

August 21, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

Dear Administrator McClellan:

The undersigned organizations appreciate the opportunity to provide our views concerning the Centers for Medicare and Medicaid (CMS) Services' proposed rule on the *Five-Year Review of Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology*, 71 *Fed. Reg.* 37,170 (June 29, 2006). We are writing to express concern regarding the agency's proposal to apply a budget neutrality adjustment to physician work, rather than to the Medicare conversion factor.

Budget Neutrality (p. 37241)

The Omnibus Budget Reconciliation Act of 1989 requires that increases or decreases in relative value units (RVUs) for a year may not cause the amount of expenditures for the year to differ by more than \$20 million from what expenditures would have been in the absence of these changes. To limit the increases in Medicare expenditures as mandated by the statute, CMS has applied various adjustments to the Medicare Physician Payment Schedule, including re-scaling the RVUs, creating a separate "work adjuster," or applying a budget neutrality adjustment to the Medicare conversion factor. CMS has proposed to create a new "work adjuster" to ensure budget neutrality following the implementation of the improved work RVUs from this Five-Year Review of the RBRVS. **Applying budget neutrality to the work RVUs to offset the improvements in E/M and other services is a step backward and we strongly urge CMS to instead apply any necessary adjustments to the conversion factor.**

In 1993 - 1995, CMS achieved budget neutrality by uniformly reducing all work relative values across all services. We strongly objected to using work relative values as a mechanism to preserve budget neutrality. These adjustments to the work relative values caused confusion among the many non-Medicare payers, as well as physician practices,

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that adopt the RBRVS payment system. The constant re-scaling also impeded the process of establishing work RVUs for new and revised services. We have consistently argued that any budget neutrality adjustments deemed necessary should be made to the conversion factor, rather than the work relative values.

In 1997, following the first Five-Year Review of the RBRVS, CMS modified the approach to apply budget neutrality and implemented a separate work adjuster. This approach was short-lived as CMS converted this adjustment to the conversion factor in 1999. CMS later articulated that the creation of the work adjuster was not effective.

“We did not find the work adjuster to be desirable. It added an extra element to the physician fee schedule payment calculation and created confusion and questions among the public who had difficulty using the RVUs to determine a payment amount that matched the amount actually paid by Medicare.” (*Federal Register*, Vol. 68, No. 216, Pg. 63246).

From 1998 to present, CMS has implemented all work neutrality adjustments by adjusting the Medicare conversion factor. CMS does not explain why it proposes to alter this long utilized method and move backward to an approach that the agency itself remarked was inappropriate. In fact, CMS recognizes the current policy on page 37171 of this Proposed Rule, stating that “we must make adjustments to the conversion factors (CFs) to preserve budget neutrality.” We request that CMS consider the history and these additional arguments in its consideration of this issue:

- 1.) Adjusting the conversion factor does not affect the relativity of services reflected in the recommended RVUs. Adjusting the RVUs has the potential to inappropriately affect relativity. If the work RVUs are adjusted as proposed, it will dampen the improvements to the E/M services valuation. CMS has publicly lauded the RUC for recommending these increases to E/M and we would surmise that the agency would want to achieve the full benefit of these improvements.
- 2.) An adjustment in the Medicare conversion factor is preferable because it has less impact on other payers who use the Medicare RVUs. That is, an adjustment in the Medicare conversion factor will not necessarily affect the payment rates of other payers who use the Medicare RVUs and their own conversion factors. However, any adjustment in the RVUs will impact the payment rates of such payers. The payment rates of payers who peg their rates to a percentage of Medicare will be affected regardless. CMS must consider such “ripple effects” as it decides how to adjust for work neutrality.

- 3.) An adjustment to the conversion factor is preferable because it recognizes that budget neutrality is mandated for monetary reasons. Thus, the conversion factor, as the monetary multiplier in the Medicare payment formula, is the most appropriate place to adjust for budget neutrality
- 4.) Applying the work neutrality adjustment to the conversion factor would coincide with CMS' current mission of making the Medicare payment transparent.

As one rationale for applying budget neutrality to work rather than the conversion factor, CMS has pointed out that adjustments for practice expense changes are made within that component rather than applied to the conversion factor. Ultimately, it may be reasonable to apply both work and practice expense budget neutrality adjustments to the conversion factor rather than within the individual components. Before this approach is adopted, however, CMS should make further refinements in its practice expense methodology, including implementation of practice expense data from a recent, consistent, reliable multi-specialty physician practice survey to determine indirect practice expenses.

There is a key difference between the work relative values and the practice expense relative values at this point in the RBRVS. The work relativity is based on a long established methodology of magnitude estimation. Changes in the work relative values from year to year, or in the Five-Year Review, are based on changes in the services performed by physicians (e.g., a patient population that has become more complex; a procedure that requires less time). These changes do not imply that other physician services have become easier, just that CMS cannot afford to pay for the deserved recognition of work. The practice expense portion of the RBRVS payment, however, is still based on a methodology that is in flux. CMS has moved from "bottom-up" to "top-down" to a proposed blended approach. Until the actual method of practice expense relativity is firmly in place, one may not make assumptions regarding specific services. We envision a point in time in which practice expense for individual services are evaluated in a Five-Year Review and at that point, a similar application for budget neutrality would be appropriate.

Finally, applying budget neutrality to the conversion factor rather than work adjuster is critical in light of the imaging cuts mandated by the Deficit Reduction Act of 2005 (DRA). Under this provision, effective January 1, 2007, payment rates for the technical component of imaging services furnished in physicians' offices cannot exceed the payment rate for the same service furnished in a hospital outpatient department. If the budget neutrality adjuster is applied to the work RVUs, payments for all physician services with work RVUs would be reduced, but payments for the technical component of imaging services that are slated to be cut under the DRA will not be affected because these services have practice expense RVUs only, not work RVUs. Because the

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differential in payment between imaging services furnished in physicians' offices versus a hospital outpatient department would not be narrowed, the DRA cuts will ultimately remove more dollars (about \$200 million in 2007, as estimated by the AMA) from the physician payment pool.

If, however, CMS applies the budget neutrality adjuster to the conversion factor, this would reduce payments for all physicians' services equally, including the technical component services, and would narrow the payment differential between imaging services furnished in physicians' offices versus a hospital outpatient department before the DRA provision is applied. Thus, when the DRA cuts are implemented, fewer dollars would be removed from the total Medicare funding for physician services. With physicians facing Medicare payment cuts of about 40% over the next nine years, draining additional money from the system only increases the risk of access problems for elderly and disabled patients and could eventually lead to physician supply problems that jeopardize care to all Americans. It is our firm hope that this Administration will work with Congress to stop the projected 40% cuts. At the very least, budget neutrality adjustments should be designed so as not to make a bad problem even worse.

Sincerely,

American Academy of Dermatology Association
American Academy of Facial, Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Home Care Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Academy of Sleep Medicine
American Association for Thoracic Surgery
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Neuromuscular and Electrodagnostic Medicine
American Association of Oral and Maxillofacial Surgeons
American Association of Orthopaedic Surgeons
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Obstetricians and Gynecologists
American College of Occupational and Environmental Medicine

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American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiology Association
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Geriatrics Society
American Institute of Ultrasound in Medicine
American Medical Association
American Medical Directors Association
American Medical Group Association
American Orthopaedic Foot and Ankle Society
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Rhinologic Society
American Society for Aesthetic Plastic Surgery
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Reproductive Medicine
American Society for Surgery of the Hand
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Breast Disease
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of General Surgeons
American Society of Pediatric Nephrology
American Society of Plastic Surgeons
American Thoracic Society
American Urological Association
Association of American Medical Colleges
Child Neurology Society
College of American Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
Infectious Diseases Society of America
International Spine Intervention Society
Medical Group Management Association

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National Association of Spine Specialists
National Hispanic Medical Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Critical Care Medicine
Society of Gynecologic Oncologists
Society of Hospital Medicine
Society of Interventional Radiology
Society of Thoracic Surgeons
The Endocrine Society