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MEDICARE PRICE PROBLEMS AND THE RUC: WAGGING THE DOG

“You have to be alert, and the public has to be alert. Cause that is the war of the future, and if you’re not gearing up, to fight that war, eventually the axe will fall.” — Conrad Brean¹

I. INTRODUCTION

Despite extensive reform under The Patient Protection and Affordable Care Act (ACA),² there remains much to be accomplished in terms of implementation and regulation of the new law and there are numerous unaddressed problems.³ Among the issues lost in the debate of health reform is the continued use of the Relative Value Scale Update Committee (RUC);⁴ a committee specifically designed to guide CMS in setting reimbursement rates for Medicare.⁵ While the RUC is not directly responsible for setting the reimbursement rates for Medicare, it heavily influences the process by which rates are initially set and subsequently reviewed.

However, since the RUC is not a licensed Federal Advisory Committee (FAC),⁶ it is not subject to the advisement standards of other FACs, as outlined in the Federal Advisory Committee Act of 1972 (FACA).⁷ Further,

1. WAG THE DOG (New Line Cinema 1998).

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10202(c)(1)(A), 124 Stat. 119, 924 (2010) (codified at 42 U.S.C. § 1396(d) (2011)) [hereinafter ACA].

3. See, e.g., John Jacobi et al., *Implementing Health Reform at the State Level: Access and Care for Vulnerable Populations*, 39 J. L. MED. & ETHICS 69-70 (2011) (discussing potential obstacles in health reform including shortages in primary care physicians in addition to issues between eligibility for health insurance versus actual enrollment).

4. See Miriam J. Laugesen, Roy Wada & Eric M. Chen, *In Setting Doctors’ Medicare Fees, CMS Almost Always Accepts the Relative Value Update Panel’s Advice on Work Values*, 31 HEALTH AFF. 965, 970 (2012) (identifying the relatively few changes made by the ACA to CMS’s update process). Section 3134 of the ACA does require that CMS increase data collection and analytics. This includes adjusting incorrect values for services most notably “services with the fastest growth in utilization, new technology, services billed together, and services that have not been reviewed since the payment system was implemented.” *Id.*

5. “RUC” is colloquially pronounced “ruck.” AM. MED. ASS’N., *AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE REPORT (2012)*, available at <http://www.ama-assn.org/resources/doc/rbrvs/ruc-is-ruc-is-not.pdf>.

6. *Id.*

7. See Federal Advisory Committee Act, Pub. L. No. 92-463, 86 Stat. 770 (1972) (codified at 5 U.S.C. App. § 2 (2012)) (noting the term “advisory committee means any

CMS's rate setting methods remain excluded from judicial review due to a procedural safeguard,⁸ leaving no effective remedy to change the outcome of misvalued Medicare rates. Here, application of the FACA to the RUC, through either legislative or regulatory change, will improve transparency of the RUC's advisement and improve the rate setting process without completely overhauling the current system.

A recent suit brought against HHS and CMS alleged that the RUC disproportionately represents specialist physicians and argued that the RUC should be subject to review under the FACA.⁹ On August 8, 2011, six primary care physicians filed a complaint against CMS and HHS for ostensibly accepting recommendations made by the RUC without review and charged that the effects of the RUC's recommendations have led to a significant gap between primary care physicians and specialists.¹⁰

This case encapsulated an ongoing battle of primary care physicians, lobbyists, and politicians over the RUC's vitality and nature.¹¹ One of the physicians most essential points is that the exclusivity, privacy, and immunity by which the RUC operates when calculating the relative value units (RVU), which disproportionately reward specialist physicians over primary care physicians, is detrimental to the Medicare fee schedule and should be subject to scrutiny under the FACA.¹²

The court dismissed the case on the grounds that "Congress has precluded courts from reviewing, not only the final relative values and RVUs, but also the method by which those values and units are generated."¹³ Previous courts have remarked that this preclusion aids the Secretary to make quick and efficient decisions regarding annual evaluations of RVUs,¹⁴

committee, board commission, council conference, panel, task force, or other similar group, or any subcommittee or other subgroup thereof . . . , which is – (A) established by statute or reorganization plan, or (B) established or utilized by the President, or (C) established or utilized by one or more agencies," which the RUC does not fit that definition and is therefore not subject to advisement standards set forth in the FACA).

8. Brian Klepper, *Medicare Physician Payment: A Hollow Victory for the RUC*, HEALTH AFF. BLOG (May 18, 2012, 10:53 AM), <http://www.healthaffairs.org/blog/2012/05/18/medicare-physician-payment-a-hollow-victory-for-the-ruc/>.

9. Brian Klepper, *A Legal Challenge to CMS' Reliance on the RUC*, HEALTH AFF. BLOG (August 9, 2011, 1:28 PM), <http://www.healthaffairs.org/blog/2011/08/09/a-legal-challenge-to-cms-reliance-on-the-ruc/>.

10. *Id.*

11. *Id.*

12. Complaint at 2-3, *Fischer v. Berwick*, 2012 WL 1655320 (D. Md. 2012) (No. WMN-11-2191).

13. *Fischer*, 2012 WL 1655320, at *2. See also Klepper, *supra* note 8.

14. *Am. Soc'y of Cataract & Refractive Surgery v. Thompson*, 279 F.3d 447, 454 (7th Cir. 2002) (discussing congressional intent of this preclusion, which helps the Secretary make

but have not commented on the fairness or accuracy of the decisions. Further, these courts and the *Fischer* court have avoided any evaluation or discussion of the requirement that federal advisory bodies adhere to the FACA.¹⁵

This comment will argue, in spite of the court's sidestepping, that the RUC should in fact be governed by the FACA. First, an examination of the RUC and the current Medicare fee schedule will demonstrate the current problems and practices exhibited by the RUC. Then, an explication on the history of the FACA and its functionality will expound on the importance of FACs and the review of those committees' decisions. Lastly, a comparison of the RUC's practices and the provisions of the FACA will show that the RUC's advising has taken place in the shadows of Medicare payment reform. This has helped lead to imbalanced reimbursement for Medicare and private payers and effectively incentivizing an entire sector of specialized healthcare.

II. BACKGROUND

The U.S. trails other developed nations in health quality and health cost efficiency.¹⁶ This crisis can be traced in part to the decline of primary care and preventative care services,¹⁷ which many scholars attribute to the adoption of the Resource Based Relative Value Scale (RBRVS).¹⁸ This payment system was implemented in 1992, as part of the newly established Medicare Physician Fee Schedule (MPFS).¹⁹ Following growing concerns about the rapid rise in the cost of physician services, Congress enacted the MPFS as a part of the Omnibus Budget Reconciliation Act of 1989.²⁰ Prior to the implementation of the RBRVS, Medicare physicians had been paid based on the Usual, Customary, and Reasonable (UCR) system founded by

quick and efficient decisions regarding RVU adjustments under a budget neutrality requirement).

15. See *generally id.* at 447-56 (lacking discussion and analysis on the requirement that federal advisory bodies adhere to the FACA). See also *Fischer*, 2012 WL 1655320, at *1-6.

16. Lewis G. Sandy et al., *The Political Economy of U.S. Primary Care*, 28 HEALTH AFF. 1136, 1136 (2009).

17. *Id.*

18. See, e.g., Paul B. Ginsberg, *Rapidly Evolving Physician-Payment Policy – More than the SGR*, 364 NEW ENG. J. MED. 172, 173 (2011); John D. Goodson, *Unintended Consequences of Resource-Based Relative Value Scale Reimbursement*, 298 JAMA 2308, 2308 (2007).

19. Stephanie Maxwell & Stephen Zuckerman, *Impact of Resource-Based Practice Expenses on the Medicare Physician Volume*, HEALTH CARE FINANCING REV., no. 2, 2007-08 at 65, 65.

20. BARRY R. FURROW ET AL., HEALTH LAW: CASES MATERIALS AND PROBLEMS 789-90 (6th ed. 2008).

Blue Shield in the 1950s.²¹ This allowed for great fluctuations between communities and eventually led to physicians setting their own rates of reimbursement, which became a significant cost problem after the enactment of Medicare.²² However, with the advent of the RBRVS, Congress hoped to address these issues by using variable rates.²³

In theory, this new practice made significantly more sense. It had less discretionary input and adjusted for a number of different particular variants. The new MPFS corrected distortions from the previous charge-based payment system and was intended to encourage efficiencies in medical practice.²⁴ The MPFS was believed to be the solution to other problems as well, such as the growing discrepancy between payments for evaluation and management services and payments for technical service procedures, as well as unexplainable cost variations arising in rural areas.²⁵ The result of these distortions is believed to have “discouraged physicians from practicing in primary care specialties and in rural areas.”²⁶ It is believed that these distortions also encouraged a “procedurally oriented style of care.”²⁷ Unfortunately, the system now suffers from myriad new problems and the accurate valuation for practice expenses has gotten worse.²⁸

Under the new MPFS, the Secretary of CMS was charged with developing a methodology for calculating valuations,²⁹ which eventually resulted in the utilization of the RBRVS when the Secretary engaged a section of the statute allowing extrapolation and “other techniques” to determine these values.³⁰ These values are known as relative value units, or RVUs, and became the basis for all payments in the MPFS.³¹

21. SARA ROSENBAUM ET AL., *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 614 (2nd ed. 2012).

22. *Id.*

23. See Paul B. Ginsberg & Robert Berenson, *Revising Medicare’s Physician Fee Schedule – Much Activity, Little Change*, 356 *NEW ENG. J. MED.* 1201, 1201 (2007).

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

28. Ginsberg & Berenson, *supra* note 23, at 1202.

29. 42 U.S.C. § 1395w-4(A)(i) (2011).

30. See 42 U.S.C. § 1395w-4(A)(ii). The system was designed through Harvard studies, but did not originally include estimates for practice expense RVUs, so the RBRVS practice expenses were based upon historical physician charges until 1999. At this time, CMS began phasing in resource-based practice expense RVUs by relying on “estimates of service-specific, direct expenses, pricing data, and specialty-specific, practice-level expenses.” Laura A. Dummit, *Medicare Physician Fees: The Data Behind the Numbers*, NAT’L HEALTH POL’Y FORUM, July 22, 2010, at 7.

31. See generally FURROW ET AL., *supra* note 20, at 790 (discussing the physician fee schedule and the method for calculating payments using RVUs).

As the fundamental unit of measure for the MPFS, and the basis for each payment calculation, the RVU component is actually three separate cost components, or three separate RVUs: (1) physician work (PW); (2) practice expenses (PE); and (3) malpractice insurance (MP).³² The PW component is the most complex. It must account for four categories of input: time, mental effort and judgment, technical skill, and psychological stress³³ (or the “time and intensity” involved in providing a medical service).³⁴

It is estimated that the work component accounts for 50% of the total payment per service.³⁵ The PE component is a reflection of the necessary equipment and resources used in providing a specific medical service.³⁶ This can include anything from renting office space, to equipment purchases, to staff costs.³⁷ Different PE RVUs can be applied depending on where the services are delivered (e.g., at a doctor’s office, ambulatory surgery center, or hospital).³⁸ The final RVU component, MP, is based upon the malpractice insurance required for the physician rendering the service.³⁹

RBRVS payment rates are founded on three different components: a weighted value, which is the RVU, prescribed to a specific medical procedure, a geographical adjuster, and a conversion factor.⁴⁰ The other two adjusters — the conversion factor (CF) and the Geographical Practice Cost Index (GPCI) — are significant factors in adjusting costs to account for medical inflation and the differences in costs to practice around the country, respectively.⁴¹ Each component is then adjusted to account for area price differences under the GPCI before the three components are summed and multiplied by the conversion factor to arrive at an appropriate reimbursement per service rendered.⁴²

32. See 42 U.S.C. § 1395w-4(c)(2)(A)(i), (c)(2)(C)(i)-(iii) (2011). See also Maxwell & Zuckerman, *supra* note 19.

33. See William C. Hsiao et al., *Estimating Physicians’ Work for a Resource-Based Relative-Value Scale*, 319 N. ENG. J. MED. 835, 836 (1988); AM. MED. ASS’N., RVS UPDATE PROCESS (2012), available at <http://www.ama-assn.org/resources/doc/rbrvs/ruc-update-booklet.pdf>; and MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: PROMOTING GREATER EFFICIENCY IN MEDICARE 236 (2007), available at www.medpac.gov/documents/jun07_EntireReport.pdf.

34. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PHYSICIAN FEE SCHEDULE: PAYMENT SYSTEM FACT SHEET SERIES 3 (2011) [hereinafter MPFS FACT SHEET].

35. *Id.*

36. *Id.*

37. *Id.*

38. FURROW ET AL., *supra* note 20, at 790.

39. *Id.*

40. *Id.*

41. See 42 U.S.C. § 1395w-4(b)(1)(A)-(C) (2011). See also MPFS FACT SHEET, *supra* note 34, at 2.

42. MPFS FACT SHEET, *supra* note 34, at 3.

The output of this equation is then assigned an identifying number under CMS's Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Common Procedural Terminology (CPT).⁴³ Essentially, to determine a single billing amount for a given medical service, there are three separate RVUs, each of which is multiplied by a separate and distinct GPCI.⁴⁴ These three totals are then added together and multiplied by the conversion factor so that the formula for MPFS payment rates ends up looking like this: $[(PW\ RVU \times PW\ GPCI) + (PE\ RVU \times PE\ GPCI) + (MP\ RVU \times MP\ GPCI)] \times CF = \text{payment amount}$.⁴⁵ However, in recent years, the conversion factor has not been applied.⁴⁶

The conversion factor is updated annually and based upon a comparison of the actual inflation of medical costs, as measured by the Medicare Economic Index (MEI), and the target rate for medical expenditures, as established by the Sustainable Growth Rate (SGR).⁴⁷ According to CMS, the SGR is based on a combination of "medical inflation, the projected growth in the domestic economy, projected growth of [Medicare] beneficiaries . . . and changes in law or regulation."⁴⁸ However, as Paul Ginsberg points out, this policy is frustrating to both physicians and policy makers, and it has not been enforced since 2003.⁴⁹ As medical expenses have continued to rise unchecked by the SGR, rates now exceed the SGR by nearly 25%.⁵⁰ Despite the Congressional Budget Office's (CBO) estimates that the annual override could cost the government nearly \$330 billion in unanticipated costs by 2020,⁵¹ the payment reform is regarded as the more appropriate method to improve rising costs and poor quality in healthcare.⁵²

43. The CPT is the charge a provider would designate for a performed service when applying for Medicare reimbursement. See AMA/SPECIALTY SOCIETY, *supra* note 33, at 4. See also FURROW ET AL., *supra* note 20, at 790.

44. See 42 U.S.C. § 1395w-4(b)(1)(A)-(C) (2011).

45. *Id.* See also MPFS FACT SHEET, *supra* note 34, at 3.

46. Ginsberg, *supra* note 18, at 172.

47. MPFS FACT SHEET, *supra* note 34, at 3.

48. *Id.*

49. Ginsberg, *supra* note 18, at 172. Ginsberg explains that "budget legislation in 1997 created the more stringent SGR formula, which allowed smaller utilization increases and tied the formula to the ups and downs of the broader economy. The SGR resulted in annual updates to the fee schedule at or above the Medicare Economic Index until 2002, when a 4.8% reduction occurred, setting the stage for Congress to repeatedly block subsequent sharp rate reductions. When the SGR formula called for another large decrease in rates in 2003, Congress blocked the cut." *Id.*

50. *Id.* at 176.

51. CONG. BUDGET OFFICE, ESTIMATE OF CHANGES IN NET FEDERAL OUTLAYS FROM ALTERNATIVE PROPOSALS FOR CHANGING PHYSICIAN PAYMENT RATES IN MEDICARE 2 (2010).

52. Ginsberg, *supra* note 18, at 176.

In addition to establishing the MPFS, the Secretary of HHS is also charged with periodic review and adjustment of the values.⁵³ According to the statute, the Secretary is required to review all values no less than every five years and make any needed adjustments.⁵⁴ In addition to this five-year review process, CMS annually evaluates new services and makes adjustments to the values of existing services.⁵⁵ This process can be quite extensive as there are over 7,600 CPT codes with corresponding RVUs.⁵⁶ In order to cope with this large demand, CMS began relying on outside recommendations almost immediately, mainly from the AMA's RUC.⁵⁷ Established in tandem with the RBRVS, the RUC is a formation of the AMA that was created to provide annual recommendations to CMS regarding changes to the RBRVS values.⁵⁸ To assist in its recommendations, the RUC sends out as many as 1,000 physician surveys, but only requires 30 responses in order to value a physician service.⁵⁹

Further, the original membership of the RUC in 1991 was designed "to include all major specialties, primarily defined as the 24 Member Boards of the American Board of Medical Specialties."⁶⁰ Future seats on the RUC have been determined by the following criteria:

1. The specialty is an American Board of Medical Specialties specialty.
2. The specialty comprises 1% of physicians in practice.
3. The specialty comprises 1% of physician Medicare expenditures.
4. Medicare revenue is at least 10% of mean practice revenue for the specialty.

53. 42 U.S.C. § 1395w-4(c)(2)(B) (2011).

54. 42 U.S.C. § 1395w-4(c)(2)(B)(i) (2011).

55. 42 U.S.C. § 1395w-4(c)(2)(B)(ii)(I) (2011) (discussing the Secretary's discretion to assign values to new services and adjust rankings of existing services).

56. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, 77 Fed. Reg. 68896 (Nov. 16, 2012) (to be codified at 42 C.F.R. pt 410, 414, 415, 421, 423, 425, 486, and 495).

57. AM. MED. ASS'N., *supra* note 5.

58. T. Reginald Harris, MD, Chairman, Am. Med. Ass'n, Physicians' Current Procedural Terminology (CPT), Statement before the Subcommittee on Health Data Needs, Standards, and Security, National Committee on Vital Health Statistics, Department of Health and Human Services (April 16, 1997), available at <http://www.ncvhs.hhs.gov/97041614.htm> [hereinafter Harris Testimony].

59. Carlos J. Lavernia & Brian Parsley, *Medicare Reimbursement: An Orthopedic Primer*, 21 J. ARTHROPLASTY (SUPP. 2) 6, 7 (2006). See also AM. MED. ASS'N. *supra* note 33 ("The societies are required to survey at least 30 practicing physicians.").

60. AM. MED. ASS'N. HOUSE OF DELEGATES, REPORT 14 OF THE BOARD OF TRUSTEES (A-08) THE RUC: RECENT ACTIVITIES TO IMPROVE THE VALUATION OF PRIMARY CARE SERVICES, EXECUTIVE SUMMARY, available at <http://www.ama-assn.org/resources/doc/rbrvs/rucbotreport.pdf>.

5. The specialty is not meaningfully represented by an umbrella organization, as determined by the RUC.⁶¹

The AMA maintains that the RUC is “an independent group exercising its First Amendment Right to petition the federal government” and explicitly states that the RUC is not “an advisory committee to CMS.”⁶² However, since its inception, it has appeared to function in exactly that capacity,⁶³ and has come under intense criticism in recent years for the vast discrepancy between the pay for specialist services and that for primary care services.⁶⁴ Kerry Weems, former CMS administrator, believes that the institutional presence of the RUC has helped lead to the poor state of primary care in the U.S.;⁶⁵ the exact problem for which the new MPFS was created to avoid.⁶⁶ Weems describes CMS as an agency that struggles with resource and staffing constraints directly affecting health reform.⁶⁷ Among these problems is the reliance on the RUC.

The intent behind creating the RUC may have been to delegate power to an independent body to inject its expertise into the RBRVS payment system;⁶⁸ however, it appears that CMS has entrusted too much responsibility to the RUC.⁶⁹ Weems describes the RBRVS as an “input measurement system,” which relies heavily on the cost of inputs and the effect of that cost on the pricing of outputs.⁷⁰ Because the assessment process “delineates and quantifies a service’s inputs in terms of its Relative Value Units which, with a monetary multiplier, define its worth,”⁷¹ this process can easily result in misvalued services. This can quickly escalate costs and pricing, thus ruining the reliability and sustainability of the Medicare reimbursement system.

In effect, the RBRVS is a microcosm of the fee-for-service issue in Medicare payment. Except with the RBRVS, the potential abuse is not unnecessarily escalating volume, but unnecessarily adjusting cost for preferred services. For example, one study considers evidence of errors in

61. *Id.* at 9.

62. AM. MED. ASS’N., *supra* note 5.

63. See *Infra* Part IV.

64. John K. Inglehart, *Doing More with Less: A Conversation with Kerry Weems*, 28 HEALTH AFF. w688, w695 (2009).

65. *Id.* at w695.

66. Ginsberg, *supra* note 18, at 173.

67. Inglehart, *supra* note 64, at w688.

68. See AM. MED. ASS’N., *supra* note 5.

69. Ann Marie Marciarille & J. Bradford DeLong, *Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board*, 22 HEALTH MATRIX 75, 107 (2012).

70. Inglehart, *supra* note 64, at w695.

71. Brian Klepper & David Kibbe, *Rethinking the Value of Medical Services*, HEALTH AFF. BLOG (August 1, 2011, 2:08 PM), <http://www.healthaffairs.org/blog/2011/08/01/rethinking-the-value-of-medical-services/>.

Medicare's prices for hospital care and physician services and discusses ways to improve the accuracy of those prices and identifies the need to conduct data analyses in consultation with the RUC.⁷² These analyses would identify services that have experienced substantial changes in volume, site of service, and other factors that may indicate changes in resource requirements.⁷³

The author's particular study found that in cardiovascular services with high rates of volume growth, the work component of that RVU stayed relatively constant over a 12-year period, despite the inclination that cardiologists became more adept at performing these procedures.⁷⁴ According to the authors of this study, the RUC does little to account for overvalued RVUs as exemplified in the above instance.⁷⁵ While CMS accounts for changes to RVUs during a five-year periodic review, seldom are overvalued services identified.⁷⁶ In fact, numerous studies have concluded that specialty work value units are inflated across the board and that many of these RVUs should be reduced as a reflection of productivity gains within that particular specialty practice.⁷⁷

Another example of skewed RVU assessment describes the rapid growth of imaging services and recent changes in how Medicare reimburses for these services.⁷⁸ The authors of the study claim that certain imaging services may still be overvalued by CMS, thus inflating Medicare spending, again due to the RUC's improper RVU valuation.⁷⁹ Among the solutions offered by the authors was a suggestion that the RUC review values to ensure that their "time estimates reflect advances in technology . . ."⁸⁰ These two studies offer similar conclusions about inflated physician work values as part of a larger trend in Medicare spending: RVUs are often overvalued for specialty

72. Kevin J. Hayes et al., *Getting the Price Right: Medicare Payment Rates or Cardiovascular Service*, 26 HEALTH AFF. 124, 131 (2007).

73. *Id.* at 135.

74. *Id.* at 133.

75. *Id.*

76. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 87 (Mar. 2010).

77. ROSENBAUM ET AL., *supra* note 21, at 618 (citing MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 76, at 87); Jerry Cromwell et al., *Missing Productivity Gains in the Medicare Physician Fee Schedule: Where Are They?*, 67 MED. CARE RES. & REV. 676, 678 (2010); and Thomas Bodenheimer et al., *The Primary Care-Specialty Income Gap: Why It Matters*, 146 ANNALS INTERNAL MED. 301, 305 (2007).

78. Ariel Winter & Nancy Ray, *Paying Accurately for Imaging Services in Medicare*, 27 HEALTH AFF. 1479, 1479 (2008).

79. *Id.*

80. *Id.* at 1488.

care and undervalued for primary care physician services.⁸¹ The growing difference in reimbursement rates under the MPFS between specialists and primary care physicians has become known as the physician payment gap, and has provided plenty of fodder for critics of the RUC, most of who call for drastic overhaul of the RBRVS system.⁸² The physician payment gap is believed to have led to a number of other complications within the field of primary care and the healthcare industry as a whole,⁸³ yet, it goes unsolved.

The American public likely has little sympathy for a primary care physician who complains about payment discrepancies because incomes of the physicians are wildly higher than that of the average American. But this discrepancy in pay is a prime reason that U.S. medical students turn to specialty careers over primary care.⁸⁴ The discrepancy is only aggravated by private insurance.⁸⁵ In fact, the primary care-specialty fee gap is actually larger for private plans than for Medicare,⁸⁶ which demonstrates that many of the principles of Medicare payment reform are incorporated in the systems of private insurers and Medicaid programs,⁸⁷ and emphasizes the leverage of Medicare in price-setting.

81. ROSENBAUM ET AL., *supra* note 21, at 618. Other examples include comparing a “moderately complex primary care office visit” for an established patient with “an ophthalmologist’s 10-15 minute cataract extraction and implantation of an intra-ocular lens.” Klepper & Kibbe, *supra* note 71. The comparative ratio for the value of these two services is greater than 1:7, respectively. *Id.* In 2011, Medicare paid \$111.36 for the primary care physician visit and a total of \$836.36 for the visit to the ophthalmologist. *Id.* Further, “[c]ataract removal, a 50 year old procedure that has been highly refined and automated, immediately improves sight, a dramatic impact. Many ophthalmologists operate ‘focused factories,’ processing an assembly line of 20 or more cataract patients. With pre-screened patients and a controlled clinical environment, the risks are relatively predictable, the mental demands limited and the work repetitive.” *Id.*

82. ROBERT GRAHAM CTR., SPECIALTY AND GEOGRAPHIC DISTRIBUTION OF THE PHYSICIAN WORKFORCE: WHAT INFLUENCES MEDICAL STUDENT AND RESIDENT CHOICES? 2, 32 (2009). See, e.g., Allan H. Goroll, *Reforming Physician Payment*, 359 NEW ENG. J. MED. 2087, 2090 (2008) (“Viewing the current fee-for-service system, its institutional mechanisms, and proposed modifications as structurally flawed, clinically questionable, and inadequate for the delivery of robust primary care [Goroll] propose[s] fundamental reform of payment for primary care, replacing volume-based payment with risk adjusted comprehensive payment for the delivery of comprehensive primary care.”).

83. Dummit, *supra* note 30, at 14. According to Dummit, the MPFS has been cited as the cause of numerous problems, including: “physician specialty imbalances, overuse of certain well-paid services and underuse of poorly paid services, and physician payment inequities. Yet even with such high stakes, ensuring the accuracy of the fee schedule continues to rely on limited data.” *Id.*

84. Bodenheimer et al., *supra* note 77, at 301.

85. *Id.* at 304.

86. *Id.*

87. Ginsberg, *supra* note 18, at 172.

In 2006, the Medicare Payment Advisory Commission (MedPAC)⁸⁸ first addressed the leading causes of this discrepancy in its report to Congress on Medicare Payment Policy.⁸⁹ Included in MedPAC's analysis were the following factors: 1) the dominance of the RUC by specialists; 2) a majority of review requests came from specialist societies; 3) a majority of the reviews were for undervalued services; 4) the adjustments must be budget neutral; and 5) "CMS generally accepts the RUC's recommendations."⁹⁰ MedPAC's analysis is essentially a blueprint for most arguments against the RUC's current influence on Medicare payment and a starting point for future cost control measures.

MedPAC's recommendations for the RUC have not yet been heeded by Congress to any effective degree, although past evidence suggests that in order to reach creative solutions for Medicare pricing reform certain vitals are required,⁹¹ including "divid[ing] industry groups by buying them off (at least, a sufficient bloc of them) to reduce their opposition to difficult payment reforms."⁹² This was effectively done during the implementation of the RBRVS. However, despite the RBRVS being designed "to lessen the fee disparity between office visits — the bread and butter of primary care — and procedures provided by specialists,"⁹³ the payment gap widened because the AMA allowed the RUC to be composed mostly of members named to specialist societies, thus by "buying off" medical specialty groups, the societies undermined the intent of the arrangement.⁹⁴

CMS finally acknowledged the issue of overvalued codes, as discussed in the MPFS rules for 2009 and 2010.⁹⁵ Efforts are now on course to

88. See MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 76. MedPAC, an independent congressional agency, advises Congress on Medicare payment issues. It was originally established by the Balanced Budget Act of 1997, Pub. L. No. 105-33. *Id.* This includes health plans participating in Medicare Advantage and providers operating through Medicare's FFS program. *Id.* In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare's traditional fee-for-service program, other responsibilities of MedPAC include analyzing access to care and quality of care. *Id.*

89. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 133-35 (2006), available at <http://www.medpac.gov/documents/Mar06entireReport.pdf>.

90. ROSENBAUM ET AL., *supra* note 21, at 618.

91. Robert F. Coulam et al., *Competitive Pricing and the Challenge of Cost Control in Medicare*, 36 J. HEALTH POL. POL'Y & L. 649, 650, 666-67 (2011) (aiming to develop prudent purchasing through competitive pricing and examining Medicare price policy).

92. *Id.*

93. Bodenheimer et al., *supra* note 77, at 301.

94. Coulam et al., *supra* note 91, at 667 n.23.

95. See Potentially Misvalued Services Under the Physician Fee Schedule, 73 Fed. Reg. 69881 (Nov. 19, 2008) (to be codified at 42 C.F.R. pts. 405, 409-15, 423-24, 485-86,

update the RBRVS, although this likely has little to do with revising the RUC, but rather increasing review of potentially overvalued CPT codes.⁹⁶ Additionally, efforts were recently included in the ACA to improve overvalued codes.⁹⁷ This is certainly a step in the right direction, however, any creative approach to Medicare payment reform is likely to be thwarted by the interest groups that are already financially well-endowed under the current process.⁹⁸

Other scholars have positioned themselves against the practice of the RUC, claiming that the medical profession needs a drastic overhaul of the current infrastructure governing the valuation of clinical services and practice expenses, increased transparency, and increased input from experts “who have the health of individuals, the nation, and the economy as their highest priorities.”⁹⁹ It is this desire for accountability that is driving the focus of this argument. The RUC, as currently structured, is private and exclusive, a grave concern for a committee so heavily involved in setting the MPFS. Operating in such a capacity without adequate review has so far been detrimental to the reimbursement for primary care physicians. While CMS has recently expressed a need to review values for primary care values under the RBRVS,¹⁰⁰ a step further would be to subject the RUC to the review standards by which every FAC abides.

489); Potentially Misvalued Services Under the Physician Fee Schedule, 74 Fed. Reg. 61775 (Nov. 25, 2009) (to be codified at 42 C.F.R. pts. 410-15, 485, 498).

96. Paul B. Ginsburg, *Rapidly Evolving Physician-Payment Policy – More Than the SGR*, 364 NEW ENG. J. MED. 172, 174 (2011).

97. See Refinements to the RVUs, 76 Fed. Reg. 73034 (Nov. 28, 2011) (to be codified at 42 C.F.R. pts. 410, 414, 415, et al.); ACA § 3134(a) (codified at 42 U.S.C. § 1395w-4(c)(2)(K)(ii) (2011)) (identifying several categories of potentially misvalued codes for review, including: codes for new technologies or services; frequently billed codes associated with a single service, common codes with low relative values; and codes that have not been reviewed since the inception of the RBRVS).

98. See Peter V. Lee & David Lansky, *Making Space for Disruption: Putting Patients at the Center of Health Care*, 27 HEALTH AFF. 1345, 1346 (2008) (examining the effect of regulation and legislation on cost-effective care). Lee and Lansky call out the RUC for its high consistency of procedural specialists and for containing “not one patient, purchaser, or payer” on the committee. *Id.*

99. John D. Goodson, *Unintended Consequences of Resource-Based Relative Value Scale Reimbursement*, 298 JAMA 2308, 2310 (2007). See also Laurence F. McMahon Jr. & Vineet Chopra, *Health Care Cost and Value: The Way Forward*, 307 JAMA 671, 671-72 (2012) (outlining the existing approaches to controlling health care costs: 1) a cost-centric approach and 2) value-centric approach). The U.S. can no longer afford to allow its health priorities to be determined solely on cost or value basis alone. Instead, the medical market should reflect clinical values for procedures which have already been analyzed and market those services according to their clinical value. *Id.* at 672.

100. Potentially Misvalued Services Under the Physician Fee Schedule, 73 Fed. Reg. at 69881; 74 Fed. Reg. at 61775. See also MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO

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On August 8, 2011, six primary care physicians filed suit against CMS and HHS for accepting recommendations by the RUC without due consideration.¹⁰¹ The physicians charged that the effects of the RUCs recommendations contributed to a significant payment gap between primary care physicians and specialists.¹⁰² The complaint directly challenged CMS's failure to comply with the FACA, the Administrative Procedure Act (APA), the ACA, the Mandamus Act, the Delegation Clause of the United States Constitution, and the Due Process Clause of the Fifth Amendment to the United States Constitution.¹⁰³

More plainly, the physicians charged that CMS was in violation of the APA and FACA for "utilizing the [RUC] as an uncharted and unofficial Federal Advisory Committee . . . in that CMS directly manages, utilizes, and relies upon the AMA RUC in the relative valuation process that forms the basis of the [MPFS]."¹⁰⁴ In their request for relief, the physicians requested declaratory judgment that CMS had violated the FACA by "failing to allow public petitioning of the AMA RUC, failing to provide public access to records of the AMA RUC meetings, and failing to ensure that the AMA RUC is constituted of members that have a balanced representation of views."¹⁰⁵ The suit thrust the previously anonymous RUC into the political spotlight, which prompted a coordinated defense campaign from the "RUC, the AMA, and 47 medical specialty societies."¹⁰⁶

THE CONGRESS: MEDICARE PAYMENT POLICY 90 (2012), available at http://medpac.gov/documents/Mar12_EntireReport.pdf.

101. Complaint, *supra* note 12, at 2-3. See also Klepper, *supra* note 9; *Six Primary Care Physicians Sue CMS, Claim Doc Payment System Favors Specialists*, BLOOMBERG BNA 1 (August 12, 2011), <http://www.bna.com/six-primary-care-n12884903037/>.

102. Complaint, *supra* note 12, at 48.

103. *Id.* at 2.

104. *Id.* at 2-3.

105. *Id.* at 3.

106. Klepper, *supra* note 9. Compare Joel Klepper, *A Letter from America's Medical Specialty Societies to Rep. McDermott (D-WA), CARE & COST* (April 8, 2011), <http://careandcost.com/2011/04/08/a-letter-from-americas-medical-specialty-societies-to-rep-mcdermott-d-wa/> (in response to his remarks before the House Ways & Means Committee, and to legislation he recently introduced, H.R. 1256), with Barbara Levy, *The RUC - Providing Valuable Expertise to the Medicare Program for Twenty Years*, KAISER HEALTH NEWS (March 28, 2011), <http://www.kaiserhealthnews.org/Columns/2011/March/032811levy.aspx> (Chair of the AMA/ Specialty Society Relative Value Scale Update Committee defending the RUC and its value), and Letter from Michael D. Maves, Executive V.P., Am. Med. Ass'n., to Rep. Jim McDermott (D-WA) (April 5, 2011) (on file with author), available at <http://careandcost.files.wordpress.com/2011/04/maves-ama-mcdermott-ltr-40511.pdf> (in response to his remarks before the House Ways & Means Committee, and to legislation he recently introduced, H.R. 1256).

This challenge brought unprecedented attention to the RUC.¹⁰⁷ It prompted Representative Jim McDermott (D-WA) to introduce a bill,¹⁰⁸ the Medicare Physician Payment Transparency and Assessment Act of 2011, which aims “to require the use of analytic contractors in identifying and analyzing misvalued physician services under the Medicare physician fee schedule and an annual review of potentially misvalued codes under that fee schedule.”¹⁰⁹ In other words, the bill demanded that CMS replace, or at least supplement, the RUC with a neutral third-party analysis when determining reimbursement rates.¹¹⁰ However, this total overhaul may not be necessary to ensure a more public process.

Representative McDermott, a long-time critic of the RUC, called for sanctioning of the RUC as a FAC, thus subjecting it to transparency and accountability,¹¹¹ claiming that no group influences price setting more in healthcare, and that the RUC is more of a concern to long-term sustainability of Medicare than the Sustainable Growth Rate (SGR).¹¹² McDermott goes on to challenge that CMS’s job is to set rates “in the public interest and not in the interest of powerful physician specialties,” claiming that increased transparency would not only provide for fairer decisions, but it would also benefit “the health of Americans as well as our federal budget.”¹¹³

The RUC and its influence is more recognized now than it has been since its inception, but its process and rationale still remain secret. The physician suit in *Fischer v. Berwick* aimed to change that, but regrettably it was unsuccessful.¹¹⁴ *Fischer* hinged on a plain accusation, that in its delegated power to create and evaluate RVUs for the MPFS, “CMS has relied heavily upon the AMA RUC, to the extent that the AMA RUC now has become a *de facto* Federal Advisory Committee and therefore must be regulated according to the FACA.”¹¹⁵ For remedy, the physicians sought for the RUC to be governed by the FACA and realigned as a FAC, as opposed

107. Klepper, *supra* note 9.

108. Medicare Physician Payment Transparency and Assessment Act of 2011, H.R. 1256, 112th Cong. (2011).

109. *Id.*

110. Press Release, Congressman Jim McDermott, McDermott’s Statement on CMS Lawsuit, (Aug. 8, 2011), http://mcdermott.house.gov/index.php?option=com_content&view=article&id=510:mcdermotts-statement-on-cms-lawsuit&catid=25:press-releases&Itemid=20.

111. Jim McDermott, *Harnessing Our Opportunity to Make Primary Care Sustainable*, 364 *NEW ENG. J. MED.* 395, 396 (2011).

112. *Id.*

113. Press Release, Congressman Jim McDermott, *supra* note 110.

114. *Fischer v. Berwick*, No. WMN-11-2191, 2012 WL 1655320, at *1 (D. Md. May 9, 2012).

115. Complaint, *supra* note 12, at 11.

to operating as a private body petitioning CMS. Despite the favorable fact scenario, the court was precluded from adjudicating the issue and dismissed the plaintiffs' action.¹¹⁶

In a Memorandum to the Opinion, the court discussed why it decided to dismiss the plaintiffs' action.¹¹⁷ Defendants moved to dismiss plaintiffs' action on grounds that judicial review of the Secretary's determinations is barred under Title XVIII of the Social Security Act, 42 U.S.C. § 1395w-4(i)(1)(B).¹¹⁸ The court agreed stating that Congress has precluded courts from reviewing the final relative values and RVUs and also the method by which those values and units were generated.¹¹⁹

Plaintiffs' claims implicated part of the actual determinations of RVUs and fell within the bar of § 1395w-4(i)(1). The statute, entitled "Restriction on Administrative and Judicial Review," plainly states:

There shall be no administrative or judicial review under section 1395ff of this title or otherwise of — (A) the determination of the adjusted historical payment basis . . . (B) the determination of relative values and relative value units . . . including adjustments . . . and (E) the establishment of the system for the coding of physicians' services¹²⁰

While the court assumed the factual validity of the plaintiffs' argument,¹²¹ it determined among the defendant's many arguments that it was correct in asserting that the plaintiffs could not bring judicial review that is otherwise barred.¹²² The court held:

Accepting as true that RUC plays a major role in the formation of the PFS and also accepting as true that this role unfairly skews the PFS toward certain medical professions and procedures, the Court, nonetheless, finds that Congress has precluded courts from reviewing, not only the final relative values and RVUs, but also the method by which those values and units are generated.¹²³

The court spends a majority of its opinion discussing the bar on judicial review, its comprehensiveness, and the statutory interpretation of the bar in previous suits.¹²⁴ While the court spends a small portion of its opinion on

116. *Fischer*, 2012 WL 1655320, at *1.

117. *See id.*

118. *Id.* at *1.

119. *Id.* at *2.

120. 42 U.S.C. § 13951-4(i)(1) (2012).

121. *Fischer*, 2012 WL 1655320, at *2.

122. *Id.*

123. *Id.*

124. *See id.* at *3-5 (reviewing *Am. Soc'y of Cataract & Refractive Surgery v. Thompson*, 279 F.3d 447 (7th Cir. 2002); *Am. Soc'y of Anesthesiologists v. Shalala*, 90 F.Supp.2d 973 (N.D. Ill. 2000); and *Am. Coll. of Cardiology v. Sebelius*, Civ. No. 09-62034, 2010 WL 9463882 (S.D. Fla. Apr. 27, 2010)).

the applicability of the Due Process Clause, it allocates none of the opinion to discussing whether or not the RUC ought to be subjected to the FACA.

As Brian Klepper explains, the court was confronted by two conflicting federal laws.¹²⁵ The first, as established by Congress, operates as a prohibition on the courts and bars the current valuation of Medicare payments from judicial review.¹²⁶ The second, the FACA, requires that groups advising the federal government abide by a set of regulated transparency standards, including public hearing and notice of meetings,¹²⁷ which is not required of the RUC. By focusing solely on the issue of judiciability, the court was able to avoid any substantive discussions regarding the RUC and the FACA.¹²⁸ The following section of this note will elaborate on the history and applicability of the FACA and discuss whether it can be applied to the RUC.

IV. FEDERAL ADVISORY COMMITTEE ACT OF 1972

The FACA was passed as a response to the rapid growth of FACs, for which there were no previous standards of cost or accountability.¹²⁹ By passing the FACA, Congress aimed to make advisory committees more “accountable, transparent, balanced, and independent from influence of special interests.”¹³⁰ A product of the “good-government” phase of the early-1970s, the FACA was intentioned to keep Congress and the public educated about “the number, purpose, membership, and activities” of any group which offered advice or recommendation to the federal government.¹³¹ Further, the FACA was passed in order to address the exact concern that the RUC’s specialist-heavy panel exemplifies: a “concern that some interests had come to enjoy unchecked and perhaps illicit access to federal executive decisionmakers.”¹³²

Unfortunately, the implementation of the FACA has not always achieved these goals, and a study by the Government Accountability Office (GAO) determined that appointments to some FACs¹³³ were made based on ideology of the appointer and not based upon experience, nor were the

125. Klepper, *supra* note 8.

126. 42 U.S.C. § 1395w-4(i)(1)(B) (2011).

127. Federal Advisory Committee Act, 5 U.S.C. app. § 2(b)(4)-(5) (2011).

128. Klepper, *supra* note 8.

129. *Examining the Federal Advisory Committee Act – Current Issues and Developments: Hearing Before the Subcomm. on Info. Policy, Census, & Nat’l Archives of the Comm. on Oversight & Gov’t Reform*, 110th Cong. 1 (2008) [hereinafter *Examining the FACA*].

130. *Id.*

131. Steven P. Croley & William F. Funk, *The Federal Advisory Committee Act and Good Government*, 14 YALE J. ON REG. 451, 452 (1997).

132. *Id.* at 453.

133. The GAO did not disclose the specific FACs in question.

appointees screened for conflicts of interests.¹³⁴ Especially in the case of sensitive and controversial issues, it is the goal of the FACA to ensure that the federal government has the assistance of a plethora of assessments, but the FACA sometimes falls short of this goal, which is why in 2008, the House Committee on Oversight and Government Reform sought to examine and amend the FACA.¹³⁵

This is not to say that the accountability issues are pervasive throughout FACs, or that the RUC is somehow better off not abiding by a broken system. Instead, it should be seen as a testament to the resolve of Congress to hold FACs accountable to the public and confirm the intentions of the FACA to dissolve special interests from controlling Washington.¹³⁶

While the RUC has never been sanctioned under the FACA as a FAC, it is not any less influential.¹³⁷ In the context of the possible 2008 amendments to the FACA, the GAO spoke out in favor of the greater accountability for federal advisory opinions:

Federal advisory committees have been called the ‘fifth arm of government’ because of the significant role they play in advising federal agencies, the Congress, and the President on important national issues. *To be effective, advisory committees must be — and, just as importantly, be perceived as being — independent and balanced as a whole.* As we reported in 2004, controversies regarding the federal advisory committee system have included concerns that some appointments have been based on ideology rather than expertise or were weighted to favor one group of stakeholders over others.¹³⁸

134. See also *Examining the FACA*, supra note 129, at 2.

135. *Id.* at 1, 3. See also Federal Advisory Committee Act Amendments of 2008, H.R. 5687, 110th Cong. (2008). While the bill passed the House, it died in the Senate but has been reintroduced several times: H.R. 1320, 111th Cong. (as introduced, Mar 05, 2009); H.R. 3124, 112th Cong. (as introduced, Oct 06, 2011). As of this publication the bill has not yet become law.

136. *Examining the FACA*, supra at 129, at 1. Examples of FACs include the U.S. Military Academy Board of Visitors or The Exxon Valdez Oil Spill Public Advisory Committee Charter. The Department of Commerce alone contains upwards of 60 FACs. UNITED STATES DEPT. OF COMMERCE, FEDERAL ADVISORY COMMITTEES, available at <http://webcache.googleusercontent.com/search?q=cache:http://www.osec.doc.gov/opog/faca.html>.

137. Miriam J. Laugesen, Roy Wada & Eric M. Chen, *In Setting Doctors’ Medicare Fees, CMS Almost Always Accepts the Relative Value Update Panel’s Advice on Work Values*, 31 HEALTH AFF. 965, 968 (2012) (finding that “CMS accepted 2,419 (87.4 percent) of the 2,768 work values proposed by the update committee”).

138. *Federal Advisory Committee Act Issues Related to the Independence and Balance of Advisory Committees: Hearing Before the Subcomm. on Info. Policy, Census, & Nat’l Archives of the H. Comm. on Oversight & Gov’t Reform*, 110th Cong. 11 (2008) (statement of Robin M. Nazzaro, Director, National Resources and Environment, Government Accountability Office) (emphasis added).

Other specifications for agencies operating FACs include: prior announcement of committee meetings, notice to interested parties about attendance, that meetings be open to the public, and that meeting minutes are publically available.¹³⁹ Of course, none of the well-intentioned amendments or current regulations under the FACA even apply to the RUC, unless it can be established as a FAC.

According to the GAO, it is the responsibility of the General Services Administration (GSA) to prescribe administrative guidelines and management controls for all advisory committees.¹⁴⁰ However, the GSA cannot approve or deny any agency decision to create a FAC or any actions regarding the management of that committee,¹⁴¹ and that is an issue for judicial review.¹⁴²

In the case of the RUC, because it was not created or initialized by CMS, it may have escaped the regulation guidelines established by the GSA and the FACA.¹⁴³ However, according to the guidelines of the FACA,¹⁴⁴ and certainly in the opinion of the physicians in *Fischer*,¹⁴⁵ the fact that the RUC was established by the AMA and not by CMS¹⁴⁶ is irrelevant.

The FACA states that a FAC is “any committee, board, commission, council, conference, panel, task force, or other similar group [that is] . . . established or utilized by one or more agencies, in the interest of obtaining advice or recommendations for . . . one or more agencies or officers of the Federal Government . . .”¹⁴⁷ This phrase alone should be the requisite means to enforce the FACA against the RUC, but it may not be that simple.

According to a statutory interpretation by the Court in *Public Citizen v. U.S. Dep’t of Justice*, “the word ‘utilize’ . . . was not to be taken literally, but rather was properly understood as an extension and qualification of the term

139. *Id.* at 13.

140. *Federal Advisory Committee Act Issues Related to the Independence and Balance of Advisory Committees: Hearing Before the Subcomm. on Info. Policy, Census, & Nat’l Archives of the H. Comm. on Oversight & Gov’t Reform*, 110th Cong. 32 (2008) (statement of Robert Flaak, Director, Committee Management Secretariat, U.S. General Service Administration).

141. *Id.* at 14.

142. See Croley & Funk, *supra* note 131, at 513-14 (discussing judicial review of FACA claims and enforceability of the courts upon successful prosecution).

143. Harris Testimony, *supra* note 58. See generally AM. MED. ASS’N., *supra* note 5 (explaining that the RUC is supported by the AMA and does advise the CMS).

144. 5 U.S.C. App. § 3(2)(C) (2012).

145. Complaint, *supra* note 12, at 12.

146. Harris Testimony, *supra* note 58. See generally AM. MED. ASS’N., *supra* note 5 (explaining that the RUC is supported by the AMA and does advise the CMS).

147. 5 U.S.C. App. § 3(2)(C) (2012) (emphasis added).

'establish.'"¹⁴⁸ Accordingly, the Court in *Public Citizen* looked into the legislative history of the FACA and found:

The phrase 'or utilized' therefore appears to have been added simply to clarify that FACA applies to advisory committees established by the Federal Government in a generous sense of that term, encompassing groups formed indirectly by quasi-public organizations such as the National Academy of Sciences 'for' public agencies as well as 'by' such agencies themselves. Read in this way, the term 'utilized' would meet the concerns of the authors . . . that advisory committees . . . 'utilized by a department or agency in the same manner as a Government-formed advisory committee' . . . would be subject to FACA's requirements.¹⁴⁹

It is not surprising that given the above interpretation,¹⁵⁰ and the subsequent disagreement,¹⁵¹ that the most commonly litigated issue under the FACA pertains to the process and determination by which a given group becomes subject to the regulations under the FACA.¹⁵² Given the Court's holding in *Public Citizen*, it could be discerned that the RUC would not qualify at all under the FACA, since while it is utilized by CMS in its determination of RVUs, it was not "directly established" by or for CMS.¹⁵³

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Regardless of the deterrents of previous decisions and the confusing statutory language of the FACA, the physicians in *Fischer* challenged the RUC on several provisions within the FACA,¹⁵⁴ including membership,¹⁵⁵ recommendations,¹⁵⁶ public access,¹⁵⁷ availability of committee records,¹⁵⁸

148. Croley & Funk, *supra* note 131, at 469 (interpreting the majority opinion in *Public Citizen v. U.S. Dep't of Justice*, 491 U.S. 440, 452-53 (1989)). Additionally, Croley and Funk point out "the Conference Report, which actually added the words 'or utilized' to the bill-without explaining the reason for the addition-stated generally that the bill did not apply to 'advisory committees not directly established by or for [federal] agencies.'" Croley & Funk, *supra* note 131, at 478 (citing H.R. REP. No. 92-1403, at 10 (1972)).

149. *Public Citizen*, 491 U.S. at 462-63.

150. *Id.* at 452. The court further stated, "[u]tilize' is a woolly verb, its contours left undefined by the statute itself. Read unqualifiedly, it would extend FACA's requirements to any group of two or more persons, or at least any formal organization, from which the President or an executive agency seeks advice. We are convinced that Congress did not intend that result."

151. *Id.* at 474-77 (Kennedy, J., concurring: "[o]ne would have thought at least that the Court would have been led to consider how the specific purposes Congress identified for this legislation might shed light on the reasons for the change. Not only does the Court's decision today give inadequate respect to the statute passed by Congress, it also gives inadequate deference to the GSA's regulations interpreting FACA." *Id.* at 477).

152. Croley & Funk, *supra* note 131, at 471.

153. *Public Citizen*, 491 U.S. at 462; MED. ASSOC., *supra* note 5.

154. See Complaint, *supra* note 12, at 12-15.

155. 5 U.S.C. App. § 5(b)(2) (2012).

156. 5 U.S.C. App. § 5(b)(3) (2012).

and oversight.¹⁵⁹ In order to initialize the regulation of these provisions, the physicians in *Fischer* relied on recognition by the U.S. Supreme Court that groups utilized by federal agencies can become *de facto* FACs under the decision in *Public Citizen*.¹⁶⁰ Further, the physicians in *Fischer* allege that *de facto* FACs are “those committees under the ‘actual management or control’ of a federal agency,”¹⁶¹ as well as “those committees utilized by a department or agency in the same manner as a Government-formed advisory committee.”¹⁶² Thus, as CMS is charged with developing RVUs,¹⁶³ but ends up accepting a substantial majority of the RUC’s recommendations for those values,¹⁶⁴ it is conceivable to align the RUC’s operation in tandem with CMS with the statutory interpretation of “utilization” under the FACA.¹⁶⁵

Regardless of the court’s refusal to address this issue¹⁶⁶ and similar previous holdings,¹⁶⁷ it appears that the RUC should indeed be governed by the FACA. In *American Society of Dermatology v. Shalala*,¹⁶⁸ a similar case brought against CMS, the court found that CMS did not meet the standard of “actual management or control,”¹⁶⁹ even though the court concluded that the RUC is “a limited number of private citizens who are brought together to give publicized advice as a group.”¹⁷⁰ The physicians in *Fischer* disagreed and challenged the court to revisit this concept.¹⁷¹ The physicians in *Fischer* rely on both the language of *Shalala*, and another case,

157. 5 U.S.C. App. § 10(a)(1)-(3) (2012).

158. 5 U.S.C. App. §§ 10(b), 11(a), 10(c) (2012).

159. 5 U.S.C. App. § 7(b), 8(b) (2012).

160. Complaint, *supra* note 12, at 15 (citing *Public Citizen v. U.S. Dep’t of Justice*, 491 U.S. 440 (1989)).

161. *Id.* at 20 (citing *Wash. Legal Found. v. United States Sentencing Comm’n*, 17 F.3d 1446, 1450 (D.C. Cir. 1994)).

162. *Id.* (citing *Public Citizen*, 491 U.S. at 457).

163. 42 C.F.R. § 414.22 (2009).

164. As noted by Kerry Weems, CMS has accepted a substantial majority of the RUC’s recommendations, 87.4 percent, to be exact. See Letter from Kerry Weems, Acting Administrator, CMS, to William L. Rich, M.D., Chair of the RUC, (June 19, 2008) (on file with author), available at www.ama-assn.org/ama1/pub/upload/mm/380/cmsapplause.pdf. See also Laugesen, Wada, & Chen, *supra* note 137, at 968 (finding that “between 1994 and 2010 found that CMS agreed with 87.4 percent of the committee’s recommendations”).

165. 5 U.S.C. App. § 3(2)(C) (2012).

166. See *Fischer*, 2012 WL 1655320, at *2.

167. *Am. Soc’y of Dermatology v. Shalala*, 962 F. Supp. 141, 146 (1996) (examining the advisory role of other AMA committees, but not the RUC); *Am. Soc’y of Cataract & Refractive Surgery v. Thompson*, 279 F.3d 447, 449 (7th Cir. 2002) (challenging the formula by which the RVUs are calculated during a congressionally mandated transition period).

168. *Shalala*, 962 F. Supp. at 141.

169. *Id.* at 147.

170. *Id.* at 148.

171. Complaint, *supra* note 12, at 89.

Association of American Physicians and Surgeons, Inc. v. Clinton,¹⁷² which, among other conclusions, found that certain “working groups” upon which a governmental entity relied were FACs to the extent that they provided advice or recommendations on which the federal government relied. The court held:

The point, it seems to us, is that a group is a FACA advisory committee when it is asked to render advice or recommendations, as a group, and not as a collection of individuals. The group’s activities are expected to, and appear to, benefit from the interaction among the members both internally and externally.¹⁷³

The physicians in *Fischer* rely directly upon this analysis in *Clinton*, asserting that CMS relies on data generated by the RUC, and that the RUC itself is “a formal group,”¹⁷⁴ and not “a collection of individuals”¹⁷⁵ which presents its findings to CMS.¹⁷⁶ The court does not address this issue of reliance as a *de facto* advisement, thus ignoring the argument under the *Clinton* standard altogether, but instead, focuses solely on the statutory provision barring judicial review of value determinations and methodology.¹⁷⁷

The holding in *Clinton* is crucial to the physicians’ argument. In addition to the “working groups” holding, the *Clinton* court established a continuum for determining whether or not a particular group is subject to the FACA.¹⁷⁸ The court wrote:

When we examine a particular group or committee to determine whether FACA applies, we must bear in mind that a range of variations exist in terms of the purpose, structure, and personnel of the group. Perhaps it is best characterized as a continuum. *At one end one can visualize a formal group of a limited number of private citizens who are brought together to give publicized advice as a group. That model would seem covered by the statute regardless of other fortuities such as whether the members are called ‘consultants.’* At the other end of the continuum is an unstructured arrangement in which the government seeks advice from what is only a collection of individuals who do not significantly interact with each other. That model, we think, does not trigger FACA.¹⁷⁹

172. *Ass’n of Am. Physicians & Surgeons, Inc. v. Clinton*, 997 F.2d 898 (D.C. Cir 1993); *Am. Soc’y of Dermatology v. Shalala*, 962 F. Supp. 141 (1996).

173. *Clinton*, 997 F.2d at 913 (emphasis added). See also Croley & Funk, *supra* note 131, at 455.

174. *Clinton*, 997 F.2d at 915.

175. *Id.*

176. See Complaint, *supra* note 12, at 52.

177. *Fischer*, 2012 WL 1655320, at *1-2.

178. *Clinton*, 997 F.2d at 915.

179. *Id.* at 915 (emphasis added).

The physicians in *Fischer* address this issue directly, claiming that the RUC is a “structured committee consisting of 26 voting members and a Chairperson who regularly meet and give their advice as a group to CMS,” thereby qualifying it under the structured end of the *Clinton* continuum.¹⁸⁰ Interestingly enough, the *Fischer* court ignored this rationale and paid no attention to the holding in *Clinton*, instead the court looked to *American Society of Cataract and Refractive Surgery v. Thompson*.¹⁸¹

The *Thompson* court found that the plaintiffs’ claims were barred under 42 U.S.C. § 1395w-4(i)(1)(B), holding that there is “strong presumption that Congress intends a judicial review of administrative action”¹⁸² and that “only upon a showing of ‘clear and convincing evidence’ of a contrary legislative intent should the courts restrict access to judicial review.”¹⁸³ While it appears that this provision may in fact bar judicial or administrative review of CMS’s value determinations, it certainly does not preclude applicability of the FACA to the RUC, which was perhaps the intention of the physicians when they brought suit.¹⁸⁴ If regulatory or legislative changes occur, such as removing the judiability bar or subjecting the RUC to the FACA, the RUC could likely be found in violation of the FACA.

Regrettably, it is nearly impossible to bring a private challenge under the FACA without first inducing the statutory immunity provision,¹⁸⁵ which is likely the reason the physicians in *Fischer* sought to challenge the enforceability of the APA.¹⁸⁶ For this, the physicians induced a ruling from a recent D.C. Circuit case, *Judicial Watch, Inc. v. United States Dep’t of Commerce*, which held that plaintiffs may bring FACA claims pursuant to the APA, thereby avoiding the private cause of action limitations for challenges under the FACA.¹⁸⁷

However, under the requirements laid out by the FACA and *Clinton*, the RUC is likely in violation of the FACA. Among the many challenges within the *Fischer* complaint, the physicians charged that the RUC was in violation

180. Complaint, *supra* note 12, at 52-53.

181. *Am. Soc’y of Cataract & Refractive Surgery v. Thompson*, 279 F.3d 447 (7th Cir. 2002).

182. *Id.* at 452.

183. *Id.* (quoting *Abbott Labs. v. Gardner*, 387 U.S. 136, 141 (1967)).

184. In their request for relief, plaintiffs sought injunction, thus freezing the relationship between CMS and the RUC until the RUC complied with the FACA. See Klepper, *supra* note 9; Complaint, *supra* note 12, at 2-4.

185. See Croley & Funk, *supra* note 131, at 514-16 (discussing standing requirements for private party claims under the FACA).

186. Complaint, *supra* note 12, at 16 (“Plaintiffs do not seek relief under FACA, but instead seek relief pursuant to the APA for violation of FACA.”).

187. *Judicial Watch, Inc. v. United States Dep’t of Commerce*, 736 F. Supp. 2d 24, 30 (D.D.C. 2010).

of several provisions within the FACA,¹⁸⁸ including membership,¹⁸⁹ recommendations,¹⁹⁰ public access,¹⁹¹ availability of committee records,¹⁹² and oversight.¹⁹³

First, the RUC likely meets the standard alleged by the physicians in *Fischer*: the advisement practices of the RUC fall within the structured end of the spectrum described in *Clinton*¹⁹⁴ and under the principle of utilization as described by *Public Citizen*.¹⁹⁵ The RUC is, by its own admission, an expert panel comprised of 31 members who annually evaluate RVUs and prepare recommendations for CMS.¹⁹⁶ The AMA concedes that CMS has adopted nearly 95% of the RUC's PW recommendations, which are free to the federal government and cost the AMA, specialist societies, and other healthcare organizations up to \$7 million per year in expenses, and boasts that "CMS could not replicate the resources to duplicate this process."¹⁹⁷ Further, the AMA admits that "[t]he high acceptance rate is very important to the RUC [and that] [t]he RUC understands the boundaries within the RBRVS and abides by the definitions constructed by CMS."¹⁹⁸ It is confirmed by the AMA that "CMS has observers at each RUC meeting [and] [i]f a concern is expressed, the RUC responds accordingly."¹⁹⁹ The AMA also describes the RUC meetings as "deliberative discussion, often requiring in depth facilitation."²⁰⁰

Considering the significant amount of effort and determination required by the RUC in their recommendations, as well as the self-admitted claim by the AMA that CMS could not replicate this process without a significant cost to taxpayers, it is understandable that the RUC is utilized by CMS in the manner originally described by the U.S. Supreme Court in *Public Citizen*,²⁰¹

188. See Complaint, *supra* note 12, at 12-15.

189. 5 U.S.C. App. § 5(b)(2) (2012).

190. 5 U.S.C. App. § 5(b)(3) (2012).

191. 5 U.S.C. App. § 10(a)(1)-(3) (2012).

192. 5 U.S.C. App. §§ 10(b); 11(a); 10(c) (2012).

193. 5 U.S.C. App. §§ 7(b); 8(b) (2012).

194. *Ass'n of Am. Physicians & Surgeons, Inc. v. Clinton*, 997 F.2d 898, 915 (1993).

195. *Public Citizen v. United States Dep't of Justice*, 491 U.S. 440, 463 (1989).

196. See AM. MED. ASS'N., *supra* note 5.

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.* Further, the AMA estimates that the RUC meetings last around 12 hours a day and that each physician service is deliberated on to determine 13 different factors. This extensive deliberation must be done for over 7000 different CPT codes, is "continuously evolving." AM. MED. ASS'N., *supra* note 5.

201. *Public Citizen v. United States Dep't of Justice*, 491 U.S. 440, 462 (1989) (describing that the phrase "or utilize" applies to advisory committees "established by the Federal Government" and "encompass[es] groups formed indirectly by quasi-public

especially in light of the *Clinton* decision.²⁰² Here, the RUC operates extensively and solely for the purpose of making recommendations to CMS regarding the RBRVS.²⁰³ Further, the RUC was formed in conjunction with the establishment of the RBRVS in 1992,²⁰⁴ and has been relied upon by the CMS for over two decades.²⁰⁵ The best indicator that CMS is actually dependant on the RUC for its recommendations might be the fact that the RUC admits that CMS could not adequately replace the RUC without sustaining substantial expenses. Of course, the substantial adoption rate of recommendations²⁰⁶ cannot be ignored, especially if the process for determination is as in depth as the AMA proclaims.²⁰⁷

Among the many issues with CMS's reliance is the secrecy and imbalance by which the RUC operates; the exact problem sought to be eliminated under the FACA.²⁰⁸ Additionally, the FACA requires that a FAC must be "fairly balanced in terms of the points of view represented,"²⁰⁹ which until recently, was a serious problem for the RUC.²¹⁰ Further, of the RUC's membership, only three of the 31 seats rotate while the other seats have no term limits, and 11 RUC members have been on the committee for at least eight years or more.²¹¹ The FACA also dictates that recommendations of a FAC cannot be "inappropriately influenced by the

organizations. . . that advisory committees . . . 'utilized by a department or agency in the same manner as a Government-formed advisory committee'. . . would be subject to FACA's requirements.)

202. *Ass'n of Am. Physicians & Surgeons, Inc. v. Clinton*, 997 F.2d 898, 913 (1993) (holding that "a group is a FACA advisory committee when it is asked to render advice or recommendations, as a group, and not as a collection of individuals. The group's activities are expected to, and appear to, benefit from the interaction among the members both internally and externally.").

203. See *AM. MED. ASS'N.*, *supra* note 5.

204. See Maxwell & Zuckerman, *supra* note 19, at 65.

205. See *supra* Part II.

206. It should be noted that the exact figure for these adoptions often differs by study. See, e.g., Letter from Kerry Weems to William Rich, *supra* note 164, at 1 (finding that CMS has accepted a substantial majority of the RUC's recommendations, 87.9%, to be exact); Laugesen, Wada, & Chen, *supra* note 137, at 968 (finding that "between 1994 and 2010 found that CMS agreed with 87.4 percent of the committee's recommendations"); *AM. MED. ASS'N.*, *supra* note 5 (boasting that CMS has adopted 95% of the RUC's work relative value recommendations).

207. See *AM. MED. ASS'N.*, *supra* note 5.

208. Croley & Funk, *supra* note 131, at 452.

209. 5 U.S.C. App. § 5(b)(2) (2012). See also Complaint, *supra* note 12, at 13.

210. Charles Fiegl, *RUC Adds 2 Seats for Primary Care*, *AM. MED. NEWS* (February 13, 2012), <http://www.ama-assn.org/amednews/2012/02/13/gvsa0213.htm>; Complaint, *supra* note 12, at 28.

211. Complaint, *supra* note 12, at 28.

appointing authority, in this case CMS, or by any special interest, but will instead be the result of the advisory committee's independent judgment."²¹²

While the AMA's official stance corresponds with this provision,²¹³ the absence of a primary care representative from the committee for nearly 20 years is alarming. Further, the data clearly shows that during the time of absence, the gap between specialist and primary care payments under the RBRVS widened.²¹⁴ A failsafe of the FACA, and one of the driving policies behind its enactment, is the opportunity for public admittance to FAC meetings.²¹⁵ The RUC, however, not subject to the FACA, does not invite the public to meetings, allow the public any input into the agenda meetings, nor does the public have any access to records, minutes, transcripts, or recordings of the meetings.²¹⁶ Allegedly, only the RUC Chairperson may extend invitations to meetings.²¹⁷

VI. CONCLUSION

Considering the RUC's aforementioned style of operations against the provisions within the FACA, should a court decide it could review the RUC against the FACA, it would likely be in clear violation. What is unmistakable is the level of reliance by CMS upon the recommendations by the RUC, the widening physician-specialist payment gap, and the privacy by which the RUC operates. Legally, it can likely be concluded that the RUC is "utilized" by CMS at the requisite level to engage the provisions within the FACA as a *de facto* FAC. However, should imposition of the FACA upon the RUC prove tedious or complicated, and at this point there have been no successful legal challenges, several other options are available. The first option is the introduction of the Independent Payment Advisory Board (IPAB), an independent, executive branch board created under the ACA, which has been afforded the task of reforming Medicare's procedure-based reimbursement system.²¹⁸ According to Ann Marie Marciarille and J. Bradford DeLong, the IPAB could offer more "coherent, technocratic, and

212. 5 U.S.C. App. § 5(b)(3) (2012).

213. AM. MED. ASS'N., *supra* note 5 (stating that RUC members "exercise their independent judgment and are not advocates for their specialty").

214. Bodenheimer et al., *supra* note 77, at 301.

215. 5 U.S.C. App. § 10(a)(1)-(3) (2012). See also Croley & Funk, *supra* note 131, at 452.

216. Complaint, *supra* note 12, at 28.

217. *Id.*

218. See Ann Marie Marciarille & J. Bradford DeLong, *Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board*, 22 HEALTH MATRIX 75, 78 (2012) (revealing the strengths and weaknesses of our hybrid healthcare system and the role of specialist physician payments).

cost-effectiveness oriented logic" to the Medicare payment system,²¹⁹ but others are much more skeptical.²²⁰ Much is still up for debate with the IPAB, as it has yet to receive a nomination for a single member.²²¹

Representative McDermott called for replacing the RUC, or at least supplementing it with a neutral third-party committee.²²² In an attempt to neutralize the RUC of specialty favor, McDermott also introduced the Medicare Physician Payment Transparency and Assessment Act of 2011. Economist Uwe Reinhardt thanked the RUC for its tremendous work, but was quick to condemn CMS's slavish adoption of value recommendations and calls for the task to be delegated instead to a "truly independent body."²²³

The evidence is overwhelming. Since the inception of the RBRVS and the RUC, physician payment discrepancies have not lessened, in fact, they have worsened,²²⁴ and it is due in part to the RUC's secrecy. While the RUC has been under more scrutiny lately, with MedPAC proposals, congressional bills, and the physician lawsuit in *Fischer v. Berwick*, change appears to be imminent. The real question is when.

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219. *Id.* at 81. See also KAISER FAMILY FOUNDATION PROGRAM ON MEDICARE POLICY, THE INDEPENDENT PAYMENT ADVISORY BOARD: A NEW APPROACH TO CONTROLLING MEDICARE SPENDING (2011).

220. Doug Schoen, *The Final Push for IPAB Repeal*, FORBES (March 15, 2012), <http://www.forbes.com/sites/dougschoen/2012/03/15/the-final-push-for-ipab-repeal/>.

221. As of the publication of this paper, the President has yet to appoint a member to the IPAB.

222. Press Release, Congressman Jim McDermott, *supra* note 110.

223. Uwe E. Reinhardt, *The Little-Known Decision-Makers for Medicare Physicians Fees*, N.Y. TIMES, (Dec. 10, 2010) available at <http://economix.blogs.nytimes.com/2010/12/10/the-little-known-decision-makers-for-medicare-physicians-fees/>.

224. Coulam et al., *supra* note 91, at 667 n.23.

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