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RFK's Medical Coding Reforms: Don't Hold Your Breath

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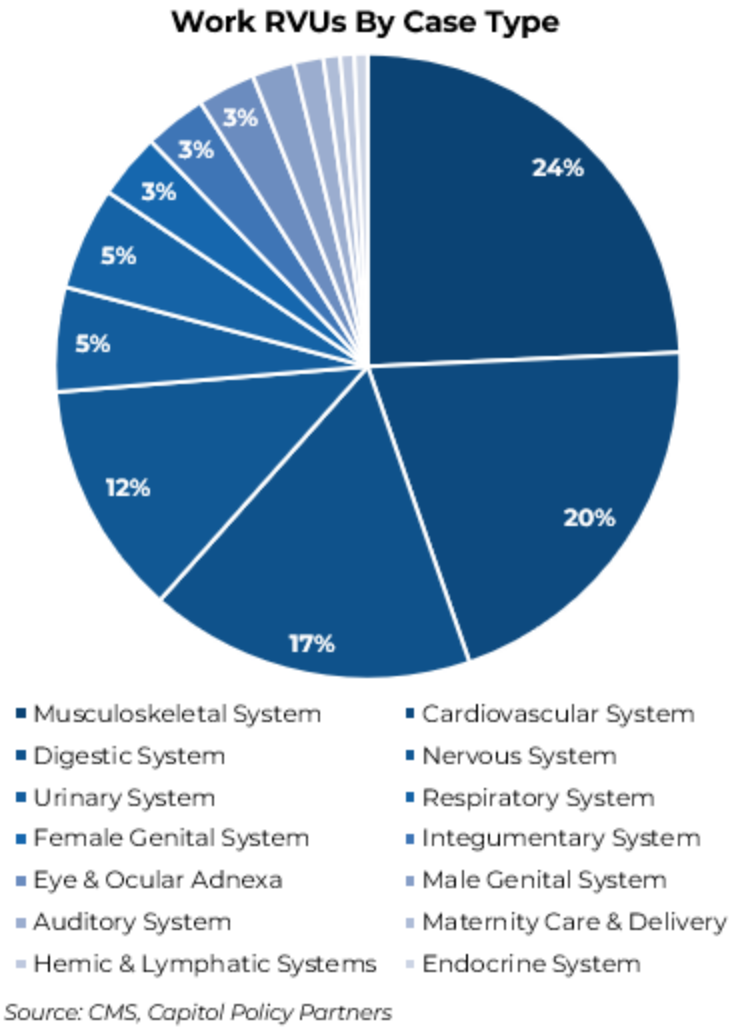
Key Takeaways: With investors questioning RFK's reported plans to restructure the medical coding system used by Medicare, Medicaid, and commercial health insurers , we remain highly skeptical of meaningful changes within the next 5-10 years, if at all, given the need for broad stakeholder agreement that will be difficult to secure. Such reforms – if implemented – would nevertheless be likely to result in rate cuts for high-cost office-based device procedures [e.g., **Teleflex (TFX)**, **Inari Medical (NARI)**, **Boston Scientific (BSX)**, **Abbott (ABT)**], similar to the 2022-2025 re-weightings that followed CMS's updates to its clinical labor inputs, where payment for these services fell ~20% during that time.

Meanwhile, we see little risk to aggregate payments for **hospitals** and **ambulatory surgery centers**, which are based on these same billing codes, though any broad overhaul would likely create some uncertainty with respect to volumes if physician incentives for surgical treatments are eroded.



Source: CMS, Capitol Policy Partners

Teleflex Incorporated (TFX)

Price:	$191.71
52-Week High:	$257.85
52-Week Low:	$185.66

Inari Medical Inc (NARI)

Price:	$49.66
52-Week High:	$67.13
52-Week Low:	$36.73

Boston Scientific Corp (BSX)

Price:	$90.00
52-Week High:	$91.93
52-Week Low:	$53.93

Abbott Laboratories (ABT)

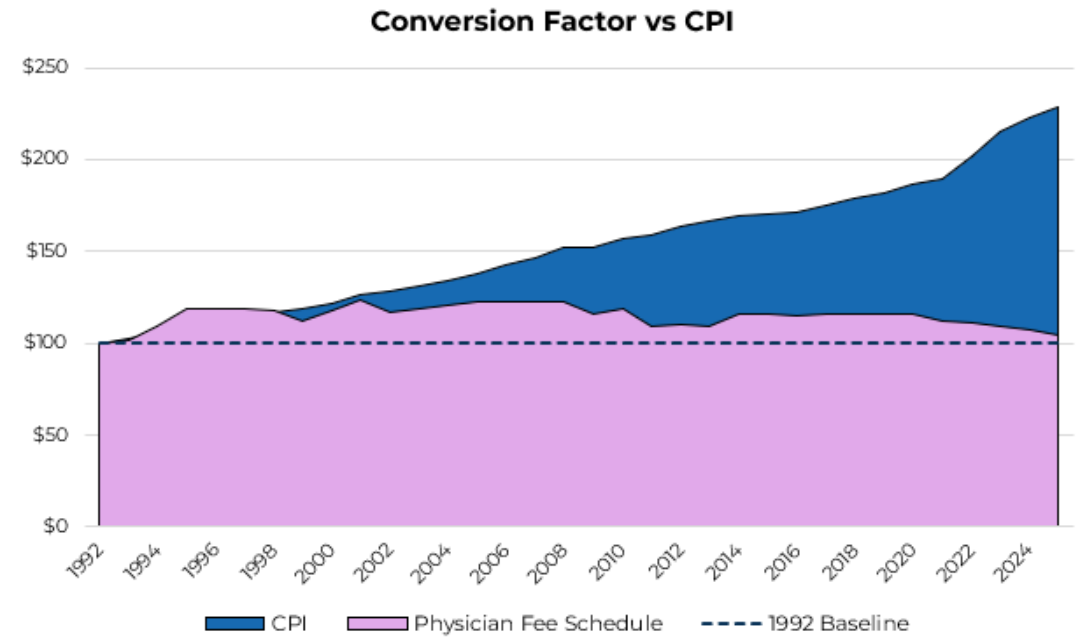
Price:	$117.76
52-Week High:	$121.64
52-Week Low:	$99.71

Quick Refresh: Coding System in Context

The Current Procedural Terminology (CPT) coding system – with its trademark / copyright owned and licensed by the American Medical Association (AMA) – is fundamentally intertwined with virtually every aspect of the U.S. healthcare system, utilized by payers, providers, employers, device / biopharma manufacturers, electronic health records (EHRs), contract research organizations (CROs), and claims databases. We therefore see no quick way of replacing the established system, and the associated complexities go far beyond mere ownership, likely forestalling material near-term reforms.

A fundamental underpinning of the Medicare Physician Fee Schedule's (PFS) use of CPT is its reliance on the Resource-Based Relative Value Scale (RBRVS), which was established via legislation in 1989 following a four-year study and implemented across a five-year transition period beginning in January 1992. This required CMS to set physician payments through an accounting of the relative value / intensity of: (A) physician work; (B) practice expenses (PE); and (C) malpractice (MP) liability risks, translating this all into the Relative Value Units (RVUs) that form the basis of payments.

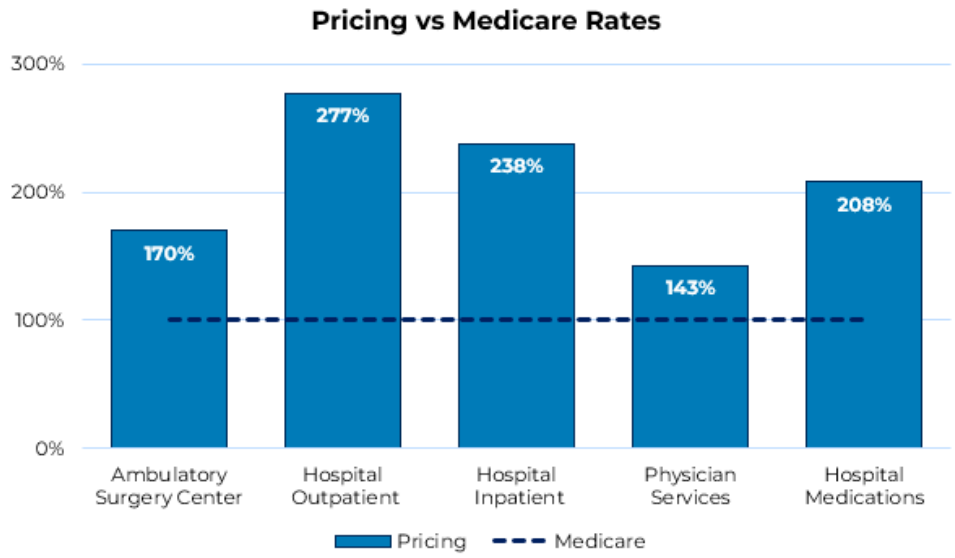
The law similarly required development of a "budget neutral" conversion factor (CF) that maintains aggregate expenditures along the same trajectory as would have been the case under the Customary, Prevailing, & Reasonable (CPR) methodology that the RBRVS replaced. Indeed, this is a primary reason why Medicare reimbursement has failed to keep up with broader price inflation.



Source: CMS, Bureau of Labor Statistics

Both academic literature and the Congressional Budget Office (CBO) have similarly found that, with Medicare accounting for ~30% of all healthcare expenditures, private insurers often shadow-price off PFS amounts. While this typically includes a set premium relative to CMS, it also effectively means that private markets tend to indirectly adopt the contours of the relative value scale as well.

We should also note that, following enactment of the Health Insurance Portability & Accountability Act (HIPAA) of 1996, use of the Healthcare Common Procedure Coding System (HCPCS) – of which the AMA's CPT codes are a component part – became mandatory for healthcare transactions.



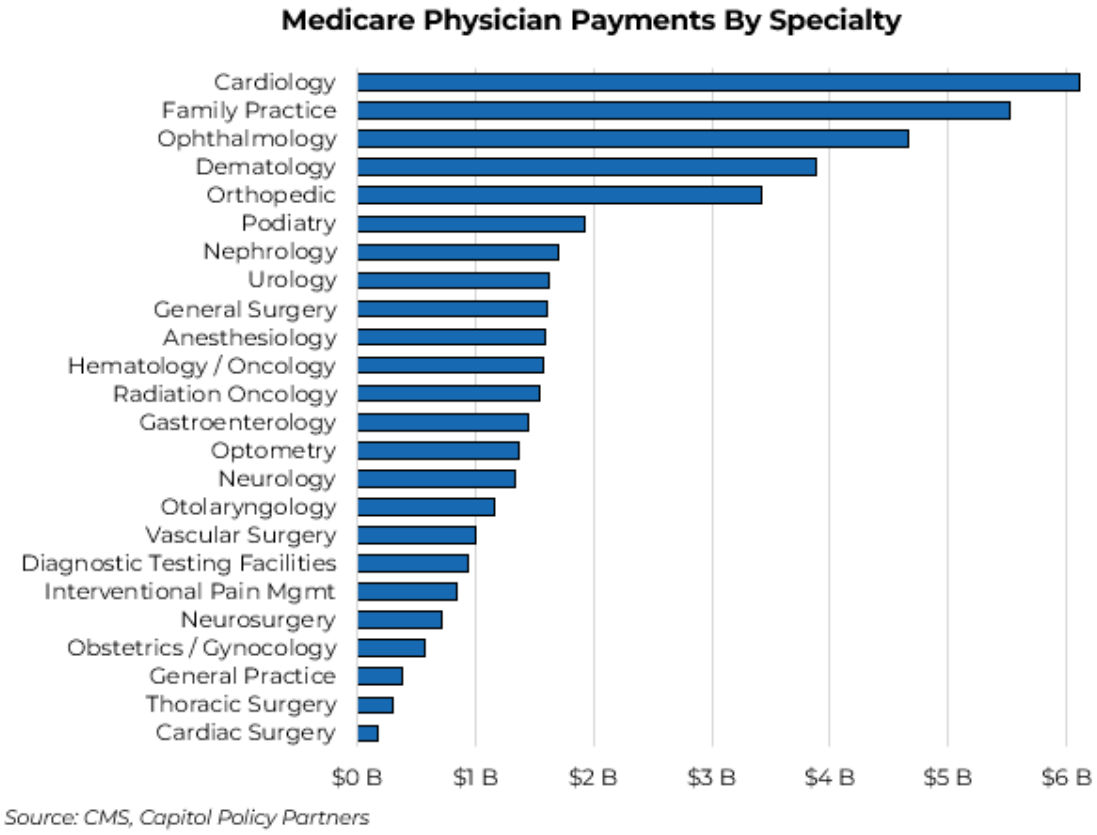
Source: Rand, Sage Transparency, Kaiser Family Foundation, Capitol Policy Partners

Not only does this suggest that RFK would likely need legislation to replace the established system and that any change would have disruptive spillover effects beyond just Medicare but, as the name implies, reimbursement for every service is currently set on a ***relative*** basis to all others. In other words, one cannot simply recalibrate established weightings for particular interventions – e.g., increasing the weights for preventive care, as RFK allies suggest would be the case – without triggering downstream adjustments to myriad other services. Under this scenario, the most likely casualty would presumably be specialty procedures with more technically intensive physician work and / or costly device inputs.

The need for careful and ongoing balancing of RVU allocations is a primary reason why CMS has historically relied upon the AMA's Relative Value Scale (RVS) Update Committee (RUC). Though criticisms over potential conflicts of interest are nothing new, we note that the RUC incorporates input from 25 different medical specialty subcommittees before a multidisciplinary board provides a consensus recommendation to CMS on the appropriate RVU allocation for any given service. Notably, CMS is under no obligation to actually *follow* these recommendations, which are typically set at the 25th percentile of provider requests, though the agency tends to agree with the RUC's recommendations ~80% of the time.

With the current CPT code book encompassing some ~13,000 individual procedures, including more than 650 temporary Category III codes that will require initial valuations over the next several years, we are dubious that CMS has the capacity to establish an in-house process to manage this workflow. The agency would also need to provide meaningful opportunities for public input and balance the inherent tradeoffs within a relative value scale in the face of what will likely be significant political pressure, all of which will be very difficult to achieve over the next four years.

Recall also that budget neutrality requirements mean that any rate increase for one service type will require offsetting cuts somewhere else, making each rate determination a much more political exercise. A broad reassignment of RVUs would likely precipitate an avalanche of lobbying efforts across all healthcare stakeholders. In fact, CMS is *obliged* to incorporate these perspectives, with the relevant statute requiring the agency to "consult with the Medicare Payment Advisory Commission and organizations representing physicians," with the AMA itself serving as the focal point for such input.



Source: CMS, Capitol Policy Partners

Past Precedent Doesn't Bode Well For Rapid Reforms

With the impact of reforms likely to be felt across such a wide array of specialties, manufacturers, employers, and payers, the absence of any meaningful consensus on how to proceed likely precludes near-term congressional action. We are similarly skeptical of just how much political capital the Trump administration would wish to spend on these efforts, particularly with the AMA itself already advocating for across-the-board rate *increases*. Moreover, CMS itself has been notoriously slow to act when it comes to broad-based payment changes that threaten downstream distributional effects.

By way of example, we offer the below precedents:

- CMS is technically required to reevaluate RVU allocations for *all* CPT codes at least once every five years, though by our accounting more than 75% of existing services have not gone through this process within the specified timeframe, and many codes remain unreviewed after more than 20 years.
- As noted above, the rollout of the RBRVS system itself was plagued by delays. Following the congressional directive in December 1989, the five-year transition was not started until January 1992, with the full implementation not actually completed until 1998, eight years after enactment. It is also important to note that the effectuating legislation was only passed "after years of debate…battles with Congress…and a four-year wait for the results" of a commissioned study on the merits of this methodological approach.
- More recently, investors may recall the October 2015 transition to the ICD-10 coding system for *inpatient hospital* services. This had originally been directed by HHS in January 2009, with a target implementation date of October 2013, but stakeholder reticence succeeded in pushing this back an additional two years. In other words, the time from directive to implementation was 6.7 years, leaving aside the years prior to 2009 when the agency devised its transition plans.
- We also remind investors of the 2022 effort by CMS to recalibrate its broader RVU weightings to account for clinical labor costs (e.g., nursing, surgical assistants) that had last been updated more than 20 years previously. While the

agency initially proposed implementing such changes all at once, based on more up-to-date Bureau of Labor Statistics (BLS) data, it ultimately settled on a four-year phase-in period, as it often does when implementing potentially disruptive payment policies. This delay was likely in response to both significant stakeholder pushback, but also the need to comply with statutory requirements that any rate reduction of more than 20% include a transition period.

Considering that each of the above precedents was itself preceded by years of work (e.g., RBRVS, ICD-10) or ready-made and widely accepted methodologies / data sources (e.g., clinical labor), but still required numerous years to implement, we are doubtful that any efforts to broadly restructure the existing CPT / RVU system can be achieved – let alone implemented – within the next four years.

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