

September 28, 2017

The Honorable Tom Price, MD
Secretary
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Price and Administrator Verma:

On behalf of the 21 undersigned medical organizations, we are writing to express our deep concerns with the new methodology for updating malpractice (MP) relative value units (RVUs) as discussed in the calendar year (CY) 2018 Medicare Physician Fee Schedule (PFS) proposed rule. The process used by the Centers for Medicare & Medicaid Services' (CMS) contractor, Acumen, to collect MP premium data is neither transparent nor precise and the proposed MP RVU updates will unfairly reduce payments for providers who regularly furnish surgical services. **We strongly urge CMS to suspend utilization of the new MP premium data for purposes of calculating MP RVUs as proposed in the CY 2018 PFS. This will allow time for the Agency and Acumen to collect accurate and complete data for calculating MP RVUs.**

BACKGROUND

RVU Assignment and Updates

CMS pays providers for their services according to the PFS, under which payments are determined based on the RVUs assigned to each service. Section 1848(c) of the Social Security Act requires CMS to create RVUs using the Medicare resource-based relative value scale. RVUs have three components: physician work; practice expense (PE); and MP insurance. Higher RVU levels indicate that a specific service requires more resources than services with lower RVUs.

MP RVUs, which reflect the relative cost of MP insurance to physician and non-physician provider (NPP) specialties, are updated annually using a Medicare claims-based specialty mix for each service. MP premium data are utilized in the MP RVU calculation; CMS generally updates the MP premium data every five years. The most recent update occurred in CY 2015, and the next MP RVU update must take place no later than CY 2020, per statute.

Current MP RVU Update Methodology

CMS utilizes the following process to update MP RVUs:

1. Calculate a national average MP premium for each specialty;
2. Calculate specialty risk factors;
3. Calculate unadjusted MP RVUs for each service based on the volume and mix of practitioners that perform a service; and
4. Adjust the RVUs for PFS relativity.

Step 1: Calculating National Average Premiums

CMS first aggregates state-level specialty and surgery class (e.g., major surgery, minor surgery, no surgery) premiums and produces a national estimate. MP premium data are collected from state departments of insurance and are then used to calculate county-level specialty/surgery class premium averages. The county-level specialty premiums are then divided by the MP geographic practice cost indices (GPCIs), which measure the regional variation of MP insurance. CMS uses the weighted average of the county-level premiums and GPCIs to create national specialty premiums.

Step 2: Calculating Specialty Risk Factors

Next, CMS establishes relative risk factors by specialty and surgery class, which are ultimately used to gauge the relative risk of furnishing specific services. Risk factors are computed by normalizing the national average premium for a certain specialty/surgery class to a standard base, which is the specialty with the lowest physician premium. Once the risk factors are calculated, CMS makes adjustments for some specialty and surgery class combinations based on the availability and quality of MP premium data. Under the current methodology, CMS adjusts risk factors for specialties that either lack MP premium data for 35 or more states across all surgery classes or demonstrate significant variation in data relative to other specialties with comparable risk.

Step 3: Calculating MP RVUs by Service

Once national specialty premiums and specialty risk factors are established, CMS calculates MP RVUs for each service by multiplying service-level risk factors by work RVUs, which reflect the physician time, technical skill, and effort required for a specific service.

Step 4: Adjusting MP RVUs for PFS Relativity

Finally, CMS adjusts the MP RVUs to achieve budget neutrality and ensure that the aggregate pool of MP RVUs relative to the pool of PE and work RVUs is the same as the prior year. CMS either scales up or scales down the new MP RVU values to maintain the current relative weights among MP, PE, and work RVUs.

CMS has proposed several modifications to this MP RVU update process in the CY 2018 PFS proposed rule.

ACUMEN REVIEW OF THE CURRENT MP RVU UPDATE METHODOLOGY

CMS contracted with Acumen to perform a review of the current methodology used to update MP RVUs. As outlined in its *Interim Report on the Malpractice Relative Value Units for the CY 2018 Medicare Physician Fee Schedule*, Acumen evaluated steps 1 through 3 of the MP RVU methodology described above and made a series of recommendations regarding possible changes to the process for calculating and updating MP RVUs.¹ In addition, Acumen was responsible for collecting new MP premium data for the next MP RVU update. Acumen's specific recommendations for calculating national average premiums, specialty risk factors, and MP RVUs by service, and for collecting new MP premium data as included in the CY 2018 PFS proposed rule, are described below.

MP RVU PROPOSALS IN THE CY 2018 PFS PROPOSED RULE

In the CY 2018 PFS, CMS proposes to use the most recent MP premium data collected by Acumen for the proposed MP RVUs for CY 2018. In the proposed rule, CMS asked for comments on this proposal, and also on methodologies and sources that might be used to improve the next update of MP premium data. **We strongly disagree with CMS' proposal to update MP RVUs for CY 2018 because we have serious concerns with the proposed changes to the MP RVU update methodology and data collection process, which heavily rely on recommendations made by Acumen.**

Calculating the National Average Premiums

Acumen was charged with collecting MP premium data and evaluating options for calculating a national average for each specialty. For CY 2018, CMS asked Acumen to test a new method in which premiums were geographically normalized before identifying the national average. Per the advice of Acumen, CMS incorporated population estimates from the American Community Survey, which collects nationwide population data at the county level, as weights for calculating specialty premiums.

To assess the effect of these changes, Acumen examined the differences among four calculation options for comparison and validation purposes. These calculation options included:

- Option 1: Sum all county-level price adjusted premiums, weighted by share of total population
- Option 2: Sum all county-level price adjusted premiums, weighted by the share of work and PE RVUs
- Option 3: Sum all county-level price adjusted premiums, weighted by the share of total RVUs
- Option 4: Sum the ratio of each total RVU weighted specialty premium to each MP RVU-weighted MP GPCI.

¹ Centers for Medicare and Medicaid Services. *Acumen Interim Report on the Malpractice Relative Value Units for the CY 2018 Medicare Physician Fee Schedule*; July 2017. Available at: [cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2018-PFS-NPRM-MP-RVU.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2018-PFS-NPRM-MP-RVU.pdf)

Acumen indicated that its review did not show any substantial differences in national average premiums (shown in Table 1 below) when comparing each option.²

Table 1:

National Average Premium Distributions across Options

Metric	Option 1	Option 2	Option 3	Option 4
Minimum	\$2	\$122	\$122	\$98
Average	\$11,538	\$12,279	\$12,280	\$12,321
Maximum	\$81,170	\$79,919	\$79,823	\$80,793

Following this analysis, Acumen recommended and CMS agreed to utilize Option 1, which weights national average premiums with population estimates. **We disagree with the assumption that the differences between these four options were not substantial.** We believe these data clearly show that Option 1 (population weighting) is different from Options 2 through 4 (RVU weighting) given the significant differences in the minimum national average premium between population and RVU weighting.

Using population to weight the national average premiums is incorrect. This method does not reflect differences in the risk of specific services among different areas of the country. Risk-of-service, not population, reflects how services differ in their contributions to MP premiums. For example, if a provider often performs a complex, difficult surgical procedure, this would have a larger impact on the provider’s premium risk classification than if the provider instead often performs elective surgery or non-surgical services. Therefore, we believe the premiums should be normalized using surgical and non-surgical work RVUs for each geographic area. Since work RVUs reflect differences in time, intensity, and difficulty among procedures, which are directly correlated with malpractice risk, we believe that they are the best available proxy for weighting geographic differences to calculate national average premiums. **We urge CMS to use work RVUs instead of population to weight geographic differences to calculate national average premiums.**

Calculating the Specialty Risk Factors

Acumen recommended and CMS agreed to maintain the current process of normalizing each specialty premium to the value of the specialty with the lowest premium, which has been implemented in all prior MP RVU updates. To calculate specialty risk factors, Acumen solicited MP premium data from all 50 States, the District of Columbia, and Puerto Rico for all physician and NPP specialties and for all risk classifications (i.e., surgical, non-surgical, other) available. However, Acumen noted that not all specialties had distinct premium data in the rate filings they obtained. Additionally, for some specialties, MP premiums were not available from the rate filings in any state. Therefore, for specialties for which Acumen did not obtain premium data for at least 35 states, and for specialties for which Acumen did not obtain distinct premium data

² Centers for Medicare and Medicaid Services. *Acumen Interim Report on the Malpractice Relative Value Units for the CY 2018 Medicare Physician Fee Schedule*; July 2017. Available at: [cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2018-PFS-NPRM-MP-RVU.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2018-PFS-NPRM-MP-RVU.pdf)

in the any of the state rate filings, Acumen mapped (“crosswalked”) the premiums for these specialties to a similar specialty that the contractor determined had comparable risk.

We have several concerns about the validity of the premium data that Acumen used to calculate the specialty risk factors that were in turn used to compute the proposed MP RVUs for CY 2018. Most importantly, we question the reliability of the MP RVU calculation methodology, as nearly 40 percent of specialties were crosswalked to other specialties because of insufficient premium data. We believe it was Acumen's obligation to find sources to obtain robust data and we question why Acumen imposed a threshold of 35 states as the minimum for having “sufficient” data. We outline our specific concerns about each individual methodology issue below.

Blending All Available Premium Data

For 24 specialties, there was wide variation across the rate filings in terms of whether or not surgery class premiums were reported and which categories were reported (e.g., major surgery, minor surgery, no surgery). Although Acumen set a minimum threshold of 35 states in order to calculate premium data, they set a lower threshold of only 25 states to calculate separate surgical and non-surgical risk factors.

For specialties with enough surgical/non-surgical premium data from at least 25 states (e.g., family practice), separate surgical and non-surgical MP premiums were calculated. For specialties where “major surgery” was the dominant premium class (e.g., general surgery, cardiac surgery), only one MP premium (surgical) was calculated. For all other specialties that did not have substantial data for the “major” and “no surgery” classes, or for specialties for which the “major surgery” class was not the dominant class, Acumen blended the available premium data into one general premium rate using a weighted average “blended” premium at the national level based on the percentage of work RVUs correlated with the surgery class premiums within each specialty. For example, the surgical premiums for a given specialty were weighted by that specialty’s work RVUs for surgical services; the non-surgical premiums for that specialty were weighted by the work RVUs for non-surgical services; and the unspecified premiums for that specialty were weighted by all work RVUs to create a single premium rate. **We do not believe that a single premium that blends insufficient data for surgical, non-surgical and unspecified premiums accurately and fairly contributes to the final calculation of MP RVUs.** This methodology will overpay providers whose practices furnish more non-surgical services and underpay providers whose practices furnish more surgical services.

As shown in Table 2 below, which includes data taken from the Acumen interim report and the CY 2018 PFS proposed rule, the “blended” proxy for the surgical premiums for dermatology, gastroenterology, cardiology, endocrinology, and nephrology are significantly less than the 2017 rates and also significantly less than those for general practice or family practice.³ In addition, in 2015, cardiology premium data were collected from 41 states for “major surgery”;

³ Centers for Medicare and Medicaid Services. *CY 2018 PFS Proposed Rule Malpractice Risk Factors and Premium Amounts by Specialty*; July 2017. Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-P.html>

in 2018, cardiology premium data were only collected from 12 states for “major surgery”. We do not believe this difference is due to a decrease in the number of interventional cardiologists performing surgery; rather, this is likely due instead to a difference in the data collection process and/or a change in practice from individual to group or employed, which would make it more difficult to obtain premium data. This difference is presumably found in the other specialties with “blended” data premium rates. **We urge CMS and Acumen to increase collaboration with state medical societies and specialty societies to obtain separate surgical and non-surgical premium data. We recommend that CMS use the previous surgical and non-surgical premium data until more data can be obtained instead of using the new proposed “blended” premiums for MP RVU calculations.**

Table 2:

Changes in Normalized Premium Rates for Selected Specialties from CY 2017 to CY 2018 (Proposed)

Specialty Code	Specialty Name	2017	2018 (proposed)	2017	2018 (proposed)
		Non-surgical Normalized Premium Rate	Non-surgical Normalized Premium Rate	Surgical Normalized Premium Rate	Surgical Normalized Premium Rate
01	General Practice	\$14,657	\$14,776 +1%	\$33,836	\$30,521 -10%
08	Family Practice	\$14,471	\$13,696 -5%	\$33,676	\$30,640 -9%
07	Dermatology	\$11,696	\$22,750 +95%	\$37,442	\$22,750 -39%
10	Gastroenterology	\$17,563	\$19,659 +12%	\$32,166	\$19,659 -39%
06	Cardiology	\$16,216	\$15,587 -4%	\$58,634	\$15,587 -73%
46	Endocrinology	\$14,252	\$14,386 +1%	\$29,754	\$14,386 -52%
39	Nephrology	\$13,787	\$12,779 -7%	\$31,080	\$12,779 -59%

Premium Rate Increases for Facility Providers

The premium rate increased by 15 percent for the seven specialty designations shown below in Table 3, which includes data taken from the Acumen interim report and the CY 2018 PFS proposed rule.⁴ For these seven specialties, the premium rates were crosswalked from the proposed allergy/immunology rate for CY 2018. We believe that most of these providers have umbrella policies that cover the facility, equipment, and technical staff, but not the physicians and NPPs who work at the centers. Therefore, we question use of these normalized premium data for MP RVU calculations. We note that, for some of these specialties, state premium data

⁴ Centers for Medicare and Medicaid Services. *CY 2018 PFS Proposed Rule Malpractice Risk Factors and Premium Amounts by Specialty*; July 2017. Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-P.html>

were obtained. We urge CMS to review the available premium data, however minimal, to verify that the data support the normalized premium rates that were increased to correspond to the premium rate for other specialties (in this case, allergy/immunology).

Table 3:

Changes in Malpractice Risk Factors and Premium Amounts for Selected Specialties from CY 2017 to CY 2018 (Proposed)

Specialty Code	Specialty Name	2017	2018 (proposed)	2017	2018 (proposed)
		Non-surgical Risk Factor	Non-surgical Risk Factor	Non-surgical Normalized Premium Rate	Non-surgical Normalized Premium Rate
03	Allergy/Immunology	1.00	1.00	\$8,398	\$8,201
45	Mammography Screening Center	0.87	1.00	\$7,306	\$8,201
47	Independent Diagnostic Testing Facility	0.87	1.00	\$7,306	\$8,201
47-TC	IDTFs (TC only)	0.87	1.00	\$7,306	\$8,201
63	Portable X-Ray Supplier	0.87	1.00	\$7,306	\$8,201
69	Clinical Laboratory (billing independently)	0.87	1.00	\$7,306	\$8,201
74	Radiation Therapy Centers	0.87	1.00	\$7,306	\$8,201
75	Slide Preparation Facilities	0.87	1.00	\$7,306	\$8,201

Crosswalking Non-Physician Providers (NPPs) to Other Specialties

Since CY 2010, CMS has crosswalked certain NPP specialties to the physician specialty with the lowest MP premium, allergy/immunology.⁵ **We do not believe that crosswalking NPP specialties to allergy/immunology is relative or supported by data.** The American Medical Association’s (AMA) Physician Practice Information (PPI) 2006 national survey data, which were comprised of practice expense and malpractice insurance premium rates from 51 specialties and are used by CMS for calculating PE RVUs, have shown that many NPP specialties have significantly lower MP premiums than allergy/immunology.⁶ For example, as shown in Table 4 below, the PPI data indicate that NPP specialties such as physical therapy and occupational therapy, which together account for approximately 10 percent of all Medicare claims, have premium rates that are less than 20 percent of the allergy/immunology premium rate. We are concerned that the large discrepancies between the PPI survey data and the CY 2018 proposed MP premium rates result in overcompensation for NPPs and believe that the continued application of these unsubstantiated crosswalks may significantly impact the

⁵ Centers for Medicare and Medicaid Services. *Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Proposed Rule*; July 2009.

⁶ American Medical Association. *Physician Practice Information Survey: PLI Data Submitted to CMS*; 2009.

MP RVUs for all other specialties due to budget neutrality **We urge CMS to review the collected data, however minimal, for these specialties to determine if the crosswalk to allergy/immunology is supported before implementation of crosswalks to the lowest physician premium specialty for future MP RVU calculations. If this methodology is not supported for the calculation of NPP premium rates, we recommend that CMS work through the national and state NPP societies to obtain more MP premium data.**

Table 4:

Comparison of AMA PPI and CY 2018 (Proposed) MP Premium Amounts for Selected Specialties

		2006	2018 (proposed)	2018 (proposed)
Specialty Code	Specialties Crosswalked to Allergy/Immunology	AMA PPI Premium Rate	Non-surgical Normalized Premium Rate	Surgical Normalized Premium Rate
03	Allergy/Immunology	\$10,067	\$8,201	\$8,201
15	Speech Language Pathology	\$1,506	\$8,201	\$8,201
35	Chiropractic	\$4,742	\$8,201	\$8,201
41	Optometry	\$8,109	\$8,201	\$8,201
62	Psychologist	\$1,466	\$8,201	\$8,201
64	Audiologist	\$1,506	\$8,201	\$8,201
65	Physical Therapist	\$1,821	\$8,201	\$8,201
67	Occupational Therapist	\$ 1,821	\$8,201	\$8,201
68	Clinical Psychologist	\$1,466	\$8,201	\$8,201
80	Licensed Clinical Social Worker	\$1,115	\$8,201	\$8,201

The 21 undersigned organizations strongly urge CMS to withhold any modifications to the MP RVU update methodology until more robust data are collected to ensure that premiums and RVUs can be determined accurately for each specialty and premium class. We stand ready to work with CMS to ensure that separate and valid surgical and non-surgical premium data are obtained to calculate resource-based MP RVUs. Thank you for your consideration.

Sincerely,

(please see next page)

American College of Surgeons
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology—Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Osteopathic Surgeons
American Congress of Obstetricians and Gynecologists
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society for Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society for Metabolic and Bariatric Surgery
American Society of Plastic Surgeons
American Society for Surgery of the Hand
American Urogynecologic Society
American Urological Association
Congress of Neurological Surgeons
Society of Gynecologic Oncology
The Society for Thoracic Surgeons
Society for Vascular Surgery