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AMA's Relative Value Scale Update Committee (RUC) - This Cash Cow Is Not A Scientific Enterprise

By Chuck Dinerstein — February 24, 2017

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In 1965, when Medicare made its appearance, physicians would send bills for their "usual and customary charges" and it quickly became apparent that usual and customary allowed a far greater range of charges than President Johnson and his team had anticipated – there was significant variation in 'fees' and they were unrelated to quality, effort, specialty or geography.

To standardize doctor's fees and their costs, Medicare commissioned a study by Harvard [1] who got assistance from the American Medical Association (AMA.) They came up with the resource-based relative value scale (RSRVS) which defined the work effort and expenses in, at that point, well over 7,000 physician services. For any given service, a doctor's actual work (52%), their expenses and overhead for this service (44%), and their malpractice costs for this service (4%) are defined and combined to create the relative value units (RVU) for the particular service. Some adjustments are made for the geographical variations for work, overhead, and malpractice and the RVUs are multiplied by a conversion factor to determine what Medicare pays a physician. From a practical point of view, that determination is what a physician will receive from all payers, although the conversion factor may vary with that established by Medicare.

Who determines the RVUs? Who controls the keys to the kingdom? The answer is the American Medical Association who own the intellectual property rights to the RSRVS system – a property that generates $72 million annually [2]. (By way of comparison, actual membership in the AMA produces about $38 million) In a nutshell, here is the process. The AMA created a Relative Value Scale Update Committee (RUC) which in their words:

- The RUC is an independent group of volunteer physicians exercising its First Amendment

Right to petition the federal government.

- The RUC is comprised of 31 members, 28 voting members (16 of these 28 voting members are from specialties whose Medicare allowed charges are primarily derived from the provision of E/M services).
- The RUC is an expert panel. Individuals exercise their independent judgment and are not advocates for their specialty.

CMS submits physician services to this committee, which in turn has the affected specialty society survey their membership for measuring the appropriate work involved. The specialty society recommendations are referred to the RUC, which may pass them on to the Center for Medicare and Medicaid (CMS) with or without further modification. They may even not recommend any change. 90% of RUCs recommendations are accepted, the remainder are modified by CMS's 'in-house' experts the Medical Payment Advisory Commission (MEDPAC) – we will ignore them for the moment.

In the words of Kaiser Health News [3] (KHN),

> *"The AMA has been involved in the reimbursement system since the beginning, serving as a contract liaison between practicing physicians and the Harvard researchers who initially ranked physician services. The role ensured medical societies were "involved in important aspects of the development of relative values for their specialties," according to an AMA handbook. The AMA shapes the payment environment for all physicians but the process has one caveat – all changes must be neutral for the system as a whole, raising values for one service must be offset by lowering values for another. And that turns this one-time academic process into a highly political battle between the specialties."*

There is one classic battle, between primary care providers, this includes family practice and internal medicine versus specialties populated by physicians performing procedures, let's call them proceduralists. The primary care providers argue that they manage the patient overall and make the referrals to the specialists. They are paid based on Evaluation and Management codes, worth about $65 a visit. Proceduralists argue that they, in fact, are responsible for providing the necessary interventions and care and that their work is more intensive. In general, proceduralists command bigger fees. You might say that the doers have overtaken the thinkers. The AMA, for its part, denies that self-interest is involved, or that there might be alliances where quid pro quos are exchanged. Again from KHN,

> *"What truly happens in the RUC is secret. Votes are typically taken by electronic ballot, and RUC members are not informed of how other members voted. Meeting minutes are not released to the public. And all RUC members and observers agree to a confidentiality pledge that they will not disseminate documents or discussions*

> *from the meetings."*

An unintended consequence of these valuations is that primary care physicians are paid 50% or less what specialists make. With an increasing burden of student loans, what graduate of medical school will continue to choose primary care, where they may be an indentured servant for years. Primary care is being filled with mid-level providers, advance practice nurses. For them, the primary care income is at the top of their clinical ladder.

Another unintended consequence is that in reviewing and updating procedure codes, what one might consider a two-way street, some codes are increasing, and some decreasing, oddly enough reduced codes were in a very small minority. "Among the 2,739 procedure codes for which the RUC made recommendations during the first three five-year-reviews, only 400 led to work values that decreased, a number that critics say is unconscionable."

MedPac is the non-partisan agency advising Congress on Medicare. Its role is similar to the General Accounting Office (GAO). They have suggested that CMS relies too heavily on RUC and that it should "establish its own group of experts, separate from the RUC." For their part, the GAO issued report on RUC [4] in 2015. They noted the conflict of interest between primary care and specialties that I have mentioned already but had additional concerns about how the relative values were determined. Part of the process is surveying physicians to understand their work

> *"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."*

I find it hard to believe that any physician representing their specialty and serving on RUC would accept, as valid, a clinical survey with a response rate of 2.2%. Why do they utilize this possibly deeply flawed data and use it to make recommendations affecting all physicians, or for that matter, the American taxpayer?

Links

[1] http://www.nejm.org/doi/pdf/10.1056/NEJM198809293191305

[2] http://www.forbes.com/sites/theapothecary/2011/11/28/why-the-american-medical-association-had-72-million-reasons-to-help-shrink-doctors-pay/#7d5f6b003089
[3] http://khn.org/news/ama-center-public-integrity/
[4] http://gao.gov/products/GAO-15-434?source=ra