



## **The American Medical Association/Specialty Society RVS Update Committee's Long History of Improving Payment for Primary Care Services**

Recent concerns regarding primary care workforce issues and resulting comparisons to specialty physician income have led many health policy experts to question the accuracy of the Resource Based Relative Value Scale (RBRVS). As a key advocate for improvements in the RBRVS, the AMA/specialty Society RVS Update Committee, commonly referred to as the "RUC," is erroneously assigned blame for any perceived flaws in this payment system, utilized by Medicare, Medicaid, and private payors. The RUC has actually led the effort to improve primary care relativity within the RBRVS since 1992. The implementation of the RUC recommended improvements have been over-shadowed by a flawed sustainable growth rate (SGR) formula, reluctance by the Centers for Medicare and Medicaid Services (CMS) to adopt several recommendations, and distortions created by private payors in their implementation of the RBRVS. It is critical that policy-makers fully understand the improvements recommended by the RUC, including:

- **Improved Payment for Evaluation and Management (E/M) Services** – The RUC has recommended increases in E/M services each time that the primary care organizations and/or CMS have requested review. However, CMS did not fully implement the RUC recommended increases in E/M values in 1997. The most recent improvements in 2007 were implemented and led to more than \$4 billion in redistribution from surgery and other services to E/M. The intense RUC review did lead to a divisive debate within medicine, that while difficult, was ultimately productive to primary care. Since the inception of the RBRVS, Medicare payment for a mid-level office visit (99213) has increased from \$31 in 1992 to \$70 in 2012. In comparison, payments for cataract surgery (66984) have decreased from \$941 to \$761 and payments for MRI of the lumbar spine (72148) have decreased from \$485 to \$411.
- **Improved Payment for Preventive Services** – The RUC review of many preventive services has led to increased Medicare payment for preventive medicine. The most dramatic improvement, immunization administration payment increases from less than \$4 in 2002 to \$24 in 2012, is a result of years of advocacy by the RUC and the AMA to ensure that the resource-costs required to provide immunizations are recognized. The preventive medicine office visits were also considered under the 4<sup>th</sup> Five-Year Review of the RBRVS and CMS published the RUC recommendations to increase valuation by 15-20% on January 1, 2012. The valuation for a preventive visit to an individual 65 years of age or older is now slightly higher than the payment for the Welcome to Medicare visit. Although Medicare, and many Medicaid plans, have implemented these valuation improvements, primary care physicians continue to report that private payors have been slow to adopt these increases.

- Continued Advocacy Related to Coordination of Care and Medical Home** – The RUC has proposed valuation and separate payment for services to describe care coordination, such as: anticoagulation management, team conferences, patient education, and telephone calls, however CMS has failed to recognize these services as distinct, and therefore, has declined to pay for these services. The RUC has joined with the CPT Editorial Panel to form the Chronic Care Coordination Workgroup (C3W) to identify gaps in description and valuation of care coordination services. CMS has expressed interest in working with the RUC to recognize these physician services. For further information on these efforts, see [www.ama-assn.org/go/carecoordination](http://www.ama-assn.org/go/carecoordination)
- Medical Home** - In May 2008, the RUC submitted comprehensive recommendations to CMS regarding the resources required to provide medical home services. CMS, the American Academy of Family Physicians, and the American College of Physicians all expressed appreciation for the RUC’s unanimous decision to submit robust recommendations for the physician work and practice costs required to serve as a medical home. This specific medical home demonstration was not implemented. Current medical home models pay monthly management rates well below the level that would reflect the resources costs identified by the RUC. The RUC’s recommendations and responses to these efforts are described at [www.ama-assn.org/go/medicalhome](http://www.ama-assn.org/go/medicalhome)
- Improved Practice Expense Payments** – The RUC insisted that Medicare practice expense payments be determined based on consistent data collection efforts, leading to the AMA led Physician Practice Information (PPI) Survey. The RUC support of this effort led CMS to begin implementation of these data in 2010. The RUC also took over responsibility for a failed CMS consultant effort to itemize direct practice expense inputs at the service level, ultimately leading to standardization and redistribution to primary care services. The practice expense and professional liability insurance relative value units for a 99213 have increased 262% since the inception of the RBRVS.
- Redistribution within the RBRVS to Address Misvaluation** – In 2006, the RUC established the Five-Year Identification Workgroup (now referred to as the Relativity Assessment Workgroup) to identify potentially misvalued services using objective mechanisms for reevaluation prior to the next Five-Year Review. The RUC formed this Workgroup in response to criticisms that, despite reducing the work RVUs for nearly 400 services in the past, the process contains “bias in the 5-year review in favor of undervalued codes as compared to overvalued codes.” Since the inception of the Relativity Assessment Workgroup, the Workgroup and CMS have identified over 1,000 services through ten different screening criteria for further review by the RUC. The RUC’s efforts have led to more than \$1.5 billion in redistribution within the Medicare Physician Payment Schedule. The cumulative result of these efforts, the 4 Five-Year Reviews, and other changes to the RBRVS and practice, are reflected in comparing the portion of allowed charges within the MFS from the inception of the RBRVS to 2010:

<b>Medicare MFS Allowed Charges (% of Total)</b>	<b><u>1991</u></b>	<b><u>2010</u></b>
Primary Care and Internal Medicine Specialties	37%	43%
Surgical Specialties	32%	21%
Other Specialties (Radiology, Anesthesiology, etc)	25%	24%
Other Health Care Professionals	06%	12%