



May 2015

MEDICARE PHYSICIAN PAYMENT RATES

Better Data and Greater Transparency Could Improve Accuracy

Why GAO Did This Study

Payments for Medicare physicians' services totaled about \$70 billion in 2013. CMS sets payment rates for about 7,000 physicians' services primarily on the basis of the relative values assigned to each service. Relative values largely reflect estimates of the physician work and practice expenses needed to provide one service relative to other services.

The Protecting Access to Medicare Act of 2014 included a provision for GAO to study the RUC's process for developing relative value recommendations for CMS. GAO evaluated (1) the RUC's process for recommending relative values for CMS to consider when setting Medicare payment rates; and (2) CMS's process for establishing relative values, including how it uses RUC recommendations. GAO reviewed RUC and CMS documents and applicable statutes and internal control standards, analyzed RUC and CMS data for payment years 2011 through 2015, and interviewed RUC staff and CMS officials.

What GAO Recommends

CMS should better document its process for establishing relative values and develop a process to inform the public of potentially misvalued services identified by the RUC. CMS should also develop a plan for using funds appropriated for the collection and use of information on physicians' services in the determination of relative values. HHS agreed with two of GAO's recommendations, but disagreed with using rulemaking to inform the public of RUC-identified services. GAO clarified that the recommendation is not limited to rulemaking.

View [GAO-15-434](#). For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

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Better Data and Greater Transparency Could Improve Accuracy

What GAO Found

The American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) has a process in place to regularly review Medicare physicians' services' work relative values (which reflect the time and intensity needed to perform a service). Its recommendations to the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers Medicare, though, may not be accurate due to process and data-related weaknesses. First, the RUC's process for developing relative value recommendations relies on the input of physicians who may have potential conflicts of interest with respect to the outcomes of CMS's process. While the RUC has taken steps to mitigate the impact of physicians' potential conflicts of interest, a member of the RUC told GAO that specialty societies' work relative value recommendations may still be inflated. RUC staff indicated that the RUC may recommend a work relative value to CMS that is less than the specialty societies' median survey result if the value seems accurate based on the RUC members' clinical expertise or by comparing the value to those of related services. Second, GAO found weaknesses with the RUC's survey data, including that some of the RUC's survey data had low response rates, low total number of responses, and large ranges in responses, all of which may undermine the accuracy of the RUC's recommendations. For example, while GAO found that the median number of responses to surveys for payment year 2015 was 52, the median response rate was only 2.2 percent, and 23 of the 231 surveys had under 30 respondents.

CMS's process for establishing relative values embodies several elements that cast doubt on whether it can ensure accurate Medicare payment rates and a transparent process. First, although CMS officials stated that CMS complies with the statutory requirement to review all Medicare services every 5 years, the agency does not maintain a database to track when a service was last valued or have a documented standardized process for prioritizing its reviews. Second, CMS's process is not fully transparent because the agency does not publish the potentially misvalued services identified by the RUC in its rulemaking or otherwise, and thus stakeholders are unaware that these services will be reviewed and payment rates for these services may change. Third, CMS provides some information about its process in its rulemaking, but does not document the methods used to review specific RUC recommendations. For example, CMS does not document what resources were considered during its review of the RUC's recommendations for specific services. Finally, the evidence suggests—and CMS officials acknowledge—that the agency relies heavily on RUC recommendations when establishing relative values. For example, GAO found that, in the majority of cases, CMS accepts the RUC's recommendations and participation by other stakeholders is limited. Given the process and data-related weaknesses associated with the RUC's recommendations, such heavy reliance on the RUC could result in inaccurate Medicare payment rates. CMS has begun to research ways to develop an approach for validating RUC recommendations, but does not yet have a specific plan for doing so. In addition, CMS does not yet have a plan for how it will use funds Congress appropriated for the collection and use of data on physicians' services or address the other data challenges GAO identified.

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Abbreviations

ABLE	Stephen Beck, Jr. ABLE Act of 2014
AMA	American Medical Association
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DPEI	direct practice expense inputs
HHS	Department of Health and Human Services
MedPAC	Medicare Payment Advisory Commission
MP	malpractice
PAMA	Protecting Access to Medicare Act of 2014
PE	practice expense
PPACA	Patient Protection and Affordable Care Act
RUC	American Medical Association/Specialty Society Relative Value Scale Update Committee

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May 21, 2015

Congressional Committees

Medicare payments for physicians' services totaled about \$70 billion in 2013.¹ Medicare sets payment rates for about 7,000 physicians' services primarily as the result of underlying relative values the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers Medicare, assigns to each service. These relative values largely reflect estimates of the level of physician work and practice expenses (PE) needed to provide one service relative to other services. Because the relative resources needed to provide an existing service can change over time—for example, due to changes in practice patterns or technology—and because each year new services are added, ensuring the accuracy of relative values requires frequent review. Accurate relative values subsequently help ensure the accuracy of Medicare payment rates for physicians' services, which are important for several reasons. For example, misvaluation of these payment rates can create distorted incentives for physicians to pursue certain specialties or to over- or underprovide services, which affects patient care. Misvaluation can also lead to unwise spending of taxpayers' and beneficiaries' money as well as affect the accuracy of payment rates used by other payers, such as Medicaid and private insurers, which are often based at least in part on Medicare rates.

To help CMS establish accurate relative values (both to generate initial relative values for new services and to maintain accurate relative values for existing services), the American Medical Association (AMA) created a special committee—the AMA/Specialty Society Relative Value Scale Update Committee (RUC)—comprising representatives from different specialties. Since 1991, the RUC has met three times per year to review a subset of physicians' services, identified in part by CMS and in part by the RUC, and to develop recommendations to CMS on the resources

¹Physicians' services are health care services provided or coordinated by licensed doctors of medicine or osteopathy.

needed to provide those specific services.² While there is no formal relationship between CMS and the RUC, CMS generally establishes relative values for those services for which it receives RUC recommendations once it has reviewed them.

We, the Medicare Payment Advisory Commission (MedPAC), and members of Congress have expressed concern about the effect that CMS's process to establish relative values based on CMS's review of the RUC's recommendations could have on the accuracy of payment rates for Medicare physicians' services. For example, in prior work we found that CMS did not always establish relative values based on sufficient data or a documented and transparent rationale, and that CMS did not systematically focus its efforts—or request that the RUC prioritize its efforts—on reviewing the physicians' services that have the greatest impact on Medicare expenditures.³ Similarly, MedPAC has expressed concern about the accuracy of the data gathered by the RUC—which has a financial stake in the payment rates CMS sets for Medicare physicians' services—and has recommended that to establish more accurate relative values and reduce its reliance on the RUC, CMS should create an independent expert panel to review RUC recommendations and collect data.⁴ Furthermore, some members of Congress have expressed concern to CMS about the timing and lack of transparency of its process to establish relative values, which deprives stakeholders of an opportunity to contribute their expertise and voice any concerns.⁵

²For the purposes of this report, the meaning of the term “review” differs depending on whether it refers to actions of the RUC or CMS. A RUC review refers to the RUC's evaluation of work and PE relative values for a particular service and its subsequent relative value recommendation to CMS based on its evaluation. A CMS review refers to either CMS's consideration of RUC relative value recommendations or CMS's ongoing assessment of whether physicians' services' relative values need to be revalued.

³See GAO, *Medicare Physician Fee Schedule: CMS Needs a Plan for Updating Practice Expense Component*, [GAO-05-60](#) (Washington, D.C.: Dec. 13, 2004). CMS responded that the majority of its changes were based on RUC recommendations. See also GAO, *Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together*, [GAO-09-647](#) (Washington, D.C.: July 31, 2009).

⁴See Medicare Payment Advisory Commission, *Moving Forward from the Sustainable Growth Rate (SGR) System*, letter to Congress (Washington, D.C.: October 2011) and *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2006), ch. 3.

⁵See letters from members of the House of Representatives to CMS, April 8 and 17, 2014.

To help ensure accuracy in accounting for the relative resources used in services furnished under the physician fee schedule, Congress recently passed laws requiring CMS to take certain actions in establishing relative values. Specifically, in addition to the requirement that CMS review the relative values of all physicians' services at least every 5 years, the Patient Protection and Affordable Care Act (PPACA), the Protecting Access to Medicare Act of 2014 (PAMA), and the Stephen Beck, Jr. ABLA Act of 2014 (ABLE) require CMS to (1) periodically identify services likely to be potentially misvalued using specified criteria; (2) establish a process to validate the accuracy of relative values; and (3) collect certain data to use to help establish more accurate relative values. Beginning in 2014, \$2 million is appropriated annually for CMS to use to collect and apply such data, and saving targets are established for adjustments resulting from the revision of relative values as 1.0 percent of Medicare physicians' services payments in 2016 and 0.5 percent in 2017 and 2018.⁶

PAMA also included a provision for GAO to study the process used by the RUC to develop recommendations for CMS regarding relative values for specific Medicare physicians' services.⁷ To respond to this provision, we evaluated

1. the RUC's process for recommending relative values for CMS to consider when setting Medicare payment rates for physicians' services, and
2. CMS's process for establishing relative values for physicians' services when setting Medicare payment rates, including how it uses RUC recommendations.

To evaluate the RUC's and CMS's processes, we focused on the processes used to recommend and establish, respectively, relative values for 2015, as well as recent and planned changes. Additionally, because the focus of our report is on how the RUC develops relative value recommendations for CMS and how CMS uses these recommendations

⁶PPACA, Pub. L. No. 111-148, § 3134(a), 124 Stat. 119, 434 (2010); PAMA, Pub. L. No. 113-93, § 220, 128 Stat. 1040, 1070; ABLE, Pub. L. No. 113-295, Div. B, Tit. II, § 202, 128 Stat. 4010, (pertinent provisions in all laws codified at 42 U.S.C. § 1395w-4(c)(2)(K) – (O)).

⁷See Pub. L. No. 113-93, § 220(g), 128 Stat. 1074.

when establishing relative values, we focused on the processes involving Medicare physicians' services specifically identified for full RUC review and the components of relative values for which the RUC provides recommendations to CMS.⁸

As a first step in evaluating the RUC's and CMS's processes, we reviewed RUC documents (including RUC documentation on its policies, procedures, and criteria) and CMS rulemaking pertaining to the establishment of relative values and we made direct observations of the RUC's process and CMS's involvement by attending the RUC's September 2014 meeting. We also conducted numerous interviews with RUC and CMS officials as well as interviewed selected stakeholders, such as specialty societies and CMS contractors.

Second, we identified key evaluative criteria to compare the current RUC and CMS processes against by reviewing (1) applicable laws and regulations; (2) goals, policies, and procedures established by the RUC and CMS; (3) federal internal control standards;⁹ and (4) relevant reports and publications on these processes. Based on these reviews, we identified seven key criteria against which we evaluated the current RUC and CMS processes.

Last, to provide additional context and summarize the outcomes of the processes, we performed several data analyses, most of which were based on publicly available CMS data on the work relative values it established for payment years 2011 through 2015, and how those values

⁸Specifically, we do not describe the process by which (1) the RUC's PE Subcommittee makes recommendations on certain components of PE for a group of services based on review of a specific issue (such as the transition from film to digital technologies) but for which the RUC did not conduct a full review of the services' relative values; (2) the RUC makes recommendations on malpractice relative values; or (3) CMS establishes relative values due exclusively to a CMS policy update, such as when the agency moved to a tiered interest rate for calculating equipment cost per minute. Similarly, we do not describe the processes CMS uses to establish components of relative values for which the RUC does not provide recommendations, such as indirect practice expenses.

⁹See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

related to the RUC's recommendations.¹⁰ For example, among other analyses, we calculated the extent to which CMS agreed with the RUC's recommendations and how this varied by the type of recommendation the RUC made. We also used data provided to us by the RUC to examine the number of respondents and range of responses to the surveys the RUC used to develop its 2015 work relative value recommendations.¹¹ To assess the reliability of all the data we used for our analyses, we reviewed related documentation, interviewed RUC staff and CMS officials, performed data checks for logic errors and out-of-bound values, and compared data sources for consistency.¹² Through this process we determined the data were sufficiently reliable for our purposes.

We conducted this performance audit from July 2014 to May 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

¹⁰We restricted our analyses of CMS's review of RUC work relative value recommendations to services that were active in the relevant payment year. Based on this restriction, we included 1,278 (90 percent) of the 1,414 recommendations CMS reviewed for payment years 2011 through 2015. Our analyses do not include Medicare physicians' services for which CMS updated relative values without first receiving a recommendation from the RUC, nor do they include all recommendations that the RUC told us it submitted during the period of our review. For example, our analyses do not include RUC recommendations for services that were not covered by Medicare, services that only had editorial changes, or services for which the RUC recommended a service be deleted or bundled with other services. We did not analyze CMS's review of the RUC's direct practice expense inputs (DPEI) recommendations because of data constraints.

¹¹The RUC provided us with all the documentation regarding relative value recommendations that it had provided to CMS for payment year 2015, including the results of specialty societies' work relative value surveys. We restricted this analysis to surveys for active services and excluded surveys that were conducted for payment years not included in our period of review or were duplicates of each other. We identified 231 work relative value surveys for active services that the RUC submitted to CMS for payment year 2015, including 2 surveys for the same service. Similar to our other analyses, this analysis did not include all work relative value surveys that the RUC told us it submitted to CMS for payment year 2015 because, for example, the RUC submitted surveys for services that were not covered by Medicare.

¹²In addition to the data sources already mentioned, we used CMS's Part B summary files for 2009 through 2013 to obtain information on Medicare expenditures for each service and used the Current Procedural Terminology (CPT) guide to categorize services into clinical categories.

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Overview of Relative Values and Their Relationship to Medicare Payment Rates for Physicians' Services

CMS changed the way it paid for Medicare physicians' services starting in 1992 when it began transitioning from payment rates based on customary charges to payment rates based on the relative resources needed to provide each service.¹³ As part of this transition to a new relative value scale system, three types of relative values were defined—one for relative levels of physician work, one for PE, and one for malpractice (MP) expense—and CMS subsequently transitioned each type of relative value from the existing charge-based system to new resource-based relative values.¹⁴

In response to this transition, the AMA created the RUC in 1991 to provide recommendations to CMS for it to consider when establishing resource-based relative values. The RUC currently has 31 members, 21 of whom represent specialty societies with permanent seats on the RUC (including for cardiology, family medicine, and internal medicine) and 4 of whom represent specialty societies with rotating seats on the RUC (including primary care and other specialties not always represented,

¹³See the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6102, 103 Stat., 2106, 2169 (codified as amended at 42 U.S.C. § 1395w-4). Some Medicare physicians' services, such as those that are priced by Medicare contractors and anesthesiology services, are still paid based on different methodologies. A discussion of these services is beyond the scope of this report.

¹⁴The first relative value component to be transitioned was work relative value, which began in 1992 and was based on the work performed by Harvard researchers through a CMS contract. Some work relative values today are still based on the work performed by these researchers and are known as "Harvard-valued" services.

such as pediatric surgery).¹⁵ These members are supported by the Advisory Committee of over 100 appointed physician representatives who are responsible for coordinating with their respective specialty societies to develop relative value recommendations to present to the RUC. According to the AMA, RUC members and the Advisory Committee donate over \$8 million in direct expenses each year, such as travel, meeting, and consulting costs. In addition, hundreds of physicians provide volunteer time to support the RUC's process.¹⁶

Under the current relative value scale system, CMS determines the Medicare payment rate in a given year for most physicians' services by summing a service's three relative values—after adjusting for geographic differences in resource costs—and then multiplying the resulting sum by a conversion factor. Work relative values are based on the estimate of two main inputs: (1) the time the physician needs to perform the service (including pre- and postservice activities, or work performed before and after the service), and (2) the intensity of the service (including the physician's mental effort and judgment, technical skill and physical effort, and psychological stress). In 2015, work relative values ranged from 0, for services that do not have any physician work, such as the technical component of imaging services, to 108.91, for the repair of a neonate diaphragmatic hernia. PE relative values are based primarily on estimates of (1) direct PE inputs (DPEI), which reflect the clinical labor, medical equipment, and disposable supplies needed to provide a specific service as well as the amount of time for which labor is required and equipment is

¹⁵The RUC also has six additional seats, three of which are nonvoting seats for the RUC Chair, the Chair of the PE Subcommittee, and a representative of the CPT Editorial Panel; and three that are voting seats for representatives from the AMA, the RUC's related committee composed of health professionals other than medical doctors or doctors of osteopathy, and the American Osteopathic Association. Specialty societies must meet certain criteria in order to have a permanent seat on the RUC; specifically, (1) the specialty is recognized by the American Board of Medical Specialties; (2) the specialty comprises at least 1 percent of physicians in practice; (3) the specialty comprises at least 1 percent of physician Medicare expenditures; (4) Medicare revenue is at least 10 percent of the mean practice revenue for the specialty; and (5) the RUC must determine that the specialty is not already represented by a similar organization. For information on the RUC's current composition, see "The RVS Update Committee," accessed May 7, 2015, <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-resource-based-relative-value-scale/the-rvs-update-committee.page>.

¹⁶In contrast, CMS officials told us the number of CMS staff responsible for updating relative values was fewer than 10 individuals as of August 2014.

used, and (2) indirect PE, which generally reflect overhead expenses not associated with a specific service.¹⁷ In 2015, DPEI costs ranged from \$0, for services that do not have any direct practice expenses, to over \$14,000, for a type of angioplasty. MP relative values are based on malpractice insurance premiums of the specialties that perform the service, weighted geographically and by specialty. The geographic-adjusted sum of the three relative values is then multiplied by a dollar value, called a conversion factor, which converts the service's relative value to a payment rate;¹⁸ in 2015, the conversion factor was \$35.80.¹⁹ (See fig. 1.) Thus, while relative values determine the payment rate of one service relative to another, they do not directly determine services' Medicare payment rates.²⁰

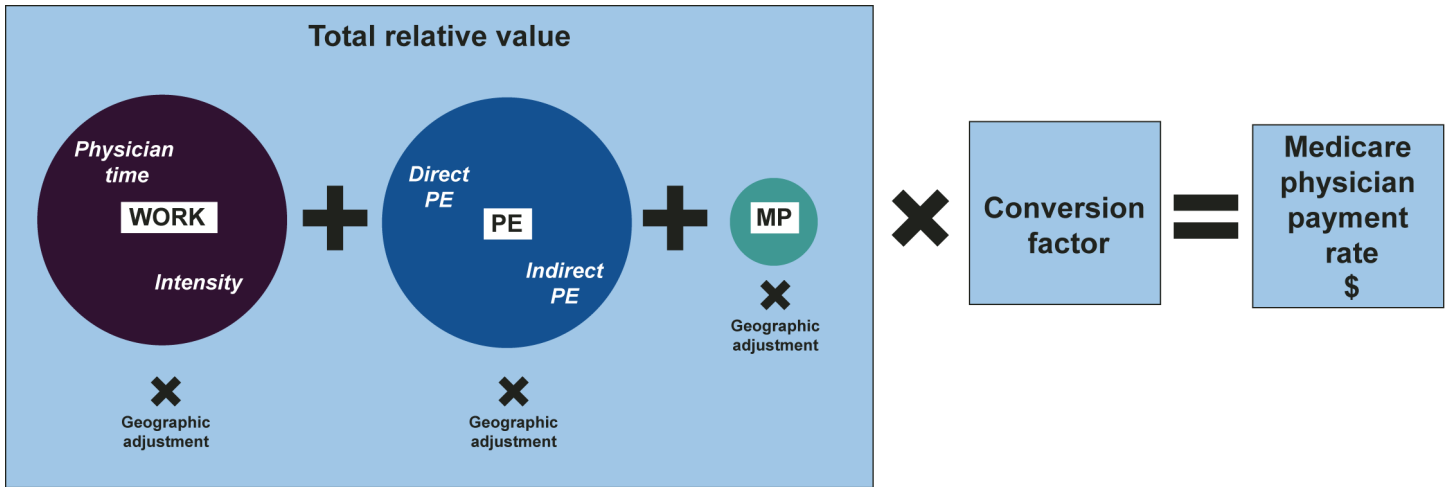
¹⁷Because Medicare pays hospitals and other facilities separately for certain practice expenses incurred by the facility, services that can be performed in either a nonfacility (such as an office) or a facility setting are assigned two separate PE relative values, one for each setting. As the general process to estimate these two different PE relative values is the same, this report will not distinguish between the two different types of PE relative values.

¹⁸When establishing relative values, CMS maintains the relative weights of the three relative value components by taking into account the Medicare Economic Index—an index that measures the prices of inputs to provide Medicare physicians' services and is used to determine the percentage of overall expenditures in a given year that are due to physician work, PE, and MP. In 2015, these adjustments have led to work relative values accounting for about half of the total Medicare expenditures on physician services, PE relative values for slightly less than half of expenditures, and MP relative values for less than 5 percent.

¹⁹This is the conversion factor through March 2015. Under current law, the conversion factor for the rest of 2015 will decrease to \$28.22. See Revisions to Payment Policies Under the Physician Fee Schedule for CY 2015, CMS final rule with comment period, 79 Fed. Reg. 67548, 67741 (Nov. 13, 2014) (preamble, II.N.4.a.); 42 U.S.C. § 1395w-4(d)(16).

²⁰For example, a service that has a total relative value that is twice that of a second service would have a payment rate twice that of the second service.

Figure 1: How Relative Values Are Used in Calculating Medicare Payment Rates for Physicians' Services



Legend: PE = Practice Expense; MP = Malpractice.

Source: GAO. | GAO-15-434

Note: CMS determines the Medicare payment rate in a given year for most physicians' services by first adjusting a service's three relative values (work, PE, and MP) for geographic differences in resources costs. These three relative values are then summed together, and the resulting sum is then multiplied by a conversion factor to determine the payment rate.

CMS establishes relative values annually, and the effect of any changes on CMS's payment rates generally must be budget neutral. In particular, if any changes to relative values result in changes to annual estimated expenditures of more than \$20 million, CMS is required to make adjustments to ensure that overall expenditures do not increase or decrease by more than this amount.²¹ However, certain adjustments may also be made to Medicare payment rates that are not subject to the budget neutrality limitation. For example, if the annual net reduction in expenditures resulting from the revision of relative values does not meet the savings target for that year (1.0 percent of Medicare physicians' services payments in 2016 and 0.5 percent in 2017 and 2018), adjustments to reduce overall Medicare expenditures to achieve that target are not subject to the budget neutrality limitation.²²

²¹See 42 U.S.C. § 1395w-4(c)(2)(B)(ii)(II).

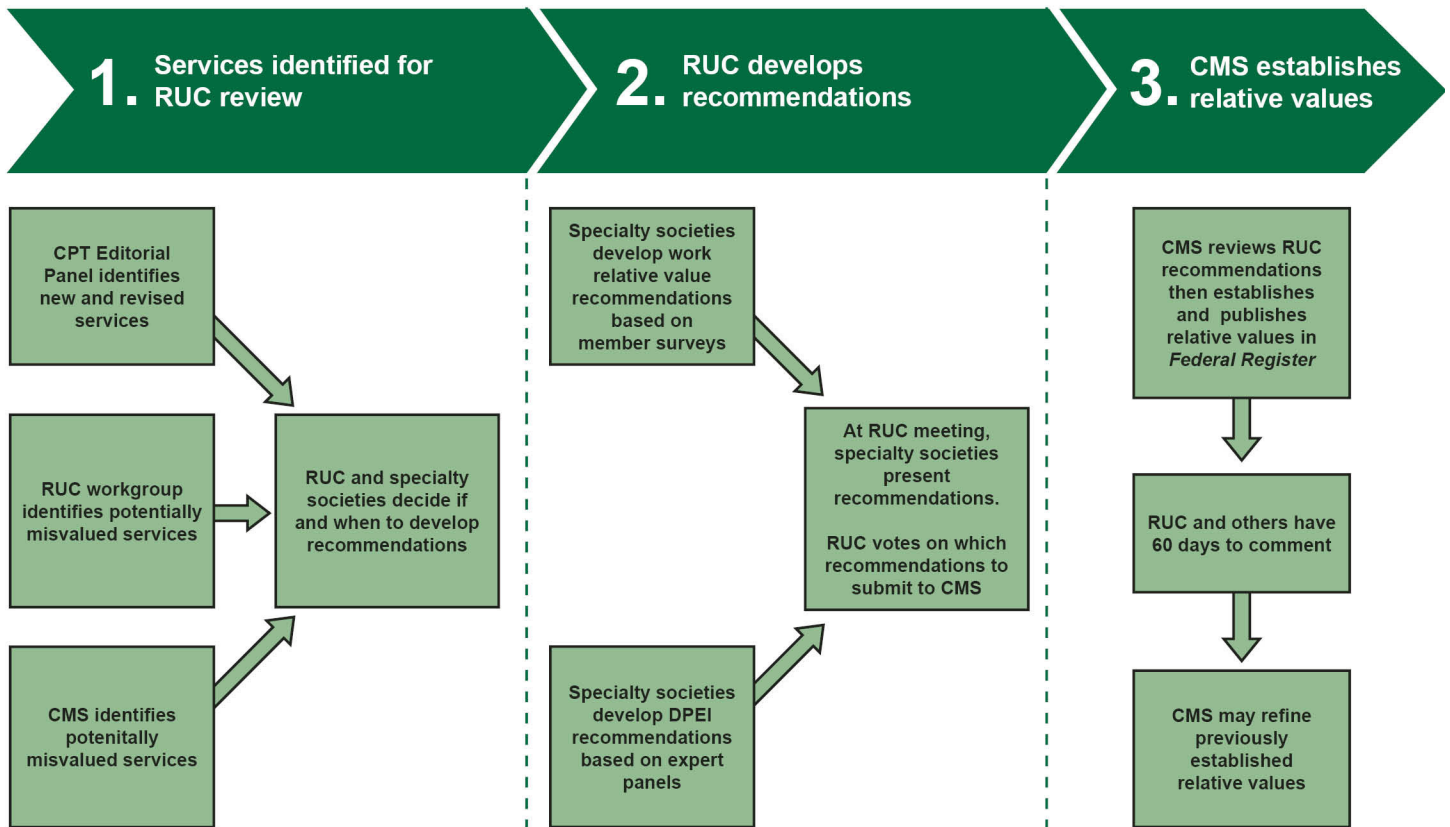
²²See 42 U.S.C. § 1395w-4(c)(2)(O).

Overview of the RUC's Process for Developing Relative Value Recommendations and How CMS Uses These Recommendations when Establishing Relative Values for Medicare Physicians' Services

The process to develop and establish relative values involves three main steps: (1) CMS, the RUC, and AMA's Current Procedural Terminology (CPT) Editorial Panel identify services for RUC review,²³ (2) the RUC works with specialty societies to use surveys and other methods to develop work relative value and DPEI recommendations for CMS for identified services, and (3) CMS reviews each RUC recommendation it receives to determine whether to use it when establishing relative values for physicians' services. (See fig. 2.) Because this process involves substantial time and effort from multiple entities, it can often take several years from when a service is initially identified for RUC review to when CMS establishes a relative value for it based on the RUC's recommendation. (See app. I for a case study describing the current process and timeline for establishing relative values for a specific service.) In total, for payment years 2011 through 2015, CMS reviewed 1,278 RUC work relative value recommendations for about 1,200 unique (new and existing) services.

²³The CPT Editorial Panel is responsible for maintaining the list of descriptive terms and CPT codes used to report physicians' services and ensuring it matches current medical practice. The Panel's duties include creating CPT codes for new services and deleting or revising CPT codes for existing services (for example, by making editorial changes to the descriptions of services).

Figure 2: Overview of CMS and RUC Processes to Establish Relative Values



Legend: RUC = American Medical Association/Specialty Society Relative Value Scale Update Committee; CPT = Current Procedural Terminology; DPEI = direct practice expense inputs.

Source: GAO. | GAO-15-434

Step 1: Services Identified for RUC Review

Each year, the CPT Editorial Panel, the RUC, and CMS each identify services for the RUC to review.

- The CPT Editorial Panel identifies new services and existing services that it has recently revised for RUC review and sends a list of these

services to the RUC.²⁴ (This list includes services identified as being in the same family as a new or revised service that the CPT Editorial Panel determines warrants concurrent review in order to help ensure relativity across the family of services.) The CPT Editorial Panel holds three meetings to decide on new or revised services for a given payment year (generally in the spring, fall, and winter preceding the payment year when the CPT change would take effect), and sends the list of services to the RUC after each meeting.

- The RUC identifies potentially misvalued services for RUC review by applying a set of criteria, called “screens,” to Medicare physicians’ services. Like the CPT Editorial Panel, the RUC also has three meetings for a given payment year, and during these meetings a RUC workgroup determines which screens the RUC should use; generally, the RUC submits its recommendations for potentially misvalued services to CMS within a year or two of these services being identified.
- CMS, too, identifies potentially misvalued services for RUC review by choosing to implement screens from among criteria identified in statute and from public nomination.²⁵ CMS then publishes a proposed list of potentially misvalued services in its annual proposed rule in the Federal Register (generally in July), and finalizes the list for RUC review in the final rule (which is generally published in November).

For each service identified for review, the RUC works with specialty societies to determine if and when to develop a recommendation. Specifically, the RUC sends level-of-interest forms to each specialty society about the new, revised, and potentially misvalued services identified for review; the specialty society then indicates which, if any, of the services it wishes to develop recommendations for. For each potentially misvalued service identified, the RUC also asks specialty societies to indicate any services in the same family as the potentially

²⁴Existing services may be revised by the CPT Editorial Panel to reflect, for example, changes in current medical practice due to new technology or editorial changes in the descriptions of the services. CPT revisions necessitate annual RUC reviews of the revised services, which could lead to revisions in the associated relative values.

²⁵PAMA specifies 16 criteria for the Secretary to use in identifying potentially misvalued services, including a catch-all criterion of any services as determined appropriate by the Secretary. Pub. L. No. 113-93, § 220(c), 128 Stat. 1072 (codified at 42 U.S.C. § 1395w-4(c)(2)(K)(ii)).

misvalued service²⁶ that the society may be interested in developing recommendations for, or if the specialty society believes that revaluing the service is not warranted (and the current values can be maintained), or whether it believes some other action, such as referring the service to the CPT Editorial Panel for revision, should be taken.

Step 2: RUC Develops Recommendations

After the RUC and specialty societies have determined which of the identified services they will develop recommendations on for the upcoming payment year, specialty societies use RUC-approved methods to develop recommendations for the RUC on work relative values and the set of DPEI and associated times and quantities, which the RUC then considers before submitting the final recommendations to CMS.²⁷ The RUC has documented instructions for specialty societies to follow when developing their proposed recommendations.

- To develop work relative value recommendations, specialty societies use the RUC’s work survey instrument to survey a random sample of their members about, among other things, (1) the time required to perform a service, (2) the complexity and intensity of performing a service relative to a reference service,²⁸ and (3) a total work relative value. Specialty societies then finalize their recommendations by applying a concept known as magnitude estimation to evaluate the survey data to determine whether the results for a service are consistent with the relative values of related services that were

²⁶For the rest of the report, we use the terms “new and revised services” and “potentially misvalued services” to include both the services originally identified as well as the services in the same families as the identified services that were determined should be reviewed at the same time.

²⁷For DPEI, specialty societies generally provide recommendations only on the set of inputs and associated times and quantities for a respective service; they do not provide recommendations on the prices of these inputs.

²⁸A reference service is a service selected by survey respondents from a list of 10 to 20 relevant services (referred to as the reference service list) that have relative values the RUC has determined are sufficiently accurate and stable to compare with other services (for example, services that were recently reviewed by the RUC and determined to be accurately valued).

recently valued, and may make a recommendation that is different from the survey results if they are not.²⁹

- To develop DPEI recommendations, specialty societies primarily use PE expert panels composed of members of their societies who use their clinical knowledge, along with comparisons to other services, to develop recommendations on the clinical labor, medical equipment, and disposable supplies required for a service. For some services, the recommended amounts of time for DPEI are determined, in part, from the responses provided in the work survey instrument. Specialty societies do not make formal recommendations on other aspects of PE relative values, such as indirect PE or DPEI prices, though they may periodically provide the RUC with invoices to submit for CMS's consideration, and the RUC may also periodically make recommendations on the overall methodology CMS uses to calculate PE relative values.

The RUC recommends that specialty societies work together to develop recommendations if more than one society has an interest in the particular service identified for review. Specialty societies develop new work relative value and DPEI recommendations for new services; for revised and potentially misvalued services, specialty societies may recommend to increase, decrease, or maintain the existing values.

Specialty societies submit the recommendations they develop and supporting documentation to RUC staff for discussion during one of the three RUC meetings each year. RUC members are assigned to prereview each recommendation before each meeting and provide feedback as needed; specialty societies may revise their recommendations on the basis of this feedback before presenting them to the RUC during the meeting. The RUC has documented criteria for reviewing specialty societies' proposed recommendations, including a series of questions RUC members should use to guide their deliberations on services during RUC meetings.

²⁹Magnitude estimation is a method used to determine the appropriate relative value for a service for which physicians are asked to use their clinical knowledge to estimate the service's relative value compared to related services that already have established relative values.

In general, members of the public may attend RUC meetings and observe RUC deliberations firsthand.³⁰ Everyone who attends RUC meetings, including RUC members, must sign a confidentiality agreement.³¹ At these meetings, specialty societies present their work relative value recommendations to the entire RUC and their DPEI recommendations to the RUC's PE Subcommittee, which, after its own review, makes recommendations to the entire RUC. During these discussions, RUC members may ask questions about the specialty societies' proposed recommendations, such as the level of work required to perform the service, and the recommendations may be modified as a result. As part of these discussions, RUC members apply magnitude estimation to determine whether a recommendation for a service is consistent with the relative value for related services. CMS officials are invited to attend and participate in RUC meetings. CMS officials stated that they often make comments, ask questions, or remind the committees of established policy, but do not generally make suggestions regarding specialty societies' recommendations. After the discussion period, each recommendation is voted on by RUC members. Proposed recommendations must reach a two-thirds majority vote of the RUC members to be accepted;³² approved recommendations are forwarded to CMS. RUC officials told us that, starting with its September 2014 meeting, the RUC sends CMS its recommendations after each RUC meeting. Prior to September 2014, CMS did not receive all of the RUC's recommendations for a given payment year until the preceding spring.

For payment years 2011 through 2015, CMS reviewed 1,278 RUC work relative value recommendations, of which 65 percent were for existing services (including potentially misvalued and revised services) and 35 percent were for new services. The number of work relative value recommendations reviewed each year varied from 187 to 337 with no consistent trend over time. Among the 833 RUC recommendations

³⁰Any individual may attend RUC meetings with approval by the RUC Chair.

³¹The RUC has stated that this provision is needed because new and revised services are discussed at RUC meetings before they are finalized in the CPT code set for upcoming payment years; premature release of such commercially sensitive information could give some industry members an unfair advantage.

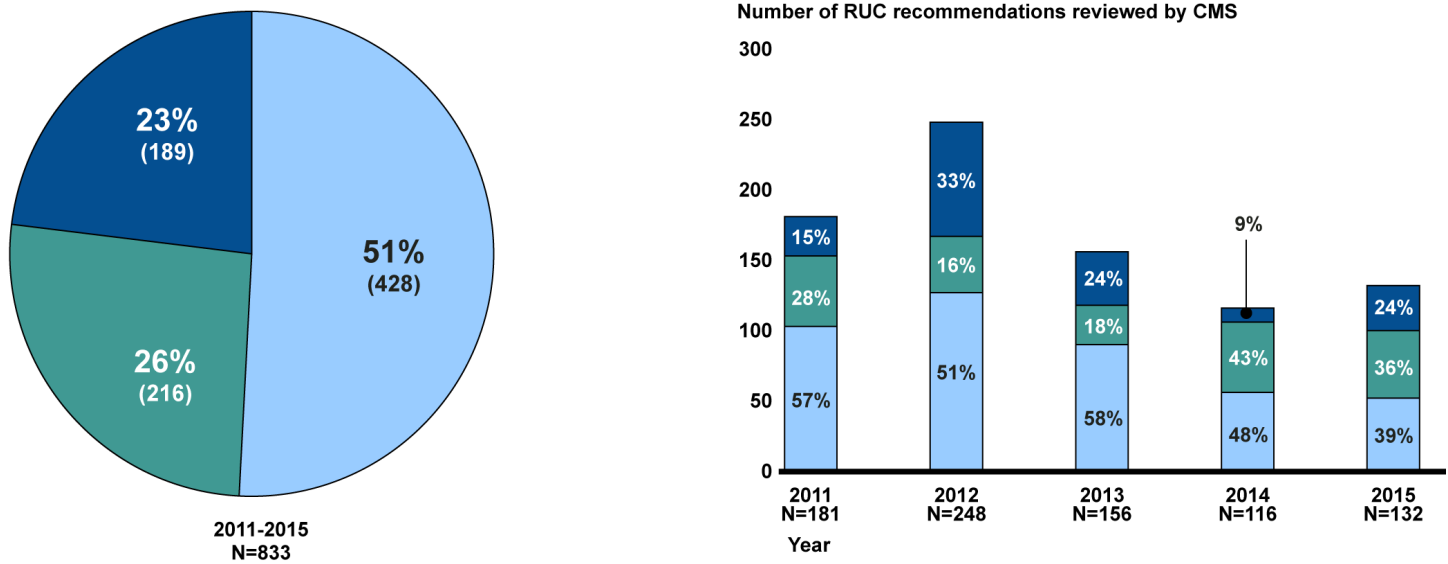
³²If a recommendation does not reach a two-thirds majority vote, it is forwarded to a facilitation panel consisting of RUC members, generally including the initial prereviewer as well as the presenting specialty society(ies) in an attempt to develop a revised recommendation that will receive a two-thirds majority vote.

reviewed by CMS for existing services across the 5 payment years, over half of them were to maintain the current work relative value, and this was the most common type of recommendation made each year.³³ (See fig. 3.) In instances when the RUC recommended an increase or a decrease to the current work relative value, the magnitude of the recommendation was typically large, especially among increases. For example, across the 5 payment years, 76 percent of the recommended increases and 65 percent of the recommended decreases were at least 10 percent of the current value, and almost a quarter of the recommended increases and 6 percent of the recommended decreases were at least 50 percent of the current value.³⁴

³³The 833 RUC work relative value recommendations for existing services exclude 2 services that the RUC recommended be established as contractor-priced, but for which CMS disagreed with these recommendations and instead established numeric work relative values. Because the RUC did not recommend numeric work relative values for these 2 services, it was not possible to calculate the direction of the RUC's recommendation for them.

³⁴This includes RUC work relative value recommendations for 4 services that had a work relative value of 0 in the prior year.

Figure 3: RUC's Work Relative Value Recommendations for Existing Services Reviewed by CMS, by Direction of RUC Recommendation (2011-2015)



Legend: RUC = American Medical Association/Specialty Society Relative Value Scale Update Committee.

No change
 Decrease
 Increase

Source: GAO analysis of CMS data. | GAO-15-434

Note: Percentages may not sum to 100 percent due to rounding. This analysis includes the 833 RUC work relative value recommendations that CMS reviewed for payment years 2011-2015 where the RUC recommended a numeric work relative value for an existing active Medicare service. This analysis does not include Medicare physicians' services for which CMS updated relative values without first receiving a recommendation from the RUC, nor does it include all recommendations that the RUC told us it submitted during the period of our review. For example, this analysis does not include RUC recommendations for services that were not covered by Medicare, services that only had editorial changes, or services for which the RUC recommended a service be deleted or bundled with other services. (Of the total 1,278 RUC work relative value recommendations for active services that CMS reviewed over this time period, this analysis thus excludes 108 recommendations for new services in 2011; 89 in 2012, 88 in 2013—plus 2 recommendations in which the RUC recommended the service be contractor-priced; 71 in 2014; and 87 in 2015.) Recommendations are listed by the payment year for which CMS reviewed them.

Step 3: CMS Reviews RUC Recommendations and Establishes Relative Values

CMS reviews and considers each of the RUC's recommendations when valuing particular services and then publishes its relative value

decisions—including whether it agrees with the RUC or decides an alternative value more accurately reflects the resources needed to provide that service—through rulemaking in the Federal Register.³⁵ Because, until recently, CMS did not receive all of the RUC’s recommendations until the spring preceding the payment year, CMS did not have time to include a discussion of the RUC’s recommendations in its proposed rule addressing changes to the physician fee schedule each year, generally each July.³⁶ Instead, CMS responds to the RUC’s recommendations, referring to them as interim final values, in the final rule it publishes, generally each November preceding the payment year for which the values would go into effect.³⁷ However, CMS recently revised its timeline for reviewing RUC recommendations to give stakeholders more time to respond to RUC recommendations before CMS considers them and to give notice of the possible changes to payment rates for identified services. Beginning with payment year 2017, CMS will include the results of its review of RUC recommendations in the proposed rule, thus generally eliminating the need for interim final values.³⁸

³⁵For the purposes of this report, we use the term “value” to refer to the actions CMS takes to determine the appropriate relative values for identified services, which include reviewing RUC recommendations, before establishing relative values through rulemaking.

³⁶See, e.g., Revisions to Payment Policies Under the Physician Fee Schedule for CY 2015, CMS proposed rule, 79 Fed. Reg. 40318 (July 11, 2014); Revisions to Payment Policies Under the Physician Fee Schedule for CY 2014, CMS proposed rule, 78 Fed. Reg. 43282 (July 19, 2013); Revisions to Payment Policies Under the Physician Fee Schedule for CY 2013, CMS proposed rule, 77 Fed. Reg. 44722 (July 30, 2012).

³⁷See, e.g., 79 Fed. Reg. 67548 (Nov. 13, 2014); Revisions to Payment Policies Under the Physician Fee Schedule for CY 2014, CMS final rule with comment period, 78 Fed. Reg. 74230 (Dec. 10, 2013); Revisions to Payment Policies Under the Physician Fee Schedule for CY 2013, CMS final rule with comment period, 77 Fed. Reg. 68892 (Nov. 16, 2012).

³⁸79 Fed. Reg. 67548, 67606 (Nov. 13, 2014) (preamble, II.F.4.). Beginning for payment year 2017, CMS must receive all RUC recommendations by February 10th in order to review and include them in that year’s proposed rule along with CMS’s decisions regarding the recommendations; generally, any recommendations received after this date will be reviewed for the following year’s proposed rule, although CMS has reserved the possibility of establishing interim final values for new services if necessary. The public will then have the opportunity to comment on the proposed relative values before CMS finalizes them in that year’s final rule.

In rulemaking establishing payment values, CMS indicated it has reviewed RUC recommendations through multiple methods, including

- assessing the results of surveys and other supporting data submitted by the RUC, including assessing the methodology and data used to develop the recommendations;
- conducting a clinical review, which includes comparison with other physicians' services to ensure relativity across services and to avoid anomalies, and review of relevant medical literature;
- analyzing other data sources with related information, such as claims data; and
- considering information provided by other stakeholders.³⁹

CMS also is authorized to use other methods to determine the relative values for services for which specific data are not available.⁴⁰

After the publication of CMS's decisions in the final rule, the RUC and other stakeholders have 60 days to provide comments. In the subsequent year's final rule, CMS may choose to refine (revise) the values it initially established in response to these comments or other new information or to finalize the previously published interim final values. CMS refined, on average, 11 percent of the work relative values that the agency established between 2011 and 2014. During this period there was no consistent trend in the percentage of services refined over time, with the percentage of annual refinements ranging from 5 to 21 percent.

Criteria Developed by GAO for Evaluating the RUC's and CMS's Current Processes

In order to evaluate the RUC's and CMS's current processes for developing recommendations for and establishing relative values, respectively, we reviewed (1) applicable laws and regulations; (2) goals, policies, and procedures established by the RUC and CMS; (3) federal internal control standards; and (4) relevant reports and publications on these processes. Examples of these include legislation such as PAMA

³⁹See, e.g., 79 Fed. Reg. 67548, 67573, 67609 (Nov. 13, 2014) (preamble, II.B. and G.); 78 Fed. Reg. 74230, 74254, 74278 (Dec. 10, 2013) (preamble, II.B. and E.); 77 Fed. Reg. 68892, 68909, 69012 (Nov. 16, 2012) (preamble, II.B. and M.).

⁴⁰See 42 U.S.C. § 1395w-4(c)(2)(A)(ii). For example, CMS may extrapolate data from other sources.

and PPACA; RUC documents describing its process for developing relative value recommendations and descriptions of CMS's process for establishing relative values described in rulemaking; federal internal control standards pertaining to, for example, control activities and information and communications;⁴¹ and previous MedPAC and GAO reports.⁴² Based on our reviews of these documents, we then developed the following seven criteria included in table 1 to evaluate the current RUC and CMS processes against.⁴³

⁴¹[GAO/AIMD-00-21.3.1](#).

⁴²See, for example, [GAO-05-60](#); [GAO-09-647](#); and Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington, D.C.: March 2006).

⁴³The RUC and CMS reviewed our developed criteria and generally agreed with them.

Table 1: Criteria Developed by GAO for Evaluating the RUC’s and CMS’s Current Processes to Establish Relative Values

Criteria	Selected source(s)
1. Entities should maintain a transparent process for establishing relative values, including having documentation about their criteria and processes for identifying services for review and disclosing information upon which decisions were based, to the extent possible.	See 42 U.S.C. § 1395w-4(c)(2)(B)(ii)(I) (CMS is to publish an explanation of the basis of any relative value adjustment); <i>Standards for Internal Control in the Federal Government</i> (Control Activities).
2. Stakeholders should have opportunities to comment and provide input.	<i>Standards for Internal Control in the Federal Government</i> (Information and Communications). ^a
3. Entities should have processes in place to address conflicts of interest.	<i>Standards for Internal Control in the Federal Government</i> (Control Environment).
4. Entities should have processes in place to ensure that relative values are reviewed regularly and revalued if necessary.	See 42 U.S.C. § 1395w-4(c)(2)(B)(i) (Relative values for all Medicare physicians’ services are to be reviewed at least every 5 years); <i>Standards for Internal Control in the Federal Government</i> (Monitoring).
5. Entities should prioritize review of services based on results of risk assessment and ongoing monitoring, including those most likely to be misvalued and those that account for a large portion of Medicare spending.	See 42 U.S.C. § 1395w-4(c)(2)(K)(i),(ii) (CMS is to periodically identify potentially misvalued services based on any or all specified criteria, and make adjustments as appropriate); <i>Standards for Internal Control in the Federal Government</i> (Risk Assessment and Monitoring). ^b
6. Entities should establish relative values on the most accurate, timely, and reliable data possible. ^c	<i>Standards for Internal Control in the Federal Government</i> (Information and Communications).
7. Entities should validate data used to establish relative values, including comparing the data against other sources to assess their reliability.	See 42 U.S.C. 1395w-4(c)(2)(L) (CMS is required to develop a process to validate relative values); <i>Standards for Internal Control in the Federal Government</i> (Information and Communications).

Source: GAO. | GAO-15-434

^aSome members of Congress have also expressed concern about stakeholders having opportunities to provide input on the process for establishing relative values.

^bWe have previously found that CMS did not systematically focus its efforts—or request that the RUC prioritize its efforts—on reviewing Medicare physicians’ services that have the greatest impact on Medicare expenditures. See [GAO-09-647](#).

^cThis includes, for example, making sure the data are (1) of sufficient sample size, (2) representative of intended universe, (3) unbiased, and (4) the most recent available.

Weaknesses in the RUC's Data and in Its Relative Value Recommendation Process Present Challenges for Ensuring Accurate Medicare Payment Rates

The RUC identifies potentially misvalued services by applying screens it has independently developed and by identifying additional services for review in response to requests from CMS. In addition, the RUC has a process to review services regularly—the timing of which could have implications for when CMS establishes relative values for those services. To ensure the accuracy of its recommendations for CMS, the RUC takes steps during its process to mitigate any possible bias from affecting its work relative value and DPEI recommendations. Despite these steps, weaknesses in the RUC's relative value recommendation process and in its survey data present challenges for ensuring accurate Medicare payment rates for physicians' services.

The RUC Process Prioritizes Review of Services It or CMS Identifies as Potentially Misvalued and Regularly Reviews Services the CPT Editorial Panel Identifies as New or Revised

The RUC's process is consistent with statutory criteria specified for CMS consideration in identifying services because the RUC prioritizes its reviews by identifying potentially misvalued services for review based on risk assessment. The RUC does this by applying screens it has independently developed on the basis of risk assessment criteria.⁴⁴ These screens are different from those used by CMS to review services,⁴⁵ although CMS officials said that many of the RUC's screens overlap with the screens used by CMS. For example, both CMS and the RUC have used screens to identify for review potentially misvalued services that had the fastest growth in Medicare utilization.⁴⁶ According to the RUC, 80 percent of the potentially misvalued services it has reviewed were identified using the RUC's screens.

⁴⁴The RUC's review of potentially misvalued services, including the development of its screens, is overseen by its Relativity Assessment Workgroup. The RUC created this workgroup in 2006 in response to MedPAC's concerns that CMS disproportionately increased relative values based on CMS's review of potentially misvalued services; additionally, RUC officials told us they created the Workgroup because the RUC believed CMS targeted certain specialties more than others when identifying services for review.

⁴⁵See 42 U.S.C. § 1395w-4(c)(2)(K)(ii).

⁴⁶Specifically, in 2013 the RUC used a screen to identify services with Medicare utilization of 10,000 or more whose utilization increased by at least 100 percent from 2006 to 2011; similarly, in 2010 PPACA specifically authorized CMS to review services and families of services for which there has been the fastest growth. Pub. L. No. 111-148, § 3134(a), 124 Stat. 434 (codified in pertinent part and as amended at 42 U.S.C. § 1395w-4(2)(K)(ii)(I)).

The RUC also identifies additional services for review in response to requests from CMS. For example, the RUC may create screens to identify services in response to CMS requests to review categories of services the agency has determined are potentially misvalued. In one instance, for payment year 2009, CMS requested that the RUC review “Harvard-valued” services (a category of services that would later be designated in statute as a screen) and prioritize reviewing those services with high utilization. Based on this request, the RUC created screens to identify Harvard-valued services—for services performed more than 1 million times in a year and then for services performed over 100,000 times in a year followed by services performed over 30,000 times in a year—and subsequently submitted relative value recommendations to CMS for a subset of the identified services for payment years 2011 through 2014. Furthermore, the RUC may identify additional services for review while developing recommendations for potentially misvalued services identified by CMS screens. For example, for payment year 2011 CMS requested that the RUC develop recommendations for services CMS had identified using a screen for services with low work relative values and high utilization. The RUC then modified CMS’s screening criteria to identify additional services for review using a broader range of work relative values, and developed recommendations for the services for payment years 2012 and 2013.

Entities should also have processes in place to review services regularly, according to relevant statutory criteria and federal internal control standards, which the RUC accomplishes by annually developing work relative value and DPEI recommendations for CMS to consider.⁴⁷ The RUC develops recommendations for almost all services that the CPT Editorial Panel identifies as new or revised in time for the upcoming payment year,⁴⁸ although it can often be several years between when the RUC or CMS identifies a service as potentially misvalued and when the RUC develops recommendations for that service. Sometimes this is because the RUC determines, as part of its process, to postpone developing recommendations for the service until more information, such

⁴⁷The RUC generally requires specialty societies to develop both work relative value and DPEI recommendations for identified services.

⁴⁸The RUC also develops recommendations for services identified as being in the same family as a new or revised service that the CPT Editorial Panel determined warranted concurrent review in order to help ensure relativity across the family of services.

as data about how new technology affects the service, becomes available. Other times, the RUC may suggest to the CPT Editorial Panel and CMS that identified services be deleted or bundled into another service, which means these services would not be valued by CMS at all or would be valued as part of the new bundled service. RUC staff also told us that they spend time discussing with CMS officials whether some services requested by CMS for RUC review need to be reviewed; for example, if specialty societies recently developed recommendations for a service, then the specialty societies may determine that another review is unnecessary. The timing of the RUC's process for reviewing services can have implications for when CMS establishes relative values for those services, since CMS officials told us they rarely establish work relative values and DPEI for individual services without first receiving RUC recommendations.

Although the RUC Takes Steps to Mitigate Possible Bias in Its Process, Potential Conflicts of Interest and Data-Related Weaknesses Present Challenges for Ensuring Accurate Medicare Payment Rates

We and others have concluded that physicians who serve Medicare beneficiaries may have conflicts of interest when making relative value recommendations.⁴⁹ The RUC has taken steps, though, to mitigate any possible biases that RUC members or specialty societies involved in the recommendation process may have from affecting the RUC's work relative value and DPEI recommendations. As previously mentioned, entities should have processes in place to address conflicts of interest. While changes to Medicare payment rates for physician services are generally required to be budget neutral—that is, increases in the payment rate for specific services will lead to a decrease in the collective payments for all other services—each individual physician who serves Medicare beneficiaries would nonetheless benefit from an increase in the relative values for the services they perform. Given this potential conflict of interest and other potential conflicts that individual physicians involved in the recommendation process may have, the RUC takes steps to mitigate any possible bias from affecting its recommendations to CMS. For example, the RUC does not assign members to prereview recommendations developed by their own specialty societies. The RUC also prohibits its members from participating in deliberations and voting on services in which they or a family member have a direct financial interest, and may preclude members of specialty societies who disclose

⁴⁹See, for example, Medicare Payment Advisory Commission, *Medicare Payment Policy* (March 2006), ch. 3; and The Center for Public Integrity, *Little-Known AMA Group Has Big Influence on Medicare Payments* (Washington, D.C.: Oct. 27, 2010).

financial conflicts from presenting at RUC meetings.⁵⁰ The RUC's deliberation process is also intended to mitigate the effects of possible biases. Through the deliberation process RUC members have the opportunity to question the different specialty societies' proposed recommendations. RUC staff said that it is in members' best interests to question specialty societies' proposed recommendations since Medicare payment rates are based on the relativity of services to each other in a budget neutral system. To lower the possibility for bias in survey data specialty societies obtain from their physician members, the RUC designed its survey instrument to ask respondents to disclose any direct financial interests they or a family member have in the surveyed service. Additionally, the RUC may discard all survey responses for a service when it believes the survey process was biased.

Nevertheless, the reliability of work relative value recommendations may be undermined by survey respondents' potential conflicts of interest. According to a member of the RUC, specialty societies' work relative value recommendations are most likely inflated due to physician bias. RUC staff stated that, while the survey data are the beginning of the process to establish work relative value recommendations, the RUC relies on magnitude estimation and the clinical expertise of its members to develop the RUC's final recommendations. According to RUC staff, this process often resulted in the RUC recommending a work relative value that was at the 25th percentile or lower of the specialty societies' survey data between 2011 and 2015.

While magnitude estimation and the clinical expertise of the RUC's members may allow the RUC to partially compensate for inflation in specialty societies' work relative value recommendations, it may not completely eliminate bias. Specifically, the accuracy of the results of magnitude estimation depends both on the accuracy of previously established relative values, which may also suffer from the same reliability issues, and physicians' abilities to accurately determine the relativity between services, which may be difficult to do for services as disparate as primary care visits and complex surgeries. It is therefore

⁵⁰The RUC defines direct financial interests to include, for example, employment by or owning stock in organizations that manufacture products used to perform the services under consideration. Additionally, individuals presenting recommendations to the RUC who disclose financial conflicts of interests may have their participation limited during relevant RUC meetings.

unclear the extent to which magnitude estimation—without other reliable data about the work it takes to perform a service—is sufficient to generate accurate work relative value recommendations.

We also identified other issues with some of specialty societies' surveys, including low response rates, low total number of respondents, and large ranges in responses that suggest shortcomings with the data. In accordance with federal internal control standards, entities should develop their relative value recommendations based on the most accurate, timely, and reliable data possible, and these shortcomings may further undermine the reliability of RUC's relative value recommendations. For example, of the 231 active Medicare physicians' services that specialty societies surveyed for payment year 2015, the median response rate was 2.2 percent and while the median number of respondents was 52,⁵¹ for 23 of these services, the number of respondents failed the minimum survey response thresholds that the RUC implemented in 2014.⁵² Of these 23 services, there were only 2 services for which the RUC submitted temporary work relative value recommendations to CMS and required the specialty society to resurvey for a subsequent RUC meeting.⁵³ Among the respondents for all 231 services, the range of estimated work relative values was broad. For example, surveys'

⁵¹The median number of respondents whose responses to the intensity portion of the survey were used was even lower: only 18 respondents. Responses to the intensity portion of the survey were only reported for those respondents that chose the most common key reference service.

⁵²These thresholds require at least 30 survey responses for services with Medicare utilization of less than 100,000; 50 survey responses for services with utilization of at least 100,000 but less than 1 million; and 75 survey responses for services with utilization of at least 1 million. Previously, the required number of survey responses for all services was 30 but, in 2014, the RUC began requiring the 50 and 75 survey responses for services with higher Medicare utilization to further mitigate possible bias. Specialty societies that do not obtain the required 50 or 75 survey responses for these services are required to conduct new surveys and present revised recommendations to the RUC at the next RUC meeting. In addition to the 23 services that we found to have failed the RUC's thresholds, there were an additional 2 services that had Medicare utilization over 1 million but had only 50 responses; these surveys were not counted as failures because the surveys for them were performed in fall 2013, prior to the implementation of the new thresholds.

⁵³There were 3 additional services with surveys that did not meet the RUC's thresholds for which the RUC submitted a temporary recommendation to CMS and referred the service to the CPT Editorial Panel for further revision, after which the services were to be resurveyed. Additionally, for 11 of the 23 services with surveys that did not meet the RUC's thresholds, the RUC submitted a work relative value recommendation to CMS that was lower than the 25th percentile of the survey response.

25th percentile work relative value responses were at least 16 percent lower than the median value for half of specialty societies' surveys in 2015.⁵⁴

Finally, survey results may be undermined by the individuals who complete the survey, but the RUC has made efforts to address these issues. Survey respondents are asked to complete surveys for services that apply to them and to indicate how many times they have performed the services in the past year. In our review of the survey data, we found most surveys had at least one respondent who reported that they had not performed the service being surveyed within the past year.⁵⁵ RUC staff told us that they try to overcome the challenge of low response rates by allowing specialty societies to survey nonrandom samples of their members, survey those who are familiar with but do not perform certain services, or both; or allowing specialty societies to collect fewer than the required number of responses for their surveys.⁵⁶ While these approaches may help the RUC to obtain additional survey responses, they also may further lower the reliability of the RUC's data. CMS officials have acknowledged that the RUC can experience difficulties collecting sufficient numbers of survey responses if, for example, the services being surveyed have relatively low Medicare utilization. In other words, it is difficult to obtain reliable data about a Medicare service if the service is rarely performed. The RUC provides CMS with its survey data when it submits its recommendations, which may help CMS to draw independent conclusions about the reliability of the RUC's recommendations and thus how services should be valued. According to the criteria we identified, CMS should establish relative values using the most accurate and reliable data possible.

Although the RUC is currently the only comprehensive source of information regarding physician work, its recommendations may be

⁵⁴Surveys' 25th percentile work relative value response ranged from 1 to 62 percent lower than the median value, with one quarter of the surveys having the 25th percentile response be at least 25 percent lower than the median value.

⁵⁵The median number of times respondents reported performing the service in the past year was 10.

⁵⁶For example, in instances where few physicians are performing the service, RUC staff told us the RUC may approve specialty societies to collect fewer than the required number of responses for their surveys.

undermined by data weaknesses and weaknesses in its process due to potential conflicts of interest. Thus, the extent to which CMS does not draw independent conclusions, and instead relies on RUC recommendations for service valuations, presents a challenge for ensuring the accuracy of Medicare payment rates for physicians' services.

Since the RUC's DPEI recommendations are generally based on input from specialty societies' PE expert panels rather than on survey data, the reliability of these recommendations is in part dependent upon the expertise of the contributors to these panels. The RUC encourages specialty societies to include in their PE expert panels both subspecialists and generalists from within the specialty to represent different practice settings, as well as to seek input from practice managers and/or clinical staff familiar with DPEI. If these expert panels do not include a mix of physician and nonphysician experts as encouraged by the RUC, it may affect the reliability of the RUC's DPEI recommendations. Currently, the extent to which specialty societies' PE expert panels include a mix of physician and nonphysician experts is unclear. One specialty society told us that specialty societies' PE expert panels may not have the ideal expertise to make DPEI recommendations. We reviewed some of specialty societies' 2015 DPEI recommendation forms, which are to include a description of the composition of specialties' PE expert panels, to determine whether specialty societies formed PE expert panels with the RUC's recommended broad composition. We found that, while some expert panels did have a broad composition, detailed information on composition was frequently missing.

The RUC Has Improved the Transparency and Representativeness of Its Recommendation Process, but Stakeholders Still Have Some Concerns about These Areas

In recent years, the RUC has taken steps to improve both the transparency and representativeness of its recommendation process. According to relevant statutory criteria and federal internal control standards, entities should maintain transparent processes for establishing relative values. To improve its transparency, the RUC increased the amount of information publicly available online, thus enhancing the public's access to information about its process. For example, in 2012, the RUC began posting the results of its votes on individual services on its website following CMS's publication of the final rule establishing the

physician fee schedule each year.⁵⁷ In 2013, the RUC began posting its meeting minutes online. Additionally, the RUC makes an online product, RBRVS DataManager Online, available for purchase that includes information on services' current DPEI and the RUC's most recent work relative value recommendations. As a result of these efforts, the public can have a better understanding of the RUC's process and knowledge of the recommendations submitted to CMS. The RUC also has taken steps to improve its representativeness by adding new specialty societies to its membership, which is important because stakeholders (such as different physician specialties) should have opportunities to comment and provide input on the RUC's process per federal internal control standards. Based on feedback from stakeholders and changing trends in patient demographics, in 2012 the RUC added a permanent seat for the American Geriatric Society, a specialty society that did not meet the criteria for having a permanent seat on the RUC but that had expertise in caring for a large, discrete patient population. The RUC also added a rotating seat for a primary care representative—in addition to the permanent seats currently held by various specialty societies that provide primary care services—to increase representation of the specialty on the RUC in response to stakeholders' concerns that primary care was underrepresented. As a result of these changes, the RUC may be able to consider an increasing variety of stakeholder perspectives.

Nevertheless, some stakeholders have continued to express concerns about both the RUC's transparency and representativeness. With respect to the RUC's transparency, some stakeholders have said that they cannot determine whether the RUC's recommendations are biased in favor of certain specialty societies because the RUC does not publish how individual members vote on services. In response to these concerns, RUC staff stated that they do not disclose how individual members vote so as to protect members' independence throughout the deliberation process from, for example, outside lobbying and potential negative feedback from colleagues. Additionally, the RUC's public total vote counts show that its votes on services are typically unanimous. RUC staff said

⁵⁷This information is posted on the RUC's website once per year and includes information from all three of the RUC's meetings for the relevant payment year. The available information on the RUC's votes on individual services includes (1) the total number of votes for and against specialty societies' work relative value and DPEI recommendations, and (2) whether specialties' work relative value recommendations were modified before and/or after they were first presented to the RUC.

this unanimity typically results from members resolving disagreements about services during deliberations (before voting occurs) and that voting does not usually align based on specialty. With respect to the RUC's representativeness, stakeholders such as the American Academy of Family Physicians have expressed concerns that primary care physicians are underrepresented on the RUC, which biases the RUC's recommendations against primary care services. According to the RUC, however, the mix of specialties represented in its membership does not affect the types of services for which it makes recommendations to CMS. The RUC also reported that it has recommended substantial increases to primary care services each time these services have been identified for review.

To try to determine whether the RUC's reviews of services underrepresented primary care services, we reviewed the categories of services for which the RUC made work relative value recommendations to CMS between 2011 and 2015. We found that over these years, the number of recommendations the RUC made to CMS for evaluation and management services (a proxy for primary care services)⁵⁸ was proportional to the total number of Medicare services in the evaluation and management category. Specifically, during this period, the 16 evaluation and management services reviewed by the RUC comprised, on average, 1 percent of the RUC's recommendations, which was equal to the percentage of all Medicare services in this category.⁵⁹ Additionally, the RUC was more likely to recommend increases for the work relative values of existing evaluation and management services than for existing services of any other category. However, evaluation and management services for which the RUC made work relative value recommendations represented only 2 percent of Medicare spending on all services with

⁵⁸We considered evaluation and management services as a useful proxy for primary care services given that the Social Security Act references certain codes for these services when making incentive payments available for primary care services. See SSA § 1833(x)(2)(B) (codified at 42 U.S.C. 1395l(x)(2)(B)).

⁵⁹The categories of services we examined (and their proportion of RUC recommendations relative to their proportion of active Medicare services, respectively) were evaluation and management (1 percent, 1 percent); medicine (22 percent, 9 percent); pathology and laboratory (3 percent, 1 percent); radiology (10 percent, 9 percent); surgery—cardiovascular/respiratory (21 percent, 14 percent); surgery—digestive (9 percent, 12 percent); surgery—integumentary (12 percent, 5 percent); surgery—musculoskeletal (9 percent, 23 percent); surgery—nervous/eye/ear (8 percent, 13 percent); and surgery—urinary/gender (5 percent, 10 percent).

RUC recommendations, which was significantly lower than the percentage of Medicare spending on all services in this category (43 percent).⁶⁰ Although these results do not indicate whether primary care services are being undervalued by the RUC, they do indicate that for payment years 2011 through 2015 the RUC reviewed these services in proportion to their numbers, but did not review these services in proportion to their impact on overall Medicare spending.⁶¹

CMS's Process for Establishing Relative Values May Not Ensure Accurate Medicare Payment Rates and Lacks Transparency

CMS's process for establishing relative values embodies several elements that cast doubt on whether it provides assurance of accurate Medicare payment rates. While CMS stated that it complies with a statutory requirement governing how often physicians' services are to be reviewed, CMS does not track when a service was last valued or have a documented standardized process for prioritizing its review of services. The agency also has limited documentation about its process, and does not have any documentation with specific information about the selected method used to review a specific RUC recommendation. Lack of transparency in its process and lack of data sources to validate RUC recommendations, combined with evidence that CMS relies heavily on the RUC for relative value recommendations despite weaknesses with the RUC's data, may undermine payment rate accuracy.

⁶⁰All other categories of services had the percentages of spending represented by reviewed services greater than the total Medicare spending on all services in those categories except for the category of alpha-numeric physicians' services, which was also underreviewed in comparison to its proportion of Medicare spending; however, these services only represented 2 percent of total 2013 Medicare spending on active physicians' services.

⁶¹According to the RUC, it conducted extensive reviews of evaluation and management services in 1997 and 2007. We did not include these reviews in our analysis because they were conducted in years that were outside the scope of our review.

CMS Does Not Track a Service's Last Valuation or Have a Documented Standardized Process for Prioritizing Reviews

CMS officials told us they comply with the statutory requirement to review relative values for all Medicare physicians' services at least every 5 years by annually identifying new, revised, and potentially misvalued services for review.⁶² Officials explained that they are not required to revalue all services every 5 years through a full revaluation process involving the RUC. Rather, CMS officials said they meet the statutory requirement to review relative values every 5 years by applying screens that are designated in statute to all services and determining whether the resulting services need to be revalued. This indicates that CMS has a process in place to ensure that relative values are reviewed regularly and revalued if necessary. The officials said they also annually identify services for review through other mechanisms as well, including conversations with stakeholders and receiving nominations from the public. Officials told us they review the results of these actions to determine which services need to be revalued.

However, we found that CMS does not have a standard process for identifying services for review each year, nor does it track when a service was last valued. To effectively apply the statutory criteria for identifying potentially misvalued services, CMS should prioritize reviews of services based on results of risk assessment and ongoing monitoring, but CMS does not have a standard process for determining which of these screens to apply in a given year. When asked how they select a screen, CMS officials said they decide in part on the basis of what they learn from (1) RUC meetings, (2) stakeholders, and (3) other sources such as the news and the internet.⁶³ Officials could not provide any supporting

⁶²See 42 U.S.C. § 1395w-4(c)(2)(B)(i). Beginning for calendar year 2012, CMS consolidated the 5-year review of relative values with the annual review of potentially misvalued services. See 76 Fed. Reg. 73206, 73055 (Nov. 28, 2011) (preamble, II.B.3.). (discussion of consolidating reviews of potentially misvalued codes). CMS officials stated they also frequently make broad-based adjustments to relative values to reflect updates to the input data used in part to establish them. However, between payment years 2011 and 2015, we found that CMS infrequently changed work relative values to active Medicare physicians' services without first reviewing a RUC recommendation.

⁶³Some of the screens CMS recently applied include Harvard-valued services for payment year 2013; high-expenditure procedural services for payment year 2012; and low-value services billed in multiple units for payment year 2011. High-expenditure procedural services referred to those services that had not been reviewed since calendar year 2006 and had calendar year 2010 allowed charges exceeding \$10 million. Low-value services that were billed in multiple units referred to those services with low work relative values (less than 0.5) that were commonly billed with multiple units in a single encounter (more than 5 times per day).

documentation to indicate how they select which screens to apply in a given year. Furthermore, CMS officials told us that they do not maintain a database to track when services were last valued; rather, they rely on the final rules addressing changes to the Medicare Physician Fee Schedule to determine when services were last valued to assist in prioritizing the review of services and then determine whether a service needs to be valued again.⁶⁴ Officials said that tracking when a service was last valued was challenging because, for example, if CMS identifies a service as potentially misvalued, the CPT Editorial Panel may then revise the service by separating it into multiple services or even deleting it. Thus, under the current process CMS officials said it was more efficient to determine when a service was last valued once it had been identified as potentially misvalued, rather than to track thousands of Medicare services individually. Although officials said they use the final rules to approximate when identified services were last valued and then determine whether a service needs to be valued again, this approach does not allow CMS to proactively flag services for review that had not been revalued over an extended period of time.

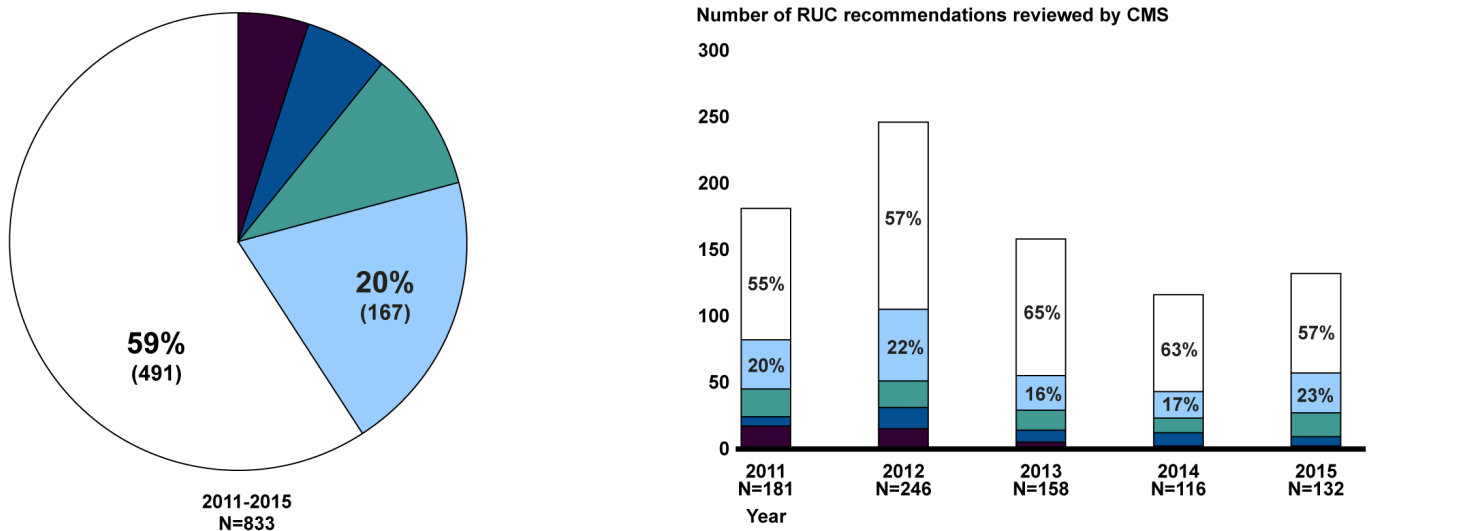
To assess the extent to which services for which CMS reviewed RUC work relative value recommendations accounted for the greatest share of Medicare spending, we reviewed the previous year's spending quintiles of the services for which the RUC developed work relative value recommendations that CMS reviewed. We found that these services were more likely to be high-expenditure services than lower-expenditure services. Specifically, for payment years 2011 through 2015, the percentage of RUC work relative value recommendations for existing services that were in the prior year's highest spending quintile and the top two spending quintiles were, on average, about 60 percent and 80 percent, respectively.⁶⁵ (See fig. 4.) In other words, the RUC and CMS prioritized their reviews of services to services that accounted

⁶⁴For example, CMS indicated in rulemaking that it has excluded identified services from RUC review because they had been reviewed for the previous payment year, and CMS determined that these services did not need to be reviewed again by the RUC so soon. In another instance, though, through rulemaking, CMS requested that the RUC review a service within 3 years of when it was last reviewed in part because of concerns that the service's DPEI did not reflect current medical practice.

⁶⁵The most recent Medicare physician services expenditure data available at the time of our analyses were from 2013, so we used 2013 expenditure data as a proxy for 2014 expenditure data when calculating the 2014 spending quintile of 2015 services.

for a large share of Medicare spending. However, due to the small number of services reviewed each year, the existing services reviewed between 2011 and 2015 represented under one-third of all Medicare expenditures on physicians' services.

Figure 4: RUC's Work Relative Value Recommendations for Existing Services Reviewed by CMS, by Previous Year's Spending Quintile (2011-2015)



Legend: RUC = American Medical Association/Specialty Society Relative Value Scale Update Committee.

Lowest spending quintile Second quintile Middle quintile Fourth quintile Highest spending quintile

Source: GAO analysis of CMS data. | GAO-15-434

Note: This analysis includes the 833 RUC work relative value recommendations for active Medicare physicians' services with spending data available from the prior year that CMS reviewed for payment years 2011-2015. This analysis does not include Medicare physicians' services for which CMS updated relative values without first receiving a recommendation from the RUC, nor does it include all recommendations that the RUC told us it submitted during the period of our review. For example, this analysis does not include RUC recommendations for services that were not covered by Medicare, services that only had editorial changes, or services for which the RUC recommended a service be deleted or bundled with other services. (Of the total 1,278 RUC work relative value recommendations for active services that CMS reviewed over this time period, this analysis thus excludes 108 recommendations for services inactive in the prior year in 2011; 89 in 2012—plus 2 recommendations for services that were active in the prior year but were missing expenditure data; 88 in 2013; 71 in 2014; and 87 in 2015.) Additionally, 2013 spending was used for both 2014 and 2015, as 2014 spending data were not available at the time of this analysis. Recommendations are listed by the payment year for which CMS reviewed them.

CMS Process for
Establishing Relative
Values Lacks
Transparency, and Heavy
Reliance on RUC
Recommendations May
Undermine Payment Rate
Accuracy

CMS makes some information about its process for establishing relative values available to the public, but some information on the services under review is not included, which limits stakeholders' knowledge about whether payment rates are likely to change for these services. Through rulemaking published in the Federal Register, CMS describes how it identifies services for review and the methods it may use to review RUC recommendations. In addition, CMS has increased the amount of information it discloses through rulemaking in recent years. For example, for payment year 2009 CMS began listing services it identified as potentially misvalued in the proposed rule. Additionally, CMS began including information in the final rule for payment year 2011 about whether it had refined the RUC's DPEI recommendations. However, although CMS rulemaking currently lists services for public comment that it or the public identified as potentially misvalued, CMS does not include information on services identified by the RUC as potentially misvalued prior to addressing the RUC's recommendations.⁶⁶ Stakeholders should have opportunities to comment and provide input on CMS's process per federal internal control standards. However, unless stakeholders monitor the RUC's activities, they are unaware that these services are under review and that payment rates for them may change until CMS publishes its responses to the RUC's recommendations for these services. Thus, stakeholder participation in CMS's process is limited because of incomplete information regarding which services are undergoing RUC—and eventually CMS—review.

Moreover, while CMS provides general information on how it reviews RUC recommendations, it does not document a process for reviewing recommendations that would identify the resources considered during its review of specific RUC recommendations. Entities should maintain a transparent process for establishing relative values, including having documentation about their processes and disclosing information upon which decisions were based to the extent possible. In the case of CMS, information provided in the proposed and final rules addressing changes to the physician fee schedule published in the Federal Register each year are the only sources of documentation about CMS's process. While past rules indicate that the agency uses multiple methods for reviewing RUC recommendations, they do not provide specific information on the

⁶⁶See, e.g., 79 Fed. Reg. 40318, 40336 (July 11, 2014) (preamble, II.B.3.); 78 Fed. Reg. 43282, 43304 (July 19, 2013) (preamble, II.B.3.); 77 Fed. Reg. 44722, 44738 (July 30, 2012) (preamble, II.B.3.).

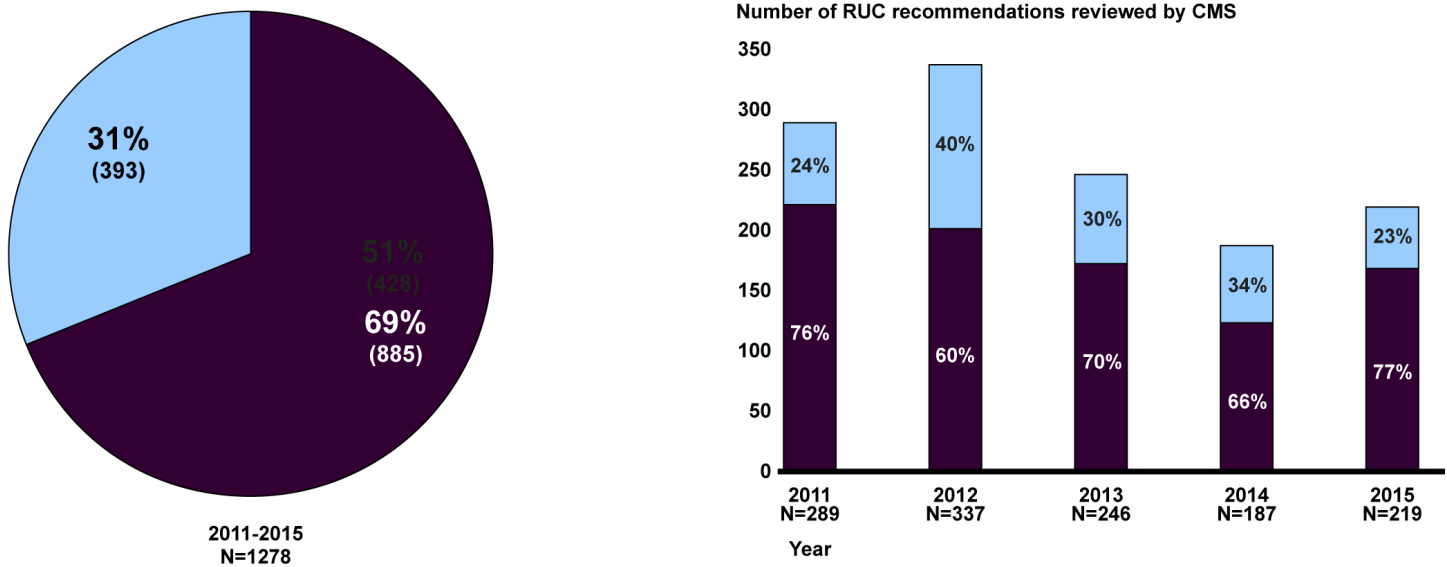
selected method used to review a particular recommendation, and thus CMS does not fully disclose information upon which its decisions were based. To try to better understand what a CMS review includes, we requested supporting documentation for two services CMS recently reviewed. However, CMS was unable to produce supporting documentation for its reviews of these services. CMS officials told us they do not have additional documentation, including internal or external policies or guidance documents, to assist them with their review of RUC recommendations. Without such documentation, there is no assurance that CMS followed a standardized process to ensure consistent reviews and accurate relative values. A standardized process is necessary to ensure that established relative values reflect differences in work relative values and DPEI rather than inconsistencies in CMS's process. Such inconsistencies may affect the relativity of services to each other and undermine the overall accuracy of Medicare payment rates for physicians' services.

While information on the process CMS uses to review specific RUC recommendations is limited, we have identified two factors that suggest CMS relies heavily on RUC recommendations when establishing relative values. First, according to CMS officials, the agency does not have its own data sources to validate RUC recommendations because such data sources do not exist, so officials generally rely on the RUC's recommendations as their primary data source for work relative value and DPEI recommendations. The RUC is currently the only source of comprehensive information available regarding the physician work, clinical staff, medical supplies, and equipment required to provide Medicare physicians' services—no alternative sources currently exist for CMS to consider that can provide information on these components for all Medicare services. Second, participation from other stakeholders in the process for establishing relative values is limited. Specifically, while CMS has provided opportunities for stakeholders to participate in the evaluation process, few stakeholders have taken advantage of them. For instance, for payment year 2012, CMS introduced a public nomination process through which anyone may nominate a potentially misvalued service for

review on an annual basis.⁶⁷ Through this public nomination process, stakeholders have an additional opportunity to provide input into CMS's process. However, CMS received no public nominations for payment year 2014, and received only two nominations for payment year 2015. CMS officials also told us that, in instances when stakeholders submit additional information for CMS to consider when reviewing a service, the submitted information often duplicates what officials had already considered. As a result, in the majority of cases, CMS has accepted the RUC's work relative value recommendation. For example, our analysis shows that between payment years 2011 and 2015, CMS agreed with the RUC's recommended work relative value on average 69 percent of the time, with its acceptance rate ranging from 60 to 77 percent. (See fig. 5.) The extent to which it agreed varied by the type of recommendation the RUC made. Specifically, CMS most often agreed with RUC recommendations to maintain the current work value (85 percent agreement rate on average, ranging from 69 to 98 percent), followed by agreement with RUC recommendations of decreases (77 percent on average, ranging from 64 to 93 percent), and RUC recommendations of work relative values for new services (64 percent on average, ranging from 46 to 77 percent).

⁶⁷See 76 Fed. Reg. 73206, 73058 (Nov. 28, 2011) (preamble, II.B.4.). (Discussion of public nomination process.) Individuals must send their nominations and any supporting documentation to CMS during the 60-day public comment period following the release of CMS's annual final rule establishing the physician fee schedule. Once it has received nominations, CMS evaluates the supporting documentation to assess whether the nominated services appear to be potentially misvalued and are appropriate for review. Supporting documentation may include (1) documentation in the peer reviewed medical literature or other reliable data that there have been changes in physician work, (2) evidence that technology has changed physician work, and (3) prices are inaccurate and do not reflect current information.

Figure 5: RUC's Work Relative Value Recommendations Reviewed by CMS, by Whether CMS Agreed or Disagreed (2011-2015)



Legend: RUC = American Medical Association/Specialty Society Relative Value Scale Update Committee.

Agreed (Dark Purple) Disagreed (Light Blue)

Source: GAO analysis of CMS data. | GAO-15-434

Note: This analysis includes the 1,278 RUC work relative value recommendations for active Medicare physicians' services that CMS reviewed for payment years 2011-2015. This analysis does not include Medicare physicians' services for which CMS updated relative values without first receiving a recommendation from the RUC, nor does it include all recommendations that the RUC told us it submitted during the period of our review. For example, this analysis does not include RUC recommendations for services that were not covered by Medicare, services that only had editorial changes, or services for which the RUC recommended a service be deleted or bundled with other services. Recommendations are listed by the payment year for which CMS reviewed them.

CMS officials have taken actions to decrease their reliance on the RUC. CMS officials said they increasingly consider additional sources of information apart from the RUC, such as the medical literature and external studies. In addition, they told us they have increased their scrutiny of the RUC's recommendations as, for example, the officials said they have become more familiar with data sources, and can identify nuances and patterns with services. As a result, CMS officials said their acceptance rate of RUC recommendations has decreased in recent

years.⁶⁸ Nevertheless, CMS's average acceptance rate of 69 percent over the past 5 years indicates that CMS continues to rely on the RUC and generally agrees with it the majority of the time. CMS officials told us they view the RUC's recommendations as a starting point and rarely establish work relative values without first receiving RUC recommendations. Officials have also stated that RUC recommendations are essential for valuing services and are a vital part of CMS's process, since the surveys conducted by specialty societies are often the best data CMS has regarding the physician work required to administer services. Although this may be true, the agency's reliance on data with identified weaknesses may still undermine the accuracy of Medicare payment rates for physicians' services.

CMS Is Developing an Approach for Validating Relative Values, but Does Not Yet Have a Specific Plan for Doing So or for Addressing Other Data Challenges

CMS does not yet have a formal process for validating RUC recommendations, but is developing an approach as required by PPACA.⁶⁹ Currently, CMS reviews the RUC's recommendations and data as part of its process for establishing relative values and agrees with or refines them based on, for example, the agency's assessment of the RUC's data or completion of a clinical review. As previously mentioned, CMS does not currently have a way to systematically (1) validate that the RUC's proposed work relative values—and the underlying time and intensity assumptions or DPEI recommendations—are correct, or (2) determine what they should be. However, PAMA specifically authorized CMS to collect and use information on physicians' services in the determination of relative values and appropriates \$2 million each year

⁶⁸According to the RUC, CMS's acceptance rate of RUC recommendations has decreased approximately 10 percent over the past decade. When asked about the declining acceptance rate, RUC staff stated that the decline in acceptance rate was due to a shift in when CMS provided feedback on RUC recommendations. According to RUC staff, CMS officials used to provide more feedback on the RUC's recommendations during RUC meetings, which would allow the RUC time to modify their recommendations before submitting them to CMS for review; today, CMS typically waits to comment on RUC recommendations through rulemaking.

⁶⁹See Pub. L. No. 111-148, § 3134(a), 124 Stat. 435 (codified in pertinent part at 42 U.S.C. § 1395w-4(c)(2)(L)). PPACA provides that the validation process may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intraservice components of work, meaning the amount of time required before a procedure, during a procedure, and after a procedure for a particular service.

beginning with fiscal year 2014 to carry out this authority.⁷⁰ Although CMS officials told us it is too soon to say how they will spend these funds, CMS has used other funds to contract with two external entities—the Urban Institute and the RAND Corporation—to develop validation models for relative values. These contracts focus on validating work relative values for which recommendations are developed by the RUC.

- The Urban Institute contract focuses on collecting time data for a selection of services from different health care entities, given that there have been concerns about the accuracy of the times used to estimate work relative values.⁷¹ The Urban Institute’s goal is to collect data from administrative sources, such as electronic health records, and direct observations in order to, among other things, compare new time data against the current times used for the selected services and to develop alternative work models of work values. As of November 2014, the Urban Institute had issued an interim report that included a discussion about the challenges it had encountered when collecting objective time data.⁷² We spoke with the researchers, who told us that their biggest challenge was trying to use the RUC’s descriptions of the services when collecting data through direct observations; specifically, the RUC’s descriptions differed from what was observed, such as the tasks actually performed and by whom (e.g., a physician versus clinical staff).
- The RAND Corporation contract focused on using existing time data to develop validation models to predict work relative values and the individual components of work relative values (time and intensity), based on a subset of surgical services.⁷³ RAND issued its final report

⁷⁰See Pub. L. No. 113-94, § 220(a)(1), 128 Stat. 1070 (codified at 42 U.S.C. § 1395w-4(c)(2)(M)). For example, CMS is authorized to collect or obtain information from any eligible professional or any other source on the resources directly or indirectly related to furnishing services for which payment is made under Medicare.

⁷¹Two other contractors, Social & Scientific Systems, Inc., and RTI International, are also involved in the Urban Institute’s project.

⁷²See the Urban Institute, et al., *Development of a Model for the Valuation of Work Relative Value Units: Objective Service Time Task Status Report* (Washington, D.C.: June 30, 2014).

⁷³Available time data used for this study included data from Medicare claims data, New York Statewide Planning and Research Cooperative System data, and data from the American College of Surgeons National Surgical Quality Improvement Program.

in November 2014.⁷⁴ RAND researchers told us they deconstructed the total work relative values for the selected services into, for example, the different times and intensities required to complete the work depending on whether it was the beginning, middle, or end of the service, such as the time required for scrubbing up before a service or evaluating a patient afterward. They used these deconstructed times and intensities to help develop models that could predict new values for these subcomponents and, when summed together, estimate new total work relative values. In developing its models, RAND found that its estimates of intraservice time estimates, which were based on data from existing databases, were typically shorter than the current CMS estimates (which consider the RUC's estimates). RAND developed several models for predicting total work relative values, each of which accounts for different modeling choices.⁷⁵

CMS officials were unable to tell us how they intend to use the results of the Urban Institute's and RAND Corporation's studies, but both contractors have highlighted areas where further work is needed before CMS will be able to fully validate relative values. For example, the RAND Corporation reported that additional research is needed in determining how to quantify and validate the intensity component of work relative values. Additionally, the Urban Institute reported that the accuracy of the RUC's descriptions of services needs further review. Further review is important because if physicians are no longer performing certain tasks associated with a service, then including these tasks in an estimate of a physician's work relative value could lead to inflated Medicare payment rates for that physician service.

CMS's validation approach will also require determining whether it is appropriate to validate relative values at the service level or physician level and the extent to which some other mechanism—such as an independent panel of experts—would be useful. The Urban Institute and RAND both adopted a “bottom-up” approach to validating work relative

⁷⁴See RAND Corporation, *Development of a Model for the Validation of Work Relative Value Units for the Medicare Physician Fee Schedule* (Santa Monica, Calif.: 2014).

⁷⁵For example, because it was unclear the effect changes to intraservice time would have on intensity and therefore valuing intra-service work, RAND developed three models to account for how changes in intraservice time that could have (1) no effect on intra-service work because the changes in time were offset by changes in intensity, (2) an effect on intraservice work because the changes in time did not affect intensity, or (3) a blend of the two previous situations.

values, meaning that the collection and analysis of data would be focused on specific services. However, in 2014 MedPAC expressed some concerns about a “bottom-up” approach, including that, among other things, analyses conducted on a service-by-service level are costly, burdensome, and subject to bias.⁷⁶ In light of these concerns, MedPAC suggested a “top-down” approach, which, in contrast, involves the physician as the unit of analysis and examines the mix of services provided by the physician and the total time worked on the services. In addition to a top-down or bottom-up approach, another mechanism for validating work relative values could come from an independent technical panel. MedPAC has previously recommended that CMS create such a panel—which may include individuals with expertise in health economics and physician payments, along with clinical expertise—to help CMS establish more accurate relative values and to reduce its reliance on the RUC.⁷⁷ When we asked whether they had considered convening such a panel, CMS officials told us they had not because determining the right balance of expertise among panelists would be challenging and that, if the panel were to include physicians, it would likely duplicate the current RUC process. However, until CMS determines what process it can use to validate the RUC’s recommendations against other sources, it will not be able to address the shortcomings with the RUC’s data.

CMS also has limited pricing information for DPEI, but the agency is exploring options for obtaining more accurate, reliable pricing data. CMS has repeatedly stated in rulemaking that it is difficult for the agency to obtain reliable pricing data for DPEI; that its pricing information is almost exclusively anecdotal; and that officials sometimes price items on the basis of a single or small number of invoices. While the RUC submits paid invoices for new medical supplies and equipment to CMS, RUC staff told us that providing pricing information for other medical supplies and equipment is outside of the scope of their expertise and that CMS should obtain this information directly from manufacturers or other sources. CMS encourages other stakeholders to provide CMS with updated pricing as

⁷⁶See Medicare Payment Advisory Commission, *Validating Relative Value Units in Medicare’s Fee Schedule for Physicians and Other Health Professionals* (Washington, D.C.: Oct. 10, 2014).

⁷⁷See Medicare Payment Advisory Commission, *Medicare Payment Policy* (March 2006), ch. 3.

well,⁷⁸ and has pursued other options for obtaining reliable pricing data in the past. For example, CMS has contracted with consultants to obtain pricing data and has considered using data from the General Services Administration medical supply schedule. When asked about revisiting these approaches, CMS officials told us that there were advantages and disadvantages to them and that they continue to consider ways to obtain reliable pricing data and that any plans for doing so will be proposed through rulemaking.⁷⁹ PPACA requires CMS to develop a plan to validate the data used to establish relative values and specifically authorized CMS to employ a range of specific activities to conduct the analysis, including the use of contractors to collect data for validating relative values.⁸⁰ These activities may then generate additional data sources against which CMS could validate the data used to establish relative values. CMS officials told us they are considering using the funds appropriated by PAMA to obtain more accurate, reliable pricing data, but they did not share whether they would use contractors to obtain these data. Because CMS does not have a specific timeline or plan for using these funds, including how these funds may be used to assist CMS with developing its validation approach, it continues to delay establishing a process to validate the accuracy of payment rates under the fee schedule, as required by statute.

⁷⁸In discussing the updating of equipment and supply price inputs for calendar year 2011, CMS indicated that it was finalizing a process to act on public requests to update these price inputs annually through rulemaking; however, CMS officials have told us that they do not receive many recommendations on prices from the public. See Payment Policies Under the Physician Fee Schedule for CY 2011, CMS final rule with comment period, 75 Fed. Reg. 73170, 73205 (Nov. 29, 2010) (preamble, II.A.3.e.).

⁷⁹For example, officials said that a disadvantage to using contractors to obtain pricing data is that the pricing information obtained by the contractor may come from vendors who, like physicians, also have a financial interest in the outcome of the process. An advantage to this approach is that the contractor would be able to spend time seeking out alternative sources of pricing data. According to officials, in terms of using the General Services Administration medical supply schedule, a disadvantage is that many of the supplies and equipment used for Medicare physicians' services are not included on this medical supply schedule. An advantage, however, is that the prices are likely more reflective of what individuals pay for these supplies.

⁸⁰See Pub. L. No. 111-148, § 3134(a), 124 Stat. 434 (codified in pertinent part at 42 U.S.C. § 1395w-4(c)(2)(K)(iii)(L)).

Conclusions

Given the amount of Medicare spending on physicians' services—approximately \$70 billion in 2013—and that other payers base their payment rates at least in part on Medicare payment rates for physicians' services, the accuracy of Medicare payment rates has major implications for the health care system. For example, financial incentives could induce some physicians to oversupply overvalued services and undersupply undervalued services. Moreover, if categories of services are systematically overvalued, the accompanying financial incentives could affect individuals' decisions to become trained in certain specialties. Thus, it is important for CMS to establish accurate Medicare payment rates for physicians' services to promote prudent spending of taxpayers' and beneficiaries' money and to promote a workforce that provides appropriate care for patients.

Weaknesses in the RUC's relative value recommendation process and in its data present challenges for ensuring accurate Medicare payment rates. First, physicians who serve Medicare beneficiaries—including members of the RUC and specialty societies—may have potential conflicts of interest with respect to the outcomes of CMS's process for setting payment rates for Medicare physicians' services. Second, we found some of the RUC's survey data to have low response rates, low total number of responses, and large ranges in responses. While we acknowledge it is difficult to collect sufficient and reliable data, especially for low-volume Medicare services, these challenges nonetheless undermine the reliability of the RUC's recommendations to CMS. Furthermore, because CMS relies on the RUC's recommendations when establishing relative values, these challenges may also result in CMS setting inaccurate Medicare payment rates for physicians' services.

In addition, CMS's process lacks transparency. In particular, because CMS does not document the data sources it considered during its review of specific RUC recommendations, it cannot demonstrate what other resources it relied on to make its decisions and cannot assure that it is following a consistent process. Furthermore, although CMS rulemaking currently lists services that CMS or the public identified as potentially misvalued, it does not include services identified by the RUC in this list. Without advance notice of all potentially misvalued services identified for review, the extent to which stakeholders can participate is limited, and CMS may be missing opportunities to enhance stakeholder involvement and improve the accuracy of relative values, and thus, payment rates.

The RUC is currently the only source of comprehensive information available regarding the physician work, clinical staff, medical supplies, and equipment required to provide Medicare physicians' services—no alternative sources currently exist for CMS to consider that can provide information on these components for all Medicare services. CMS has begun taking steps to improve its process by beginning research on how to develop an approach for validating relative values; however, it does not yet have a specific plan for how it will do so, nor how it will use funds appropriated for the collection and use of data on physicians' services or how it will address other data challenges. Without a timeline and a plan for determining its approach, including how it will use the funds appropriated by PAMA to assist it with validation, CMS risks continuing to use payment rates that may be inaccurate.

Recommendations for Executive Action

The Administrator of CMS should take the following three actions to help improve CMS's process for establishing relative values for Medicare physicians' services:

1. Better document the process for establishing relative values for Medicare physicians' services, including the methods used to review RUC recommendations and the rationale for final relative value decisions.
2. Develop a process for informing the public of potentially misvalued services identified by the RUC, as CMS already does for potentially misvalued services identified by CMS or other stakeholders.
3. Incorporate data and expertise from physicians and other relevant stakeholders into the process as well as develop a timeline and plan for using the funds appropriated by PAMA.

Agency and Third Party Comments and Our Evaluation

We provided a draft of this report for review to HHS and received written comments that are reprinted in appendix II. Because of the focus on the RUC in this report, we also provided the AMA an opportunity to review a draft of this report. We received written comments from the AMA, which we have summarized below. Following is our summary of and response to comments from HHS and the AMA.

HHS Comments

In its comments, HHS concurred with two of our three recommendations, and summarized the steps the agency has already taken to increase transparency of its process and stakeholder involvement. Specifically, HHS concurred with our recommendation that CMS better document its process for establishing relative values, including the methods it used to review RUC recommendations. HHS stated that CMS establishes work relative values for new, revised, and potentially misvalued services based on its review of a variety of sources of information, including the RUC. HHS also stated that CMS assesses the methodology, data, and underlying rationale the RUC uses to develop its recommendations, and that CMS continues to improve the transparency of its process by including more detail on its process in its rulemaking. As an example, HHS noted that CMS has provided more details in its rulemaking regarding its review of the RUC's DPEI recommendations. While we acknowledge that CMS has increased documentation of its process in rulemaking, we believe that documentation is lacking for other aspects of CMS's process. For example, as we stated in the report, CMS officials told us they do not have additional documentation, including internal or external policies or guidance documents, to assist them with their review of RUC recommendations. Without such documentation, stakeholders have no assurance that CMS followed a standardized process to ensure consistent reviews and accurate relative values.

HHS also concurred with our recommendation that CMS incorporate data and expertise from relevant stakeholders into its process and develop a timeline and plan for using the funds appropriated by PAMA. HHS stated that CMS's process allows stakeholders to annually nominate potentially misvalued services for review, and that members of the public may attend RUC meetings. HHS also stated that CMS is assessing the outcomes of the Urban Institute's and RAND's research to determine the most effective and fiscally responsible way to use the funds appropriated by PAMA. HHS indicated that CMS is using the outcomes of this research to help inform the development of a timeline for use of the funds appropriated by PAMA, but since this work is ongoing, HHS did not provide an estimate of when CMS might finalize such a timeline. We acknowledge that CMS has taken steps to incorporate additional data and expertise into its process, and we describe these steps in our report. However, we believe that CMS needs to do more in both of these areas to increase the accuracy of Medicare physician payment rates. For example, CMS could take specific actions to determine how to incorporate more accurate and reliable sources of pricing data into its process. In addition, CMS could incorporate input from stakeholders apart from the RUC into its process—such as from salaried physicians or those

who serve non-Medicare beneficiaries, or from individuals with expertise in physicians' payments—through methods not limited to public comment on rulemaking.

HHS did not concur with our recommendation to include the services identified as potentially misvalued by the RUC in its rulemaking to allow for public comment, prior to finalizing its list of potentially misvalued services for the RUC to review. While HHS acknowledged that some stakeholders may not be aware of all potentially misvalued services being reviewed by CMS prior to the establishment of interim final values for those services in a final rule, HHS expressed concern that implementing the recommendation would require CMS to identify all potentially misvalued services through notice and comment rulemaking before the RUC begins its review process. It was not our intention to recommend CMS establish a new rulemaking process or delay the timing of its reviews of services. Therefore, we reworded our recommendation to clarify that CMS may determine how best to inform stakeholders of services identified as potentially misvalued by the RUC and for which payment rates may subsequently change. HHS also described the steps it had already announced it would take to improve the transparency of its process, beginning for payment year 2017, such as including proposed changes in the relative values for almost all services in the proposed rule, and finalizing changes only after CMS considers and responds to public comments in the final rule. The elimination of most interim final relative values will allow stakeholders to comment on values before they become effective, which is not the case under the current process. However, under the new process CMS does not plan to inform the public of services identified by the RUC as potentially misvalued. We believe it is important for CMS to inform stakeholders of those services identified by the RUC as potentially misvalued before CMS receives RUC recommendations for these services and subsequently publishes values in the proposed rule each year, as CMS does for services the agency or the public has identified as potentially misvalued. Informing stakeholders about all potentially misvalued services identified for review—including those identified by the RUC—would facilitate greater transparency of CMS's process and give stakeholders more time to provide input on values for these services if they so choose.

AMA Comments

Overall, the AMA agreed with our recommendations, though the AMA also stated that it is important for CMS to implement our recommendation regarding publishing the services the RUC identified as potentially misvalued in a way that does not delay the RUC's process. The AMA also stated that the draft report did not sufficiently acknowledge the challenges in collecting reliable survey data—especially for low-volume services—and that the RUC's survey methodology, followed by rigorous cross-specialty review, is the best available approach to collecting this data.

In particular, the AMA stated that the report's principle criticism of the RUC process of developing work relative value recommendations is that the RUC's reliance on survey data is insufficient to ensure accurate work relative value recommendations. The RUC requires a random sample from specialty societies, and the AMA pointed out that many specialty societies email their entire membership or a large sample of their membership to obtain survey responses. The AMA also noted that a low response rate is "understandable" given that 80 percent of services paid under the Medicare Physician Fee Schedule with physician work relative values assigned to them are performed under 10,000 times per year. The AMA stated that it is a testament to the RUC's efforts that we found specialty societies collected an average of 52 physician responses. Furthermore, in response to our finding that most of the surveys we reviewed for payment year 2015 had at least one response in which the respondent reported not performing the surveyed service within the past year, the AMA asserted that the opinion and experience of physicians who have performed the service (even if not very recently) are still valid contributions. We recognize it is difficult to obtain reliable survey data, especially if a service is rarely performed, and that physicians can still provide clinical expertise for a service even if they did not perform the service within the past year. However, these issues still call into question the reliability of the RUC's recommendations, which underscores the importance of our recommendations that CMS seek additional sources of reliable data to incorporate into its process, as well as develop a timeline and plan for using the funds appropriated by PAMA to develop its approach for validating relative values, including the RUC's recommendations.

The AMA also described how the RUC relies on magnitude estimation as the methodology to develop physician work relative values, and noted that the RUC's use of physician survey data is only the beginning of the process to establish work relative value recommendations. However, we have some concerns with relying on the RUC's review of services through magnitude estimation to supplement the absence of reliable data on

specific services. As we stated in the report, the accuracy of the results of magnitude estimation depends both on the accuracy of previously established relative values, which may also suffer from the same reliability issues, and physicians' abilities to accurately determine the relativity between services, which is very difficult to do for services as disparate as primary care visits and complex surgeries. It is therefore unclear the extent to which magnitude estimation—without other reliable data about the work it takes to perform a service—is sufficient to generate accurate work relative value recommendations.

Finally, the AMA noted that the RUC would welcome the identification of other reliable data that would provide a representative and consistent source of information to be considered in addition to survey data. To date, the AMA has found only one reliable set of extant physician time data, the Society of Thoracic Surgeons Database, which the RUC has used in its valuation process. We agree that the RUC is currently the only source of comprehensive information available regarding the physician work, clinical staff, medical supplies, and equipment required to provide Medicare physicians' services, and have clarified this point in our report. The AMA also stated that the report suggested the Urban Institute was unable to obtain accurate time data based on the RUC's definition of time or services, and commented that the RUC's definitions of physician time were established by Harvard and CMS, not the RUC. While it is true that Harvard and CMS were responsible for determining the initial definitions for the physician work required to provide Medicare physicians' services, the AMA was also involved in that effort. For example, when Harvard researchers surveyed physicians about the work required to perform services, the descriptions of the services were based on AMA's CPT descriptions or on descriptions provided by small groups of physicians representing different specialties that were identified through a process coordinated by the AMA. With respect to RAND's research, the AMA commented that we failed to mention that RAND generally found that CMS's current work valuations of services were consistent with RAND's predicted work valuations. As we stated in the report, RAND's estimates of intraservice time were typically shorter than the current CMS estimates. As a result, RAND developed several models for predicting work relative values, because the implications of these shorter times on intensity and hence overall work relative values are currently unknown.

AMA also provided technical comments on a draft of this report, which we have incorporated as appropriate.

We are sending copies of this report to appropriate congressional committees, the Administrator of CMS, and other interested parties. In addition, the report is available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or at cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

A handwritten signature in black ink, appearing to read "James C. Cosgrove". The signature is stylized with large, flowing loops and a prominent initial "J".

James C. Cosgrove
Director, Health Care

List of Committees

The Honorable Orrin G. Hatch
Chairman

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman

The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Paul Ryan
Chairman

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
House of Representatives

Appendix I: Establishing Relative Values for a Medicare Physician Service through the RUC and CMS Processes

The process to develop and establish relative values involves three main steps: (1) the Centers for Medicare & Medicaid Services (CMS), the American Medical Association's (AMA) Relative Value Scale Update Committee (RUC), and the AMA's Current Procedural Terminology (CPT) Editorial Panel identify services for the RUC to review;¹ (2) the RUC works with specialty societies to use surveys and other methods to develop work relative value and direct practice expense input (DPEI) recommendations for CMS for identified services; and (3) CMS considers each RUC recommendation it receives to determine whether to use it when establishing relative values for physicians' services. To describe how a service is reviewed through the RUC's and CMS's processes and the timeline for establishing relative values, we selected an active Medicare physician service that had recently been valued through these processes for a case study. The service we selected was CPT code 31647, which is used to report the insertion of bronchial valve(s).² RUC staff told us that this service was reviewed through its standard process.

Step 1: Services identified for RUC review (October 2011 – February 2012)

At its October 2011 meeting, the CPT Editorial Panel identified CPT code 31647—a new service—for the RUC to review. This service was one of three new services created to report the sizing and insertion or removal of bronchial valves.³ CPT code 31647 and the other two new services were previously reported using temporary CPT codes that are reserved for tracking new and emerging technologies and were assigned final CPT codes once the CPT Editorial Panel determined that the services had become more widespread; in other words, that the services were

¹The CPT Editorial Panel is responsible for maintaining the list of descriptive terms and CPT codes used to report physician services and ensuring it matches current medical practice. The Panel's duties include creating CPT codes for new services and deleting or revising CPT codes for existing services (for example, by making editorial changes to the descriptions of services).

²According to the CPT Editorial Panel, this service is a bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe.

³The other two new CPT codes were 31648 and 31649, both of which involve the removal of bronchial valves.

generally performed by many physicians in clinical practice in multiple locations.

Once the CPT Editorial Panel identified CPT code 31647 for review, it forwarded the service—along with the other additions and revisions to services it was proposing for payment year 2013—to RUC staff, who then worked with RUC specialty societies to determine what action the RUC would take regarding the service. For example, the RUC may decide to develop work relative value and DPEI recommendations to submit to CMS for a service, or may decide to refer a service to the CPT Editorial Panel for further review. In the case of CPT code 31647, the American College of Chest Physicians and the American Thoracic Society both indicated an interest in developing work relative value and DPEI recommendations for this service. Given their shared interest, these two specialty societies agreed to survey physicians about CPT code 31647 and develop joint recommendations for the RUC to consider during its January 2012 meeting.⁴

RUC staff told us that during the January 2012 RUC meeting, the American College of Chest Physicians and the American Thoracic Society recommended that the description of CPT code 31647 be revised, as well as that a second code be established to report the insertion of bronchial valves, to parallel the two services the CPT Editorial Panel had established to report the removal of bronchial valves.⁵ The RUC accepted this recommendation, and referred the service to the CPT Editorial Panel for review. During its February 2012 meeting, the CPT Editorial Panel accepted the RUC's recommendation to revise CPT code 31647. The CPT Editorial Panel then forwarded the service to RUC staff,

⁴The RUC recommends that specialty societies work together to develop recommendations if more than one society has an interest in the particular service identified for review.

⁵RUC staff told us that CPT code 31647 was originally established as an “add-on code” to describe the insertion of bronchial valves in lungs; that is, it could only be reported in conjunction with codes that described the primary procedure of which it was a part, a bronchoscopy. Conversely, CPT code 31648 was established as a code that could be reported separately (a “stand-alone code”) to describe bronchoscopies that include the removal of valves from one lobe of the lung, and 31649 was established as an accompanying add-on code to describe the removal of valves from additional lobes of the lung. In January 2012, the American College of Chest Physicians and the American Thoracic Society recommended that 31647 be revised as a stand-alone code with its own add-on code, to parallel the structure of 31648 and 31649. In February 2012, the CPT Editorial Panel revised 31647 and created add-on code 31651.

after which the American College of Chest Physicians and the American Thoracic Society reaffirmed their decision to survey the service and to develop joint recommendations for the April 2012 RUC meeting.

Step 2: RUC develops recommendations (February 2012 – May 2012)

Specialty societies develop work relative value recommendations based on surveys

In preparation for the April 2012 RUC meeting, the American College of Chest Physicians and the American Thoracic Society distributed the RUC's standard work survey to a random sample of their members but did not receive a sufficient number of responses; the specialty societies then distributed the survey to a targeted sample of 85 physicians who were trained to perform the service and/or who owned the equipment required to perform the service based on a list of physicians provided by a medical device vendor. The specialty societies obtained responses from 30 out of 85 physicians for a response rate of 35.2 percent, which met the RUC's required minimum number of survey responses.⁶ The specialty societies used 16 out of 30 responses (53.3 percent) for the intensity portion of the survey.⁷

The American College of Chest Physicians and the American Thoracic Society's joint relative value committee analyzed the survey data collected for CPT code 31647 and determined that the median work relative value of 4.40 (survey responses ranged from 1.50 to 6.00) and median intraservice time of 60 minutes were appropriate. The joint relative value committee also determined that 30 minutes of postservice time was appropriate. Although the median survey results for preservice time were 42.5 minutes, the committee determined that the RUC's standardized preservice package of 25 minutes was appropriate for CPT

⁶The RUC requires specialties to obtain 30 responses for services with Medicare utilization under 100,000; the American College of Chest Physicians and the American Thoracic Society estimated that CPT code 31647 was performed 450 times per year nationally, including 225 times for Medicare patients. Both specialty societies indicated that their physicians rarely performed the service.

⁷Responses to the intensity portion of the survey are only reported for those respondents that choose the most common reference service. A reference service is a service selected by survey respondents from a list of 10 to 20 relevant services (referred to as the reference service list) whose relative values the RUC has determined are sufficiently accurate and stable to compare with other services.

code 31647.⁸ RUC staff told us that if specialty societies cannot justify survey respondents' median preservice time estimates, they usually recommend using the RUC's standardized time packages.

Specialty societies develop DPEI recommendations based on PE expert panels

The American College of Chest Physicians and the American Thoracic Society's joint practice expense (PE) committee met via conference call to review the set of direct practice expense inputs—and the associated times and quantities—necessary to perform the service. The joint PE committee consisted of 2 private practice physicians, 2 academic-based physicians, 2 medical practice administrators, 1 registered nurse consultant, and 1 certified public accountant. The committee determined that 13 minutes of preservice clinical labor time divided among completing patient referral forms (5 minutes), coordinating presurgery services (3 minutes), scheduling space and equipment (3 minutes) and allowing for follow-up phone calls and prescriptions (2 minutes) was required to perform CPT code 31647.

Specialty societies present work relative value and DPEI recommendations at RUC meeting; RUC then decides on recommendations to send to CMS

At the April 2012 RUC meeting, three members of the American College of Chest Physicians and the American Thoracic Society presented their joint committee's work relative value and DPEI recommendations for CPT code 31647 to the RUC and the RUC's PE Subcommittee, respectively. RUC staff told us that prior to the meeting, a fourth member disclosed a financial interest in 31647 because he worked as a consultant and researcher for a relevant medical device manufacturer. The RUC's Financial Disclosure Workgroup determined that this member could provide a brief (less than 5 minutes) presentation describing how the service was performed, and then had to leave the RUC deliberation

⁸In 2008, the RUC created standard estimates of the time it takes physicians to complete the common preservice activities (1) evaluating patients; (2) positioning patient; and (3) "scrub, dress, wait," for specialty societies to use when developing work relative value recommendations.

table.⁹ Also prior to the meeting, RUC staff assigned members of the RUC to prereview each recommendation and lead the RUC's deliberations on the service.

During the meeting, the RUC PE Subcommittee reviewed the specialty societies' DPEI recommendation for CPT code 31647 and forwarded it to the full RUC committee for consideration without modification. The RUC reviewed the work relative value and DPEI recommendations for CPT code 31647 and achieved a two-thirds majority vote to accept both recommendations without modification.¹⁰ The RUC also flagged CPT code 31647 as a new technology service, to be rereviewed in 2016 after additional years of Medicare utilization data would be available. In May 2012, the RUC sent its work relative value and DPEI recommendations for CPT code 31647—as well as for other services deliberated during the April 2012 meeting—to CMS to be considered for the upcoming 2013 payment year.

Step 3: CMS establishes relative values (May 2012 – December 2013)

CMS reviews RUC recommendations, then establishes and publishes relative values in Federal Register

Between May 2012 and November 2012, CMS reviewed the RUC's recommendations for CPT code 31647. In the November 2012 final rule establishing the physician fee schedule for payment year 2013, CMS indicated that it accepted the RUC's recommended work relative value of 4.40 without refinement on an interim final basis but refined elements of the RUC's recommended clinical labor DPEI.¹¹ However, CMS's refinements matched the original DPEI recommendations submitted by

⁹The RUC established a permanent Financial Disclosure Workgroup in 2008 to (1) review the financial disclosure statements individuals who present recommendations to the RUC are required to complete prior to the RUC meeting, and (2) determine whether any restrictions should be placed on individuals' presentations to the RUC.

¹⁰RUC staff told us that they did not record total vote counts in 2012 and so could only report whether the recommendations achieved the two-thirds majority vote required to be accepted by the RUC.

¹¹77 Fed. Reg. 68892, 69035, 69046, 69094 (Nov. 16, 2012) (preamble, tables 30, 39 and 74). Specifically, CMS refined the RUC's clinical labor DPEI recommendations for completing preservice patient referral forms from 3 minutes to 5 minutes and for coordinating presurgery services from 5 minutes to 3 minutes.

the RUC. CMS was unable to provide additional supporting documentation on its review of the service when asked, and RUC staff told us they did not have any information about CMS's clinical review of its recommendations for the service apart from what was included in the Federal Register.

RUC and others have 60 days to comment

In December 2012, the RUC commented in writing on CMS's final rule, including CMS's decisions regarding the RUC's recommendations for CPT code 31647. According to the comment letter, the American Thoracic Society agreed with CMS's refinements to its clinical labor DPEI recommendations for CPT code 31647; RUC staff told us that the American College of Chest Physicians did not comment on CMS's refinements to the service. CMS's interim final values included in the November 2012 final rule went into effect for the 2013 payment year beginning January 1, 2013.

CMS may refine previously established relative values

In the final rule establishing the physician fee schedule for payment year 2014, which was published in December 2013, CMS finalized the interim final work relative value and DPEI for CPT code 31647 without further refinement.

Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

APR 27 2015

James Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy*" (GAO-15-434).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICARE PHYSICIAN PAYMENT RATES: BETTER DATA AND GREATER TRANSPARENCY COULD IMPROVE ACCURACY (GAO-15-434)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS is committed to ensuring that Medicare payment rates for physicians' services are accurate and appropriate, thereby acting as a good steward of taxpayer dollars.

The Centers for Medicare and Medicaid Services (CMS) sets relative values for physician services, which are then converted to payment rates to accurately establish the value of services relative to each other. Since the inception of the Physician Fee Schedule (PFS), it has been a priority of CMS to revalue services regularly to assure that the payment rates reflect the changing trends in the practice of medicine and the relative costs of furnishing services using the most accurate data possible. CMS encourages participation of all stakeholders in the revaluation process and continually seeks new data and methods to assist in determining accurate relative values.

GAO Recommendation

Better document the process for establishing relative values for Medicare physicians' services, including the methods used to review RUC recommendations and the rationale for final relative value decisions.

HHS Response

HHS concurs with this recommendation. CMS establishes work relative values for new, revised and potentially misvalued codes based on our review of information that generally includes, but is not limited to, recommendations received from the American Medical Association/Specialty Society Relative Value Update Committee (RUC), the Health Care Professionals Advisory Committee (HCPAC), the Medicare Payment Advisory Commission (MedPAC), and other public commenters; medical literature and comparative databases; as well as a comparison of the work for other codes within the Medicare PFS, and consultation with other physicians and health care professionals within CMS and the federal government, as stated in the CY 2015 PFS Final Rule. We also assess the methodology and data used to develop the recommendations submitted to us by the RUC and other public commenters, and the rationale for their recommendations. CMS continues to improve the transparency of its process by revising the rules on a regular basis to include more detail on the process and address public comments. For example, over several years, HHS has continued to provide more details regarding how CMS uses the RUC-recommended direct Practice Expense (PE) inputs in the PE methodology. Currently, the RUC recommends direct PE inputs to CMS through inconsistent formats that are not conducive to public transparency. At significant cost, CMS is developing a means of displaying the RUC-recommended direct PE inputs in a consistent and transparent manner that will allow for greater documentation of the information crucial to the development of PE Relative Value Units (RVUs).

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICARE PHYSICIAN PAYMENT RATES: BETTER DATA AND GREATER TRANSPARENCY COULD IMPROVE ACCURACY (GAO-15-434)

GAO Recommendation

Include the services identified as potentially misvalued by the RUC in its rulemaking to allow for public comment, prior to finalizing its list of potentially misvalued services for the RUC to review.

HHS Response

HHS does not concur with this recommendation. This recommendation would have CMS go through notice and comment rulemaking to identify all potentially misvalued codes prior to the RUC undertaking any review. The RUC is a committee of the American Medical Association that is completely independent of CMS. CMS has no authority to set the RUC's agenda for which codes are reviewed. CMS currently identifies codes as potentially misvalued in order to facilitate prioritization of public review, not to limit when codes can be considered as potentially misvalued by members of the public or by CMS itself. For example, through our process for public nomination of potentially misvalued codes, we have on several occasions reviewed requests and proposed appropriate revaluations based on information presented in the request. In all of these cases, the proposed revaluations were adopted through the rulemaking process subject to public comment, but the initial review was not undertaken at the direction of CMS. We believe annual notice and comment rulemaking is the proper means to propose new values for services, regardless of whether or not a code has previously appeared in a prioritized list of potentially misvalued codes for public review.

As we have stated in rulemaking (79 FR 67604), we recognize that some stakeholders, including those practitioners represented by societies that are not participants in the RUC process, may not be aware of the new, revised, and potentially misvalued codes that are under review by CMS prior to the establishment of interim final values in a final rule. This is one of several reasons that, through rulemaking in CY 2015, we proposed and finalized a significant change in the process for establishing or revising values for new, revised and potentially misvalued codes. Beginning in CY 2016, CMS will begin to include proposed values for some new, revised or misvalued codes in the annual proposed rulemaking, instead of establishing values on an interim final basis in the final rule with comment period. This means that the changes in values for these services will be open for public comment, permitting us to hear from those whose views may not have been fully represented in the RUC review process and who may recommend alternative values, prior to the implementation of changes to payment. CY 2016 will be a transition year where proposals are included in the proposed rule for some new, revised and potentially misvalued codes, while others will continue to be valued as interim final subject to public comment in accordance with our previous process. We adopted 2016 as a transition year to enable us to continue rapidly revaluing misvalued codes, while allowing code and valuation review schedules to adapt to our new process. Beginning in CY 2017, changes in values for almost all misvalued codes will be included in the PFS proposed rule, and implemented only after we consider and respond to public comments.

Finally, making proposed revaluations for individual services contingent on the inclusion of the services on prioritized lists would likely undermine the entire misvalued code initiative by

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICARE PHYSICIAN PAYMENT RATES: BETTER DATA AND GREATER TRANSPARENCY COULD IMPROVE ACCURACY (GAO-15-434)

delaying the revision of misvalued codes by several years, creating perverse payment incentives by eliminating (or postponing) appropriate revaluations of related services within the relative value scale, and undermining CMS's ability to improve the accuracy of RVU calculations using updated data.

GAO Recommendation

Incorporate data and expertise from physicians and other relevant stakeholders into the process as well as develop a timeline and plan for using the funds appropriated by the Protecting Access to Medicare Act of 2014 (PAMA).

HHS Response

HHS concurs with this recommendation. Presently, stakeholders have the opportunity each year, through a public nomination process, to nominate potentially misvalued services for review. Members of the public may also attend RUC meetings and observe deliberations. As noted in the GAO Report, CMS has contracted with the Urban Institute and the RAND Corporation to gain insight on validating work relative values that are recommended by the RUC. CMS is assessing this research to determine the most effective and fiscally responsible way to use the funds appropriated by PAMA. This work is ongoing and CMS is using this work to understand the data collection limitations that exist and help inform the development of a timeline for the use of PAMA funds.

Appendix III: GAO Contacts and Staff Acknowledgments

GAO Contact:

James C. Cosgrove, (202) 512-7114 or cosgrovej@gao.gov

Staff Acknowledgments

In addition to the contact named above, Gregory Giusto, Assistant Director; Marissa D. Barrera; Alison Binkowski; George Bogart; Kaitlin Coffey; Elizabeth T. Morrison; Vikki Porter; and Daniel Ries made key contributions to this report.

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