

AMA/Specialty Society RVS Update Committee

Pending Recommendations to the Centers for Medicare and Medicaid Services to Improve the Resource-Based Relative Value Scale

- **Eliminate the work neutrality adjuster and re-establish long standing CMS policy to apply all budget neutrality adjustments to the conversion factor.** *The RUC recommended more than \$4 billion in increases to the work relative values for Evaluation and Management services. However, the full impact of these improved payments to E/M was diluted by CMS's decision to apply a -10.1% work adjuster to all physician services, including E/M. This work adjuster methodology is favorable to services that obtain a greater proportion of payment from practice expenses (imaging, diagnostic tests, etc) and unfavorable to services where payment is largely derived from face-to-face time with patients. 75 specialty societies signed-on to a letter urging CMS to apply the budget neutrality adjustment to the conversion factor. The RUC convened a meeting with CMS leadership in October 2006 to implore the agency to apply the adjustment to the conversion factor. Unfortunately, CMS nonetheless implemented the work adjuster on January 1, 2007.*
- **CMS should assume a higher equipment utilization rate for all equipment, providing an opportunity to specialties to provide data to support lower utilization rates, if appropriate, based on clinical or geographic considerations.** *When CMS initially proposed the practice expense methodology, the agency utilized data from the Abt Associates to assign an equipment utilization rate (assumed percentage of time the equipment would be in use in an office) of 70%. After the medical profession raised concerns with this assumption, CMS used a lower utilization rate (50%), despite the lack of any actual data to support it. The RUC has repeatedly told CMS "we were wrong" and urged the agency to reinstate a higher rate, leaving open the ability to appeal if specialties provide actual data to justify a lower rate. MedPAC staff conducted a survey of CT and MRI only that indicated that a 50% utilization rate for those equipment items was too low. An increase in the utilization rate would redistribute practice expense relative values to other services that do not rely on expensive equipment.*
- **CMS should adjust the 11% cost of capital rate to a market competitive rate.** *CMS currently utilizes an interest rate of 11% in pricing medical equipment. This rate has not been reviewed or modified since 1998. Like the equipment utilization discussion above, a decrease in the cost of capital rate would redistribute practice expense relative values to other services that do not rely on expensive equipment.*
- **CMS should review the pricing of high cost medical supplies on an annual basis.** *The RUC has expressed concern that the pricing for high cost disposable medical supplies (priced at or above \$200) is not frequently updated. The RUC has recommended that these supplies be separately reported with J codes or individually identified within the payment bundle and then be re-priced on an annual basis.*

- **CMS should work with the AMA and other health professional organizations to conduct a multi-specialty survey effort to ensure that all practice expense payment is based on consistently obtained timely data.** *CMS is currently utilizing practice cost data from 1995-1999 surveys conducted by the AMA's Center for Health Policy Research, adjusted to 2005 dollars for the majority of specialty societies (including internal medicine, pediatrics, and family medicine). CMS has accepted more recent data from 13 Medicare specialties (eg, diagnostic testing facilities, radiology, cardiology, and dermatology) and implemented this data into the 2007 practice expense relative values. The AMA is leading an effort to collect consistent, reliable data for all Medicare specialties. CMS has been supportive of this effort. However, data will not be available for CMS consideration until March 2008 for the 2009 MFS.*
- **Improve the valuation for the Welcome to Medicare benefit.** *The RUC has requested that CMS allow the RUC to review the valuation of the initial preventive physical examination.*
- **Consider the establishment of office-based payment rates for services previously performed only in a facility to be a change in regulation and incorporate the resulting costs in the SGR formula.** *Beginning in 2004, the RUC expressed concern that CMS requests to newly price services in the office-setting, when those services are predominately performed in a facility setting, were not adequately captured in the SGR. The RUC contends that this is a change in regulation as the proposed values are published in rulemaking. The RUC is concerned that pricing the services in the office-setting will result in a migration of procedures from the hospital outpatient setting to the physician office, without a corresponding flow of expected MFS spending allowances within the SGR.*
- **Improvements required in the professional liability insurance (PLI) relative value methodology.** *The PLI component of the RBRVS comprises only 4% of the Medicare payment, averaged across all services, on a national level. However, for many specialties in markets with high premium rates (eg, a neurosurgeon in Detroit, Michigan), the PLI component is a substantial percentage of their overall payment. CMS has not responded to several RUC recommendations to improve the PLI determinations. CMS has yet to implement resource-based PLI relative values for the technical component of imaging and diagnostic tests. Currently, CMS PLI payment for the technical component of mammography is at a higher rate than the rate for the physician's interpretation of the mammogram. The PLI payment for a chest x-ray is higher than for a high level office visit.*
- **CMS should modify the definition of physician pre-service time to be consistent with the pre-service definition utilized for the practice expense methodology.** *The RUC has requested that CMS define physician pre-service activities (eg, review of records, communicating with other professionals, etc) to begin the day the decision for surgery is made. Once the definition is final, the RUC plans to recommend standardized pre-service times that would provide consistency across the RBRVS.*