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

Primary care physicians play a crucial – and expanding – role in the RVS Update Committee's (RUC) highly technical work. In April 2012, the RUC added an additional seat for Geriatrics and an additional rotating primary care seat to increase the share of primary care physicians represented on the Committee. The Committee's relative value recommendations to CMS also reflect the continued importance of services that all doctors, including primary care physicians, perform. In fact, the RUC has made recommendations to establish values for a broad range of patient-centered services that primary care physicians formerly provided free of charge.

The implementation of such RUC-recommended improvements was overshadowed 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 payers in their implementation of the Resource Based Relative Value Scale (RBRVS). Nevertheless, since 1992, the RUC has led the effort to improve primary care relativity within the RBRVS.

It is crucial 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 $74 in 2018. In comparison, payments for cataract surgery (66984) have decreased from $941 to $656 and payments for MRI of the lumbar spine (72148) have decreased from $485 to $229.

- **Improved Payment for Preventive Services –** The RUC review of many preventive services has led to increased Medicare payments for preventive medicine. The most dramatic improvement, immunization administration payment, increased from less than $4 in 2002 to $21 in 2018, as 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 4th Five-Year Review of the RBRVS and CMS published the RUC recommendations to increase valuation by 15-20% on January 1, 2012.

- **Transitional and Chronic Care Management -** The CPT Editorial Panel developed new codes to describe Transitional Care Management (TCM) and Chronic Care Management (CCM) services to be reported for care coordination provided over a 30-day period. After development of these codes in May 2012, RUC reviewed the physician work and practice costs associated with the provision of these services and submitted its recommendations to CMS in October. On January 1, 2013, Medicare implemented the RUC recommendations and began payment for CPT codes 99495 and 99496 for the care of transitioning patients from a hospital or skilled nursing facility to the home. CMS began Medicare payment for monthly CCM, describing a medical home model of care for the chronically ill, on January 1, 2015. The AMA is hopeful that these new payments will allow physicians to invest in nurses and other infrastructure, which will help reduce emergency room visits and readmission rates.

- **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

- **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 260% 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 more than 2,350 services through 17 different screening criteria for further review by the RUC. The RUC's efforts have led to $5 billion in redistribution within the Medicare Physician Payment Schedule. The cumulative result of these efforts, the four 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 2016:

Medicare MFS Allowed Charges (% of Total)	**1991**	**2016**
Primary Care and Internal Medicine Specialties	37%	44%
Surgical Specialties	32%	20%
Other Specialties (Radiology, Anesthesiology, etc)	25%	23%
Other Health Care Professionals	6%	13%