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## Finding Value in Unexpected Places — Fixing the Medicare Physician Fee Schedule

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“Moving from volume to value” is health care reform’s latest mantra. Policymakers hope to replace fee-for-service systems with value-based approaches that reward improved outcomes achieved at lower cost. Ground zero in these efforts is the Medicare Physician Fee Schedule (MPFS).

What payment reformers often fail to recognize is that the specific MPFS payment rates have important implications for Medicare and its beneficiaries. The relative payment levels for the thousands of service codes and the absence of payment for other activities powerfully influence how physicians spend their time — and their tendency to perform unneeded tests and procedures. The mix of services that physicians provide under a particular fee schedule can affect value at least as much as any improvements derived from rewarding physicians on the basis of quality measures — the approach Congress took in the Medicare Access and CHIP Reauthorization Act of 2015.

Variation in payment rates — and resulting incomes — also influences new physicians’ spe-

cialty choices and contributes to growing shortages of primary care physicians and geriatricians. A substantially improved, carefully managed MPFS could not only pave the way to more fundamental value-based payment reform but also improve performance among physicians who are likely to be paid according to fee schedules for the foreseeable future.

Of course, fee schedules have inherent flaws. Having separate fee-for-service payment streams maintains provider silos instead of promoting care integration. And no matter how “accurate” the fee valuations, fee schedules inevitably reward provision of more services, necessary or not, thereby increasing spending.

But the goal of moving from volume to value hinges on a false dichotomy between these approaches. The Department of Health and Human Services categorization of payment methods acknowledges that most value-based, physician payment models being tested are built on top of the MPFS, as are the two value-based payment initiatives that replaced the sustainable growth rate formula — the Merit-Based

Incentive Payment System and Alternative Payment Models. If the foundation of Medicare’s fee schedule isn’t sound, these systems will be unstable.

Under the MPFS, fees are based on the cost of providing the thousands of services codified in the Current Procedural Terminology manual of the American Medical Association (AMA). The fee schedule’s core element is the resource-based relative value scale (RBRVS), under which each physician service is assigned a number of relative-value units (RVUs). Fees are set by multiplying the RVUs by a conversion factor that is adjusted annually and according to location. By better aligning fees with production costs — including the costs attributed to physician effort — the RBRVS was meant to correct payment distortions that produced large income disparities among specialties.

This objective hasn’t been achieved; income disparities are as large now as when the Centers for Medicare and Medicaid Services (CMS) introduced the MPFS in 1992. When physician compensation is calculated as if all payers used Medicare’s fee sched-

Selected Common Clinical Services with Seemingly Inflated Physician-Work Times Used in the Medicare Physician Fee Schedule.*		
CPT Code	Physician Service	Total Physician Time (min)
17000	Liquid nitrogen freezing of a single actinic keratosis	23†
20610	Aspiration and steroid injection into an inflamed knee joint	21
45385	Colonoscopy with polyp removal	78
55700	Twelve-sector prostate needle biopsies	65
76700	Abdominal ultrasound	21
92557	Complete audiogram with interpretation	28
93010	Electrocardiogram, interpretation and reporting only	6

\* CPT denotes Current Procedural Terminology. Data are from the AMA Specialty Society RVS Update Committee database.

† Add 1 minute for each additional lesion.

ule, cardiologists and radiologists have incomes up to 2 to 2.5 times those of family physicians, general internists, pediatricians, and psychiatrists.<sup>1</sup> And in fact, virtually all payers base their fee schedules on Medicare's RBRVS.

We believe that two key flaws in the RBRVS are its substantial misvaluations of physician work and the failure of current service codes to capture the range and intensity of nonprocedural physician activities, known as evaluation and management (E/M) services. Correcting these flaws could improve outcomes and support movement toward payment models that will better serve Medicare beneficiaries.

Reflecting a phenomenon that economists call “downward sticky” prices, work RVUs for many high-volume, high-cost services haven't been adjusted downward to account for automation, experience, personnel substitution, and other productivity improvements that have substantially reduced the amount of physician time and work involved. For example, since the broad implementation of picture archiving and communica-

tion systems about 15 years ago, radiologists can scroll through several hundred separate cross-sectional images, rather than having to create a mental three-dimensional image by moving around film sheets. The MPFS still assumes that it takes nearly 30 minutes to interpret a magnetic resonance image of the brain, although it now typically takes about 10. Similarly, the MPFS assumes that it takes 31 minutes to interpret an echocardiogram, when it actually takes 5 to 10. RBRVS stagnation has thus turned many procedure and test-interpretation codes into financial winners, while other services, especially E/M activities, have become relative losers (see table).

Lacking sufficient resources to evaluate and update work RVUs, CMS depends on an AMA-sponsored expert panel, the RVS Update Committee, which in turn relies on specialty societies to voluntarily identify overvalued codes and propose more accurate work times and RVUs. Not surprisingly, updates that reduce RVUs are rarely proposed. Both

the Medicare Payment Advisory Commission and the Government Accountability Office have suggested that the specialists on the committee and the specialty-society advisory groups have conflicts of interest that render their advice suspect. After more than two decades, CMS still doesn't rely on what we believe should be the standard for setting work RVUs — empirical information on how long it actually takes physicians to do things. CMS has recently started testing the feasibility of collecting such empirical data.

Existing service codes are especially flawed when it comes to measuring cognitive work — the critical thinking involved in data gathering and analysis, planning, management, decision making, and exercising judgment in ambiguous or uncertain situations.<sup>2</sup> MPFS coding for cognitive work hasn't kept up with practice. The E/M service codes, which account for 27% of fee-schedule payments, reflect medical practices that prevailed 30 years ago. Now, Medicare beneficiaries often have several chronic conditions, take

multiple medications, and see numerous clinicians. When patients present with an acute illness, their physician's decision making — the core work involved — is more complex, and these efforts aren't well reflected in the single-condition history and physical on which the code definitions are based.<sup>3</sup>

Because people are living longer with chronic conditions and because more care options are available, research suggests that the complexity of the work performed in office visits has in-

creased substantially, at least in some specialties.<sup>4</sup> Furthermore, as clinical practice and care management approaches evolve, some physicians, especially those in primary care or other “cognitive specialties,” probably spend more time planning care and communicating with other health professionals outside office visits. CMS has added codes to support some non-visit-based activities, such as overseeing patients' transitions from hospital to home. Nevertheless, physicians spend substantial time performing tasks that remain unrecognized in the MPFS. More research is needed

to determine how best to compensate them for these activities. Ambiguity in current E/M visit-code definitions also invites “upcoding.” In response, 20 years ago CMS developed documentation guidelines requiring physicians to list elements of history taking and physical examinations they performed during a visit to support the level of payment being requested. Electronic health records now permit physicians to cut and paste from prior entries, actually facilitating upcoding, while also cluttering the record

decision making and counseling. It would also help to gather data on the extent of physicians' non-face-to-face communication with patients and other providers, both in practices that depend on fee-schedule-based revenues and among clinicians whose salary isn't determined by RVU-based productivity. CMS could use this information to reconfigure E/M service codes to emphasize clinical thinking.

Because the MPFS is the foundation of new payment methods, its deficiencies will reverberate through them. Payment reform will be more likely to achieve its aims if there's a transparent, accountable, dynamic process for determining the resources required for various services and assurance that we've accounted for the cognitive aspects of care while addressing coding ambiguities. The Center for Medicare and Medicaid Innovation is well positioned to support the research and development required to bring the MPFS into the 21st century. Implementing new incentives and quality measures in new payment models while maintaining a broken fee schedule is a prescription for failure.

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with redundant and inaccurate information.<sup>5</sup> Policymakers would benefit from a more nuanced understanding of patterns of E/M work in various specialties. Research could elucidate the number and severity of conditions that physicians address during visits; their use of formal evaluation protocols; the number of test results and consultations they review and order; the number of medications they review; variations in work based on patient factors, such as the presence of cognitive deficits or language problems; and the amount of time they spend on

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