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Inside Job

How an Influential Group of Doctors Exerts Influence Over Medicare Payments to Physicians

Acknowledgments

This report was written by Adam Crowther, Researcher for Public Citizen's Congress Watch division, and edited by Congress Watch Research Director Taylor Lincoln and Congress Watch Director Lisa Gilbert.

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Public Citizen's Congress Watch
215 Pennsylvania Ave. S.E
Washington, D.C. 20003
P: 202-546-4996
F: 202-547-7392
http://www.citizen.org

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> And that was the point where I knew the system had been co-opted … It had become a political process, not a scientific process. And if you don't think it's political, you only have to look at the motivation of why AMA wants this job."
> *--Harvard School of Public Health Professor William Hsaio, commenting on the government's decision to give the American Medical Association authority over the committee that recommends values used in setting Medicare payments.*

The key data point in the formula that is used to set Medicare payment rates is largely determined by a secretive committee that is managed and funded by the American Medical Association ("AMA"), the overarching trade association of physicians.[1] This committee is the AMA's Relative Value Scale Update Committee (commonly referred to as the "RUC"), whose recommendations to the Centers for Medicare and Medicaid Services ("CMS") are a major factor in determining physician payments for each procedure covered by Medicare Part B. This component of Medicare, also known as supplemental insurance, was responsible for $255.1 billion out of $575 billion in payments by the entire Medicare program in 2013.[2] About 75 percent of Medicare Part B funding comes from taxpayers.[3]

The RUC has been accused of overstating many of the factors used to determine a physician payment. In one example, the *Washington Post* reported that a physician was able to bill the government for procedures that would have required him to work an average of 26 hours a day for a year, based on the RUC-influenced data used by CMS.[4] When the RUC has recommended adjusting the values that determine physician payments, it has been more than five times as likely to increase pay for a procedure as decrease it. Although the RUC is not an official federal advisory committee, CMS has historically accepted its recommendations approximately 90 percent of the time, although the rate has decreased somewhat in recent years.[5]

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[1] Peter Whoriskey and Dan Keating, *How a Secretive Panel Uses Data that Distorts Doctors' Pay*, WASHINGTON POST (July 20, 2013), http://wapo.st/1rS6qi7.

[2] Part B covers many services not covered by Medicare Part A, or hospital insurance. See also *The Facts on Medicare Spending and Financing*, KAISER FAMILY FOUNDATION (viewed September 11, 2014), http://bit.ly/1pchvq4.

[3] *The Facts on Medicare Spending and Financing*, KAISER FAMILY FOUNDATION (viewed September 11, 2014), http://bit.ly/1pchvq4.

[4] Peter Whoriskey and Dan Keating, *How a Secretive Panel Uses Data that Distorts Doctors' Pay*, WASHINGTON POST (July 20, 2013), http://wapo.st/1rS6qi7.

[5] Miriam J. Laugesen, Roy Wada, and Eric M. Chen, *In Setting Doctors' Medicare Fees, CMS Almost Always Accepts the Relative Value Update Panel's Advice on Work Values*, 31 HEALTH AFFAIRS 965, 965-972 (2012).

In theory, the total amount spent paid by CMS to physicians participating in Medicare Part B is a fixed pie. In general, if adjusting the underlying framework that determines physician payments is expected to cause an increase or decrease of $20 million in Medicare expenditures, CMS must make adjustments to offset that increase.[6]

The RUC's influence over physician payments extends well beyond Medicare payments because private insurers also use the Medicare payment framework as a baseline for determining their payments.[7] Private insurance companies often set their payments based on the underlying Medicare fee schedule.[8] Because private-sector costs are not limited by an overarching cap, the RUC's upward pressure on per-procedure pay is likely increasing the nation's overall health care bill.

Specialists are overrepresented on the RUC at the expense of primary care physicians. To the extent that the RUC's members are biased towards their own specialties, this results in the overvaluing of specialty procedures at the expense of primary care. Because there are significantly more specialty procedures than primary care procedures, the overvaluation of specialty and procedural services has caused U.S. specialists' pay to rise much more rapidly than primary care physicians since the formation of the RUC.[9]

Higher pay to specialists creates greater incentives for medical students to practice specialty or procedural medicine, resulting in a shortage of primary care physicians. Wait times to see primary care physicians already are much longer than for specialists, and the percentage of primary care physicians accepting new patients is lower than for specialists. The shortage of primary care physicians is likely to grow worse in the coming years.[10]

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[6] 42 C.F.R. 405, 410, 411, et al, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Final Rule, (December 2013).

[7] Brian Klepper, *The RUC, Health Care Finance's Star Chamber, Remains Untouchable*, HEALTH AFFAIRS BLOG (February 1, 2013), http://bit.ly/1Beb7YG.

[8] Elisabeth Rosenthal, *Patients Costs Skyrocket; Specialists' Income Soar*, NEW YORK TIMES (January 18, 2014), http://nyti.ms/1BU4ydg.

[9] Press Release, *McDermott Bill: "Family Doctor for Every Family Act,"* Office of Rep. Jim McDermott (D-Wash.) (March 30, 2011), http://bit.ly/1tRW3hp.

[10] Press Release, *MMS Study Shows Patient Wait Times for Primary Care Still Long*, Massachusetts Medical Society (July 15, 2013), http://bit.ly/1o7cowo. See also *Health Resources and Services Administration Bureau of Health*, PROJECTING THE SUPPLY AND DEMAND FOR PRIMARY CARE PRACTITIONERS THROUGH 2020 2 (2013), http://1.usa.gov/1oVpTi4.

Further, because the RUC is not an official federal advisory committee, it is exempt from federal transparency requirements. Even the codes that serves as the foundation for Medicare Part B payments is owned by the AMA and hidden from public view. Very little information about the procedures associated with the codes is publicly available. This leaves the public in the dark about a process that determines how a significant percentage of their tax dollars are being allocated.

Several former CMS administrators and a prominent public health expert who was influential in developing the current Medicare Part B physician payment system have criticized this arrangement for its self-dealing nature.

The RUC is a "political process, not a scientific process. And if you don't think it's political, you only have to look at the motivation of why AMA wants this job," said William Hsaio, a professor at the Harvard University School of Public Health whose work formed the foundation of the current Medicare Part B physician payment system.[11] That committee's work was performed in an unbiased fashion in which medical specialties were prohibited from wielding influence. The framework developed by Hsaio and other researchers at Harvard was funded by the federal government, which explicitly prohibited medical societies from participating due to potential conflicts of interest. In the end, however, the AMA still gained control over the process.

Because of its influential role in setting health care prices, the function performed by the RUC should be performed by CMS. The work of the CMS or another committee of unbiased experts should be accompanied by greatly enhanced transparency and other safeguards against self-interested decision-making.

Criticisms of the RUC

- Absence of Transparency: Despite its public function, the RUC is exempt from regulations that govern government committees. The RUC's proceedings are conducted behind closed doors and its results and processes are largely hidden from the public.
- Self-Regulating: The RUC is an industry managed, industry funded committee whose recommendations are largely decisive in determining Medicare payments to physicians. Historically, its recommendations are accepted about 90 percent of the time, though the rate has declined slightly in recent years..
- Membership imbalance: The RUC's composition is overwhelmingly stacked in favor of specialists and against primary care givers.
- Effects:
  - The RUC's recommendations contribute to higher Medicare payments to specialists.
  - The RUC's recommendations likely lead to higher costs for privately funded health care services.
  - The RUC's upward pressure on payments to specialists contributes to the shortage of primary care physicians.

[11] Haley Sweetland Edwards, *Special Deal: The Shadowy Cartel of Doctors that Controls Medicare*, WASHINGTON MONTHLY (July/August 2013), http://bit.ly/1vbX1Xr.

I. Background on Medicare's Relative Value-Based Payment System

In 1992, the Health Care Financing Administration ("HCFA") (which became the Centers for Medicare and Medicaid Services in 2001) overhauled its system for paying physicians who treat patients enrolled in Medicare Part B. Prior to 1992, Medicare Part B payments were determined largely through a system in which providers were paid a set amount for each patient they discharged.[12] However, beginning in the 1980s, the HCFA began to explore other payment systems, eventually arriving at a system that would pay physicians per procedure rather than per patient treated.

As part of the transition, the HCFA funded a study examining the feasibility of implementing what is now known as a resource-based relative value system.[13] The study was conducted by Harvard School of Public Health researchers, who worked with the AMA to randomly distribute surveys to members of 33 medical specialty societies.[14] These physicians were unaware that their responses would form the foundation for a new system for physician payments under Medicare Part B. The methodology used to develop the new payment system was transparent and subjected to high levels of academic peer review.[15] The HCFA barred medical specialty societies from administering the study due to potential conflicts of interest.[16]

In 1991, during the transition to the new system, the HCFA received a letter from the AMA in which the organization offered to assume responsibility for maintaining and updating the newly established physician payment system at no cost to the government. The HCFA granted this request, giving the AMA and the newly formed RUC authority over a process from which it was explicitly excluded just a few years before.[17] Some have suggested that the AMA was granted control over this process because President George H.W. Bush was wary of giving a government agency direct

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[12] NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE, MEDICARE FROM THE START TO TODAY (June 1998), http://1.usa.gov/1oc9SVC.

[13] PETER BRAUN AND NANCY MCCALL, RTI INTERNATIONAL, METHODOLOGICAL CONCERNS WITH THE MEDICARE RBRVS PAYMENT SYSTEM AND RECOMMENDATIONS FOR ADDITIONAL STUDY: A REPORT BY STAFF FROM RTI INTERNATIONAL FOR THE MEDICARE PAYMENT ADVISORY COMMISSION 2 (December 2011), http://1.usa.gov/1uEZXab,

[14] *Id.*

[15] *Id.*

[16] *Id.*

[17] *Id.*

control over health care pricing.[18] The AMA spends approximately $7 million each year maintaining the RUC.[19]

[18] Haley Sweetland Edwards, *Special Deal: The Shadowy Cartel of Doctors that Controls Medicare*, WASHINGTON MONTHLY (July/August 2013), http://bit.ly/1vbX1Xr.
[19] Peter Whoriskey and Dan Keating, *How a Secretive Panel Uses Data that Distorts Doctors' Pay*, WASHINGTON POST (July 20, 2013), http://wapo.st/1rS6qi7.

II. Components of a Medicare Part B Physician Payment

The system developed by the Harvard researchers was implemented in 1992. It created three inputs to value each medical service provided by Medicare: physician work, practice expenses, and malpractice expenses (described below). Each service was valued relative to all other services. The rationale was that prices for medical care in a well-functioning market should be based on the value of the resources needed to provide that care.[20]

Work RVUs, which are currently the most heavily weighted of the three components, are designed to capture the relative time and intensity of effort associated with a given procedure. In measuring work RVUs, the RUC considers "the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient" as the primary factors that influence work RVU valuation.[21]

Practice expense RVUs are designed to measure the costs associated with maintaining a medical practice.[22] There are two inputs that determine the value of a practice expense RVU: direct practice expenses and indirect practice expenses. Direct practice expenses concern those for clinical labor, medical supplies, and medical equipment. Indirect practice expenses concern administrative labor, office expenses, and all other expenses.[23] Practice expense RVUs are derived from data collected through an AMA-sponsored survey and through practice-based reporting of expenses.[24]

Malpractice expense relative value units are based on malpractice insurance premium data collected from commercial and physician-owned insurers.[25] These values are generated by CMS without input from the AMA.[26]

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[20] PETER BRAUN AND NANCY MCCALL, RTI INTERNATIONAL, METHODOLOGICAL CONCERNS WITH THE MEDICARE RBRVS PAYMENT SYSTEM AND RECOMMENDATIONS FOR ADDITIONAL STUDY: A REPORT BY STAFF FROM RTI INTERNATIONAL FOR THE MEDICARE PAYMENT ADVISORY COMMISSION 2 (December 2011), http://1.usa.gov/1uEZXab,

[21] *Overview of the RBRVS*, AMERICAN MEDICAL ASSOCIATION (viewed July 29, 2014), http://bit.ly/1zrE3L8.

[22] 42 C.F.R. 405, 410, 411, et al, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Final Rule, (December 2013).

[23] *Id*.

[24] *Id*.

[25] *Id*.

Table 1: Components of a Relative Value Unit, the Foundation for a Physician Payment under Medicare Part B, Calendar Year 2014

Component	Description	Percentage of Total RVU
Work RVU	Time; technical skill; physical effort; mental effort; stress due to patient risk	50.9 percent
Practice Expense RVU	Clinical labor; medical supplies; medical equipment; administrative labor; office expenses; other expenses.	44.8 percent
Malpractice RVU	Costs related to malpractice insurance premiums	4.3 percent

Source: RVS Update Process, American Medical Association 1 (2014).

To determine the total physician payment, the values of these three components are adjusted for geography (called the "geographic cost price index"), added together and multiplied by a CMS-determined conversion factor, to determine the payment rate for a given procedure. [See Figures 1 and 2 below.]

Figure 1: Formula for Determining Physician Payment per Procedure

Physician Payment = [(Work Relative Value Unit * Geographic Adjustment) + (Practice Expense Relative Value Unit * Geographic Adjustment) + (Malpractice Expense Relative Value Unit * Geographic Adjustment)] * CMS-Determined Conversion Factor

For example, code 64755, which refers to an incision of stomach nerves, has work, practice expense, and malpractice RVU values of 15.05, 7.98, and 3.07, respectively. If the procedure were performed in the Washington, D.C., area, the geographic adjustments for work, practice expense, and malpractice expense, would be 1.05, 1.202, and 1.205, respectively. For calendar year 2014, the conversation factor is $35.8228.[27]

Washington, D.C., physicians would be paid $1,042 for administering this procedure, as shown in Figure 2:

[26] *AMA Specialty Society Relative Value Scale Update Committee*, AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS (viewed July 31, 2014), http://bit.ly/1k9eGtO.

[27] *The Medicare Physician Payment Schedule*, AMERICAN MEDICAL ASSOCIATION (viewed July 28, 2014), http://bit.ly/1rYoaYU.

Figure 2: Steps for Determining Physician Payment for Code 64755 (Incision of Stomach Nerves)

❶ *Determine Geographically Adjusted Relative Value Units for Work, Practice and Malpractice*						❷ *Add Adjusted Relative Value Units and Multiply by Conversion Factor*				
Component	**Relative Value Unit**		**Geographic Adjustment**		**Geographically Adjusted Relative Value Units**	**Geographically Adjusted Relative Value Units**		**Conversion Factor**		**Payment**
Work	15.05	x	1.05	=	15.8025	15.8025				
Practice	7.98	x	1.202	=	9.59196	9.59196				
Malpractice	3.07	x	1.205	=	3.69935	3.69935				
						= 29.09381	x	$35.8228	=	**$1,042.22**

The RUC is primarily responsible for recommending work RVUs for new, revised, or potentially misvalued codes. These codes, known as Current Procedural Terminology codes ("CPTs") are owned by the AMA. Medicare uses a coding a system based on the AMA codes, but does not release detailed information about the codes themselves.[28]

[28] *Overview of the RBRVS*, AMERICAN MEDICAL ASSOCIATION (viewed July 29, 2014), http://bit.ly/1zrE3L8. See also Press Release, Centers for Medicare and Medicaid Services, *New CMS Coding Changes Will Help Beneficiaries* (October 6, 2004), http://go.cms.gov/1l7f8Uu.

"The idea that $100 billion in federal spending is based on fixed prices that go through an industry trade association in a process that is not open to the public is pretty wild."
--Former CMS Administrator Thomas Scully

III. Criticisms of the RUC

Criticisms of the RUC can be divided into three categories: its lack of transparency, biased recommendations stemming from its self-regulatory status, and allegations that its role in inflating costs for specialized procedures has contributed to the shortage of primary care physicians.

RUC Proceedings and Results Are Not Readily Available to the Public

The process through which medical services are valued by the RUC is challenging to understand, in part because of its complexity but also because of a lack of transparency on behalf of the AMA. The RUC has enormous power in setting health care prices, but most of its proceedings occur behind closed doors and without public scrutiny. Minutes from each of the RUC's three annual meetings are not made publicly available. Additionally, when the RUC votes each spring to assign work RVU values to CPT codes, the voting results are not released to the public. In what was a relatively recent change, the RUC started disclosing the vote totals, but they are only accessible to those who have an AMA account and only a year after the votes occur. This and most of the AMA's documentation about the RUC and its proceedings require an account, which can be acquired on the AMA's website by anybody possessing an e-mail address.

One critical piece of information that is not disclosed to anybody (including RUC members) is any indication of how each member of the RUC voted. (A list of the vote totals from the RUC's 2013 meeting can be found in the Appendix.) Because of its unofficial status, the RUC is exempt from rules governing official federal advisory committees.[29]

In 2011, a group of Georgia primary care physicians brought a lawsuit against the U.S. Department of Health and Human Services over its relationship with the AMA and the RUC process. In *Fischer v. Berwick,* the plaintiffs argued that because of the rate at which CMS accepted the RUC's recommendations, the RUC should be regulated under the Federal Advisory Committee Act ("FACA"). The FACA imposes

[29] Federal Advisory Committee Act, 5 U.S.C. §1-10 (2012).

organizational and procedural requirements on committees that provide advice to the federal government, including requirements that the committees remain unbiased, open their meetings to the public, and provide records of their meetings and reports. The law applies to advisory committees "established or utilized" by federal agencies.[30] The plaintiffs argued that the RUC was operating as a *de facto* advisory committee to the federal government, and therefore its proceedings should be subject to greater levels of transparency and accountability. The case was dismissed on jurisdictional grounds.

The Self-Regulation Authority Granted to the RUC Fails to Ensure Unbiased Recommendations

After the RUC votes, it sends its recommendations to CMS. CMS is not required to accept the RUC's recommendations. In fact, the RUC is insistent that its role in the process is only to exercise its right to petition the government.[31] However, studies have demonstrated that CMS accepts RUC recommendations at overwhelmingly high rates. A 2012 article in *Health Affairs* reported that between 1994 and 2010, CMS accepted the RUC-recommended work RVU values nearly 90 percent of the time.[32]

The degree to which CMS accepts the RUC-recommended values has contributed to the belief that the RUC has become a self-regulating industry group. Two additional but related drivers of this criticism are how the RUC collects its data and the results of the RUC's reviews of new, revised, and potentially misvalued codes.

Time Values Submitted by Physicians to the RUC Often Are Vastly Inflated

The RUC's process for collecting the physician time data that drives work RVU valuations is controversial. The time value assigned to a given procedure is derived from estimates provided to the RUC from surveys that are administered by medical specialty societies. Physicians are aware that their survey responses will have direct implications for their payment under Medicare.

One unnamed specialist group's survey, reported upon by the *Wall Street Journal*, included language advising that returning the survey was "important to you and other physicians because these values determine the rate at which Medicare and

[30] *Id*.

[31] *The RVS Update Committee*, AMERICAN MEDICAL ASSOCIATION (viewed July 28, 2014), http://bit.ly/1nRbdiQ.

[32] Miriam J. Laugesen, Roy Wada, and Eric M. Chen, *In Setting Doctors' Medicare Fees, CMS Almost Always Accepts the Relative Value Update Panel's Advice on Work Values*, 31 HEALTH AFFAIRS 965, 965-972 (2012).

other payers reimburse for procedures."[33] This stands in stark contrast to how the first round of data collection that was conducted by the Harvard researchers. Those surveys were distributed to a random sample of physicians who had identified themselves as members of a specialty but were not necessarily members of the relevant specialty society or the AMA.[34]

Several analyses of Medicare data have revealed that time values submitted by physicians are often inflated. A 2013 story in the *Washington Post* revealed that time estimates for colonoscopies were sometimes inflated by as much as 100 percent.[35] In one example, the *Washington Post* reported on a physician who was able to bill the government for procedures that would have required him to work an average of 26 hours a day for a year, based on the RUC-influenced values used by CMS. The doctor, in reality, worked only nine to 10 hours per day.[36]

A review by the *Wall Street Journal* revealed that the time value used for carpal tunnel surgery was overestimated by between 28 and 32 percent.[37] A 2006 study by RTI International, a think tank, used surgery logs to compare RUC-reported times to actual time needed to perform the procedure. The researchers discovered that the RUC-reported times were longer by as little as 30 minutes and as much as two hours.[38]

The RUC Process for Evaluating New, Revised, and Potentially Misvalued Codes Produces Highly Skewed Results

Whether due to its evaluations of how much time it takes to complete a procedure or other less quantifiable factors that make up the work component of the relative value formula, results of the RUCs recommendations in reviewing codes suggest that it is not a fair arbiter.

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[33] Anna Wilde Mathews and Tom McGinty, *Physician Panel Prescribes the Fees Paid by Medicare*, WALL STREET JOURNAL (October 26, 2010), http://on.wsj.com/1mV1nIj.

[34] PETER BRAUN AND NANCY MCCALL, RTI INTERNATIONAL, METHODOLOGICAL CONCERNS WITH THE MEDICARE RBRVS PAYMENT SYSTEM AND RECOMMENDATIONS FOR ADDITIONAL STUDY: A REPORT BY STAFF FROM RTI INTERNATIONAL FOR THE MEDICARE PAYMENT ADVISORY COMMISSION 4 (December 2011), http://1.usa.gov/1uEZXab,

[35] Peter Whoriskey and Dan Keating, *How a Secretive Panel Uses Data that Distorts Doctors' Pay*, WASHINGTON POST (July 20, 2013), http://wapo.st/1rS6qi7.

[36] *Id*.

[37] Anna Wilde Mathews and Tom McGinty, *Physician Panel Prescribes the Fees Paid by Medicare*, *Wall Street Journal* (October 26, 2010), http://on.wsj.com/1mV1nIj.

[38] NANCY MCCALL, JERRY CROMWELL AND PETER BRAUN, RTI INTERNATIONAL, VALIDATION OF PHYSICIAN SURVEY ESTIMATES OF SURGICAL TIME USING OPERATING ROOM LOGS (2006), http://bit.ly/XhicbK.

The RUC, at the request of CMS, has evaluated the work RVU values of new, revised, or potentially misvalued codes. New codes are reviewed and assigned work RVU values when the AMA's CPT Editorial Panel has determined that a medical service is different enough from an existing service to warrant an entirely new code. Revised codes are those in which the CPT Editorial Panel has determined that the medical service that corresponds to an existing code has been slightly modified, which prompts a reevaluation of the work RVU. Finally, potentially misvalued codes are those that CMS or the RUC have determined could have values that are no longer consistent with medical practices.

New and revised codes have been reviewed annually since 1992. Potentially misvalued codes were reviewed in five year intervals between 1995 and 2010, and have been reviewed annually in more recent years.

In order to identify potentially misvalued codes, CMS uses a variety of screens and filters, as well as through comments submitted to proposed rule makings. Section 3134 of the Patient Protection and Affordable Care Act outlines several (but not all) of the criteria available to CMS to determine which codes are potentially misvalued. They are:

- Codes (and families of codes as appropriate) for which there has been the fastest growth in use;
- 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 that have not been subject to review since the implementation of the RBRVS;
- And such other codes determined to be appropriate by the Secretary.[39]

Interestingly, Section 3134 also exempts the new criteria from the provisions of the Federal Advisory Committee Act. In 2014, Congress passed the Protecting Access to Medicare Act, which provides additional guidance for determining which codes can

[39] The Patient Protection and Affordable Care Act, H.R. 3950, 111th Congress, Section 3134.

be selected for review. Given advances in medical technology and increased familiarity with existing procedures, a reasonable assumption would be that when potentially misvalued codes are reviewed, the result would be a decrease in work RVU values. However, this has not been the case, either with the annual review process or the five year review process.

Results of Five Year Reviews (1995 to 2010)

Congress passed legislation in 1990 that required CMS to review the newly established relative value units at least every five years.[40] This process was first implemented in 1995, with subsequent reviews taking place in 2000, 2005, and 2010. Codes were reviewed based on public comments submitted to CMS, as well as codes specifically selected by CMS. Over the four reviews, the RUC recommended increasing values five times more frequently than it recommended decreasing values.

During these four reviews, the RUC made recommendations to CMS for more than 3,000 work RVUs. It recommended no change for 1,399, or about 46 percent of codes. The RUC recommended either increasing or decreasing the value of 1,341 codes. Of those 1,341, it recommended increasing the work RVU for 1,133, or more than 84 percent of those that required modification. [Table 2]

Table 2: The RUC's Recommendations to CMS following its Five Year Reviews of Work RVUs, 1995-2010

Year of Review	Total Codes	Increased Values	Percent Increased	Decreased Values	Percent Decreased	No Change	Percent Maintained	Referred to CPT Ed. Panel
1995	1,118	296	26 %e	107	10 %	650	58 %	65
2000	870	469	54 %	27	3 %	311	36 %	63
2005	751	285	38 %	33	4 %	294	39 %	139
2010	290	83	29 %	41	14 %	144	50 %	52
Total	*3,029*	*1,133*	*37 %*	*208*	*7 %*	*1,399*	*46 %*	*319*

Source: RVS Update Process, American Medical Association 12 (2014).

CMS, in turn, has accepted the RUC's recommendations at overwhelming rates. [See Table 3, below.]

[40] *RVS Update Process*, AMERICAN MEDICAL ASSOCIATION 9 (2014).

Table 3: Percentage of RUC-Recommendations Accepted by CMS Following Five Year Reviews, 1995-2010

Year	Percent of RUC Work RVU Recommendations Accepted by CMS
1995	96 %
2000	98 %
2005	97 %
2010	75 %
Total	*92 %*

Source: RVS Update Process, American Medical Association 12 (2014).

Results of Annual Reviews of Misvalued Codes (2012-2014)

Beginning in 2009, CMS, working with the RUC, started reviewing potentially misvalued codes on an annual basis. After the set of codes for review has been established, CMS refers them to the RUC, which then generates its own recommendations for work RVU and time values and sends those values back to CMS. Public Citizen analyzed data from the last three annual reviews, which included RUC-recommendations and CMS-finalized work and time values for calendar years 2012, 2013, and 2014. This analysis revealed several key points.

1. First, CMS continues to accept RUC-recommended work values at high rates, with a three-year average of 65 percent.

2. Second, when CMS does modify a RUC-recommended work RVU, it is much more likely to decrease the RUC value than increase it, suggesting that the RUC's recommendations tend to be inflated. Over the last three annual reviews, CMS elected to change 35 percent of RUC-recommended work values. When it did opt to change the value, CMS lowered the RUC-recommended values more than 90 percent of the time. [Table 4]

3. Third, CMS rarely adjusts the RUC's recommended time values, which are a key component of the work RVU. For 2014, CMS accepted the RUC-recommended time value 97 percent of the time. [Table 5]

Table 4: Results of CMS Action on RUC-Recommended Work RVUs, Annual Reviews of New, Revised, or Potentially Misvalued Codes, 2012-2014

Year	Codes Reviewed[41]	Accept RUC Value	Accept Percentage	Decrease RUC Value	Decrease Percentage	Increase RUC Value	Increase Percentage
2012	169	114	67 %	52	31 %	3	5 %
2013	252	162	64 %	82	33 %	8	9 %
2014	187	117	63 %	67	36 %	3	4 %
Total	*608*	*393*	*65 %*	*201*	*33 %*	*14*	*2 %*

Source: PFS Federal Regulation Notices, Centers for Medicare and Medicaid Services (viewed August 26, 2014), http://go.cms.gov/1onBvFM.

Table 5: Results of CMS Action on RUC-Recommended Time Values, Annual Reviews of Potentially Misvalued Codes, 2012-2014

Year	Total Time Values	Accept RUC Values	Percent of RUC Values Accepted	Adjust RUC Value	Percent of RUC Values Adjusted
2012	164	154	94 %	10	6 %
2013	262	196	75 %	56	21 %
2014	193	187	97 %	6	3 %
Total	*619*	*537*	*87 %*	*72*	*12 %*

Source: PFS Federal Regulation Notices, Centers for Medicare and Medicaid Services (viewed August 26, 2014), http://go.cms.gov/1onBvFM.

> The current payment system "is central to the income problem of primary care physicians."
> *--Bruce Vladeck, Former Administrator of Health Care Financing Administration*

The RUC's Membership Imbalance Contributes to the Shortage of Primary Care Physicians

The RUC has 31 members, 21 of whom are permanent representatives on the committee and represent medical societies. The chairperson, who is appointed by the AMA, has a seat, as do representatives from four AMA committees and the American Osteopathic Association. The remaining four seats rotate between medical societies on a two-year basis.[42] Of the four rotating seats, one is reserved for an

[41] This refers to the number of codes for which CMS either accepted or changed the RUC-recommended value.

[42] *The RVS Update Committee*, AMERICAN MEDICAL ASSOCIATION (viewed July 28, 2014), http://bit.ly/1nRbdiQ.

internal medicine subspecialty and one is reserved for a primary care representative.

Of the RUC's 31 members, 28 are voting members.[43] Depending on the RUC session, primary care representatives on the RUC represent as few as 7 percent of the voting members, even though they are responsible for 44 percent of Medicare-paid office visits.[44] What emerges is a committee that is overwhelmingly dominated by specialists at the expense of primary care physicians.[45]

Many medical experts believe that the degree to which the RUC's membership is skewed towards specialists is one of the driving forces behind the current shortage of primary care physicians.[46] The existing payment system values specialty procedures at much higher rates than it does management and evaluation procedures (management and evaluation codes are those that primary care providers use most frequently). A March 2010 report by the Medicare Payment Advisory Commission discovered that if all physician services were paid under the Medicare Fee Schedule, the average hourly wage for primary care physicians would have been $101 per hour. Surgeons would have been paid at $162 per hour. Radiologists and dermatologists would have been paid at $214 and $193 per hour, respectively. This almost certainly incentivizes medical students to enter specialties rather than primary care.

Since the debut of the RUC, the income gap between primary care physicians and specialists has increased from 61 percent to 89 percent.[47] Many European countries have a broad foundation in primary care; those physicians make up between 70 and

[43] The non-voting members are the chairperson, the AMA's CPT Editorial Panel representative, and the AMA's Practice Expense Review Committee representative.

[44] Press Release, *AAFP Backs Legislation to Make Medicare Payment Process More Transparent, Accurate*, American Academy of Family Physicians (April 5, 2011), http://bit.ly/XERgTg. See also Joe Eaton, *Family Docs Not Ready to Leave AMA Group With Influence Over Medicare Pay*, CENTER FOR PUBLIC INTEGRITY (May 6, 2011), http://bit.ly/XESaio.

[45] The American Academy of Family Physicians and the rotating primary care seat were the two societies that were considered purely primary care for this calculation. Several other medical societies represented on the RUC, including the American College of Physicians, the American Geriatrics Society, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, have members that could practice either primary care or specialty medicine. Therefore, they were not included in determining the minimum number of members of the RUC who represent practice primary care.

[46] John D. Goodson, *Unintended Consequences of the Resource-Based Relative Value Scale Reimbursement*, 298 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2308, 2308-2310 (November 2007).

[47] Press Release, *McDermott Bill: "Family Doctor for Every Family Act,"* Office of Rep. Jim McDermott (D-Wash.) (March 30, 2011), http://bit.ly/1tRW3hp.

80 percent of all practicing physicians.[48] However, in the United States, barely one-third of practicing physicians work mostly in primary care.[49] This makes it difficult for Americans to receive basic care. A 2013 study by the Massachusetts Medical Society revealed that in Massachusetts, the average wait time for a new patient to see a primary care physician was 39 days.[50] Wait times for specialists and the percent of specialists accepting new patients were much lower than for primary care physicians.[51] The shortage is expected to grow. By 2020, the demand for primary care physicians is expected to grow by 14 percent, but the supply is only expected to increase by 8 percent, resulting in a national shortage of more than 20,000 physicians.[52]

> "Evaluation and management services (E/M) provided by primary care physicians have long been undervalued compared to procedural services…Because of this payment disparity, medical students are less likely to choose to specialize and remain in primary care careers."
> --*Statement by the American Academy of Family Physicians*

The American Academy of Family Physicians ("AAFP"), a medical society that represents family doctors, has been vocal in its criticism of the RUC process and its impact on primary care. In a statement to Public Citizen, the AAFP outlined its position on the impact of the RUC on primary care. "Evaluation and management services (E/M) provided by primary care physicians have long been undervalued compared to procedural services," it wrote. "Because of this payment disparity, medical students are less likely to choose to specialize and remain in primary care careers. This payment disparity also makes it difficult for family physicians in practice to invest in practice transformation to the patient-centered medical home model of care and to sustain this improved model of delivering primary care."

Bruce Vladeck, who was administrator of the Health Care Financing Administration (CMS's predecessor agency) under President Clinton highlighted the impact of the RUC and the current payment system for physicians on the shortage of primary care

[48] John D. Goodson, *Unintended Consequences of the Resource-Based Relative Value Scale Reimbursement*, 298 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 2308, 2308-2310 (November 2007).
[49] *The Number of Practicing Primary Care Physicians in the United States*, AGENCY FOR HEALTH CARE RESEARCH AND QUALITY(viewed August 15, 2014), http://1.usa.gov/1oAl4vj.
[50] Press Release, *MMS Study Shows Patient Wait Times for Primary Care Still Long*, Massachusetts Medical Society (July 15, 2013), http://bit.ly/1o7cowo.
[51] *Id.*
[52] *Health Resources and Services Administration Bureau of Health*, PROJECTING THE SUPPLY AND DEMAND FOR PRIMARY CARE PRACTITIONERS THROUGH 2020 2 (2013), http://1.usa.gov/1oVpTi4.

physicians. "To the extent that [the current payment system] continues to over-reward procedural, interventional, technologically intensive services and under-rewards basic primary care services, it exacerbates the already serious and worsening problem we have in our health care system of just having not having enough primary care physicians and too many specialists" he said. The current payment system "is central to the income problem of primary care physicians."[53]

> "Part of the problem is that [the Medicare payment system] not only sets relative Medicare payments, it's used by almost everybody else in the health care system as a way of evaluating the relative worth of physician services."
> --*Bruce Vladeck, Former Administrator of the Health Care Financing Administration*

Health Care Experts Criticize RUC Process

Many experts who have been highly influential in the creation and maintenance of the Medicare payment system are critical of the RUC. William Hsaio, a Harvard professor who helped create the relative value scale, has criticized how the process has evolved. In a 2013 interview, Hsaio lamented that the AMA was permitted to take over the process in 1991. "And that was the point where I knew the system had been co-opted," Hsiao said. "It had become a political process, not a scientific process. And if you don't think it's political, you only have to look at the motivation of why AMA wants this job."[54] When the intellectual foundation for the RVU system was being established in the late 1980s and early 1990s, physician groups, including the AMA, were explicitly excluded from exercising any power over the process.[55]

Thomas Scully, an administrator of the Centers for Medicare and Medicaid Services under President George W. Bush, also has been highly critical of the RUC, and particularly the power the AMA has over the process. "The idea that $100 billion in federal spending is based on fixed prices that go through an industry trade

[53] *Roundtable Discussion on Medicare Physician Payments: Understanding the Past so We Can Envision the Future,* Senate Finance Committee, 112th Congress (2012).
[54] Haley Sweetland Edwards, *Special Deal: The Shadowy Cartel of Doctors that Controls Medicare*, WASHINGTON MONTHLY (July/August 2013), http://bit.ly/1vbX1Xr.
[55] PETER BRAUN AND NANCY MCCALL, RTI INTERNATIONAL, METHODOLOGICAL CONCERNS WITH THE MEDICARE RBRVS PAYMENT SYSTEM AND RECOMMENDATIONS FOR ADDITIONAL STUDY: A REPORT BY STAFF FROM RTI INTERNATIONAL FOR THE MEDICARE PAYMENT ADVISORY COMMISSION 2 (December 2011), http://1.usa.gov/1uEZXab,

association in a process that is not open to the public is pretty wild," Scully said in 2013.[56]

During a March 2012 Senate Finance Committee hearing, Scully joined with three other former CMS administrators, Gail Wilensky, Bruce Vladeck, and Mark McClellan, to criticize the RUC process and call for its reform.[57]

Wilensky, who ran the HCFA under President George H.W. Bush was critical of the RUC system, suggesting that it use better data when determining RVU values. "You could try to refine the relative value scale," she said "A number of people have made suggestions about how to do it, to make it more accurate than it is now, using better data."[58] Mark McClellan, who ran CMS under President George W. Bush, commented that the process is inherently political and therefore biased. "The RUC has taken a lot of criticism for being too political. Anytime you take a fixed pie and you're dividing it up between a bunch of different medical specialties, it's going to get political."[59]

Vladeck said that the RUC process has an inflationary impact on the entire health care system because so many private plans use the Medicare system as a baseline when paying physicians. "Part of the problem is that [the Medicare payment system] not only sets relative Medicare payments, it's used by almost everybody else in the health care system as a way of evaluating the relative worth of physician services, " he said at the March 2012 Senate hearing."[60]

[56] Peter Whoriskey and Dan Keating, *How a Secretive Panel Uses Data that Distorts Doctors' Pay*, WASHINGTON POST (July 20, 2013), http://wapo.st/1rS6qi7.

[57] Brian Klepper, *The RUC, Health Care Finance's Star Chamber, Remains Untouchable*, HEALTH AFFAIRS BLOG (February 1, 2013), http://bit.ly/1Beb7YG.

[58] *Roundtable Discussion on Medicare Physician Payments: Understanding the Past So We Can Envision the Future,* Senate Finance Committee, 112th Congress (2012).

[59] *Roundtable Discussion on Medicare Physician Payments: Understanding the Past So We Can Envision the Future,* Senate Finance Committee, 112th Congress (2012).

[60] *Roundtable Discussion on Medicare Physician Payments: Understanding the Past So We Can Envision the Future,* Senate Finance Committee, 112th Congress (2012).

IV. Policy Solutions

The most important policy change is for CMS to stop relying on the AMA to maintain the existing system for determining the value of Medicare payments to physicians. CMS could achieve this goal in two ways. First, it could assume full control over the process, by bringing it completely under the control of CMS. Second, CMS could create a competitive bidding system wherein contractors would be responsible for maintaining the system. These contractors' should be subjected to higher transparency thresholds than are currently applied to the RUC and be required to make their methodologies and results available to the public. Using contractors to replace the work of the RUC is not unrealistic. CMS recently commissioned a study by the Urban Institute, RTI International, and Social and Scientific Systems Inc., to study the feasibility of developing a process within CMS for validating work RVU values.[61] It was published in 2014.

If CMS does not assert greater control over the current framework for determining physician payments, it should implement several safeguards to improve the process. First, it should require the RUC to become transparent. Any committee responsible for nearly $80 billion in federal spending should open its proceedings and records to the public. Specifically, the RUC should be required to adhere to the standards set forth by the Federal Advisory Committee Act, which applies to committees established or utilized by federal agencies. Making RUC meetings subject to open meetings regulations would increase transparency and accountability.

Second, the composition of the RUC should be altered to more accurately reflect Medicare's stakeholders. Specifically, the RUC should add members that represent consumers, health insurance plans, health systems, and health economists. Additionally, the RUC's composition should more accurately reflect the composition of the physician workforce. This approach already has been proposed by primary care physicians. In a comment to Public Citizen, AAFP laid out several of its key reforms. "The AAFP has long advocated for the reassessment of the composition of the RUC. We would like to see more primary care physicians on the panel, as well as consumers, employers, health care economists and other important stakeholders."

In June 2013, Rep. Jim McDermott (D-Wash.) introduced the Medicare Physician Payment Transparency and Assessment Act of 2013, which was designed to bring

[61] STEPHEN ZUCKERMAN, ROBERT BERENSON, KATIE MERRELL, TYLER OBERLANDER, NANCY MCCALL, REBECCA LEWIS, SUE MITCHELL, MADHU SHRESTHA, PREPARED BY THE URBAN INSTITUTE, SOCIAL AND SCIENTIFIC SYSTEMS, AND RTI INTERNATIONAL FOR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEVELOPMENT OF A MODEL FOR THE VALUATION OF WORK RELATIVE VALUE UNITS (June 2014), http://go.cms.gov/1pUbTRl.

additional transparency to the RUC. McDermott's bill would have required CMS to establish a panel of independent experts that would identify, review, and adjust the values assigned to physician services under Medicare.[62] The RUC could still have an active role in the process, but its reviews would only occur if initiated by the panel established by CMS. All subsequent finds by the RUC would also be reviewed by the panel, which would be subject to the terms of the Federal Advisory Committee Act.

McDermott introduced similar legislation in 2011.[63] In response, 47 medical societies, including many of the specialty societies represented on the RUC, wrote a letter to Speaker of the U.S. House of Representatives John Boehner (R-Ohio) opposing the legislation.[64]

As others have observed, the intensity of physicians' desire to remain in control of this process shows that it is in need of reform.

[62] Press Release, McDermott Introduces the Accuracy in Medicare Physician Payment Act of 2013 to Reform Physician Pay, Office of Rep. Jim McDermott (D-Wash.) (June 2013), http://1.usa.gov/1wo0fUz.

[63] Press Release, McDermott Bill: *"Family Doctor for Every Family Act,"* Office of Rep. Jim McDermott (D-Wash.) (March 30, 2011), http://bit.ly/1tRW3hp.

[64] Letter from Coalition of Medical Societies, to Rep. John Boehner (R-Ohio), Speaker of the House of Representatives (April 6, 2011), http://bit.ly/1scXB58.

Appendix A: Current Members of the RUC

Representative
Chairperson
American Medical Association Representative
CPT Editorial Board Representative
Health Care Professionals Advisory Committee Representative
Practice Expense Review Committee Representative
American Osteopathic Association
American Society of Anesthesiologists
American College of Cardiology
American Academy of Dermatology
American College Emergency Physicians
American Academy of Family Physicians
American College of Surgeons
American Geriatrics Society
Renal Physicians Association*
American College of Physicians
American Academy of Neurology
American Academy of Neurological Surgeons
American College of Obstetricians and Gynecologists
American Society of Clinical Oncology*
American Academy of Ophthalmology
American Academy of Orthopedic Surgeons
American Academy of Otolaryngology – Head and Neck Surgery
College of American Pathologists
American Academy of Pediatrics
American Pediatric Surgical Association*
American Society of Plastic Surgeons
Primary Care Seat*
American Psychiatric Association
American College of Radiology
Society of Thoracic Surgeons
American Urological Association

*Rotating seat
Source: American Medical Association

Appendix B: Frequency of Vote Counts, April 2013 RUC Meeting

Vote Count	Frequency of Count	Percentage of all Votes
28-0	142	66 percent
27-0	1	1 percent
27-1	32	15 percent
26-2	12	6 percent
25-3	5	2 percent
24-3	2	1 percent
24-4	12	6 percent
22-5	1	<1 percent
23-5	5	2 percent
22-6	1	<1 percent
21-7	1	<1 percent
20-8	1	<1 percent
19-9	1	<1 percent

Source: *AMA/Specialty Society Relative Value Update Committee (RUC): Final Vote Release – CPT 2014*, AMERICAN MEDICAL ASSOCIATION (2014).