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September 11, 2017

Seema Verma
Administrator, Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS–1676–P; Docket ID: CMS-2017-009; RIN: 0938-AT02

Dear Ms. Verma:

Thank you for the opportunity to comment on the proposed rule, *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program*. Many features of the notice of proposed rulemaking (NPRM) are important, but here we focus on one issue of grave concern: CMS's proposal to "shift [its] approach" to physician payment rates. Accepting practitioner calls to "rely more heavily on RUC-recommended values," the NPRM states a policy of "generally propos[ing] RUC-recommended work RVUs [Relative Value Units] for new, revised, and potentially misvalued codes."[1] The proposed rule thus accepts 262 out of 263 recommendations from the American Medical Association's RVS Update Committee (RUC) for 2018 work RVUs.[2] This 99.6% agreement rate is 30 percentage points higher than the 69% rate reported by the Government Accountability Office (GAO) in 2015,[3] reflecting CMS's dramatic change in policy. (The relevant language from the NPRM is reproduced below.)

We urge the Administration to reject this proposed policy of near-absolute deference to the RUC. Instead, CMS should actively supervise and take responsibility for setting physician payments based on reliable, objective evidence. This will require additional CMS staff and data-gathering resources. Further detailed guidance has been offered by the Medicare Payment Advisory Commission (MedPAC), among others.

Medicare RVUs are critically important. They directly determine Medicare fee schedule payments, which in 2015 totaled nearly $90 billion, but they also form the basis of fee schedules for many private insurers and other public programs, including Medicaid. Even alternative payment models (APMs) typically rest on a foundation of fee-for-service valuation—for example, in determining the baseline to which APM costs are compared.

It is no exaggeration to describe Medicare physician payment rates as a core feature of American health care financing. Their effects on consumers are thus profound. Both for Medicare beneficiaries and others, the current imbalance between payment for specialty and primary care, driven in significant part by Medicare fee schedules, greatly undermines consumers' access to essential primary care services. Higher costs also directly affect consumers, whether through increased Part B copayments or higher premiums for individual health insurance.

It is therefore troubling that Medicare payment rates are often based on poorly-evidenced recommendations from the very physician specialty groups whose livelihoods are directly at stake. Illustrating serious shortfalls in the data on which the RUC bases its recommendation, GAO determined that the median response rate among the RUC's physician surveys for payment year 2015 was only 2.2 percent. GAO concluded that "low response rates, low total number of responses, and large ranges in responses … may undermine the accuracy of the RUC's recommendations." Even the NPRM itself observes the continued validity of "concerns similar to those we have recognized in prior years," including an example in which the RUC would base nationwide payment rates on survey answers from exactly 20 physicians—a number well "below the threshold typically required for submission of a survey."[4]

GAO also noted that "the physicians who serve Medicare beneficiaries may have conflicts of interest when making relative value recommendations." Finding that, despite safeguards, the RUC's recommendations

FamiliesUSA.org
1225 New York Avenue, NW, Suite 800
Washington, DC 20005
main 202-628-3030 / fax 202-347-2417

"may be undermined by data weaknesses and weaknesses in its process due to potential conflicts of interest," GAO concluded that "the extent to which CMS does not draw independent conclusions, and instead relies on RUC recommendations for service valuations, presents a challenge for ensuring the accuracy of Medicare payment rates for physicians' services." CMS concurred with the resulting GAO recommendations.[5]

For more than a decade, MedPAC has sounded similar warnings. In 2006, MedPAC reported, "CMS relies too heavily on physician specialty societies to identify services that are misvalued and to provide supporting evidence,"[6] expressing concerns about "disparities in remuneration between primary and specialty care, and the implications of those disparities for the future of the physician workforce." MedPAC's most recent annual reports repeatedly declare that the Medicare fee schedule "includes mispriced services [that] cause an income disparity between primary care and specialty physicians."[7] The March 2015 report accordingly urged that "the imbalance in payment between primary care and specialty care must be corrected to ensure adequate beneficiary access to these services and to support the role of primary care in delivery system reform."[8]

MedPAC's most recent report, issued in March 2017, continues the Commission's longstanding push for CMS to exercise more independent review of RUC recommendations, not less: "Validation of the fee schedule's RVUs can help correct the fee schedule's inaccuracies and ensure that physicians at the high end of the compensation scale are not overcompensated. CMS has a statutory mandate and resources to validate RVUs, and the Commission has provided CMS with ideas for how to do so."

The statutory mandate referenced by the Commission is acknowledged by the NPRM itself: "[Social Security Act] Section 1848(c)(2)(K) … requires the Secretary … to review and make appropriate adjustments to the relative values for [potentially misvalued] services. Section 1848(c)(2)(L) … requires the Secretary to develop a process to validate the RVUs … and to make appropriate adjustments." Rather than remedy past limitations in CMS's compliance with the Medicare statute, the NPRM moves in the opposite direction to flatly ignore clear Congressional directives.

In justifying this new policy, the NPRM disregards the clear consensus of expert opinion.[9] Instead, it argues that "the majority of **practitioners** … would prefer CMS rely more heavily on RUC recommended values…" (Emphasis added) CMS's approach to setting physician payment rates should prioritize beneficiaries' needs over "practitioner preferences." Also meriting consideration are the interests of both taxpayers and the many stakeholders harmed by CMS's misevaluations within the Medicare Physician Fee Schedule. These factors demand a strengthened CMS role exercising independent judgment in setting payment rates, given CMS's statutory mandate[10] and the RUC's well-documented limitations and inherent potential for conflicts of interest. CMS should reject the NPRM's proposal for almost complete deference to the RUC, instead providing strong, independent review.

Sincerely,

Families USA

Relevant NPRM language[11]

Several stakeholders, including the RUC, in general have objected to our use of these methodologies and deemed our actions in adjusting the recommended work RVUs as inappropriate; other stakeholders have also expressed concerns with CMS refinements to RUC recommended values in general. .. In the CY 2017 PFS proposed rule, we requested comments regarding potential alternatives to making adjustments…; however, we did not receive any specific potential alternatives as requested.

In developing proposed values for new, revised, and potentially misvalued codes for CY 2018, we considered the lack of alternative approaches to making the adjustments, especially since many stakeholders have routinely urged us to propose and finalize the RUC recommended values. We also considered the RUC's consistent reassurance that these kinds of concerns (regarding changes in time, for example) had already been considered, and either incorporated or dismissed, as part of the development of their recommended values. These have led us to shift our approach to reviewing RUC recommendations, especially as we believe that the majority of practitioners paid under the PFS, though not necessarily those in any particular specialty, would prefer CMS rely more heavily on RUC recommended values in establishing payment rates under the PFS.

For CY 2018, we have generally proposed RUC-recommended work RVUs for new, revised, and potentially misvalued codes. We are proposing these values based on our understanding that the RUC generally considers the kinds of concerns we have historically raised regarding appropriate valuation of work RVUs. During our review of these recommended values, however, we identified some concerns similar to those we have recognized in prior years. Given the relative nature of the PFS and our obligation to ensure that the RVUs reflect relative resource use, we have included descriptions of potential approaches we might have taken in developing work RVUs that differ from the RUC recommended values. We are seeking comment on both the RUC-recommended values as well as the alternatives considered.

[1] CMS. July 21, 2017. 82 *Federal Register* 33950, 33987.

[2] CMS, op cit. 82 *Federal Register* at 34014-34022.

[3] GAO. May 2015. *Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy*. GAO-15-434.

[4] CMS, op cit. 82 *Federal Register* at 33993, 33987.

[5] The only area of disagreement involved GAO's recommendation for increased use of formal rulemaking.

[6] MedPAC. March 2006. *Report to the Congress: Medicare Payment Policy*.

[7] E.g., MedPAC. March 2017. *Report to the Congress: Medicare Payment Policy;* MedPAC. March 2015. *Report to the Congress: Medicare Payment Policy*.

[8] In one compelling example, the 2015 report observed that that orthopedic specialists appeared to be paid based on "inflated time estimates" that exceeded practitioners' actual level of effort by 92 percent.

[9] The GAO and MedPAC findings noted earlier are consistent with much other evidence and many other recommendations. Illustrating the latter, the National Commission on Physician Payment Reform concluded as follows: "CMS has a statutory responsibility to ensure that the relative values it adopts are accurate and therefore it should develop additional open, evidence-based, and expert processes beyond the recommendations of the RUC to validate the data and methods it uses to establish and update relative values." *Report of the National Commission on Physician Payment Reform,* March 2013. Illustrating the former, see, e.g., Miriam J. Laugesen, Roy Wada and Eric M. Chen. May 2012. "In Setting Doctors' Medicare Fees, CMS Almost Always Accepts The Relative Value Update Panel's Advice On Work Values." *Health Affairs* 31(5):965-972; Christine A. Sinsky and David C. Dugdale. 2013. "Medicare Payment for Cognitive vs Procedural Care: Minding the Gap." *JAMA Intern Med.* 173(18):1733-1737; Miriam J. Laugesen. 2016. *Fixing Medical Prices: How Physicians are Paid*. Cambridge: Harvard University Press.

[10] See, e.g., Social Security Act §§1848(c)(2)(K)(iii), (L), (M), and (N).

[11] CMS, op cit. 82 *Federal Register* at 33987.