Health Policy Update 2017: The Evolution of Physician Payment

William P. Moran MD MS
Professor and Director,
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

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1945: The End of World War II
The Evolution of Physician Compensation

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<tr>
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<td>Employer-based Insurance</td>
<td>Medicare and Medicaid</td>
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<td>Unstructured fee for service</td>
<td>Fixed payments</td>
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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

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."

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

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

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

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<table>
<thead>
<tr>
<th>Specialty</th>
<th>Model fee schedule to Proposed Rule</th>
<th>Proposed Rule to Final Rule</th>
<th>Change from model fee schedule</th>
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<tbody>
<tr>
<td>Pediatrics</td>
<td>$33,692,000</td>
<td>$24,430,000</td>
<td>$10,777,000</td>
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<tr>
<td>Nuclear medicine</td>
<td>$5,171,000</td>
<td>$4,700,000</td>
<td>$205,000</td>
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<tr>
<td>Neurology</td>
<td>$7,379,000</td>
<td>$10,323,000</td>
<td>$954,000</td>
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<td>Pulmonary disease</td>
<td>$3,353,000</td>
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<td>$301,000</td>
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<td>Ophthalmology</td>
<td>$4,348,000</td>
<td>$2,760,000</td>
<td>$9,600,000</td>
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<td>Neurosurgery</td>
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<td>$25,040,000</td>
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<td>$32,375,000</td>
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<td>Anesthesiology</td>
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<td>Family practice</td>
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<td>$30,071,000</td>
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<td>Urology</td>
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<td>$3,756,000</td>
<td>$761,000</td>
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<td>Internal medicine</td>
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<td>$4,465,000</td>
<td>$709,000</td>
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<tr>
<td>General surgery</td>
<td>$3,520,000</td>
<td>$2,050,000</td>
<td>$1,470,000</td>
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<tr>
<td>Orthopedic surgery</td>
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<td>$3,761,000</td>
<td>$1,293,000</td>
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<td>Cardiology</td>
<td>$8,168,000</td>
<td>$4,465,000</td>
<td>$3,703,000</td>
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<tr>
<td>Ophthalmology</td>
<td>$3,77,000</td>
<td>$2,050,000</td>
<td>$1,470,000</td>
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<tr>
<td>Total</td>
<td>$11,310,020</td>
<td>$2,008,771,000</td>
<td>$1,359,203,000</td>
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</tbody>
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Source: Data reproduced with permission and supplemented from Bulla (1998, 1997), Table 2.

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“...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 Hsiao, 2013 (in Laugesen, 2016)
Medicare Payment for Cognitive vs Procedural Care: Minding the Gap

- 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

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

<table>
<thead>
<tr>
<th>Service to Medicare Patients, Source</th>
<th>Time for Service, min</th>
<th>$RVU per Service</th>
<th>$RVU per Hour</th>
<th>Hourly Revenue, $</th>
<th>% of Cognition Service</th>
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</thead>
<tbody>
<tr>
<td>Cognitive service</td>
<td>46</td>
<td>1.30</td>
<td>2.35</td>
<td>71</td>
<td>150</td>
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<tr>
<td>Colonoscopy</td>
<td>75</td>
<td>2.89</td>
<td>2.95</td>
<td>100</td>
<td>156</td>
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<tr>
<td>Cataract extraction</td>
<td>94</td>
<td>4.98</td>
<td>3.56</td>
<td>121</td>
<td>157</td>
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Medicare Payment for Cognitive vs Procedural Care: Minding the Gap

"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."

"[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?"
Unintended Consequences of Resource-Based Relative Value Scale Reimbursement

John D. Goodman, MD

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

• 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
Did the Resource-Based Relative Value Scale achieve its 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)
“...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

<table>
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<tr>
<th>Year</th>
<th>Usual and customary fee</th>
<th>Employer-based Insurance</th>
<th>Medicare and Medicaid</th>
<th>RBRVS, SGR</th>
<th>managed care</th>
<th>Unstructured fee for service</th>
<th>Filling the &quot;gap&quot;</th>
<th>&quot;Resource-Based&quot; FFS Payment</th>
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Other things have changed which are accelerating evolution...

“reimbursement reform that appropriately rewards clinicians’ cognitive work is long overdue.”
—Singh and Graber NEJM 2015

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

**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**

- 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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<th>Unstructured fee for service</th>
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<th>RBRVS, SGR managed care</th>
<th>ACA</th>
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<td>1930</td>
<td>Employer-based insurance</td>
<td>Fixed payments</td>
<td>Filling the &quot;gap&quot;</td>
<td>&quot;Resource-Based&quot; FFS Payment</td>
<td>&quot;Volume to Value&quot;</td>
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Patient Protection and Affordable Care Act of 2010

Population measures of value:
The Triple Aim - Berwick

- Better healthcare experience
- Higher quality/better outcomes
- Lower cost
- Patient satisfaction with care
- Utilization measures
- Quality measures
### Health Care Legislation: 2009-2015

- **Patient Protection and Affordable Care Act of 2010 (delivery system reform)**
  - Accountable care organizations
  - Bundled payments
  - Patient-centered Medical Homes
- **MACRA – 2015**
  - Consolidates quality programs and payments under fee-for-service

#### The Evolution of Physician Compensation

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<th>ACA</th>
<th>MACRA and SGR repeal</th>
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<td>&quot;Volume to Value&quot;</td>
<td>FFS and capitation</td>
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<td>1945</td>
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- **Evolving from fee-for-service to capitation**
- **Evolving from volume to value**: incentives and penalties
Former DHHS Secretary Burwell

Accountable Care Organizations In 2016: Private And Public-Sector Growth And Dispersion
David Muhlestein and Mark McClellan

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
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)
1. Advanced Alternative Payment Models

**Participate in the Advanced APM path:**
If you receive 20% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2018.

The cycle of the program looks like this:

- 2017: +4%
- 2018: +5%
- 2019: +7%
- 2020: +9%
- 2022: +9%

**What models are Advanced APMs?**
In 2017, the following models are Advanced APMs:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (PCP+)
- 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
2. Merit-based Incentive Program

Pick Your Pace in MIPS
If you choose the MIPS path of the Quality Payment Program, you have three options:

- Don’t Participate
- Submit Something
- Submit a Partial Year
- Submit a Full Year

Net participating in the Quality Payment Program:
If you don’t enroll in any 2017 MIPS, then you receive a negative 4% payment adjustment.

Test:
If you submit a lower amount of 2017 data to Medicare for example, one quality measure or one improvement activity for any point in 2017, you may avoid a downward payment adjustment.

Partial:
If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment.

Full:
If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

What’s the Merit-based Incentive Payment System (MIPS)?
The Merit-based Incentive Payment System (MIPS) measures how well you provide quality, patient care, cost and practice-structured care.

How Does MIPS Work?
MIPS is a part of the Medicare program that measures how well you provide quality, patient care, cost and practice-structured care.

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
<th>Cost</th>
<th>Total Score</th>
</tr>
</thead>
</table>
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

<table>
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<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021+</th>
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<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>50%</td>
<td>30%</td>
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<tr>
<td>Cost</td>
<td>15%</td>
<td>22%</td>
<td>15%</td>
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<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>12%</td>
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<tr>
<td>Advancing Care Information</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

The Advisory Board, 2017

Maximum EC Penalties and Bonuses

Budget neutrality adjustment: Scaling factor up to 3x may be applied to upward adjustment to ensure payout pool equals penalty pool.

The Advisory Board, 2017
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
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.

"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
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...
Primary care payment model:

- Risk-adjusted panels
- Quality targets
- RVU component

“Nobody knew that healthcare could be so complicated…”
Thanks for listening. Questions?