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Profit Over Professionalism: The Case of the Medicare Physician Fee Schedule

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"The Medicare Physician Fee Schedule and Unethical Behavior" by Berenson and Emanuel (JAMA 2023; 330:115)

- My motivation --
  - Experience on the RVS Update Committee (RUC), CMS, and MedPAC
  - Insights from researching two recent comment letters to CMS
    - Astounded by the brazen misrepresentation in work descriptions
  - Have learned that the RUC actually sanctions misrepresentation as an expected part of their process
  - So I approached Zeke Emanuel, MD, a health care ethicist and policy expert. But we then agreed that there is nothing special about the unethical behavior to be described later is related uniquely to health care – rather, it's plain vanilla, individual and organizational ethics, and particular sensitivity to using the L word, so I will try not to.

Medicare fee schedule: a primer

- Called the Medicare Physician Fee Schedule in statute but now pays a broad range of health professionals, including NPs, PAs, physical and occupational therapists, mental health professionals, podiatrists, etc.
- For services furnished in all settings
- Health professionals are paid under Part B of Medicare – currently about $93 billion, of which Medicare pays about $71 billion (the difference is beneficiary cost sharing.)
  - Represents about 16 percent of all traditional Medicare spending
- Medicare Advantage plans, which now serve 51% of beneficiaries, typically use the fee schedule and pay close to Medicare fees.
- The MPFS is the basis for fee schedules for most payers

Coding

- The MPFS includes about 9000 codes, mostly drawn from the CPT coding system – called Level 1 codes
- CMS adds some additional codes – Level 2 -- that along with the Level 1 codes comprise the Healthcare Common Procedural Coding System (HCPCS)
- Most of the codes represent single services, but have long included bundled payments, including procedures for which payment includes estimates of follow up visits for either 10 or 90 days; monthly capitated payment for management of dialysis; and monthly payment for chronic care management.
- CMS takes the position that it lacks authority to include prospective, capitation, narrowly interpreting the statute's language that refers to payment for "services furnished"

Components of clinical work

- Fees are based on relative weights, called relative value units (RVUs), which by statute should account for the relative costliness of the inputs used to provide services: defined as clinician work, practice expenses (PE), and professional liability insurance.
- Work and PE are the major components, each at about 50% of total RVUs
- Whereas calculation of PE raises data collection issues, it is mostly a CMS issue, not involving clinician estimates (except for the contribution of "direct practice expenses – staff involvement with performing specific services.
- The RVUs for work are supposed to represent the relative levels of clinician *time* and *intensity* associated with each code.
  - Intensity is a subjective concept meant to capture a code's mental effort, judgment, technical skill, physical effort, and psychological stress.
  - But there are no relative weights associated with attributes of intensity – it is a global estimate that with consideration of time is referred to as *magnitude estimation*
- It is magnitude estimation that opens the door to controversy across specialties and policymakers about the subjective value assigned to time.

Calculating RVU weights and fees

- Adjustments are also made based on provider characteristics, e.g., whether the clinician is facility-based or independent, geographic designations called geographic practice cost indexes (GPCIs), and some other factors.
- CMS determines the fee schedule amount by summing the adjusted weights and then multiplying the total by a dfixed dollar amount – the conversion factor – that changes annually.
- Medicare pays 80% of the allowed amount, with the beneficiary liable for the 20% coinsurance – though > 80% of beneficiaries have supplemental coverage to pick up some or all of the coinsurance.

From the outset, judgments trumped data

"The process is fundamentally a judgment-laden task for which there is no objectively correct solution. Developing a formula for calculating relative costs gives the appearance of removing judgment from the process, but in fact does not remove judgment from either the construction of the formula or the measurement of what goes into it."

-- Hadley et al 1984. *Final Report on Alternative Methods of Developing a Relative Value Scale of Physicians' Services*, Urban Institute

The AMA structure for its fee schedule activities*

- The CPT Editorial Panel – 21 members, 19 physicians
- The RUC – 26 of 32 members appointed by medical specialty societies, with 4 rotating on and off; others include representatives of other professional groups, AMA, AOA, CPT Editorial Board
- The Advisory Committee – representing each of 125 specialty societies in the AMA House of Delegates
- The Health Care Professionals Advisory Committee
- Specialty societies and their RVS committees
- Individual health professionals – voluntarily participating
- The RUC members are meant to be objective experts, without regard to their specialty interests, whereas Advisors are understood to be society advocates

*from *AMA/Specialty Society RVS Update Committee: An Overview of the RUC Process*

The process*

- Societies indicate interest in developing an RV recommendation by surveying their members on the work involved with a coded service.
- Societies survey >29 practicing members, guided by a list of 10 to 20 reference services provided by its RVS committee.
- The RVS committee manages the surveys, reviews and may modify the results, and prepares recommendations for the RUC.
- Specialty advisors present the recommendations with a highly granular description of the clinical work at a RUC meeting, where it is discussed
- The RUC may accept, refer back for further work or send it to a "facilitation" committee, or directly modify the prosed RVU. A recommendation to CMS must be adopted by a two-thirds majority.
- CMS may accept or alter the RUC recommendation and put it into notice-and-comment rulemaking in July and in final after considering comments in Nov. 60 days prior to a Jan 1 start date.

*from *AMA/Specialty Society RVS Update Committee: An Overview of the RUC Process*

Challenges in estimating times using judgment

- Time – especially intra-service time -- is the dominant predictor of estimated work, and the major cause of distortion in fees.
- We can compare RUC-approved time estimates and empirically-based measured time.
- OR logs and time stamps in EHRs are reliable for intra-service time procedures performed in procedure rooms/operating rooms, but not pre- and post-service time.
- For other services, one needs observational approaches to measuring time as lots of multitasking makes time stamps unreliable
- Studies have shown that skin-to-skin, surgical times are overestimated by ~20%.
- Observational studies performed by Urban Institute and RAND show much greater time inflation for a range of high $ volume, non-surgical services, including office procedures, especially dermatology; imaging and test interpretations; endoscopy.

Exaggerated work estimates

- Magnitude estimation – a global assessment of work rather than separately assessing time and intensity – permits highly exaggerated, unaccountable estimates because there are no objective standards to assess the estimates against.
- The RUC process encourages intentional work inflation beyond understandable bias by clinicians assessing their own work
- Work descriptions that societies routinely provide for their codes as part of the review process are sometimes fabricated to support inflated work estimates
  - Dermatology claimed that when freezing actinic keratoses, each lesion is anesthetized and then dressed after liquid nitrogen application and that patients typically make a visit within 10 days (it almost never occurs)
  - Cardiology claimed that in interpreting ambulatory ECGs physicians use calipers to measure intervals and typically compare the reviewed tracing to prior ones. But the typical ECG is “WNL” (within normal limits)

The RUC process encourages RVU distortions

- The following gleaned from personal experience, discussions with RUC members, and documented in depth in *Fixing Medical Prices*, by Columbia Professor Miriam Laugeson, Harvard U. Press, 2016
- The high workload combined with the RUC leadership interest in supporting society work RVU proposals compromise objectivity
- Many decisions are made in facilitation committees and small group agreements rather than open and full discussion by the 30+ member RUC
- *RUC members engage in strategic behavior related to the services their society provide.*
  - From Laugeson – "According to the interviewee, societies ignore overvalued services performed by other societies, because to do so would invite retaliation and scrutiny of the codes their members use."

The RUC process encourages work distortions

- Laugeson summary of causes for inaccurate work values:

1. The assertions that it is a panel of experts, rather than advocates, cannot be substantiated. The RUC members are too embedded in their home society to be "impartial judges of physician work."
2. The RUC uses surveys that rely on apparently poor sampling methods and thus subject to biases.
3. The problem of inaccurate estimates explained by biases and group effects observed by psychologists and behavioral economists in other settings.

RUC leadership defends all of this by asserting that they know the estimates are wrong/inflated but because all participants inflate their *relative* resource-based estimates are not distorted.

"None of us believe the numbers are fine-tuned…We do believe we get them right with respect to each other." – Barbara Levy, MD, former RUC Chairperson in response to a news story showing time inflation for colonoscopies.

Flawed processes produce fee distortions (fees that vary substantially from costs)

- Overall, procedures, imaging, tests, and other treatments are overvalued, while E/M services are undervalued.
  - Further, over the past 30 years, new codes have overwhelmingly been procedures and imaging, not E/M services, so under budget neutrality requirements the fees for E/M services have been continuously, passively devalued over time.
  - This now may be changing with new care management, care transition, and collaborative behavioral health codes, and, in 2024 the G2211 add-on code for complexity associated with caring for those with chronic conditions.
  - To the RUC's credit, based on its initiative to survey many specialties re office visits work, CMS in 2021 increased office visit fees, helping primary care and other "cognitive" specialties at the expense of the procedural specialties.
  - Should we congratulate the RUC for this initiative or ask why it took it nearly 30 years to do so? I suggest it was a one-off.

Some of the perverse results

- The current fee for liquid nitrogen freezing of 15 or more actinic keratoses is $168; the fee for a level 5 office visit is $180.
- RAND has documented that less than half of assumed visits in 90-day global procedures actually occur. Only 3.7% of 10-day globals.
- FFS is criticized for "paying for everything physicians do," needed or not, yet studies show that >25% of primary care clinical activities are not recognized for payment. Patient portal communications, etc. are greatly increasing the non-paid activities for some clinicians.
- Work intensity varies more than 40-fold across procedures with no relationship between RUC assigned intensity and any traditional measure of surgical intensity.*

* Childers et al. Association of implicit intensity values incorporated into work RVUs with objective measures. Am J. Surg, 2020;2019(6): 976

AMA/RUC's summary of the RUC's work on potentially overvalued services

- MedPAC flagged persisting, overvalued codes as an issue in 2005 and suggested some process improvements that the RUC ignored.
- The RUC did set up a Relatively Assessment Workgroup in 2006 that adopted reasonable criteria for codes to review -- basically high $ impact codes -- through its standard review process
- RAW Progress Reports through 2023 claimed:
  - 2751 codes identified for review
  - 54% of codes reviewed either had work RVUs decreased, or the codes were deleted
  - $5 billion of fees annually were reallocated from RVU reductions or deletions.
  - WOW!!!! –.

AMA/RUC misrepresentations of this work

- The analysis identified the number of codes reviewed -- with 40% decreased in work RVUs -- but apparently never calculated what percentage of total work RVUs were decreased. It appears that many of the decreases were small, with major distortions remaining.
- More egregiously, the $5 billion reduction available for reallocation to other codes included deletions – which surely produced a large percentage of the "savings." But deletions invariably are replaced with new codes – the codes reviewed are selected because they represent high $ value codes. In short, the $5 billion was gross, not net, savings when including only deletions but not replacements.
- As evidence of the puny impact of the RUC's efforts to address potentially overvalued codes, Congress established a requirement that for 2016, 2017, and 2018, the RUC should redistribute 0.25-0.5% of work RVUs or else forfeit the shortage gap to reduce total RVUs. CMS and the RUC failed to meet the statutory targets, thereby actually forfeiting RVUs from the pool.

The CMS/RUC approach to potentially overvalued codes also illustrates the failure of the RUC estimation approach

- CMS has a process by which the public can nominate "potentially overvalued codes" for review and reconsideration.
- Anthem (now Elevance) nominated a handful of codes for which empirical time data produced by CMS contractors had shown much lower times than assumed in the specialty society/RUC estimates.
- The RUC essentially dismissed reconsideration of the codes because this empirical data did not conform with the RUC's magnitude estimation approach. It rejected empirical data that its own members did not produce.
- The RUC showed no interest in learning whether the empirical data, might have merit. Rather, it dismissed the nominated codes out-of-hand and never considered the potential utility of the provided data
- Nor did CMS consider the clear need to have an appeals process that was different from the RUC's 31-year approach to determining work RVUs.

A broken process produces perverse results

From Medscape Data Collection published June 10, 2022 based on survey from Oct 5, '21 through Jan 19, '22

Overall Average Compensation Across Specialties -- $339,000

Primary Care Physicians -- $260,000

Specialists -- $368,000

Specialist : Primary Care Ratio – 1.42

12 procedural, mostly surgical, specialties earn >$400K with a median of $446K, producing a Specialty : PC ratio of 1.75.

Compensation for internal medicine, family medicine and pediatrics clustered between $244k to $264k.

Cognitive internal medicine specialties' compensation was not much higher

The MPFS produces similar but somewhat smaller differentials but reflects the distorted fee setting

An Urban Institute/MGMA study from a decade ago simulated incomes assuming the Medicare Physician Fee Schedule (MPFS) was used by all payers.*

The relativities in the compensation surveys across specialties are similar to those that Medicare produces, although specialists have somewhat more negotiating leverage with commercial insuers tan do primary care and other specialties, especially geriatricians (for Medicare Advantage) and behavioral health professionals.

Overall, MedPAC finds that commercial insurance pays 130% of Medicare fees but with huge payment variations, related to negotiating leverage -- specialists have more leverage.

The clearest policy-related implication is that the current RUC-influenced fee schedule exacerbates specialty shortages.

There are 7300 geriatricians to care for 65 million Medicare beneficaries

Tax records show higher compensation and greater disparities*

Tax records include all sources of income**

The following data compile averages for US physicians ages 40-55, 2005 to 2007.

Neurosurgery total income - $920,500 for 63 hour workweek

Orthopedics total income - $788,600 for 58 hour workweek

Dermatology total income - $655,200 for 44 hour workweek

Internal medicine total income - $278,400 for 50 hour workweek

Family practice total income - $230,100 for 49 hour workweek

Dermatology: family practice ratio – 3.17

Diagnostic radiology: FP ratio - 2.33

* Andrew Van Dam, Washington Post, August 4, 2023

** in 2017 dollars. 94% was considered “wages” – some with business income/cap gains

Physicians have lost the moral high ground

- Don Berwick's important essay in JAMA – "Salve Lucrum ["Hail, Profit"]: The Existential Threat of Greed in US Health Care" -- fingered greed by drug companies, insurers, and hospitals, but left out physicians. (JAMA 2023; 329:629)
- The late Princeton health economist Uwe Reinhardt 25+ years ago opined that physicians had a political choice to make -- either maintain their professional authority and autonomy or go for the money, giving up their prior position of deference over policy. He thought they made a bad choice and thus near the bottom of the policy totem pole.
- The House of Medicine's powerful influence over the MPFS, an example of "regulatory capture," has served the financial interests of physicians who perform procedures or interpret tests and imaging but has produced shortages of primary and geriatric clinicians, allowing the growth of insurers', health systems' and private equity's domination over health care delivery.

Conclusion

- Physicians cannot be relied to put their financial interests aside and act in the public's interest
- Their behavior naturally includes biases, but with numerous examples of misrepresentation of the clinical work they do.
- Misrepresentation is actually promoted by specialty society and RUC leadership.
- The AMA egregiously misrepresents the RUC's performance and so far has successfully fended off reforms that would lead to more accurate, objective, empirically-based relative fees.
- Its success is due in large part to the fee schedule's unnecessary complexity, lack of transparency, and misguided belief that fee-for-service payment has no link to value, so below the policy radar screen.
- Finally, Medicare stakeholder politics grants AMA hegemony over the fee schedule, even when the flaws in results are compelling.

THANK YOU