

April 6, 2011

The Honorable John Boehner
Speaker
U.S. House of Representatives
H-232 Capitol Building
Washington, D.C. 20515

Dear Speaker Boehner:

On behalf of our physician members who care for the full range of patient needs, the undersigned organizations write to respond to comments made during the March 15, 2011 hearing before the Ways and Means Subcommittee on Health to discuss the Medicare Payment Advisory Commission (MedPAC) March 2011 *Report to the Congress: Medicare Payment Policy* and to share concerns regarding the “Medicare Physician Payment Transparency and Assessment Act”, recently introduced by Representative Jim McDermott. Specifically, we want to address the apparent misconceptions about the composition and role of the American Medical Association’s Relative Value Update Committee (RUC).

The RUC is a multispecialty physician expert panel convened by the AMA with the support and cooperation of the physician and health care practitioner specialty societies who petition the government to provide a fair and equitable system of reimbursement for physician services. In addition to annual updates reflecting changes in Current Procedural Terminology (CPT), Section 1848(C)2(B) of the Omnibus Budget Reconciliation Act of 1990 requires the Centers for Medicare and Medicaid Services (CMS) to comprehensively review all relative values at least every five years and make any needed adjustments. The success of the RUC’s role in the annual updates led CMS to seek assistance from the RUC for each of the three Five-Year-Review processes. CMS participates in every RUC meeting. After each review is completed, the Secretary of Health and Human Services and CMS review the RUC’s recommendations and will then accept, modify, or reject any of the recommendations.

Given the Secretary and CMS’ current authority to alter any recommendations made by the RUC and their unsuccessful prior attempts at using contractors, we believe the concerns raised by Subcommittee members are unfounded and the legislation introduced by Representative McDermott is unnecessary. In the late 1990s, CMS used a contractor to develop practice expense inputs for all physician services and when the process failed, the RUC stepped in to develop a new process with uniform standards and re-reviewed every service and cost input resulting in the redistribution of practice expense payments to primary care. Another CMS contractor hired to obtain the overall practice costs of each specialty could not fulfill its contract and, in 2007, CMS relied on the AMA and national specialty societies to collect the cost information. In addition, the RUC assumed the activity of identifying potentially misvalued codes, when CMS, using contractors, failed in its attempt. To date, the RUC has identified more than 900 services and redistributed more than \$1.5 billion.

One of the common criticisms of the RUC has been a purported bias to non-primary care specialties. However, it is important to note that the RUC does not review “primary care” or any specific specialty in terms of relative value. Rather, it reviews the relative value of individual services that physicians perform – regardless of specialty. Even as Medicare payments for many physician services have steadily declined over the past two decades, the RUC has taken significant steps to improve reimbursement for services that are performed by primary care including:

- The RUC review of services in 1995, which included recommended increases for evaluation and management services, resulted in a shift of \$2.7 billion and net increases for family practice and

internal medicine of 2.0 percent to 2.5 percent. Surgical specialties saw net decreases ranging from 1.0 percent to 5.5 percent.

- The third five-year review of work in 2005 resulted in the shifting of more than \$4 billion to evaluation and management (E & M) codes—which are largely provided by primary care practitioners—from other physician services in the 2007 Medicare Physician Fee Schedule (MPFS).
- The third five-year review also resulted in a 37 percent increase in the work values associated with an intermediate office visit (CPT 99213), the most frequently billed Medicare physician service for family practice and internal medicine physicians.
- Between 2006 and 2011, while Medicare payments for many physician services were reduced from 2006 levels for non-primary care physicians, Medicare payments to primary care have increased by 22.5 percent according to MedPAC's most recent report.
- Of the 22.5 percent increase to primary care, only 2.9 percent of that increase resulted from annual Medicare payment updates, while 19.6 percentage points were a result of the recommendations made by the RUC. This includes increases in preventive services such as the increase in immunization administration.

In addition, we firmly believe that the RUC has provided a reasonable venue in which the primary care community has successfully participated in discussions of the needs of the primary care community and what would best serve the interests of patients. Of note, each time a primary care organization has asked the RUC to assist and evaluate their requests, the RUC has, with few exceptions, provided the changes. For example:

- While not yet implemented by CMS, in addition to the 22.5 percent increase (of which non-primary care physicians have been deprived), the RUC has valued medical home payment.
- The RUC provided a value for observational care which is principally provided by primary care.
- The RUC has also valued telephone and team management services.

While no payment process is flawless, our organizations strongly believe the RUC exists to provide relative valuation of medical services. No other entity has the expertise to decide if a service provided is *relatively* more complex, *relatively* more intense, or *relatively* more risky than the collective deliberative panel of the RUC.

Some, including MedPAC, have suggested an additional RUC-like panel, which would include economists and lay-persons in addition to physicians, to make recommendations regarding particular physician services that are perceived to be overvalued. We question the value of creating another panel and argue that this would not only be duplicative, but would add yet another bureaucratic layer to an already complicated process. In addition, the Secretary and CMS already enjoy considerable authority regarding the recommendations issued by the RUC and currently have the authority and ability to obtain input from economists and other individuals.

The strength of the RUC is that the committee is convened by and comprised of physicians with additional representation by non-physician health care practitioners. Our members and our organizations are dedicated to improving the quality of outcomes for patients, and our numerous efforts through the AMA Physician Consortium for Performance Improvement (PCPI), physician-led databases and registries, and other quality initiatives are bearing fruit and improving outcomes for patients of all ages. With the authority that the Secretary and CMS already possess to alter the RUC's recommendations, we believe that the inclusion of additional purported experts, who are unfamiliar with clinical practice and the potential implications for patients, would only undermine a process that is, in our estimation, the best available for the reasons cited above.

We greatly appreciate your dedication to the challenges facing America's physicians and the health of all Americans and believe that finding physician-led solutions in Medicare and beyond are essential. We are confident that the Relative Value Update Committee has not only shown the ability to face these challenges, but understands the relative value of all physician services, including those of our esteemed primary care colleagues, for whom the RUC has shown consistent support.

As you consider solutions to improve Medicare's payment system, please know that we continue to work diligently to not only increase the quality and value of the care our patients receive, but to find meaningful and lasting policy solutions that will not only maintain but improve Americans' access to quality care as well.

Sincerely,

American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Osteopathic Surgeons
American College of Radiology
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Pediatric Surgical Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Metabolic and Bariatric Surgery
American Society for Radiation Oncology
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of General Surgeons
American Society of Neuroradiology
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Thoracic Society
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons

Heart Rhythm Society
Infectious Diseases Society of America
North American Spine Society
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Gynecologic Oncology
Society of Interventional Radiology
The Society of Thoracic Surgeons