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Physician Payment Reform: The Stages of Change

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The longstanding and profound undervaluation of complex primary care is changing, and SGIM has been a key leader in this process. There is more hope now for payment reform than any time in the last 25 years.

The Tale of Our Demise

In 1991, Medicare declared that physician payment would be based on the resource-based relative value scale (RBRVS). All subsequent payment models, including commercial carriers, the Department of Defense, the VA system, and current innovative payment models, use the RBRVS paradigm in some fashion. The premise of RBRVS is that physician services can be priced relative to one another on the bases of "resources." The definition of "resources" is subject to considerable debate. Officially, the Centers for Medicare and Medicaid Services (CMS) define these as "physician time and intensity," but there is no established measure of "intensity" *per se*. In the original research that preceded RBRVS, intensity was defined in terms of "technical skill, mental/physical effort, and psychosocial stress."

Since implementation, the assignment of values for each physician service—paid in relative value units (RVUs)—has consistently favored proceduralists and interventionalists.[1,2] As a consequence, the primary care workforce has dwindled. With starting salaries that are less than half those of the elite procedure-based specialties,[3] such as interventional radiology, the numbers of graduates who choose primary care has dropped to levels that make the primary care workforce unsustainable. Non-physician providers have backfilled gaps, but when medical care becomes complicated and nuanced, there are far too few fully qualified physicians to meet the need. This substantial decline of the specialty of primary care has happened in real time. We are an endangered profession.

"Don't get mad, get organized"

There is real change coming. SGIM has been the key thought leader and broker in this process. This began in 2004 with the formation by the American College of Physicians (ACP) of the Subspecialty Advisory Group on Socioeconomic Affairs (SAGSA), a multispecialty committee. SGIM was invited to participate. SAGSA provided opportunities for physician-to-physician networking and collaboration around shared concerns. Between 2005 and 2007, SGIM participated in the most recent revisions of the work RVUs assigned to the outpatient evaluation and management (E/M) codes. The work values went from 1.1 RVUs to 1.42 and ultimately to 1.5 for a 99214 service code. Without survey participation by SGIM members, this effort led by ACP would likely have foundered.

In 2012, SGIM was invited by the American Academy of Family Physicians (AAFP) to participate in a physician payment reform task force. SGIM was a leader in mapping out payment reform options. This participation resulted in a new set of peer-to-peer relationships. With discussions around common concerns, knowledge and understanding evolved. Through shared work, credibility and trust developed.

This year SGIM began its own effort to effect real change in the Medicare payments for primary care. This began with an open phone call in early February and progressed to the formation of a coalition of 16 professional organizations ranging from family medicine to neurology and including infectious disease, gastroenterology, rheumatology, endocrinology, and many more.

This coalition submitted a letter to CMS requesting the redefinition and revaluation of the outpatient E/M codes and the creation of more appropriate documentation expectations. This was followed by direct conversations with the key leadership within CMS and the Center for Medicare and Medicaid Innovation (CMMI), House leadership and staff (both Democratic and Republican), key House and Senate committees (both Democrat and Republican), and the Medicare Payment Advisory Commission (MedPAC). Erika Miller from CRD, working on behalf of SGIM, provided the energy and continuous support for the innumerable contact points.

There were months of uncertainty. We were concerned that other specialty societies would commandeer Congressional opinion, but there was also a steadfast commitment on the part of the 16 participating organizations that deficiencies of the E/M codes must be addressed. All were convinced that real change in the Medicare payments for complex cognitive services was long overdue. All came to share a common belief in the compelling need for the E/M service codes to be reworked.

continued on page 2

NEW PERSPECTIVES

continued from page 1

CMS Engages with Purpose

CMS responded with an alternate pathway in the calendar year (CY) 2016 Physician Fee Schedule proposed rule. This required a shift in thinking, but the coalition held. The proposed rule, released for public comment in July, commits the agency to a change in payment for E/M services across the board—a much broader and more ambitious agenda than the coalition proposed. Rather than rework the existing E/M codes, the agency will develop add-on codes that can be attached using a -25 modifier to the existing E/M codes. In the case of outpatient primary care, these codes could be attached to a 99214 service code and would provide added payment for both the increased intensity of medical decision making (MDM) of complicated outpatient care and the added post-visit work that extends from a complex visit. How many RVUs would be generated from these codes has not been determined, but the concept that there is a broader range of E/M work than can be captured by the existing service code definitions and a commitment to reform is the most important change in the "relative" valuation process since the inception of RBRVS. SGIM has led this coalition and without SGIM, this would not have happened.

SGIM Opens a Pathway for Future Research and Development

There is more. CMS and CMMI are coming to understand that the accurate valuation of E/M services is not only relevant to the world of fee-for-service medicine but also to all new innovative payment schemes. But more research is needed to fully understand the complete topology of E/M work for the cognitively dependent specialties. This includes the broad and complicated agenda we face in primary care and deep and complicated world of our colleagues in specialties such as infectious disease, rheumatology and endocrinology. To support this, SGIM has now moved on to lead the creation of a new more formal Alliance of Cognitive Specialty Societies that will become an enduring presence in the debate on how to ensure the appropriate definition and valuations for physician work within the RBRVS use by Medicare. This Alliance will press the need for evidence-based physician payment policies.

References

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