Rebalancing the physician fee schedule towards ambulatory evaluation and management services

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Two main topics

- Fee schedule underprices ambulatory E&M services relative to other services
  - Option: Increase payment rates for ambulatory E&M services
- Concerns about primary care in Medicare
  - Option: Special payment for primary care clinicians
This year’s agenda for clinician payment policy

- Assessing payment adequacy for physician/other health professional services (March 2018 report)
- Repealing Merit-based Incentive Payment System (March 2018 report)
- Advanced Alternative Payment Models and ACOs (January 2018 meeting)
- Rebalancing fee schedule towards ambulatory E&M services (June 2018 report)
Fee schedule underprices ambulatory E&M services relative to other services

- Payment rates for clinician work are based on estimates of time and intensity
- Because E&M services are labor-intensive, clinician time is unlikely to decline
- But time needed for other services (e.g., procedures) often declines due to changes in productivity, clinical practice, and technology
- Reduced time should lead to lower prices for procedures, which would increase prices for E&M
- But this two-step sequence often does not occur
- Therefore, ambulatory E&M services are underpriced relative to other services – “passive devaluation”
Fee-schedule time estimates exceed actual hours worked for some specialties more than others.

Source: Zismer et al. 2014.
CMS has reviewed potentially mispriced services since 2008 but process has not been sufficient

- Services that comprise 35% of fee schedule spending have not yet been reviewed
- RVUs for clinician work did not decline as much as time estimates
- Potential explanation: decreases in time were partially offset by increases in intensity

<table>
<thead>
<tr>
<th></th>
<th>Number of services revised, 2008-2016</th>
<th>Average percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work RVUs</td>
<td>607</td>
<td>-9%</td>
</tr>
<tr>
<td>Time estimates</td>
<td>607</td>
<td>-18</td>
</tr>
</tbody>
</table>

Note: Reflects changes to RVUs adopted by CMS. Services had a decrease in work RVUs, time estimates, or both. Results are preliminary and subject to change. Source: MedPAC analysis of physician time and RVU files from CMS.
Increasing fee schedule payment rates for ambulatory E&M services

- Prior incremental efforts to address relative underpricing of E&M services have not succeeded in rebalancing fee schedule
- Option: Increase payment rates for ambulatory E&M and psychiatric services by 10% for all clinicians
- Would increase spending for these services by $2.7 billion
- To maintain budget neutrality, payment rates for all other services would be reduced by 4.5%
Types of services that would receive higher payment rates

- Ambulatory E&M services
  - E&M codes for office visits, home visits, visits to patients in long-term care settings
  - Chronic care management, transitional care management, welcome-to-Medicare visits, annual wellness visits
- We included psychiatric services due to concerns about access to behavioral health care
- Psychiatric services include psychiatric diagnostic evaluation and psychotherapy
- Question: should we continue to include welcome-to-Medicare and annual wellness visits?
Impact of increasing payment rates for ambulatory E&M and psychiatric services by 10%, by specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Amount of payment increase (in millions)</th>
<th>Share of total payment increase (across all specialties)</th>
<th>Net change in fee schedule payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed clinical social worker</td>
<td>$50</td>
<td>1.9%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Clinical psychologist</td>
<td>65</td>
<td>2.4</td>
<td>8.0</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>36</td>
<td>1.4</td>
<td>6.5</td>
</tr>
<tr>
<td>Family practice</td>
<td>423</td>
<td>15.7</td>
<td>5.7</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>37</td>
<td>1.4</td>
<td>5.4</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>77</td>
<td>2.9</td>
<td>4.8</td>
</tr>
<tr>
<td>General practice</td>
<td>25</td>
<td>0.9</td>
<td>4.4</td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td>176</td>
<td>6.6</td>
<td>4.4</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>12</td>
<td>0.4</td>
<td>3.6</td>
</tr>
<tr>
<td>Hematology/oncology</td>
<td>69</td>
<td>2.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Physician assistant</td>
<td>85</td>
<td>3.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>493</td>
<td>18.3</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Results are preliminary and subject to change.
Source: Analysis of claims data for 100% of Medicare beneficiaries, 2016.
Concerns about primary care in Medicare

- Fee schedule oriented towards discrete services, but primary care includes ongoing care coordination
- Other specialties can more easily increase volume of services than primary care clinicians, who focus on E&M services that are labor-intensive
- Compensation for primary care is substantially less than other specialties, which could deter medical students from pursuing primary care careers
- Pipeline of future primary care physicians is shrinking; decline in share of internal medicine residents who plan to practice primary care
Prior Commission recommendations on primary care

- Create budget-neutral bonus for primary care services (2008)
  - Congress created Primary Care Incentive Payment (PCIP) program, 2011-2015 (not budget neutral)
- Repeal SGR and provide higher updates for primary care than specialty care (2011)
- Establish per beneficiary payment for primary care clinicians to replace PCIP (2015)
  - Fund payment at same level as PCIP (~$700 million)
  - Fund payment by reducing fees for all fee schedule services other than ambulatory E&M services
Option: Special payment for primary care clinicians

- In addition to 10% increase for ambulatory E&M and psychiatric services billed by all clinicians
- How should eligibility be determined (e.g., specialty designation, share of payments from ambulatory E&M services, or both)?
- Should clinicians from other specialties also be eligible?
- How much money should be allocated?
- Where should funding come from?
  - $500 million/year from MIPS exceptional performance bonus?
  - Payment reduction for non-ambulatory E&M services?
How should special payment for primary care clinicians be distributed?

- Based on number of eligible services billed by each primary care clinician?
- Based on number of beneficiaries attributed to each primary care clinician (per beneficiary payment)?
  - How to attribute patients to clinicians?
  - Is risk adjustment necessary?
Illustration of special payment for primary care clinicians

- 10% add-on for eligible services billed by primary care clinicians who derive at least 60% of payments from eligible services
- Total payments = $1 billion
- 220,000 eligible clinicians
- To maintain budget neutrality, payment rates for all other services would be reduced by 1.7%
  - Reduction would be smaller if add-on is funded with $500 million from MIPS exceptional performance bonus
Policy options for Commissioner discussion

- Increase payment rates for ambulatory E&M and psychiatric services by 10% for all clinicians
- Special payment for primary care clinicians (future work)
  - How should it be structured and funded?