NATIONAL HEALTH POLICY
FORUM

FORUM SESSION

Assessing Progress on Improving the Data Behind Medicare's Physician Fee Schedule

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The Medicare program spent over $61 billion on services paid under its physician fee schedule in 2009. Medicare's physician fee schedule, which contains fees for about 7,000 service codes, is based on the resource-based relative value scale (RBRVS) that ranks services by their resource use, as measured by relative value units (RVUs). The RVUs are determined separately for three categories of resources—physician work, practice expense, and malpractice expense—required to provide each service. Physician work values for each service code are based on estimates of the time it takes to provide the service, the technical skill and physical effort, mental effort and judgment, and stress due to risk to the patient. Practice expenses are divided into two components, direct and indirect expenses. Direct expenses are resources used to provide a service and can be directly attributed to a particular service such as non-physician clinical staff, equipment, and supplies. Indirect expenses, such as rent, utilities, and administrative staff, are resources that cannot be directly attributed to a particular service. Professional liability insurance (PLI) expenses are the insurance costs for malpractice insurance. Medicare's payment for a service for a given year is determined by multiplying that service's RVUs (adjusted for geographic differences using geographic practice cost indices, or GPCIs) by a constant conversion factor that translates the RVUs into dollars.

$$\textbf{Payment} = ((RVU_{work} * GPCI_{work}) + (RVU_{practice\ expense} * GPCI_{practice\ expense}) + (RVU_{PLI} * GPCI_{malpractice})) * \textbf{Conversion Factor}$$

The physician work and practice expense components together account for about 96 percent of Medicare physician payments.

Because inaccuracies in the fee schedule could adversely affect Medicare beneficiaries, providers, and the overall program, the Centers for Medicare & Medicaid Services (CMS) is charged with

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making adjustments to improve the accuracy of the RVUs when the amount of work or other resources required to provide a service changes or when evidence is identified that a service is misvalued.[1] The estimates of physician work were originally based on research conducted at Harvard University and completed in the late 1980s. Over time new codes have been added, and most work values have been revised to reflect changes in service delivery. Practice expense RVUs were not estimated in the original Harvard study. Resource-based RVUs, based on estimates of direct expenses, pricing data, and specialty-specific practice expenses, were phased in beginning in 1999 and have also been revised over time.[2]

CMS is required to review and revise the relative rankings of all physician services at least every five years. In addition to this systematic five-year review process, CMS annually assigns values to new services, adjusts rankings for certain existing services, and makes other changes to the physician fee schedule. Collectively, all adjustments to RVUs must be budget neutral.[3] To accomplish these revisions and determine physician work RVUs and direct practice expense RVUs for new and revised codes, CMS relies on recommendations from the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC). The RUC is an independent group of 29 volunteer members (26 are voting members) from different medical specialties whose principal purpose is to provide relative value scale update recommendations to CMS based on its review of service-specific data from physician specialty-sponsored surveys.[4] Twenty-three of the RUC's 29 members are appointed by major national medical specialty societies (three are rotating seats with two-year terms, indicated with an asterisk below):

- Anesthesiology
- Cardiology
- Colon and Rectal Surgery*
- Dermatology
- Emergency Medicine
- Family Medicine
- General Surgery
- Internal Medicine
- Nephrology*
- Neurology
- Neurosurgery
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Plastic Surgery
- Pulmonary Medicine*
- Psychiatry
- Radiology
- Thoracic Surgery
- Urology

The remaining six members are the RUC Chair, the Co-Chair of the RUC Health Care Professionals Advisory Committee Review Board, and representatives of the AMA, American Osteopathic Association, the Chairs of the Practice Expense Review Committee and CPT Editorial Panel. Based on specialty society surveys and presentations of data, the RUC makes annual recommendations to CMS regarding new and revised physician services and performs a broad review of the RBRVS every five years. The RUC uses processes similar to the original Harvard study to develop the work RVUs, but it has refined the process over time.

Critics of the RUC have charged that it is not transparent in its processes, is beholden to the influence of specialists, has been inclined to identify services that are undervalued but not overvalued, and relies on data that may be not be representative of efficient practices or accurately reflect the resources required to provide a service. Primary care groups have been among the most vocal critics of the composition of the RUC and have pushed for more representation on the Committee. For example, the American Academy of Family Physicians (AAFP) called on the RUC to make changes to its structure, process, and procedures, first in a letter to the RUC in June 2011, followed by a presentation to the RUC in September 2011. Specifically, the AAFP requested that the RUC:

- add four primary care seats: one each for the AAFP, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association;
- create three new seats to represent outside entities, such as consumers, employers, health systems and health plans;
- add an additional seat to represent the specialty of geriatrics;
- eliminate the three current rotating subspecialty seats when the current representatives' terms expire; and
- implement voting transparency.[5]

In February 2012, the AMA announced that the RUC will grow to 31 members with the addition of seats for a geriatrician and an actively practicing primary care physician.[6]

CMS's reliance on the RUC's data and processes has drawn criticism from a number of observers, who would like CMS to develop expertise in reviewing RVUs and to collect data, independent of the RUC, to revise RVUs.

To address ongoing concerns about potentially misvalued services on the physician fee schedule, the Patient Protection and Affordable Care Act (PPACA) directs the Secretary to examine seven specific categories of codes as the Secretary determines to be appropriate:

- codes (and families of codes as appropriate) for which there has been the fastest growth;
- codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses;
- codes for new technologies or services within an appropriate period (such as three years) after the relative values are initially established for such codes;
- multiple codes that are frequently billed in conjunction with furnishing a single service;
- codes with low relative values, particularly those that are often billed multiple times for a single treatment;
- codes which have not been subject to review since the implementation of the RBRVS (the so-called "Harvard-valued codes"); and
- other codes determined by the Secretary to be appropriate.[7]

Since 2009, as part of the annual review of misvalued codes, CMS and the RUC have identified and reviewed several hundred misvalued codes in each of the seven PPACA-specified categories. PPACA also specifies that, in reviewing and adjusting the RVUs for misvalued codes, the Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services; may conduct surveys, other data collection activities, studies, or other analyses or use contractors to conduct these activities; and may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment. In its final rule with comment on the physician fee schedule for 2012, CMS announced that it plans to continue this work consistent with legislative requirements, with continued input from the RUC.[8]

In addition to identifying and reviewing misvalued codes, PPACA also requires the Secretary to establish a process to validate RVUs under the fee schedule.[9] The process may include validation of work elements involved with furnishing a service and validation of the pre-, post-, and intraservice components of work. CMS has solicited public input on possible methods for validation, but it has yet to establish

the process it will use. It plans to discuss the RVU validation process further in future physician fee schedule rulemaking.

Although both CMS and the RUC have updated and improved the data and methods for estimating the work and practice expense resources for physician services, concerns remain about the adequacy of the data, the transparency of the processes, the involvement of medical specialty societies, CMS oversight, and the standards against which the estimates are evaluated. The Medicare Payment Advisory Commission (MedPAC) noted in October 2011 that "the Secretary lacks current, objective data needed to set the fee schedule's RVUs for practitioner work and practice expenses."[10] MedPAC specifically raised concerns that some of the time estimates underlying the work RVUs may be too high and that the data used to develop the practice expense RVUs are not timely or accurate. For example, of the 42 physician specialties surveyed using the Physician Practice Information Survey (PPIS), just 23 had 70 or more responses used to calculate practice expense per hour and 8 specialties had fewer than 50 completed responses.[11] Nevertheless, CMS believed that, when corrected for non-response bias, the PPIS (fielded in 2007 and 2008) better represented practice patterns and costs than the even older data it had been using. In light of concerns about robustness of the data behind the physician fees, in 2011 MedPAC made the recommendation to the Congress that it should direct the Secretary to collect data to establish more accurate work and practice expense values.

Although improving the accuracy of the fee schedule is important to ensure responsible financial stewardship of the Medicare program and to ameliorate the negative consequences of over- and undervalued services, such an effort may encounter several barriers. Collecting and using timely and accurate data in the development and refinement of the fees is costly, time consuming, and controversial among some stakeholders.

SESSION

In this Forum session, speakers discussed the data underlying Medicare's physician fees and described and assessed efforts to improve the accuracy of those fees over time. **Stephen Zuckerman, PhD**, senior fellow at the Urban Institute, provided an overview of the resource-based relative value scale (RBRVS), including sources of data to develop and revise work and practice expense relative value units (RVUs), and concerns about codes identified for review and data sources. **Jonathan Blum**, deputy administrator and director of the

Center for Medicare at the Centers for Medicare & Medicaid Services (CMS), discussed CMS's role in the work and practice expense RVU update process as well as changes CMS has made and plans to make to its processes and data. **Barbara Levy, MD**, chair, American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) discussed the RUC's processes and the data the RUC uses to develop its value recommendations. **John Goodson, MD**, associate professor of medicine at Harvard Medical School, discussed the RVU update process with specific focus on the valuation of primary care services in the payment system and potential improvements that could be made to the process and the data for updating the RVUs.

KEY QUESTIONS

- What are the current sources of data underlying the work and practice expense RVUs? How could they be improved further? How are data elements such as physician time validated? How can this be improved?
- How does the RUC review services? What data does it consider in its valuation of services? How have CMS and the RUC changed their processes and data for updating work and practice expense RVUs over time?
- Recently CMS accepted a smaller share of the RUC's work value recommendation than it had traditionally accepted. What was the reason for this? What were the magnitudes of the adjustments that CMS made to the RUC's recommended values? Where did CMS obtain the data to make those adjustments?
- What are the possible options for CMS to collect data on service volume and work time to establish more accurate work and practice expense values and validate the RVUs?
- Are primary care physicians underrepresented on the RUC? Would additional primary care representation lead to more accurate estimates of physician time? Better identification of over-valued services?

ENDNOTES

1. For more detailed information about the process and the data to update the physician fee schedule's RVUs see Laura Dummit, "Medicare Physician Fees: The Data Behind the Numbers," National Health Policy Forum, Issue Brief No. 838, July 22, 2010, available at www.nhpf.org/library/details.cfm/2812.

2. Dummit, "Medicare Physician Fees," pp. 4–10.

3. Changes to RVUs resulting from addition of new services to the fee schedule or adjustments to the RVUs of existing services must maintain budget neutrality across the entire fee schedule. This means that changes increase or decrease spending by more than $20 million. As a result of this requirement, CMS must adjust the RVUs of other services when new services are added or existing services are adjusted. Budget neutrality does not restrict increases in Medicare spending for physician services—rising volume and service intensity continue to increase Medicare spending—but it constrains the value of individual services.

4. American Medical Association, "The RVS Update Committee," available at www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-resource-based-relative-value-scale/the-rvs-update-committee.page?.

5. Sheri Porter, "AAFP Addresses RUC Subcommittee Regarding Changes the Academy Seeks," AAFP News Now, September 26, 2011, available at www.aafp.org/online/en/home/publications/news/news-now/practice-professional-issues/20110926goertztoruc.html.

6. Charles Fiegl, "RUC adds 2 seats for primary care," American Medical News, February 13, 2012, available at www.ama-assn.org/amednews/2012/02/13/gvsa0213.htm.

7. Patient Protection and Affordable Care Act (PPACA), Section 3134, p. 356, available at http://docs.house.gov/energycommerce/ppacacon.pdf.

8. Federal Register, vol. 76, no. 228, November 28, 2011.

9. PPACA, p. 357.

10. Medicare Payment Advisory Commission, "Moving Forward From the Sustainable Growth Rate System," letter to the Chairs and Ranking Members of the Senate Committee Finance, the House Committee on Ways and Means, and the House Committee on Energy and Commerce, October 14, 2011, available at www.medpac.gov/documents/10142011_medpac_sgr_letter.pdf.

11. Dummit, "Medicare Physician Fees," p. 10.