ACP
American College of Physicians
INTERNAL MEDICINE | Doctors for Adults®

August 4, 2011

Barbara S. Levy, MD
Chair, AMA/Specialty Society RVS Update Committee
American Medical Association
515 North State Street
Chicago, IL 60654

Dear Dr. Levy:

The American College of Physicians (ACP) is pleased to share with you our positions on the structure and function of the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC). ACP represents 132,000 internal medicine physicians and medical student members. Internists specialize in primary and comprehensive care of adolescents and adults. Like our colleagues at the American Academy of Family Physicians (AAFP), ACP has concerns about the RUC composition and processes, but we also believe that there is a role for physician organizations to come together to discuss evidence on the relative value of their services and to provide recommendations to the Medicare program.

With regard to the composition of the RUC, ACP has repeatedly called for changes. **The College has urged that the RUC add representation from primary care and internal medicine subspecialties to reflect the growing need for expertise on the panel in the diagnosis, treatment, and management of chronic diseases.** Like our colleagues at the American Academy of Pediatrics (AAP), we see significant value in reconsidering the addition of a rotating primary care seat to the RUC, as was discussed during the 2007 deliberations of the RUC Administrative Subcommittee. We are also supportive of adding a permanent seat for Geriatrics, as their growing patient population makes their perspective increasingly important. However, ACP does not support the elimination of the current rotating subspecialty seats. These subspecialists provide important services to a significant number of Medicare beneficiaries. **ACP urges the RUC Administrative Subcommittee to reassess the composition of the RUC, taking into account the longstanding recommendations by ACP, as well as those made by AAFP, AAP, and the American Osteopathic Association.**

ACP shares the concern stated by AAFP about using the traditional RUC methodology for valuing the complex evaluation and management services provided by primary care physicians, as well as by subspecialists—particularly those involved in the treatment and management of patients with chronic conditions. The College has recommended to CMS that it take additional steps to fulfill its responsibility to maintain accurate relative value assignments and optimal methodologies. These steps

should include diversifying the information CMS uses in pursuit of optimal valuation of physician services—by looking to the RUC as well as other sources—and employing greater transparency in public discussions of CMS' methods and resources.

This multi-faceted approach is particularly important for the valuation of chronic care and other evaluation and management services, since, as noted above, the traditional survey methodology employed by the RUC is inadequate. Therefore, ACP has chosen to participate in the task force created by AAFP that plans to review and make recommendations to AAFP Board of Directors for alternative methodologies to appropriately value evaluation and management services. **ACP also recommends that the RUC review the methodology it employed when assessing the work relative value and the direct practice expense inputs for the Medicare Medical Home Demonstration. The RUC should work with the CPT committee in conducting this review and develop recommendations for an alternative methodology(ies) to valuing evaluation and management codes used by primary care physicians, as well as subspecialists that are involved in providing comprehensive care to patients with complex and chronic conditions.** This type of approach would be much more favorable and appropriate than what has been outlined by CMS in the notice of proposed rulemaking for the 2012 physician fee schedule.

In addition to the AAFP task force, ACP is participating in the AMA-led Physician Payment and Delivery Reform Leadership Group, which is using "evidence-based approaches to support the development of new payment and delivery systems that: meet patient and population needs; provide opportunities for physician participation across specialties, practice types, and community settings; and provide a sound and sustainable economic foundation for physician practices."

Finally, ACP would like to highlight a set of comprehensive proposals we have developed to reform physician payments to recognize the value of internists' care[1]. These proposals outline several recommendations for payment models, including that they should recognize:

- the value of primary care physicians and services;
- services provided outside of face-to-face encounters with the patient;
- the value of patient-centered, longitudinal, coordinated care services and the cost of providing these services; and
- the value of critical elements of chronic care delivery, such as disease self-management and follow-up, and the cost of providing these services.

ACP built upon these proposals to submit a "Framework for *Stabilizing, Improving, and Innovating* Medicare Physician Payments Leading to Broad Adoption of Value-Based

[1] "Reforming Physician Payments to Achieve Greater Value in Health Care Spending" 2009. (http://www.acponline.org/advocacy/where_we_stand/policy/reforming_pp.pdf) and "A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care" 2006. (http://www.acponline.org/advocacy/where_we_stand/policy/change.pdf).

Payment Models" to the House Energy and Commerce Committee in April 2011.[2] This framework advocates for immediate higher payments and protection from budget-neutrality requirements for undervalued evaluation and management services, noting that the undervaluation of evaluation and management services acts as a barrier to physicians spending sufficient time with patients. The framework then calls for the development of innovative payment models that, in part, recognize and support the value of care provided by primary and comprehensive care physicians and create incentives for physicians to go into primary and comprehensive care specialties and other specialties facing shortages.

Thank you for the opportunity to comment on the proposal submitted by AAFP. We appreciate your consideration of our recommendations and comments above. Please contact Shari Erickson, Director, Regulatory and Insurer Affairs, by phone at (202) 261-4551 or e-mail at serickson@acponline.org if you have questions or need additional information.

Sincerely,

Lawrence Martinelli, MD, FACP
ACP RUC Advisor

cc: Virginia L. Hood, MBBS, MPH, FACP, President
Steven Weinberger, MD, FACP, Executive Director and CEO
Robert Doherty, Senior Vice President, Governmental Affairs and Public Policy
Debra Lansey, Associate
Dale Blasier, MD, Chair, RUC Administrative Subcommittee

[2] "Framework for *Stabilizing, Improving, and Innovating* Medicare Physician Payments Leading to Broad Adoption of Value-Based Payment Models" 2011. (http://www.acponline.org/advocacy/where_we_stand/phys_pay_pro_paper.pdf).