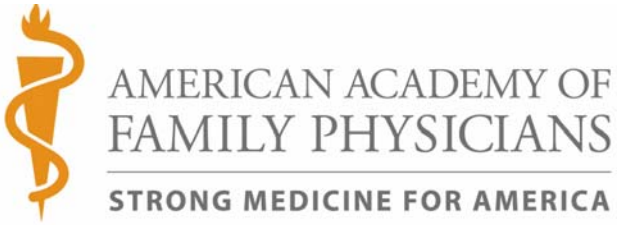

October 8, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Berwick:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents more than 94,700 physicians and medical students nationwide. Specifically, I am writing to advocate with you as it relates to the Centers for Medicare and Medicaid Services (CMS) use of and reliance upon the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC).

The role and influence of the RUC is well-documented, as is CMS's acceptance of the RUC's recommendations. As a participant society in the RUC process, we acknowledge that the RUC has extensive expertise and a unique infrastructure and perspective that facilitate the valuation of codes under the Medicare physician fee schedule. However, we remain concerned that CMS continues to rely too heavily on the RUC in this regard.

In 2006, the Medicare Payment Advisory Commission (MedPAC) recommended that CMS establish a group of experts, separate from the RUC, to help the agency review relative value units (RVUs). Specifically, MedPAC recommended:

> The Secretary should establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC. The group should include members with expertise in health economics and physician payment, as well as members with clinical expertise. The Congress and the Secretary should ensure that this panel has the resources it needs to collect data and develop evidence.

AAFP strongly supports MedPAC's recommendation that CMS establish such a group of experts (including consumer and employers), separate from the AMA RUC, to help the agency review and validate RVUs on an ongoing basis. Although the RUC provides valuable expertise, the review process would benefit if CMS had an additional means of identifying misvalued services and validating RVUs and if supporting evidence was collected and analyzed not only by medical specialty societies but also by experts who were less invested financially in the outcome.

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Like MedPAC, we believe that such a panel would not supplant the RUC, but would augment it. Likewise, we believe that such a panel would assist CMS by using the results of data analyses to identify potentially misvalued services and validate RVUs. We anticipate that the RUC would be allowed to comment on any recommendations or findings of such a group.

As MedPAC observed in the rationale for its recommendation, the tendency of the current process is to identify and correct undervalued services. This is a natural consequence of CMS's and the RUC's reliance on physician specialty societies to identify services that merit review. In the current system, where changes in RVUs are budget neutral across the fee schedule, specialty societies have no vested interest in identifying potentially overvalued services.

Further, as MedPAC also observed, the five-year review process, as currently designed, does not do a good job of identifying services that may be overvalued. We believe that MedPAC is correct that there is no reason to believe that physician services are more likely to become undervalued over time than overvalued. Yet, previous five-year reviews have led to substantially more increases in RVUs than decreases.

To its credit, the RUC has made a concerted effort in recent years to identify potentially misvalued services through its Five-Year Review Identification Workgroup and to correctly revalue identified services. Also to its credit, the RUC has had some success in this regard.

However, we think it unfair to rely entirely upon the RUC to do this work. Consequently, we have come to a similar conclusion to MedPAC. Namely, although the RUC provides valuable expertise, the review process would benefit if CMS had an additional means of identifying misvalued services and if supporting evidence was collected and analyzed not only by specialty societies but also by experts who were less invested financially in the outcome.

In addition to creating alternatives to the RUC process, we believe that CMS should also use its influence to encourage more transparency in the RUC process as well as a fundamental change in the composition of the RUC that more equitably recognizes the value of primary care. As regards transparency, we note that currently RUC votes are done electronically in such a manner that how RUC members vote is not known to anyone except the individual members themselves. In this time of transparency throughout all areas of medicine, business and government, we believe that it makes no sense for the RUC voting to be "secret." We believe the process would benefit from greater openness and transparency in decision-making, and we would encourage CMS, as the primary recipient and user of the RUC's product, to insist on such transparency.

Along with more transparency, we would like to see a fundamental change in the composition of the RUC that more equitably recognizes the value of primary care. We acknowledge the effort that CMS is making to address primary care issues within the parameters permitted by the current statute. For instance, we appreciate CMS's decision to eliminate Medicare payment for the consultation codes in 2010 and to redistribute the work values for those codes to other evaluation and management (E/M) services, which are commonly provided by primary care physicians. It is apparent to us that CMS recognizes that a high quality, efficient health care system must rest on a foundation of primary medical care.

Unfortunately, the composition of the RUC does not demonstrate a similar recognition. Primary care, which we define as family medicine, general internal medicine, and general pediatrics, has, at most, five seats on the RUC, and that presumes that the American College of Physicians, American Academy of Pediatrics, American Osteopathic Association, and American Medical Association all appoint primary care physicians, not subspecialists, to represent them. We would encourage CMS, again as the primary recipient and user of the RUC's product, to insist on greater input from true primary care members of the RUC, consistent with the agency's emphasis on primary care as essential to a high quality, efficient health care system.

Finally, we want to extend our support of CMS's ongoing efforts, both inside and outside the RUC, to revalue under- and over-valued services. We commented at length on this subject in our response to the proposed rule on the 2011 Medicare physician fee schedule and would commend those comments to you for your consideration. We tried to highlight areas where we thought services might be over-valued, and we also explained why we believe E/M services remain under-valued. If there is anything that we may do to support the agency's efforts to re-examine codes in either category, please let us know.

In closing, I want to thank you for your time and consideration of our concerns and to wish you much success in this new endeavor as Administrator of CMS. We look forward to working with you on this and other matters during your tenure. On this particular matter, if you or your staff has any questions or if we may otherwise be of assistance, please contact Mr. Kent Moore (kmoore@aafp.org) at the AAFP.

Sincerely,

Lori Heim

Lori Heim, M.D.
Board Chair

LH:kjm