“Thinking Differently About Payment for Primary Care”: Why The Medicare Fee Schedule Needs Attention

Robert A. Berenson, M.D.
Institute Fellow, The Urban Institute
Robert Graham Center
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Given the Push for Value-Based Payment, Why Worry About FFS?

- Other payment models being explored are very challenging, with no clear roadmap to success
- So payers will be using the Medicare Physician Fee Schedule (MFS) for a while, at least in some places
- New payment approaches often leave out particular specialties or disciplines
- New payment approaches often wrap around current payment approaches, e.g., shared savings

Why Worry About FFS (cont.)

- Current payment rates are often the building blocks of a bundled payment – if the component parts are off, the sum of the parts will be off as well
- The resource-based relative value scale's relative value units (RVUs) per service code are the basis for fee schedules by most public and private payers
- Many provider organizations, esp. hospitals and ACOs, use RVUs as the measure of clinician productivity as the core of their own compensation to their employed clinicians

So What's Wrong With the MFS?

Conceptually --

- The current statutory basis for setting RVUs is to capture the relative costs of production, whether or not the activities paid for actually produce more or less relative value
- Some would "weight activities [reimbursable codes] according to whether they demonstrably improve patient outcomes"
  - Stecker and Schroeder, "Adding Value to Relative Value Units," *NEJM*, Nov 20, 2013

What's Wrong (cont.)

Operationally –

- Many believe the process for determining RVUs relies too much on surveyed estimates of practice expenses and physician time and work rather than relying on empirical data
- This process in turn produces distorted prices that disproportionately reward tests and procedures over evaluation and management activities and, thus, certain specialties over primary care and other "cognitive" clinicians
  - "What if All Physician Services Were Paid Under the Medicare Fee Schedule?", a contractor report for MedPAC by the Urban Institute and the Medical Group Management Association, March, 2010

What's Wrong (cont.)

- Increasingly many physicians, esp. in primary care, believe that the >20 year old CPT codes for E&M activities, the HIPAA approved code set for the MFS, no longer capture the work they actually perform for the growing patient population of longer-lived patients with chronic conditions.
- Further, approaches to preventing "up-coding" which occurs because of ambiguity in the code descriptions seem to be backfiring, with EHRs actually promoting up-coding, while compromising the medical record and the potential of EHRs
  - Berenson, Basch, and Sussex, "Revisiting E&M Visit Guidelines — A Missing Piece of Payment Reform," *NEJM,* May 19, 2011