Health Policy Update 2017: The Evolution of Physician Payment

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General Internal Medicine and Geriatrics
Medical University of South Carolina

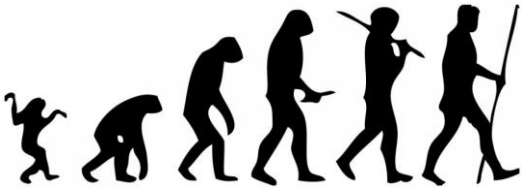
Declarations

- Financial Declaration: I have a minor equity interest in Decision Dynamics, Inc. (DDI), Lexington SC, a company which produces care coordination software

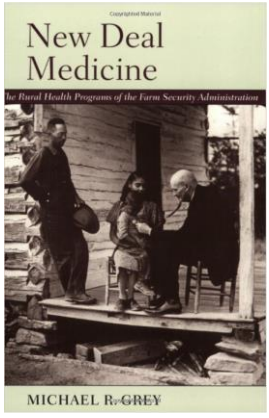
Agenda

- What is Congress not talking about?
  - Value-based care and 'bending the cost curve'
  - MACRA, MIPS, ACOs and CMS: The Quality Payment Program

The Evolution of Physician Compensation



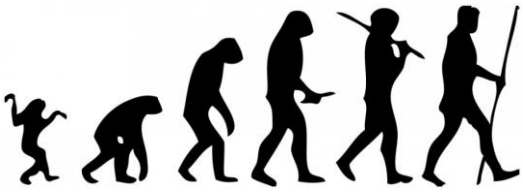
1930	1945	1965	1992	2010	2015
Usual and customary fee					
Unstructured fee for service					



1945: The End of World War II

1965 – The war on poverty
Medicare and Medicaid

The Evolution of Physician Compensation



1930	1945	1965	1992	2010	2015
Usual and customary fee	Employer-based Insurance	Medicare and Medicaid			
Unstructured fee for service	Fixed payments	Filling the "gap"			

How many of you were in practice prior to 1992?

1987: The three goals of the Resource-Based Relative Value Scale (RBRVS)

1. Develop an empirically based rational payment model based on the inputs required to deliver a physician service – the Relative Value Unit (RVU)
2. Control physician costs
3. Improve payment to physicians whose services were not procedures, especially primary care


ARTICLE | August 14, 1987

The Resource-Based Relative Value Scale
Toward the Development of an Alternative Physician Payment System

William C. Hsiao, PhD; Peter Braun, MD; Edmund R. Becker, PhD; Stephen R. Thomas, PhD

JAMA. 1987;258(6):799-802. doi:10.1001/jama.1987.03400060075033. Text Size: A A A

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Three input components of an RVU:

1. Physician work = time, skill, effort, intensity (wRVU)
   Times = Pre-service, intra-service, post-service
2. Practice overhead = Staff, space, equipment
3. Professional liability = mean cost by specialty

Every CPT code is assigned an RVU value based on these inputs. RVUs would be ***"grounded in data and refined by professional judgement of physicians."***

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Total RVU = Physician work (wRVU) + overhead cost + liability cost

CPT Payment = Total RVU x geographically adjusted conversion factor in dollars ($$/RVU)

Different Views

A Critique of the Harvard Resource-Based Relative Value Scale

LAURENCE F. MCMAHON, JR., MD, MPH

- Survey methodology to assess physician work used too few patient cases
- Physician sample sizes too small
- Survey sampling method was biased
- Inconsistent extrapolations across CPT codes and specialties (cross-walk)
- No adjustment for quality of care
- No adjustment for physician experience

Different Views

A Critique of the Harvard Resource-Based Relative Value Scale

LAURENCE F. MCMAHON, JR., MD, MPH

Refinement and Expansion of the Harvard Resource-Based Relative Value Scale: The Second Phase

EDMUND R. BECKER, PHD, DANIEL DUNN, PHD, PETER BRAUN, MD, AND WILLIAM C. HSIAO, PHD

1992: Congress ordered HCFA (CMS) to implement RBRVs for Medicare

Who would do the ongoing work of assigning RVU values to CPT codes? The AMA steps forward

"Congress and HCFA [CMS] were more than happy to let the AMA preside over the inevitable 'food fights' within the profession."

-Mayes and Berenson, 2006

AMA Relative Value Update Committee (RUC)

- AMA owns the CPT system
- The RUC - 31 members (29 voting)
  - 1 from each of 22 AMA specialty societies
  - 5 appointed by AMA or represented bodies
  - 4 members rotate (1 is primary care)
- Data collected by self-reported survey from specialty members
- Meetings are closed and voting is anonymous
- Recommendations are made to CMS

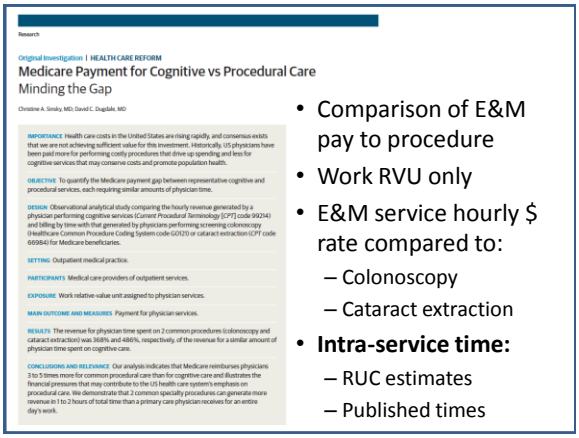
TABLE 3.3 Revenue Changes in Proposed and Final Rules

Specialty	Model fee schedule to Proposed Rule	Proposed Rule to Final Rule	Change from model fee schedule
Podiatry	−$13,662,000	−$24,439,000	−$10,777,000
Nuclear medicine	$5,171,000	$4,506,000	−$665,000
Neurology	$735,000	$10,225,000	$9,490,000
Pulmonary disease	−$15,185,000	$14,923,000	$30,108,000
Otolaryngology	−$16,140,000	$24,769,000	$40,909,000
Neurosurgery	−$17,887,000	$25,039,000	$42,926,000
Obstetrics/gynecology	−$17,520,000	$33,378,000	$50,898,000
Anesthesiology	−$25,718,000	$28,071,000	$53,789,000
General practice	−$22,856,000	$39,743,000	$62,599,000
Family practice	−$32,704,000	$47,575,000	$80,279,000
Radiology	$359,868,000	$449,789,000	$89,921,000
Dermatology	−$16,651,000	$103,511,000	$120,162,000
Thoracic surgery	−$80,339,000	$45,035,000	$125,374,000
Urology	−$117,359,000	$100,785,000	$218,144,000
Internal medicine	−$75,191,000	$146,650,000	$221,841,000
General surgery	−$189,787,000	$125,040,000	$314,827,000
Orthopaedic surgery	−$177,547,000	$177,619,000	$355,166,000
Cardiology	−$8,990,000	$477,580,000	$486,570,000
Ophthalmology	−$657,770,000	$258,972,000	$916,742,000
Total	−$1,119,532,000	$2,088,771,000	$3,208,303,000

Source: Data reproduced with permission and supplemented from Balla (1998, 667). Table 2.

"…that was the point where I knew the system had been co-opted… It had become a political process not a scientific process. And if you don't think it's political, you only have to look at the motivation of why the AMA wants the job"

- Bill Hsaio, 2013 (in Laugesen, 2016)



Research

Original Investigation | HEALTH CARE REFORM

Medicare Payment for Cognitive vs Procedural Care
Minding the Gap

Christine A. Sinsky, MD; David C. Dugdale, MD

IMPORTANCE Health care costs in the United States are rising rapidly, and consensus exists that we are not achieving sufficient value for this investment. Historically, US physicians have been paid more for performing costly procedures that drive up spending and less for cognitive services that may conserve costs and promote population health.

OBJECTIVE To quantify the Medicare payment gap between representative cognitive and procedural services, each requiring similar amounts of physician time.

DESIGN Observational analytical study comparing the hourly revenue generated by a physician performing cognitive services (*Current Procedural Terminology* [CPT] code 99214) and billing by time with that generated by physicians performing screening colonoscopy (Healthcare Common Procedure Coding System code G0120 or cataract extraction (CPT code 66984) for Medicare beneficiaries.

SETTING Outpatient medical practice.

PARTICIPANTS Medical care providers of outpatient services.

EXPOSURE Work relative-value unit assigned to physician services.

MAIN OUTCOME AND MEASURES Payment for physician services.

RESULTS The revenue for physician time spent on 2 common procedures (colonoscopy and cataract extraction) was 368% and 486%, respectively, of the revenue for a similar amount of physician time spent on cognitive care.

CONCLUSIONS AND RELEVANCE Our analysis indicates that Medicare reimburses physicians 3 to 5 times more for common procedural care than for cognitive care and illustrates the financial pressures that may contribute to the US health care system's emphasis on procedural care. We demonstrate that 2 common specialty procedures can generate more revenue in 1 to 2 hours of total time than a primary care physician receives for an entire day's work.

- Comparison of E&M pay to procedure
- Work RVU only
- E&M service hourly $ rate compared to:
  - Colonoscopy
  - Cataract extraction
- **Intra-service time:**
  - RUC estimates
  - Published times

Medicare Payment for Cognitive vs Procedural Care: Minding the Gap

Table 4. Comparison of Hourly Physician Revenue Using RUC Estimates for Time for Cognitive Service and Procedures

Service to Medicare Patients	Time, min	wRVU per Service	wRVU per Hour	Hourly Revenue, $	% of Cognitive Service
Cognitive service[a]	40	1.50	2.25	77	
Screening colonoscopy	75	3.69	2.95	100	130
Cataract extraction	84	4.98	3.56	121	157

Abbreviations: RUC, Relative Value Scale Update Committee; wRVU, work relative-value unit.

[a] Indicates *Current Procedural Terminology* code 99214.

Table 3. Sensitivity Analysis of Physician Revenue Using Literature Estimates for Time for Colonoscopy and Cataract Extraction

Service to Medicare Patients, Source	Time for Service, min[a]	wRVU per Service	wRVU per Hour	Hourly Revenue, $	% of Cognitive Care
Screening colonoscopy					
Wexner et al,[19] 2001	32.7	3.69	6.77	230	264
Nelson et al,[20] 2002	40.6	3.69	5.45	185	212
Cataract extraction					
Gogate et al,[21] 2003 (lowest time)	21	4.98	14.23	484	556
Gogate et al,[21] 2003 (highest time)	27	4.98	11.06	376	432

Abbreviation: wRVU, work relative-value unit.

[a] Indicates published times plus 10 minutes for same-day preservice and postservice times.

Sinsky and Dugdale, JAMA Intern Med. 2013;173(18):1733-1737.

TABLE 5.1 Percentage Time Differences between Medicare and Observed Times for Selected Procedures, 2013

Procedure	Percent greater than times recorded in operating theaters
Deviated septum surgery	127
Transurethral resection prostate	92
Upper gastrointestinal endoscopy, with biopsy	88
Radical abdominal hysterectomy	74
Cataract removal	63
Hip replacement revision	57
Neuroplasty	56
Laparoscopic cholecystectomy	45
Bronchoscopy	36
Implant pacemaker	36
Lung removal	34
Cystourethroscopy	30
Aneurysm repair	30
Carotid artery endarterectomy	29
Abdominal hysterectomy	21
Craniectomy	15
Colectomy	7
Dilatation and curettage	5
Knee replacement	2
Total hip arthroplasty	1
Coronary artery bypass	0
Breast reduction surgery	−16
Upper gastrointestinal endoscopy	−17
Vaginal hysterectomy	−24

Business

How a secretive panel uses data that distorts doctors' pay

The Washington Post

"A little-known committee of doctors help establish the value of every procedure in medicine. Critics say the American Medical Association, doctors' chief lobbying group, is the wrong organization to do the work."

By Peter Whoriskey and Dan Keating July 20, 2013

Business

Data uncover nation's top Medicare billers

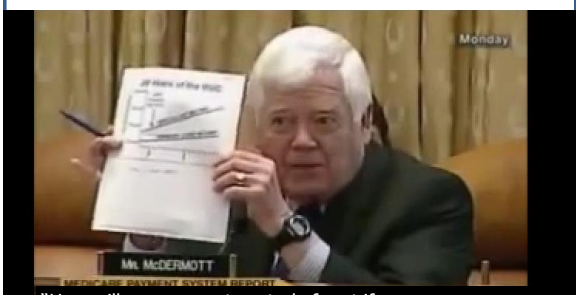
The Washington Post

By Peter Whoriskey, Dan Keating and Lena H. Sun April 9, 2014

"[Medicare] paid nearly 4000 physicians in excess of $1 million dollars each in 2012… figures do not include what doctors billed private insurance firms."

Medicare cost: $4 BILLION

"



"How will you ever get control of cost if you let the fox decide what the keys to the henhouse are used for?"

COMMENTARY

Unintended Consequences of Resource-Based Relative Value Scale Reimbursement

John D. Goodson, MD

MEDICINE'S GENERALIST BASE IS DISAPPEARING AS a consequence of the reimbursement system crafted to save it—the resource-based relative value scale.[1] The US physician work-

JAMA, 2007;298(19):2308-10

Unintended Consequences of Resource-Based Relative Value Scale Reimbursement

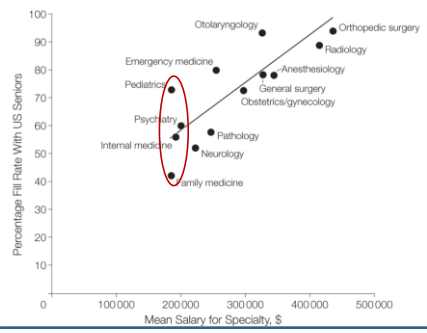
John D. Goodson, MD

- The RUC is dominated by procedural specialists
  - Primary care is almost 50% of all physicians but 16% of RUC votes
- Non-procedural physician workforce has contracted, especially primary care
- Increasing emphasis on treatment, not prevention
- The RBRVS "defies gravity"

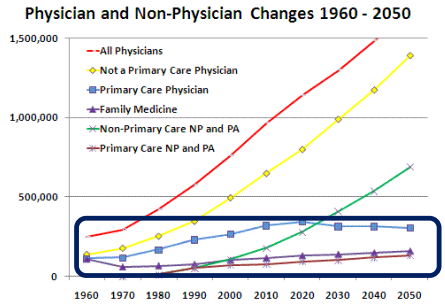
JAMA, 2007;298(19):2308-10

The JAMA Network

From: **Future Salary and US Residency Fill Rate Revisited**
JAMA. 2008;300(10):1131-1132. doi:10.1001/jama.300.10.1131



Primary care workforce projections



Did the Resource-Based Relative Value Scale achieve it's goals?

- Control physician costs
- Improve payment to physicians whose services were not procedures, especially primary care
- Develop an empirically based rational payment model based on the inputs required to deliver a physician service – the Relative Value Unit (RVU)

Did the Resource-Based Relative Value Scale achieve it's goals?

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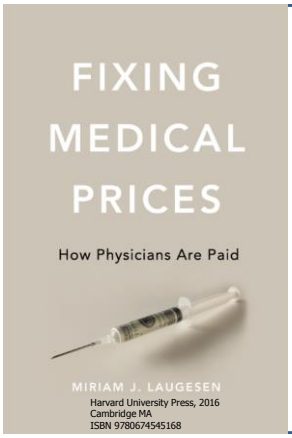
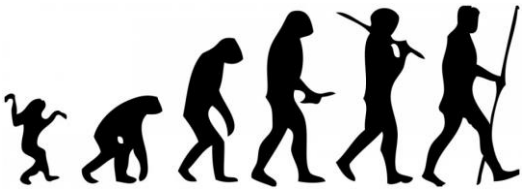


"…exposes how seemingly technical decisions on physician prices are actually highly political - riddled with conflicts of interest and largely immune from public accountability"

- Judith Feder

The Evolution of Physician Compensation



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Usual and customary fee	Employer-based Insurance	Medicare and Medicaid	RBRVS, SGR managed care		
Unstructured fee for service	Fixed payments	Filling the "gap"	"Resource-Based" FFS Payment		

Other things have changed which are accelerating evolution…

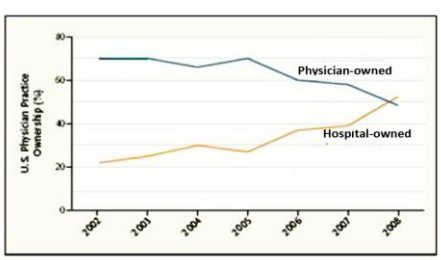
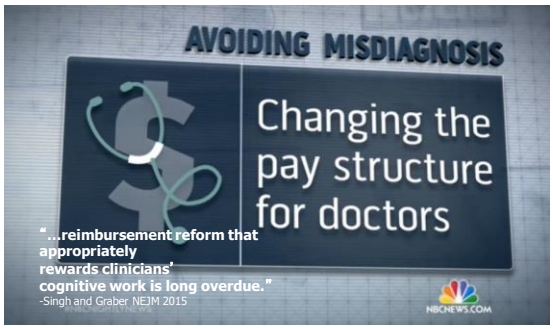
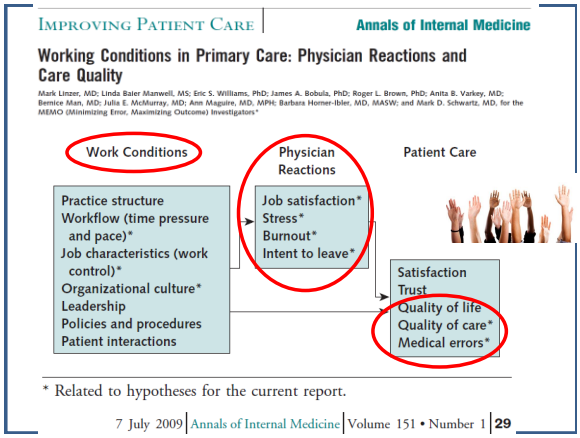


Figure 1. Percentages of U.S. Physician Practices Owned by Physicians and by Hospitals, 2002-2008.
Data are from the Physician Compensation and Production Survey, Management Association, 2003-2009.





Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Systems and Health Rand Health 2013

Satisfied

- Quality of patient care
- ***Autonomy***
- Collaborative team
- ***Fair compensation***
- Respect
- ***Physician leadership***
  - ***transparent decision-making***
  - ***Value alignment***

Dissatisfied

- Electronic Medical Records
  - Data entry
- ***Income uncertainty***
- ***Unsustainable pace***
- Over-regulation
- ***Work-life balance***

RAND HEALTH

Report of

The National Commission on
PHYSICIAN PAYMENT REFORM

March 2013

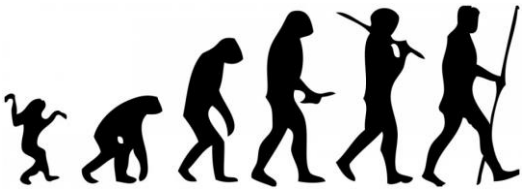
Chairs: William 'Bill' Frist MD, Steven Schroeder MD

> "Our nation cannot control runaway medical spending without *fundamentally changing how physicians are paid.*"

Health Care Legislation: 2009-2015

- The American Recovery and Reinvestment Act of 2009 (HITECH Act)
- Patient Protection and Affordable Care Act of 2010 (delivery system reform)
  - Accountable care organizations
  - Bundled payments
  - Patient-centered Medical Homes
- Medicare Access CHIP Reauthorization Act – 2015
  - Eliminated SGR and consolidates quality programs and payments under aAPMs and MIPS

The Evolution of Physician Compensation



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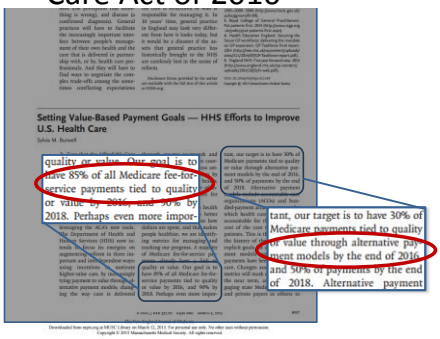
Unstructured fee for service	Fixed payments	Filling the "gap"	"Resource-Based" FFS Payment	"Volume to Value"	

Patient Protection and Affordable Care Act of 2010



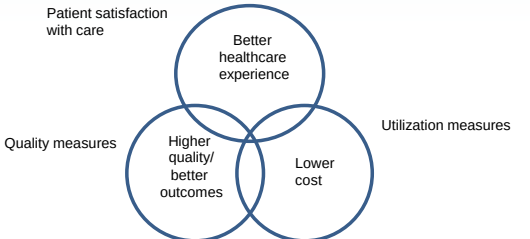
Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell

quality or value. Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 50% by 2018. Perhaps even more impor-

tant, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018. Alternative payment

Population measures of value: The Triple Aim - Berwick



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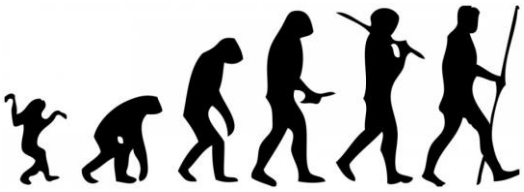

1930	1945	1965	1992	2010	2015
Usual and customary fee	Employer-based Insurance	Medicare and Medicaid	RBRVS, SGR managed care	ACA	MACRA and SGR repeal
Unstructured fee for service	Fixed payments	Filling the "gap"	"Resource-Based" FFS Payment	"Volume to Value"	FFS and capitation

Health Care Legislation: 2009-2015

- The American Recovery and Reinv… t Act of 2009 (HITECH Act)
- Patient Protecti… of 2010 (d…
  - …
  - …
  - P… …Medical Homes
- MAC… 2015
  - Consolidates quality programs and payments under fee-for-service

Evolving from 'volume to value': incentives and penalties

Health Care Legislation: 2009-2015

- The American Recovery and Reinvestm… ct of 2009 (HITECH Act)
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- MACRA – 2015
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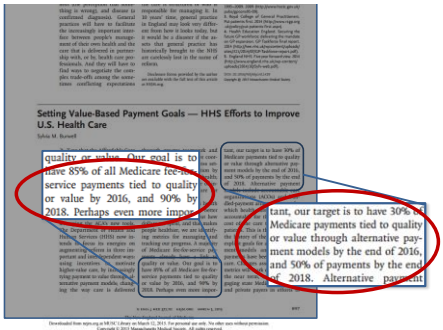
Evolving from fee-for-service to capitation

Former DHHS Secretary Burwell



Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell

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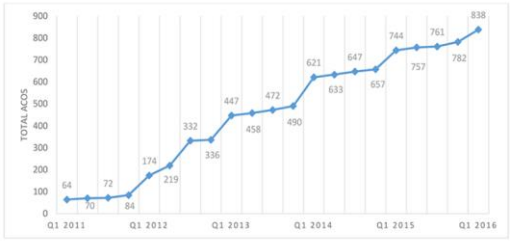
Accountable Care Organizations In 2016: Private And Public-Sector Growth And Dispersion

David Muhlestein and Mark McClellan

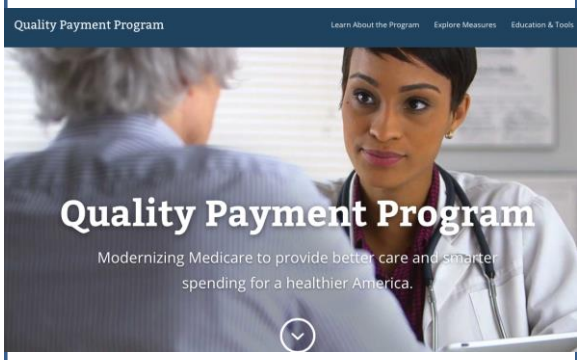
Figure 1 – ACOs Over Time



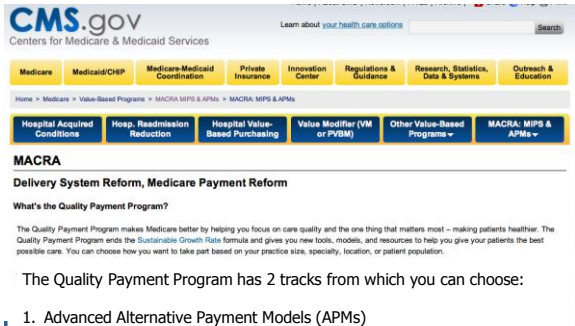
2015: MACRA

Builds a new framework for rewarding value not volume

- Eliminated the failed SGR
- Merit-Based Incentive Payment Systems (MIPS)
  - Consolidates PQRS, Value-based modifiers, meaningful use
- Alternative Payment Models (APMs)
  - Accountable Care Organizations
  - Bundled payments
  - Patient-centered Medical Homes



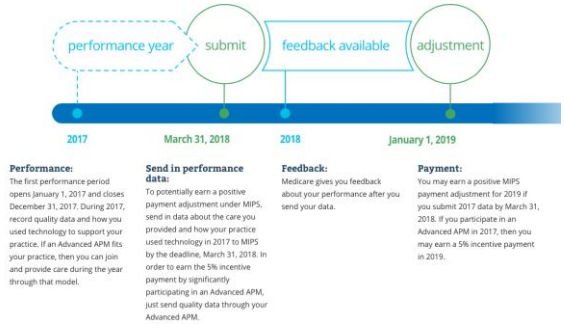
https://qpp.cms.gov/



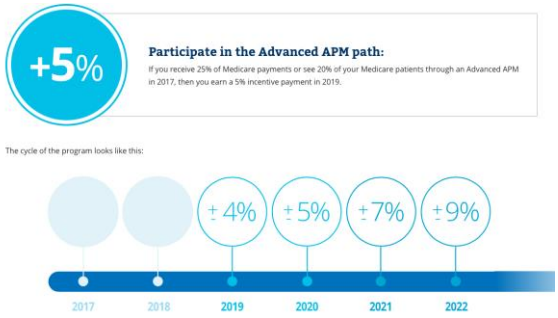
The Quality Payment Program has 2 tracks from which you can choose:

1. Advanced Alternative Payment Models (APMs)
2. The Merit-based Incentive Payment Program (MIPS)

MACRA Payment Schedule



1. Advanced Alternative Payment Models

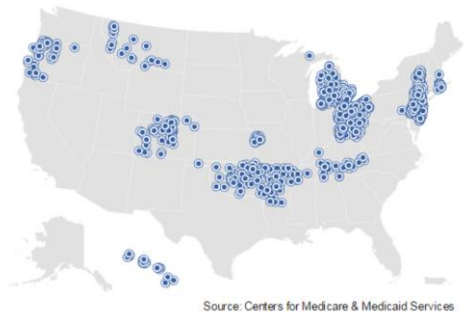


What models are Advanced APMs?

In 2017, the following models are Advanced APMs:

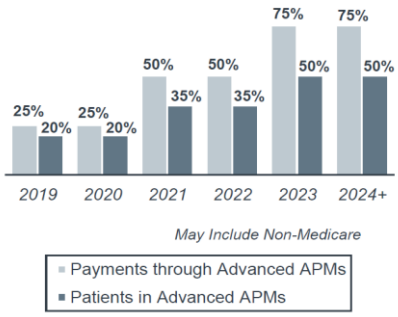
- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

CPC+: Rounds in 2017 and 2018



Source: Centers for Medicare & Medicaid Services

APM Entities Must Meet Percent of Payments or Patient Counts



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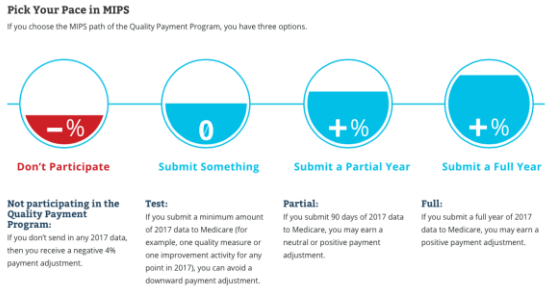
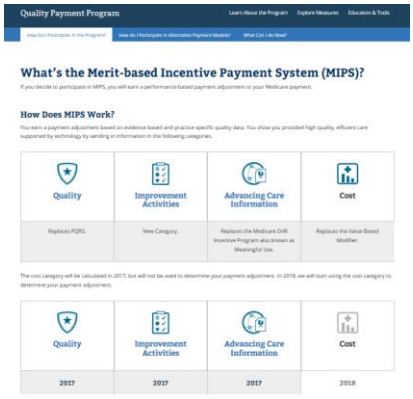
2. Merit-based Incentive Program





MIPS Domains: #1 Quality

- Weight at the outset (50%)
- Menu of 200 sub-measures
  - Choose six that best accommodate practice or specialty.
  - One must be an outcome measure
  - One must be "cross-cutting" (applicable to all specialties)
- Selection criteria: High volume, high performance and ability to improve

http://medicaleconomics.modernmedicine.com/medical-economics/news/mips-explained-4-categories-physicians-must-master

MIPS Domains: #2 Clinical improvement activities

- Weight 15%
- choose from among 90 activities
  - care coordination
  - beneficiary engagement
  - patient safety (e.g. medication reconciliation)

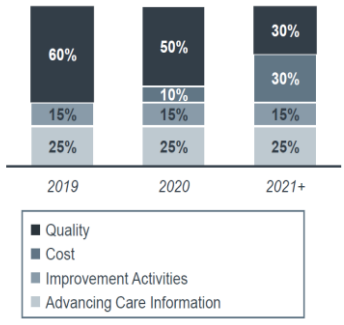
MIPS Domains: #3 Advancing Care Information

- Weight 25%
- Six dimensions replace Meaningful Use:
  1. protecting health information
  2. patient access to electronic records
  3. patient engagement
  4. coordination of care
  5. electronic prescribing
  6. health information exchange
- Quality of information not just quantity
- No longer 'just' an MU checklist

MIPS Domains: #4 Resource use & cost

- Initial weight 10%
- Does not require reporting by physicians or practices
- Data from claims sent to Medicare
- 40 episode-specific measures to MIPS for specialists

Weights of MIPS Score Components



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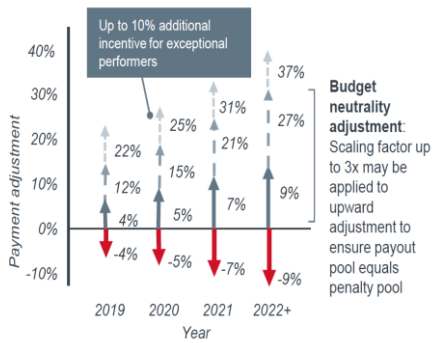
Maximum EC Penalties and Bonuses



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Quality Payment Program

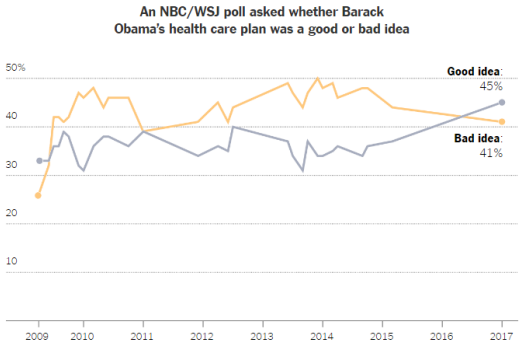
CMS Patient Relationship Categories and Codes

- Continuous/Broad Services – Primary care
- Continuous/Focused Services - Rheumatologist
- Episodic/Broad Services - Hospitalist
- Episodic/Focused Services – Orthopedic surgeon
- Only as ordered by another clinician - Radiologist

Election results: Now what?

Senate: R 52 - D 48
(Need 60 for repeal; need 50+ for reconciliation)

House: R 240 - D 193



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With Tom Price in charge, doctors are winning again in Washington

By ERIN MERSHON @emershon / AUGUST 1, 2017

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POLITICS

With Tom Price in charge, doctors are winning again in Washington

By ERIN MERSHON @emershon / AUGUST 1, 2017

Medicare is giving doctors a lot of power over their own pay

Medicare has signaled it will rubber-stamp almost every 2018 payment proposal made by a little-known American Medical Association's panel of doctors - raising the ire of numerous advocacy groups and primary care doctors, who believe the federal government is bending to the will of the powerful medical lobby.

Why it matters: CMS pays out roughly $100 billion per year for physician services, and its prices also affect what private insurers are willing to pay.

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POLITICS

With Tom Price in charge, doctors are winning again in Washington

By ERIN MERSHON @emershon / AUGUST 1, 2017

"The RUC does not control the Medicare payment system, nor does it set rates for medical service."

"Yet only physicians are singled out for criticism when making recommendations in a manner so organized, thorough and accurate that those recommendations often are accepted."

-Peter Smith MD, a heart surgeon at Duke University who chairs the RUC

Unpacking The Sanders Medicare-For-All Bill

Katie Keith and Timothy Jost

September 14, 2017

Health Affairs Blog

Unpacking The Sanders Medicare-For-All Bill

Katie Keith and Timothy Jost

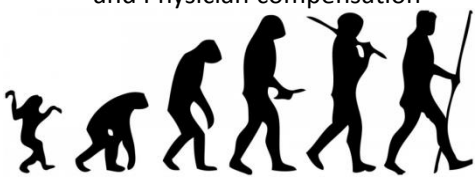
September 14, 2017

The bill would require more frequent reviews of the relative value of physicians' services, direct the Secretary of HHS to consult with the Medicare Payment Advisory Commission, and require the development of a public, standardized process for reviewing the relative values of physicians' services.

HHS to present Congress with 1) a written plan for using funds to collect and use information on physicians' services in the determination of relative values; and 2) a proposed plan to track HHS' review of the relative values of physicians' services…

Health Affairs Blog

The **Evolution** of healthcare delivery and Physician compensation

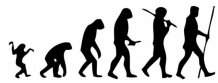


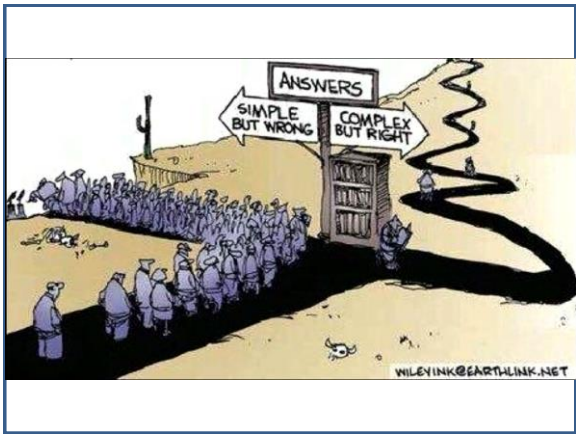
1930	1945	1965	1992	2010	2015	2017+
Usual and customary fee	Employer-based Insurance	Medicare and Medicaid	RBRVS, SGR managed care	ACA	MACRA and SGR repeal	?
Unstructured fee for service	Fixed payments	Filling the "gap"	"Resource-Based" FFS Payment	"Volume to Value"	FFS and capitation	Capitation and panels

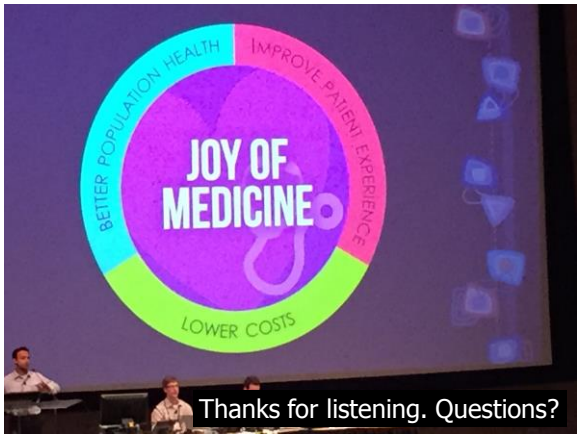
https://hcp-lan.org/workproducts/pcpm-whitepaper-final.pdf

Primary care payment model:

- Risk-adjusted panels
- Quality targets
- RVU component



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Thanks for listening. Questions?