CMS determines that it does not have sufficient statutory authority, the agency should seek new legislation. We would support this effort. We also believe that the Congress should provide sufficient resources to CMS to develop and enforce broader quality standards for imaging.

Physician self-referral and anti-markup issues

CMS proposes to create an exception under the physician self-referral law (also known as the Stark law) that would protect cash payments from hospitals to physicians when physicians participate in quality improvement or shared savings programs that meet certain criteria. These criteria include transparency, quality controls, and safeguards against paying for referrals. Under shared savings or shared accountability arrangements, hospitals and physicians agree to share savings from reengineering clinical care in the hospital. These programs have the potential to encourage cooperation among providers in reducing costs and improving quality.

We have recommended that the Congress grant the Secretary the authority to allow shared accountability arrangements between physicians and hospitals with safeguards to ensure that cost-saving measures do not reduce quality or influence physician referrals (MedPAC, *Report to the Congress: Physician-owned specialty hospitals*, March 2005). Therefore, the Commission strongly supports CMS's proposal to create an exception under the Stark law that would allow shared accountability programs with safeguards. However, we are concerned that the civil monetary penalty (CMP) provision in the Social Security Act, which prohibits hospitals from offering physicians financial incentives to reduce or limit services to Medicare patients, could inhibit broader development of appropriate shared accountability arrangements. Thus, we encourage CMS to seek legislation to modify the CMP provision so that it allows shared accountability programs with safeguards.

Physician Quality Reporting Initiative (PQRI)

Based on statutory authority provided by Section 1848(k) of the Social Security Act as amended by the Medicare, Medicaid and SCHIP Extension Act of 2007, CMS proposes in the rule to continue the Physician Quality Reporting Initiative (PQRI) in 2009. Since the proposed rule was published, MIPPA was enacted, specifying that providers who meet PQRI participation requirements for 2009 will be eligible for additional Medicare Part B payments equal to 2.0 percent of total allowed charges for all covered professional services they furnished during the reporting period (i.e., during 2009). CMS has proposed a list of 175 quality measures from which it will select the final set of 2009 PQRI measures, to be published in the physician fee schedule final rule later this year.

The Commission's position is that the Congress should establish a pay-for-performance (P4P) program in Medicare for physician services. The essential component of P4P programs is a set of

rewards and penalties, all based on the content of the measurement data reported, i.e., based on the provider's actual performance. With respect to physicians, the Commission has recommended starting P4P by measuring the functionality of physicians' offices (e.g., the office's ability to produce patient registries and track whether its patients receive appropriate follow-up care). Rewarding functionality would be a precursor to rewarding process and outcomes, where providers are rewarded when they improve care and meet or exceed specified performance benchmarks. By contrast, PQRI allows providers to receive bonus payments by reporting on a certain number of measures, but the substance of a provider's performance on those measures is not taken into consideration in determining their eligibility for a bonus payment.

The Commission notes that MIPPA directs the Secretary to develop a plan to transition to a value-based purchasing program for covered professional services and report to the Congress by May 1, 2010 on this plan, including recommendations for legislative and administrative actions for its implementation. We look forward to reviewing that plan and anticipate that it will describe ways for PQRI to make the transition to a P4P program for physicians.

On the quality measures that CMS proposes, the Commission supports the effort to gain endorsement of measures by an entity such as the NQF. In recommending P4P programs, the Commission addressed the importance of measure sets that are vetted by a credible, independent entity. In addition to examining measures for statistical validity and reliability, this entity should consider each measure's relative usefulness toward improving the outcomes of care for beneficiaries (i.e., the potential impact of the care process or structural component being measured on improving health outcomes for beneficiaries care, relative to other measures). This consideration will encourage specialty societies to devote resources toward bringing the most meaningful and effective measures to the table for review.

The Commission also supports the policy of reconsidering existing measures and dropping them if warranted. Measures should not allow physicians to receive rewards for providing marginally effective care or care that is already routinely furnished. Measures based on this type of care could diminish the overall effectiveness of the quality reporting initiative, and eventually could work at cross-purposes to Medicare's efforts to increase efficiency, as well as quality, of physician services delivered to beneficiaries.

Potentially misvalued services under the physician fee schedule

The proposed rule describes approaches CMS is using or proposes to use to identify services billable under the physician fee schedule that may be misvalued. CMS believes these approaches respond to concerns expressed by the Congress, the Commission, and others about the accuracy of prices under the physician fee schedule.

The approaches to identifying potentially misvalued services consist of:

- a process to update the prices of high cost supply items every 2 years,
- review of services often billed together to be followed perhaps by proposals to either bundle services or expand the current policy of applying a multiple procedure payment reduction when a physician furnishes multiple services to a patient on a single day, and

- a recent request to the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) for review of potentially misvalued services to occur either immediately or on an ongoing basis.

CMS requested that the RUC conduct three different reviews: the work relative value units (RVUs) for services whose use grew rapidly from 2004 though 2007; work RVUs that are still based on research in the 1980s by William Hsiao and colleagues at Harvard; and practice expense (PE) inputs, especially the PE inputs for high-volume services whose PE payments are significantly increasing during the transition to the new PE methodology.

Misvalued services can have a significant impact on Medicare spending. Without change, the Medicare program is fiscally unsustainable over the long term. Moderating spending requires fundamental reforms in payment and delivery systems to improve quality, coordinate care, and reduce cost growth. Setting accurate payment rates is one of those reforms.

Mispricing in the fee schedule is a longstanding concern for the Commission and has been the subject of several MedPAC recommendations. In work for our March 2006 Report to the Congress, we found what appears to be a bias in the existing policy for addressing misvalued services: the 5-year review. Before 2006, the two 5-year reviews that had been conducted—for 1997 and 2002—had led to substantially more recommendations for increases than decreases in RVUs, even though many services are likely to become overvalued as time passes. The 5-year review completed for 2007 produced similar results.

More recently, in our June 2008 Report to the Congress, the Commission linked mispricing in the fee schedule to undervaluation of primary care. When a physician focuses his or her practice on primary care services, it is difficult to achieve efficiency gains over time. The services are composed largely of activities such as taking the patient's history; examining the patient; and engaging in medical decision making, counseling, and coordinating care. These activities require the clinician's time either with the patient or before and after seeing the patient. By contrast, efficiency can improve more easily for other types of services, such as procedures, with advances in technology, technique, and other factors. Ideally, when such efficiency gains are achieved, the fee schedule's RVUs for the affected services should decline accordingly, while budget neutrality would raise the RVUs for the fee schedule's primary care services. Because of problems with the 5-year review, this two-step sequence—lower RVUs for overvalued services and higher RVUs for primary care—tends not to occur, giving rise to concerns that primary care services are undervalued.

A further concern is that overvalued services have consequences for all services in the fee schedule, not just primary care. To account for the increases in work RVUs that occurred as part of the 5-year review for 2007, the fee schedule now includes a budget neutrality adjustment that applies to the work RVUs for all services. The adjustment equals −12 percent. In other words, Medicare's payments for the work of physicians are reduced across-the-board by 12 percent, at least in part because of a review process that has not adequately accounted for overvaluation of some services. The MIPPA requires a change in this budget neutrality adjustment so that it reduces the fee schedule's conversion factor instead of the work RVUs. Nonetheless, the adjustment will continue to have the effect of devaluing services. CMS should work to reduce or eliminate the

need for this adjustment through steady progress toward correcting the RVUs for overvalued services.

The specific approaches CMS has proposed to address misvalued services show a sense of urgency by making work on misvalued services an ongoing effort instead of waiting until the next round of the 5-year review. In addition, the proposals are consistent, at least in spirit, with some of the recommendations we made in our March 2006 Report to the Congress to improve the 5-year review. For instance, two of the approaches to identifying misvalued services discussed in the proposed rule—review of services often furnished together and review of the fastest growing procedure codes—are consistent with the Commission's recommendation that CMS make greater use of Medicare data to identify services that have experienced changes in physician work. Changes in volume, increases in claims for multiple services, among other changes, can signal the need to revise valuations of physician work. Similarly, the proposal on reviewing Harvard-valued codes is consistent with our recommendation that CMS review the valuation of all services periodically—including those services that have not been reviewed since the inception of the fee schedule—to keep RVUs as accurate as possible.

Beyond these areas of agreement, however, the Commission disagrees with CMS on the process for identifying misvalued services. The Commission recommended previously that CMS establish a standing panel of experts to help identify overvalued services and to review recommendations from the RUC. The RUC and the specialty societies play an important role, which should continue, but CMS's responsibility to identify potentially misvalued services, especially overvalued ones, is central. The panel envisioned would include members with expertise in health economics and physician payment in addition to members with clinical expertise. The Commission recommended further that the Congress and the Secretary ensure that the panel has the resources it would need to collect data and develop evidence. We anticipate that this panel would help CMS reduce its reliance on physician specialty societies and take a more central role in identifying potentially misvalued services. Discussion in the proposed rule shows that CMS has chosen instead to rely on the RUC and specialty societies for recommendations on misvalued services.

We understand that CMS has undertaken much work already in developing new approaches to identifying potentially misvalued services. For instance, the proposed rule presents a process for updating high cost supplies and provides a list of 65 items that would be subject to review under this process. The proposed rule also lists over 100 procedure codes that have been sent to the RUC for review because they are used in billing for services that have experienced rapid growth in use since 2004. Nonetheless, we remain concerned that, in relying on current processes, not enough evidence will be brought to bear on the question of whether services are misvalued. Furthermore, CMS will lack the assistance that an expert panel could provide in review of recommendations from the RUC. If CMS does not establish the expert panel the Commission recommends, the agency should at least further strengthen the approaches to identifying misvalued services that are presented in the proposed rule. Below, we offer comments and suggestions on each one, organized according to subheadings that appear in the proposed rule: updating high cost supplies, review of services often billed together, review of fastest growing procedure codes, and review of PE RVUs.

Updating high cost supplies
The Commission supports CMS's efforts to update the information on the prices of higher-priced supply items (e.g., renal cryoablation probes) every two years. Inaccurate prices of high-cost medical supplies could result in distortions in the relative weights for practice expense over time. Likewise, inaccurate prices of higher-cost medical equipment (e.g., MRI machines) could also distort the weights for practice expense over time. Prices for both new supplies and equipment are likely to drop over time as they diffuse into the market and as other companies begin to produce them. Consequently, the Commission encourages the agency to regularly update the price information of high-cost medical equipment *and* supplies, as we suggested in our June 2006 Report to the Congress.[d]

CMS is proposing to continue to obtain the "typical price" of higher-priced medical supplies in the marketplace from a variety of sources, such as copies of catalog pages; hard copies from web pages; invoices; and price quotes from manufacturer, vendors, or distributors. (The agency also uses information from multiple sources to calculate the "typical price" of medical equipment.) CMS has requested comments on alternatives that could be used to update prices in the absence of information provided by the specialty societies and organizations.

Obtaining price information from specialty societies might not result in objective and accurate prices of medical supplies and equipment because specialty groups have a financial stake in the process. Ideally, prices of supplies and equipment should be based on an independent source that captures average transaction prices net of discounts and rebates that manufacturers give to providers, rather than manufacturers' suggested list prices.

Review of services often billed together
Efficiencies can be obtained when physicians furnish multiple services together. The rule describes several existing payment policies intended to account for these efficiencies. Under the multiple procedure payment reduction (MPPR) policy, payments are reduced when multiple surgical procedures are performed on the same patient, by the same physician, and on the same day. Similar policies apply to selected nuclear medicine diagnostic procedures performed on the same patient on the same day and to certain diagnostic imaging procedures performed on contiguous areas of the body.

The proposed rule draws attention to inequities that may exist between specialties and in the coding of certain types of services. For instance, primary care physicians typically bill for their services using evaluation and management (E&M) codes that represent a relatively broad package of services consisting not just of the time spent with the patient but also arranging for other services and coordinating care with other professionals. Similarly, physicians in specialties such as general surgery and cardiac surgery are paid under global surgical policies that encompass pre- and post-surgical procedure services in addition to the surgical procedure itself. By contrast, the codes for many other services billable under the fee schedule are defined more narrowly with units of service that represent relatively small portions of the total service furnished.

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

To address these issues, CMS proposes to conduct a data analysis of services that are often furnished together to determine if there are inequities in payment due to variation in the comprehensiveness of billing codes or due to payment policies, such as the MPPR or the global surgical policy. Results of this analysis may then inform development of proposals to either bundle services or expand the existing MPPR. If CMS develops such proposals, the agency would use rulemaking to seek public comment before any change in policy.

Our first comment on these proposals is that the design of the data analysis and any further expansion of the MPPR should consider payment for physician work in addition to payment for practice expense. The proposed rule is not clear on this point. It mentions three types of inputs considered in the method for determining practice expense RVUs—clinical labor, supplies, and equipment—but there is no explicit reference to physician work.

The Commission makes this comment because we believe that, under current policy, some payments for physician work may be duplicative. As discussed in our March 2006 Report to the Congress, time savings are likely when services are furnished together instead of independently, and changes in payments for physician work may be appropriate when this occurs. CMS and the RUC base work RVUs on the time, effort, skill, and stress that accompany three types of activities:

- pre-service work—review of records, review of prior radiographs, and any discussions with other physicians or clinical staff prior to the onset of the procedure;
- intra-service work—performing the procedure, communications with clinical staff performing the examination, review of preliminary images or data, processing of images and data, and interpretation of the examination; and
- post-service work—dictating, reviewing and signing a report for the medical record, and any discussions with the patient and referring physician.

At least with pre-service and post-service work, there should be efficiencies when a physician furnishes multiple services together instead of during separate encounters. For instance, when a physician furnishes both a myocardial perfusion study and a cardiovascular stress test during a single encounter, the review of records and other activities would occur only once. Yet, the current valuation of physician work in such circumstances assumes that the services are furnished separately and all of the payment for physician work should be additive. An expansion of the MPPR is one option for addressing what we perceive as a problem of duplicative payments. Coding changes are another option. When a package of services is often furnished together, a single billing code can be defined for the package and an RVU can be set that accounts for efficiencies in furnishing the services together.

In setting priorities among services to consider for a change in policy, we encourage CMS to consider both variation in the frequency that services are furnished together, by type of service, but also variation in the volume of services, by type of service. Our analysis shows that the percent of claims with two or more services is relatively high for some types of service (Table 1). In addition, some of those same types of service account for relatively large shares of the total volume of services. For instance, among claims paid in 2006 that had a nuclear medicine service as the service with the highest allowed charge, 66.4 percent of those claims included two or more services. (A cardiovascular stress test was the additional service furnished most frequently.) By

Table 1. Claims with multiple services, 2006

Type of service	Percent of claims with two or more services	Percent of total volume
All services	**16.0 %**	**100.0 %**
Evaluation and management	**9.1**	**39.5**
Office visit--established patient	9.5	16.9
Hospital visit--subsequent	0.7	7.7
Consultation	12.2	5.5
Emergency room visit	16.3	2.6
Nursing home visit	2.0	2.0
Hospital visit--initial	2.3	1.8
Office visit--new patient	25.8	1.8
Imaging	**19.6**	**16.6**
Standard--nuclear medicine	66.4	2.4
Advanced--CT: other	48.9	2.4
Echography--heart	10.0	2.3
Advanced--MRI: other	12.3	2.0
Standard--musculoskeletal	25.2	1.2
Advanced--MRI: brain	19.2	1.1
Standard--chest	3.3	0.6
Advanced--CT: head	22.3	0.6
Major procedures	**43.9**	**9.1**
Knee replacement	5.7	0.7
Coronary artery bypass graft	10.5	0.5
Coronary angioplasty	72.2	0.5
Hip fracture repair	18.6	0.4
Hip replacement	4.4	0.4
Explore, decompress, or excise disc	17.3	0.4
Other procedures	**38.8**	**22.1**
Oncology--radiation therapy	31.2	2.3
Ambulatory procedures--skin	46.9	2.1
Minor procedures--skin	22.0	2.0
Cataract removal/lens insertion	2.3	1.8
Minor procedures--musculoskeletal	59.7	1.5
Colonoscopy	4.1	1.1
Upper gastrointestinal endoscopy	9.4	0.6
Cystoscopy	36.6	0.6
Tests	**20.0**	**5.4**
Other tests	29.5	2.3
Electrocardiogram	3.6	0.7
Cardiovascular stress test	44.7	0.6
Electrocardiogram monitoring	9.6	0.2

Note:Type of service is the service on each claim with the highest charge allowed under the physician fee schedule. All services included had the same date of service as the service that determined type of service. Services were excluded if payments were subject to an existing policy that accounts for differentials in physician work when multiple services are furnished together: add-on codes, multiple procedure reduction (modifier equal to 51), and distinct procedural service (modifier equal to 59). Services were also excluded if work RVUs equal zero, including technical component only services. Within each general type of service category (evaluation and management, imaging, etc.), services are ordered from highest to lowest volume in 2006.

Source: MedPAC analysis of claims data for 0.1 percent of Medicare beneficiaries.

contrast, the average for all services was only 16.0 percent. Nuclear medicine also accounted for 2.4 percent of the volume of physician services in 2006, the highest share of volume among imaging services. The Commission, the Congressional Budget Office, and others have all cited the volume of services as an important factor influencing the sustainability of the Medicare program. Therefore, high-volume services could be ones to consider first for a change in policy.

When considering services furnished together, CMS could also go beyond the bounds of the current MPPR policy. In other words, it may be appropriate to consider more than just the services furnished to the same patient, on the same day, by the same physician. For instance, it may be appropriate to package services furnished during diagnosis and treatment of selected acute or chronic conditions, such as pneumonia or glaucoma, even if those services are not all furnished on the same day. Another option may be to build on the global surgical payment policy and create additional incentives for efficiency within a surgical episode by extending the global period.

Review of the fastest growing procedure codes
CMS has identified 114 billing codes for services with rapid growth in use from 2004 through 2007 and has sent them to the RUC for review. To make the list, the codes had to meet certain criteria:

- growth in units of service of at least 10 percent for three consecutive years (2004 through 2007),
- total allowed charges in 2007 of at least $1 million, and
- continuing as separately payable in 2008.

When grouped by type of service, 29 of the codes are major procedures, 51 are other procedures, 22 are imaging, and the remaining 12 are tests or other services. None of the codes are for primary care or other evaluation and management services.

In asking the RUC to review the codes, CMS states that they may warrant a reassessment to determine why there has been an increase in utilization, suggesting that there may be a clinical rationale for the increase or there may have been changes in the relative resources used in furnishing the procedure.

The Commission supports CMS's plans to review the fastest growing procedure codes. As we discussed most recently on our March 2008 Report to the Congress, rapid volume growth may signal that Medicare's payment is too high. Specifically, the physician work component of a given procedure may be overvalued if physicians (or their staff) are able to perform the procedure considerably more quickly than they did when it was first introduced. Consequently, physicians can increase their volume of these procedures with little change in the number of hours they work. As these procedures become increasingly profitable, physicians face clear financial incentives to favor them over other procedures that may be less profitable.

We agree also that it is important to set priorities among the codes to be reviewed. The review will require use of limited resources at CMS and the RUC. In setting priorities, we urge CMS to consider each code's contribution to spending growth. As discussed earlier, the Medicare program is fiscally unsustainable over the long term without fundamental changes, and setting accurate

prices is one element of the reform needed. By using contribution to spending growth to set priorities among the codes to be reviewed, CMS and the RUC would be acknowledging this link.

Our analysis shows important differences among the codes to be reviewed in their contribution to spending growth from 2004 to 2007 (Table 2). A single code (77418, delivery of intensity modulated radiation therapy) accounted for 23.5 percent of the spending growth for these codes. The top ten codes—ranked in order of their contribution to spending growth—accounted for 64.2 percent of the total. By contrast, many codes among the 114 sent to RUC made very small contributions to growth. Those codes tend to have relatively low levels of units of service and allowed charges. Their growth is high, but it is off a low base.

The Commission is also concerned about CMS's perception of the purpose of the review and its possible outcomes. The rule states that these codes may warrant a reassessment to determine why there has been an increase in utilization. The rule states further that there may be a clinical rationale for an increase or there may have been changes in the relative resources involved in furnishing a procedure.

We encourage CMS to look at these matters somewhat differently. First, while we agree that the review could reveal instances of increases in utilization that have an uncertain rationale, we urge a stronger assertion here that the overriding purpose of the review is to identify whether codes are misvalued. Second, we do not believe that a clinical rationale for an increase in service use precludes the possibility that there may have been a change in resources used in furnishing the services. To the contrary, we believe that increases can have a clinical rationale *and* that resource requirements have changed also. Indeed, we believe it is quite likely that resource requirements change when volume goes up.

As discussed in our March 2006 Report to the Congress, the time, effort, stress, and skill required to furnish services are believed to be influenced by a number of factors: learning by doing, work process reengineering, technology diffusion, technology substitution, and allied health personnel substitution. Any or all of these factors are likely to be correlated with growth in units of service and are likely to change the resource requirements. Support for this position comes from research that considered cardiac surgery and how advances in techniques and technology allowed physicians to become more proficient in performing the procedures, taking less time per procedure.[e] Valuation of codes should account for any such improvements in proficiency.

Review PE RVUs

We request that CMS clarify the timing for the five-year review of practice expense RVUs. The proposed rule is not clear about the timing of such a review. It is important for CMS to set a reasonable schedule for reviewing practice expense RVUs at least every five years as required and more often for services experiencing rapid changes. The statute requires that the Secretary review and make adjustments to the relative values for all physician fee schedule services at least every five years. Periodic review of practice expense RVUs is important because the resources needed to perform a service can change over time. CMS should adjust the value of the service accordingly.

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[e] Cromwell, J., J. B. Mitchell, and W. B. Stason. 1990. Learning by doing in CABG surgery. *Medical Care* 28, no. 1(January): 6-18.

Table 2. Contribution to spending growth for billing codes with rapid growth in service use

HCPCS	Description	Allowed charges (in millions) 2004	2007	Growth	Contribution to growth
	All 114 of CMS's fastest growing codes	$ 1,545	$ 3,004	$ 1,459	100.0 %
77418	Radiation treatment delivery, IMRT	339	681	342	23.5
67028	Injection eye drug	27	151	124	8.5
92135	Ophthalmic diagnostic imaging	131	246	115	7.9
66982	Cataract surgery, complex	49	148	99	6.8
64483	Injection, foramen epidural, lumbar or sacral	63	157	94	6.5
77301	Radiotherapy dose plan, IMRT	37	81	44	3.0
27245	Treat hip fracture	54	88	34	2.3
71250	CT thorax without dye	111	140	29	2.0
72194	CT pelvis without and with dye	44	72	28	1.9
64484	Injection, foramen epidural add-on	18	46	28	1.9
					64.2

Note: HCPCS (Healthcare Common Procedure Coding System), CT (computed tomography), IMRT (intensity modulated radiotherapy). Codes listed are from CMS's list of 114 fastest growing procedure codes and are the 10 codes with the highest contribution to spending growth from 2004 to 2007. Contribution to growth is each code's increase in allowed charges as a percentage of the increase in allowed charges for all 114 codes on CMS's list of fastest growing codes.

Source: MedPAC analysis of data in Table 25 of the proposed rule and 2004 claims data for 100 percent of Medicare beneficiaries.

Otherwise, Medicare's practice expense payments will be too high or too low, relative to the resources needed to provide different services.

A five-year review would give CMS the opportunity to review the estimates of the inputs in the direct cost database. The inputs required to furnish many—although not all—services can be expected to change over time. Currently, the RUC recommends the types and quantities of direct inputs for new and refined codes to CMS. The agency has generally accepted the RUC's recommendations.

CMS has requested that the RUC focus its review of PE inputs on high-volume codes whose payments are significantly increasing during the transition to the new practice expense methodology. Similar to our comments on the review of work RVUs, we encourage CMS and the RUC to initially evaluate the PE inputs of services that have contributed the most to spending growth (Table 2). As a secondary priority, CMS and the RUC could review the PE inputs of high-volume services, particularly those whose inputs are not based on physician surveys. For services reviewed between 1999 and 2005, the RUC recommended that CMS refine most of the PE inputs using estimates proposed by specialty societies. For services reviewed since then, by contrast, the RUC has used data gathered from physician surveys. We believe that it is preferable to use physician surveys because these are likely to be more accurate than estimates proposed by specialty societies.

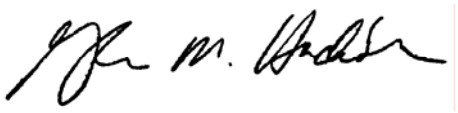
CT services are contributing significantly to spending growth and may be ripe for review. The equipment and clinical labor portions of the practice expense RVU for imaging services are based on the estimated number of minutes it takes to perform a study. The time estimates for most CT codes were developed by the RUC in 2002 or 2003. These estimates may not reflect recent technological advances in CT equipment that have reduced scanning times. For example, the development of 64-channel CT machines has made it possible to scan patients faster.[f] CMS and the RUC could examine whether the time estimates for CT services are still accurate.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC 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 Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

GMH/kh/aj

[f] Mitka, M. 2006. Radiologists adjusting to revolution in CT. *Journal of the American Medical Association* 295, no. 7.