How do physicians get paid: The devil of the details

“The best-laid schemes o' mice an' men
gang aft agley”

Robert Burns

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Harvard Medical School
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Boston
Welcome to the land of RVUs

The “inside baseball” of physician payment.
My goals

1. The country needs a valid and accountable system for assigning values to physician services.

2. The processes for assigning these values must meet publicly accountable standards:
   - Evidence-based
   - Accurate
   - Peer reviewed
Key terms


HCPCS (Healthcare Common Procedure Coding System). CMS rendition of CPT

**Why:** ICD (International Classification of Diseases): The code assigned to each for disease for transactional simplicity

**RVU** (Relative Value Unit): The currency of the realm, the land of RVUs
How do we use the currency of the realm?

Do we pay based on charges?
No. Health care is not a free market.

Do we pay based on outcomes?
No. There are too many ways for providers to shed risk (AKA “cherry picking”)

Do we have a fee schedule?
Yes. But it who is in charge of the “monetary policy?”
A NATIONAL STUDY OF RESOURCE-BASED RELATIVE VALUE SCALES FOR PHYSICIAN SERVICES

FINAL REPORT

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HCFA Contract No. 17-C-98795/1-03

September 27, 1988
Creating a rational fee schedule: The Resource-based Relative Value System (RBRVS)

RBRVS origins with California Medical Society/BCBS in 1950s

The chaos of “Usual and Customary” payments, 1980s, HCFA (preceded CMS)

Hsiao report, 1988: *A National Survey of Resource Based Relative Value Scales for Physician Services*

*Value = work X training costs X X practice expenses*
Compensation = payments for services \( \times \) number of services…FFS

Services are doctor/patient encounters, tests interpreted, procedures completed etc.

Revenue is derived from the payments for these services, the “building blocks” for physician, institutional, testing etc. revenue.
All models of care delivery use these same building units

Salary models use the same concepts to establish productivity goals/bonus thresholds.

PCMH service models derived from the clinical care services delivered by each clinician.

ACO revenue distribution derived from the relative values assigned to the work done by each clinician.
Compensation is based on work done, not the outcomes of our work.
**Work done...the production:** The FFS model

- Incentivizes more to be done
- Empowers patients since their needs drive the work done
- Allows manipulation of both the providers and the patients

**Health outcomes...the product:** The business model

- Allows a value proposition
- Requires attribution
- Incentivizes “cherry picking” and lost patients
Physician payment since 1992

Payment =

\[
\left( (RVU_w \times GPCI_w) + (RVU_p \times GPCI_p) + (RVU_m \times GPCI_m) \right) \times CF
\]

= [Total RVUs] \times CF

CF: Conversion Factor, published annually by CMS
Payment is based on the RVUs assigned by CMS to each CPT

Payment for each CPT service = RVUs X CF

Total payment = Sum of all RVUs X CF

**CMS is the ultimate authority**
Some critical assumptions in RBRVS

**Bundling:** Payments made for the preparation, face to face and after visit work of each encounter, pre, intra and post service times.

**Global payments:** Payments made for the projected average care experience for a given service (zero, 7 days, 90 days).
What the Medicare RBRVS model does not cover

Non face to face care
  Telephonic
  Electronic
  Off hours care
Care management
  Oncall
  Screening
  Vaccinations
  Counseling/coaching
So what has happened since 1992?

Growth of need
Growth in health care spending
Expansion of capacity for tests, procedures
Shift in workforce composition, the decline of primary care from 40-50% to 30%
Impending loss of sufficient primary care capacity.

Can we save primary care?
Resident interest in primary care has plummeted!

The proportion of third year residents in GIM is falling:

Woo, N Engl J Med 2006;355:
A Primary Care workforce crisis is inevitable without action

44,000 PC MD deficit by 2020

EXHIBIT 4
Care For Adults: Projected Percentage Change In Workload And Number Of Generalists, 2005–2025

Percent change relative to 2005
25
20
15
10
5
0

2005 2010 2015 2020 2025

Workload

Unadjusted supply

Adjusted supply

Adjusted supply with graduate decline

Primary care workload 2025

Primary care workforce without correction 2025

SOURCES: Data on workload (visits) are from the authors' analysis of data from the National Ambulatory Medical Care Survey (NAMCS), combined 2003–2005 data. Data on supply are from the authors' calculations using the Physician Supply Model, Bureau of Health Professions.


Colwell et al. Health Affairs 2008;29:232
What is the root cause?

The world of primary care has expanded and become more complicated. The compensation for these activities has not grown enough to attract the needed talent.
How are the service codes used by primary care valued?

E/M (Evaluation and Management) are the codes used by all physicians for the non-procedural service.

Traditionally based on problem solution:
- Diagnosis: Think *House*
- Acute care: Think *ER*
- Disease management: Think… *Marcus Welby*
The world of my grandfather and father, the William Goodsons 1939-1985, 1909-1963

The WHGs, 1962
I live in a much different world

Evaluation and Management’s New Paradigm:
Proactive health care
  Screening
  Vaccinations

Typical patient in my practice: 50 something with Back pain + HTN + DM + Arthritis + Hypercholesterolemia…and is 30 pounds overweight. I need to track screening, vaccination, health habits and be accessible 24 hours a day.
Primary care MDs are spending more time with their patients

Addition minutes spent with patients by selected conditions, 1997 vs. 2005

Chen et al. Arch Intern Med 2009;169:1866
Average 63 yr old male statin user fills 11.4 prescriptions for 6.3 different medications by 2 prescribers over 3 months.
The PC crisis can be traced to the under valuation of PC E/M work

The MD payment has not kept pace with the work of primary care.

A major portion of the work is not covered by the existing assumptions

- Follow of tests and extended post visit problem resolution
- Non face to face problem resolution
- Care management
E/M for all MDs is dramatically undervalued

Primary care payment is much lower for each service delivered

<table>
<thead>
<tr>
<th>Service</th>
<th>Total visit time</th>
<th>Work RVUs</th>
<th>Practice Expense RVUs</th>
<th>Total RVUs</th>
<th>CMS RVUs revenue</th>
<th>% Higher for SS care</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC visit (99214)</td>
<td>35</td>
<td>1.50</td>
<td>1.09</td>
<td>2.64</td>
<td>$95</td>
<td></td>
</tr>
<tr>
<td>Colonos - copy</td>
<td>24</td>
<td>3.69</td>
<td>1.88*</td>
<td>5.87*</td>
<td>$211</td>
<td>222 %</td>
</tr>
<tr>
<td>Cataract</td>
<td>23.5</td>
<td>7.25</td>
<td>6.96*</td>
<td>17.71*</td>
<td>$638</td>
<td>606%</td>
</tr>
</tbody>
</table>

Sinsky, SGIM 2010
PC MD hourly income is about half those of non PC MDs

Income ratios vs. PC

GP mean hourly wage = $57.55
Gastroenterologist mean hourly wage = $93.27
Ophthalmology mean hourly wage = 103.63

Arch Intern Med 2010; 170: 1728-1734
NIHCM Foundation Sept 2010
PC pay is HALF OR LESS than specialty payment

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>General family practice</td>
<td>$197,655</td>
</tr>
<tr>
<td>General internal medicine</td>
<td>$205,441</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$202,832</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>$389,385</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>$476,083</td>
</tr>
<tr>
<td>Diagnostic radiology</td>
<td>$438,115</td>
</tr>
<tr>
<td>Dermatology</td>
<td>$350,627</td>
</tr>
</tbody>
</table>

Source: American Medical Group Association 2009 survey
Our economic future demands that we “bend the curve”

Higher primary care “score” is associated with lower per capita costs in all other mature economies of the world.
Improved Patient Outcomes

• Hospitalization rate among enrolled patients was 20% lower than comparison
• Emergency department visit rates were 13% lower for enrolled patients
• Annual mortality 16% among enrolled versus 20% among comparison group

Achieved Savings Target

• 12.1% in gross savings among enrolled patients
• 7% in annual net savings among enrolled patients after accounting for the management fee paid by CMS to MGH
• Return on investment - for every $1 spent, the program saved at least $2.65
MGH CMS Primary Care Management program, 2006-10

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- Return on investment - for every $1 spent, the program saved at least $2.65.
How did we get into this predicament?

This was a foundational problem when RBRVS started and it was never addressed.

Hsiao (1988): “Important research needs to be done including… Developing a more suitable extrapolation method for E/M services… to address the ambiguity in the CPT-4 descriptions of these services.”
<table>
<thead>
<tr>
<th>Year</th>
<th>Acceptance Rate</th>
<th>Year</th>
<th>Acceptance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>79%</td>
<td>1999</td>
<td>93%</td>
</tr>
<tr>
<td>1994</td>
<td>89%</td>
<td>2000</td>
<td>88%</td>
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<td>1995</td>
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<td>96%</td>
<td>2003</td>
<td>96%</td>
</tr>
<tr>
<td>1998</td>
<td>96%</td>
<td>2004</td>
<td>96%</td>
</tr>
</tbody>
</table>
## RUC Composition

- American Medical Association
- CPT Editorial Panel
- American Osteopathic Association
- Practice Expense Advisory Committee
- Health Care Professionals Advisory Committee

<table>
<thead>
<tr>
<th>Medical Specialty</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>Neurology</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Neurosurgery</td>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Obstetrics/Gynecology</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>Ophthalmology</td>
<td>Radiology</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>Orthopaedic Surgery</td>
<td>Thoracic Surgery</td>
</tr>
<tr>
<td>Gastroenterology*</td>
<td>Otolaryngology</td>
<td>Urology</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Pathology</td>
<td>Vascular Surgery*</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Pulmonary Medicine*</td>
<td></td>
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</tbody>
</table>

* indicates rotating seat
What’s wrong with the way CMS has assigned values to the service codes?

Not based on the best knowledge base
  “Convenience surveys”
Not accountable to economic interests of the US economy.
  We have been “spending RVUs” with abandon
Not accountable to the profession
  RUC participation is based on AMA membership
Not subjected to peer review
  Proceedings not available for any form of public review
Doctors and farmers

Doctors = Farmers
Time = Acres (every farmer with 50-60 acres)
Specialty = Crops you grow

Income = productivity (bushels/acre) X acres X commodity price ($/bushel)

Imagine if your commodity price was controlled by the rice growers and you grew corn…and the rice growers were paid so well that they could continue to expand their productivity to higher and higher levels …but the country needs corn.
What is the alternative?

Can we develop a nationally supported and funded knowledge base for CMS and all others to use for assigning value to health services?
Evidence-based policy

**Accurate:** What is the work (time, intensity, risk) of each service based on the best research techniques?

**Reliable:** How can we be sure that our data accurately represent the world of practice?

**Transparent:** How should the vetting be determined?

**Dynamic:** How can we best use evolving data sets to keep the whole system current with contemporary practice?
This is an issue of accuracy and reliability of the tools we use

Health care is the result of the many stake holder investments therefore there needs to be a higher authority...a public agency

Health care is essential to economic stability/productivity since cost shifting will have unequal benefits and harms

Health care is a national resource. There are many who can rightfully claim ownership. Clinicians, scientists, pharma, health insurance providers, device manufactures, labor, management, corporate, investment, and on and on.
Key points

1. The country needs a valid and accountable system for assigning values to physician services.

2. We will need Federal funding for this work.

3. The processes for assigning these values must meet publically accountable standards:
   - Evidence-based
   - Accurate
   - Peer reviewed
Thank you