

CHAPTER

3

**Rebalancing Medicare's
physician fee schedule toward
ambulatory evaluation and
management services**

Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services

Chapter summary

Ambulatory evaluation and management (E&M) services, such as office and hospital outpatient visits, are essential for a high-quality, coordinated health care delivery system. These visits enable clinicians to diagnose and manage patients' chronic conditions, treat acute illnesses, develop care plans, coordinate care across providers and settings, and discuss patients' preferences. E&M services are critical for both primary care and specialty care. The Commission is concerned that these services are underpriced in the fee schedule for physicians and other health professionals ("the fee schedule") relative to other services, such as procedures. This mispricing may lead to problems with beneficiary access to these services and, over the longer term, may even influence the pipeline of physicians in specialties that tend to provide a large share of E&M services.

Payment rates in the fee schedule are based on relative weights, called relative value units (RVUs), which account for the amount of work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. Work RVUs are based on an assessment of how much time and intensity (e.g., mental effort and technical skill) services require relative to one another. If estimates of time and intensity are not kept up to date, especially for services that experience efficiency improvements, the work RVUs become inaccurate. Because of advances in technology, technique, and clinical practice, efficiency improves more easily for procedures, imaging, and

In this chapter

- Background on the fee schedule for physician and other health professional services
- Ambulatory E&M services are underpriced relative to other services
- An approach to rebalance the fee schedule toward ambulatory E&M services
- Conclusion

tests than for ambulatory E&M services, which are composed largely of activities that require the clinician's time and so do not lend themselves to efficiency gains. When efficiency gains reduce the amount of work needed for a service, the work RVUs for the affected services should decline accordingly. Because the fee schedule is budget neutral, a reduction in the RVUs of these services would raise the RVUs for all other services, such as ambulatory E&M services. Because of problems with the process of reviewing overpriced services, this two-step sequence tends not to occur. Therefore, ambulatory E&M services become passively devalued over time.

CMS, with input from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), has reviewed the work RVUs of many potentially mispriced services since 2009. However, CMS's review has taken several years and has not yet addressed services that account for a substantial share of fee schedule spending. CMS's review is hampered by the lack of current, accurate, and objective data on clinician work time and practice expenses. To estimate clinician work time for specific services, CMS relies on data from surveys conducted by specialty societies that are reviewed by the RUC. We have concerns about these data; for example, the surveys have low response rates and low total number of responses, which raises questions about the representativeness of the results.

To address this problem, the Commission previously recommended that CMS use a streamlined method to regularly collect data from a cohort of efficient practices—including service volume and work time—to establish more accurate work and practice expense RVUs. These data should be used in a “top-down” approach to calculate the amount of time that a physician worked over the course of a week or month and compare it with the time estimates in the fee schedule for all of the services that the physician billed over the same period. If the fee schedule's time estimates exceed the actual time worked, this finding could indicate that the time estimates are too high.

Contractors working for CMS and the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services found that the fee schedule's time estimates for clinician work for a broad range of services—particularly imaging, procedures, and tests—are inflated when compared with ambulatory E&M services. Indeed, errors in some of the fee schedule's time assumptions were very large—multiples of the actual time spent by physicians. For example, the time assumption for MRI of the brain was more than twice as high as the actual time spent by physicians on this service, according to a physician survey. By contrast, the time assumption for three ambulatory E&M services in the survey was about the same as the actual time spent by physicians.

There is also evidence that payment rates for global surgical services—which include the procedure itself and certain services that are provided immediately before and after the procedure—are too high. The global payment rate assumes that the same physician who performs the procedure also provides all the postoperative care, such as E&M visits. However, a study by the RAND Corporation observed that postoperative care is shifting from the physician who performed the procedure to other clinicians, such as hospitalists and nonphysician practitioners, who bill separately for each postoperative visit. This change suggests that physicians who bill for a global surgical service may be receiving payments for postoperative visits that in reality are provided by other clinicians. In addition, the Office of Inspector General reviewed medical records for several types of global surgical services and found that physicians frequently provided fewer E&M visits during the postoperative period than were included in the global payment rate.

There are also major problems with the accuracy of the data used to set practice expense RVUs (practice expense includes the cost of nonphysician clinical and administrative staff, medical equipment and supplies, office rent, and other expenses). First, CMS does not have a comprehensive data source with current information on the prices of medical equipment and supplies; consequently, the price estimates for these items are often outdated. Second, practice expense RVUs are based on data from a survey of total practice costs. Because this survey was conducted in 2007 and 2008, the data are unlikely to reflect current practice costs.

We describe a budget-neutral approach to rebalance the fee schedule that would increase payment rates for ambulatory E&M services while reducing payment rates for other services (e.g., procedures, imaging, and tests). Under this approach, the increased payment rates would apply to ambulatory E&M services provided by all clinicians, regardless of specialty. We modeled the impact of a 10 percent payment rate increase for ambulatory E&M services, although a higher or lower increase could be considered. A 10 percent increase would raise annual spending for ambulatory E&M services by \$2.4 billion. To maintain budget neutrality, payment rates for all other fee schedule services would be reduced by 3.8 percent.

Certain specialties would receive a large increase in their total fee schedule payments (on net) as a result of this change. The three specialties that would receive the highest proportional increase in payments are endocrinology (6.6 percent net increase in fee schedule payments), rheumatology (5.5 percent increase), and family practice (4.9 percent increase). These specialties concentrate on ambulatory E&M services. Several specialties—including diagnostic radiology, pathology, physical therapy, and occupational therapy—would experience reductions in their fee

schedule payments of about 3.8 percent because they provide very few ambulatory E&M services.

This change would be a one-time adjustment to the fee schedule to address several years of passive devaluation of ambulatory E&M services. Even if this approach is adopted, we urge CMS to accelerate its efforts to improve the accuracy of the fee schedule by developing a better mechanism to identify overpriced services and adjust their payment rates. If successful, these efforts would improve the accuracy of prices for ambulatory E&M and other services going forward and could reduce the need for future significant adjustments to the prices of E&M services. ■

Background on the fee schedule for physician and other health professional services

In 2016, Medicare paid about \$70 billion under the fee schedule for physician and other health professional services (“the fee schedule”). The fee schedule contains payment rates for over 7,000 distinct services, classified using the Healthcare Common Procedure Coding System (HCPCS). Payment rates are based on relative weights, called relative value units (RVUs), which account for the amount of work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. Collectively, these three components make up the Resource-based Relative Value Scale. Together with the fee schedule’s conversion factor (or base payment amount), the RVUs produce a total payment rate for each service. CMS, with input from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), revises the RVUs for some services each year based on changes in clinical practice, new data, and other factors. In addition, CMS annually sets RVUs for new and revised HCPCS codes.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a new set of updates for clinicians billing under the fee schedule and repealed the prior framework—the sustainable growth rate (SGR) formula—that set the conversion factor.¹ The SGR was established to limit total fee schedule spending by restraining annual updates when spending exceeded certain parameters. MACRA provided a new framework for updating fee schedule payments. It established two payment paths: one path for clinicians who participate in advanced alternative payment models (A-APMs), such as certain accountable care organization and episode of care models, and another path for other clinicians known as the Merit-based Incentive Payment System (MIPS) (Medicare Payment Advisory Commission 2018). The Commission has recommended that the Congress eliminate MIPS and establish a new voluntary value program in fee-for-service (FFS) Medicare (Medicare Payment Advisory Commission 2018). MACRA established incentive payments for clinicians who participate in A-APMs to encourage them to move toward these models. A-APMs generally require participating entities to assume financial risk for their patients, which encourages providers to

improve care coordination and quality while controlling cost growth.

However, it is still important to ensure the accuracy of fee schedule prices under traditional FFS Medicare because many beneficiaries remain in traditional FFS. In addition, all A-APM models use FFS payment rates as either the basis of payment or the reference price for setting the global or bundled payment amount. Further, the benchmarks used to determine payments to Medicare Advantage plans are based on FFS spending, which reflects fee schedule payment rates. Moreover, many commercial plans use RVUs from the fee schedule to determine their own payment rates for clinicians.

Pricing distortions can influence the mix of services provided by clinicians by encouraging them to focus on services that are relatively more profitable than others, leading to volume increases for the higher profit services. Some of these additional services may represent low-value care, which refers to services that have little or no clinical benefit or care in which the risk of harm from the service outweighs the potential benefit (see Chapter 10 in this report on Medicare coverage policy and use of low-value care). In addition to increasing health care spending, low-value care has the potential to harm patients by exposing them to the risk of injury from inappropriate tests or procedures.

Ambulatory evaluation and management (E&M) services—which we define as office visits, hospital outpatient department visits, visits to patients in certain other settings such as nursing facilities, and home visits—are essential for a high-quality, coordinated health care delivery system. These visits enable clinicians to diagnose and manage patients’ chronic conditions, treat acute illnesses, develop care plans, coordinate care across providers and settings, discuss patient preferences, and engage in shared decision-making with patients. These services are critical for both primary care and specialty care. Therefore, to ensure that clinicians have an incentive to provide ambulatory E&M visits, these services should not be priced too low relative to other services.

In this chapter, we first discuss why ambulatory E&M services tend to be underpriced in the fee schedule and evidence that the prices for other services are inflated. We then suggest an approach to rebalance the fee schedule toward ambulatory E&M services through a one-time price increase for these services that would be funded by reducing payment rates for other services.

Ambulatory E&M services are underpriced relative to other services

When CMS implemented the fee schedule in 1992, one of the main goals was to reduce payment disparities between primary care physicians and specialists (Ginsburg 2012, Laugesen 2016). A large share of services provided by primary care physicians are ambulatory E&M services. From 1991 to 1996 (a period that includes the first five years of the new fee schedule), payment rates for office and hospital outpatient visits grew by 4.3 percent per year and rates for nursing facility/rest home visits increased by 9.4 percent per year (Medicare Payment Advisory Commission 1998). During this period, payment rates for most types of procedures and imaging declined (e.g., rates for cataract lens replacement fell by 6.5 percent per year). However, CMS's review of certain fee schedule services in 1996 and 2001 led to substantially more services receiving higher prices than lower prices (Medicare Payment Advisory Commission 2006b). The budget-neutral nature of the fee schedule means that raising prices for certain services leads to lower prices for others, such as ambulatory E&M services. These issues led the Commission to express concern in 2006 that ambulatory E&M services were underpriced relative to other types of services (Medicare Payment Advisory Commission 2006b).

Using recommendations from the RUC, CMS increased work RVUs for several E&M services in 2007 and 2008, such as office and hospital outpatient visits. In addition, practice expense RVUs for E&M services increased between 2007 and 2013 because CMS adopted new methods and new data to calculate practice expense values (Medicare Payment Advisory Commission 2007, Medicare Payment Advisory Commission 2011b). Since 2013, however, payment rates for office and outpatient visits have changed very little. For example, total RVUs for a Level III office or outpatient visit for an established patient (HCPCS 99213), the most frequently billed office or outpatient visit, declined slightly from 2.14 in 2013 to 2.06 in 2018.² Therefore, the Commission remains concerned that ambulatory E&M services are underpriced relative to other services.

The Commission has made prior recommendations to increase payment rates for ambulatory E&M services provided by certain clinicians (see text box on the Commission's prior recommendations). One of these recommendations—a temporary bonus for certain E&M services provided by designated clinicians—was adopted but expired in 2015.

As services experience efficiency gains, their work RVUs should decline but often do not

Work RVUs for clinician services are based on an assessment of how much time and intensity services require relative to one another. Intensity refers to the mental effort, technical skill, psychological stress, and risk of performing a service. If estimates of time and intensity are not kept up to date, especially for services that experience efficiency improvements, the work RVUs become inaccurate.

Procedures, imaging, and tests are more likely to experience efficiency gains than ambulatory E&M services

Due to advances in technology, technique, and clinical practice, efficiency gains are more likely to occur for procedures, imaging, and tests than for other services. For example, when a new test or procedure is added to the fee schedule, it may be assigned a relatively high work RVU because of the additional time, technical skill, mental effort, and risk associated with performing the service. Over time, however, as clinicians become more familiar with the service and more efficient at performing it, they can complete it faster and with less mental effort, skill, and risk (Medicare Payment Advisory Commission 2006b).

Ambulatory E&M services, by comparison, tend to be labor intensive and so do not lend themselves to efficiency gains (Medicare Payment Advisory Commission 2008). They are composed largely of activities that require the clinician's time, such as taking the patient's history, examining the patient, and engaging in medical decision-making.

Because the time and effort needed to perform procedures, imaging, and tests generally declines over time, clinicians should be able to provide more of these services per day. However, because it is more difficult to achieve efficiency gains for ambulatory E&M services, we can expect lower volume growth for these services. As evidence, the cumulative growth in the volume of E&M services from 2000 to 2016 was much less than the cumulative growth in the volume of tests, imaging, and other procedures (Figure 3-1, p. 72).

Ambulatory E&M services experience passive devaluation over time

Ideally, when efficiency gains reduce the amount of work needed for a service, the work RVUs for the affected services should decline accordingly. Because the fee schedule is budget neutral, a reduction in the RVUs of

Prior Commission recommendations to improve payment for ambulatory E&M services

The Commission has made prior recommendations to increase payment rates for ambulatory evaluation and management (E&M) services provided by certain clinicians relative to other services. In 2008, the Commission recommended that the Congress establish a bonus for designated ambulatory E&M services billed by eligible primary care practitioners (Medicare Payment Advisory Commission 2008). The designated E&M services included office visits, home visits, and visits to patients in certain other settings (e.g., skilled nursing and intermediate care facilities). Eligible primary care practitioners included clinicians whose designated specialty is primary care (e.g., family medicine) and who received at least 60 percent of their fee schedule–allowed charges from ambulatory E&M services.³ To help rebalance the fee schedule, the Commission recommended that spending for the bonus be budget neutral. While the Commission did not recommend a specific amount, we analyzed two levels for the bonus: 5 percent and 10 percent.

In response to this recommendation, the Patient Protection and Affordable Care Act of 2010 created a temporary primary care bonus program called the Primary Care Incentive Payment (PCIP) program. However, the program was not budget neutral and thus required additional funding. The PCIP, which existed from 2011 to 2015, provided a 10 percent bonus payment on fee schedule payments for certain primary care visits provided by eligible primary care practitioners. The PCIP’s definitions for these terms were as follows:

- **Primary care visits** were ambulatory E&M services (e.g., office visits, home visits, and visits in skilled nursing facilities) (Centers for Medicare

& Medicaid Services 2010). E&M services in inpatient hospital settings and emergency departments, annual wellness visits, chronic care management services, and transitional care management services were not considered primary care visits under the PCIP.

- **Primary care providers** included providers with a primary Medicare specialty designation of family practice, internal medicine, pediatrics, geriatrics, nurse practitioner and clinical nurse specialist, and physician assistant and for whom primary care visits accounted for at least 60 percent of allowed charges under the fee schedule.

In 2011, the Commission recommended that the Congress replace the sustainable growth rate (SGR) system with payment updates that would have been higher for certain E&M services billed by eligible primary care practitioners than for other services (Medicare Payment Advisory Commission 2011a). Specifically, the Commission recommended that payment rates for certain E&M services be frozen at their current levels for 10 years and rates for all other services be reduced in each of the first 3 years and then frozen for the subsequent 7 years. Although the SGR was replaced, the Congress did not adopt differential updates for E&M services and other services.

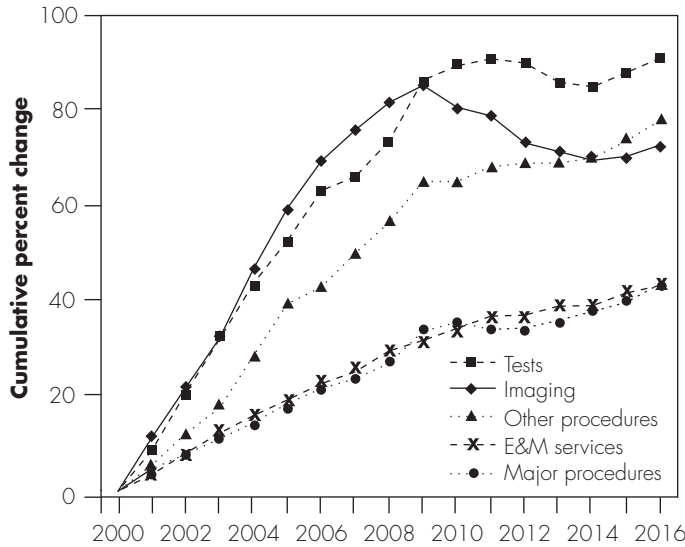
In addition to recommendations specific to the fee schedule, the Commission recommended that the Congress establish a per beneficiary payment for primary care providers to replace the PCIP after it expired at the end of 2015 (Medicare Payment Advisory Commission 2015). The payment would provide funds to support the investment in infrastructure and staff that facilitate care management and care coordination. ■

these services would raise the RVUs for all other services, such as ambulatory E&M services. Because of problems with the process of reviewing mispriced services and the data used to set prices, this two-step sequence tends not

to occur. Therefore, ambulatory E&M services become passively devalued over time. In other words, their relative prices are too low because the prices for other services have become artificially high.

FIGURE 3-1

Cumulative growth in the volume of E&M services per fee-for-service beneficiary was much less than growth in volume of tests, imaging, and other procedures, 2000-2016



Note: E&M (evaluation and management). Volume growth for E&M services from 2009 to 2010 is not directly observable because of a change in payment policy for consultations. To compute cumulative volume growth for E&M services through 2016, we used a growth rate for 2009 to 2010 of 1.85 percent, which is the average of the 2008 to 2009 growth rate of 1.7 percent and the 2010 to 2011 growth rate of 2.0 percent.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

CMS’s review of potentially mispriced services has not been sufficient

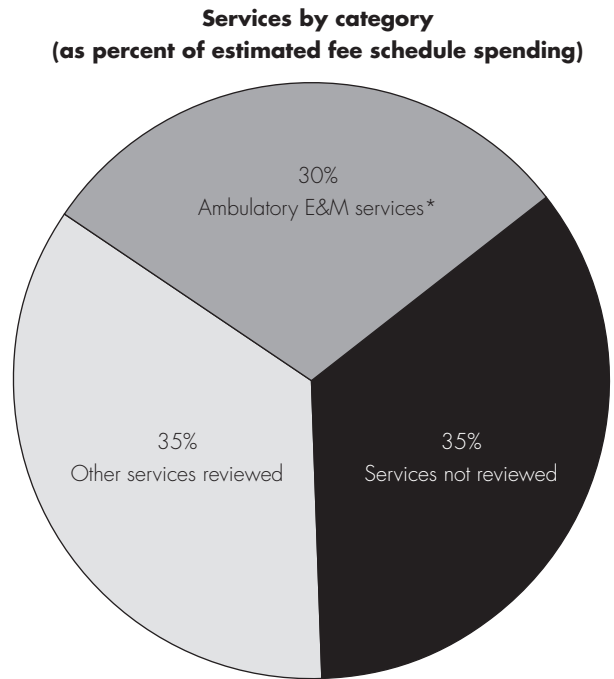
CMS, with assistance from the RUC, has reviewed the work RVUs of many potentially mispriced services since 2009, but has not yet addressed services that account for a substantial share of fee schedule spending.⁴ After a service has been identified as potentially misvalued, it can often take several years for the RUC to develop a recommendation for that service (Government Accountability Office 2015). CMS’s review is also hampered by the lack of current, accurate, and objective data on clinician work time and practice expenses. Even among the services for which CMS reduced the work RVUs, the RVUs did not decline as much as the estimated amount of time needed to provide the services.

Although CMS’s review of potentially mispriced services began in 2009, the agency has not yet reviewed many

services. Services that have had their work RVUs reviewed since 2009—whether new services, revised services, or services reviewed as potentially mispriced—accounted for 35 percent of fee schedule spending in 2016 (Figure 3-2). Services that have not yet been reviewed accounted for an additional 35 percent of fee schedule spending. If CMS were to review these services, the agency could identify mispriced services and redistribute payments from overpriced to underpriced services. Ambulatory E&M services accounted for the remaining 30 percent of fee schedule spending, and CMS updated the payment rates for many of these services in 2007 and 2008.

FIGURE 3-2

CMS has not yet reviewed the work RVUs of services that accounted for a significant share of fee schedule payments, 2016



Note: RVU (relative value unit), E&M (evaluation and management). Percentages are each category’s share of total fee schedule-allowed charges in 2016. Services that had their work RVUs reviewed are those listed in fee schedule final rules for 2009 to 2016 as new, revised, or potentially misvalued or reviewed during the fourth five-year review. Ambulatory E&M services include office visits, home visits, and visits to patients in certain other settings (e.g., nursing facilities). *CMS increased payment rates for many of these services in 2007 and 2008.

Source: CMS fee schedule final rules and MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

**TABLE
3-1**

The RUC recommended a decrease in work RVUs for approximately half of the potentially mispriced services for which it reviewed work RVUs, 2009–2017

Work RVUs	Number of services	Percent of services reviewed
No change	647	39%
Increase	210	13
Decrease	<u>795</u>	<u>48</u>
Total	1,652	100

Note: RUC (Relative Value Scale Update Committee), RVU (relative value unit). The RUC examined a total of 2,220 services from 2009 to 2017. Work RVUs were reviewed for 1,652 services, practice expense RVUs (but not work RVUs) were revised for 158 services, and billing codes were deleted for 410 services.

Source: American Medical Association 2017.

CMS and the RUC have identified potentially mispriced services for review. From 2009 to 2017, the RUC recommended lower work RVUs for only half of the potentially mispriced services for which it reviewed work RVUs, a somewhat counterintuitive outcome given that CMS and the RUC identified services for review that were likely to be overpriced (Table 3-1). According to an American Medical Association progress report, the RUC reviewed work RVUs for 1,652 services as of October 2017 (American Medical Association 2017).⁵ The RUC recommended that CMS decrease the work RVUs for 795 services (48 percent) but recommended no change for 647 services (39 percent) and increases for 210 services (13 percent).⁶ The RUC used several screening criteria to identify potentially mispriced services for review, such as services with new technology, surgical procedures that are performed less than half the time in inpatient settings but include inpatient E&M services in their payment rates, services with rapid volume growth, and services that are frequently performed together by the same physician on the same date. These types of services are more likely to be overpriced than underpriced, and thus the majority of services identified with these criteria should have been candidates for RVU reductions. For example, the amount of time required for services that experience rapid volume growth should decline over time as clinicians become more familiar with these services and can perform them faster. Therefore, we would have expected the RUC to have recommended lower work RVUs for more than half of the services they reviewed.

Even among the services for which CMS reduced the work RVUs, the decreases were not consistent with

reductions in the estimated amount of time needed to provide the services. The statute defines the work of clinicians as consisting of the time spent providing a service and the intensity of work effort per unit of time (e.g., mental effort and technical skill). For a number of services, CMS (with input from the RUC) reduced the estimated amount of time that clinicians spend providing these services and the work RVUs for these services. However, CMS did not reduce the work RVUs for these services as much as the time estimates: The agency decreased the time estimates by an average of 18 percent but decreased the work RVUs by an average of 9 percent (Table 3-2). A potential explanation for this disparity is that decreases in time were offset by increases in intensity. In the absence of an increase in intensity, CMS could have reduced work RVUs by the same percentage as the time estimates, thereby making it possible to redistribute more money to other services.

**TABLE
3-2**

Time estimates have decreased more than work RVUs, 2008–2016

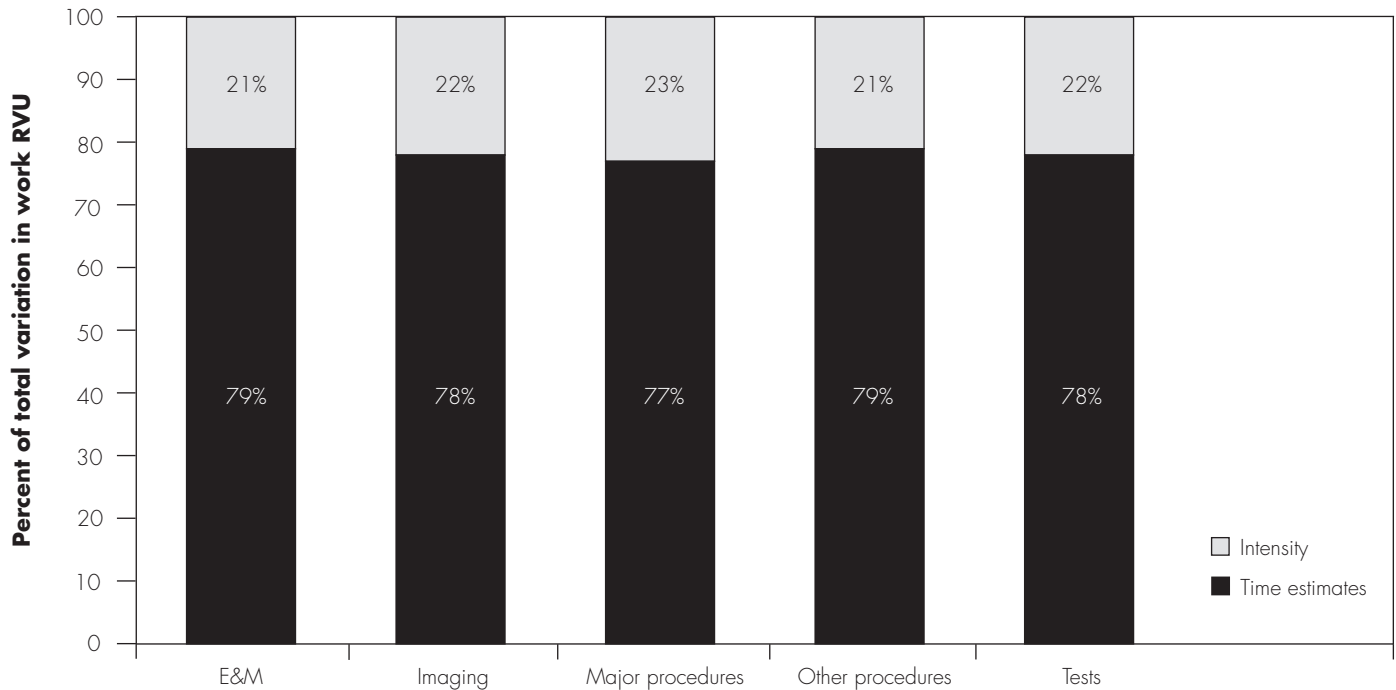
	Average percent change
Time estimates	-18%
Work RVUs	-9

Note: RVU (relative value unit). Table reflects changes to RVUs adopted by CMS. The 607 services evaluated had work RVUs and work-time estimates in 2008 and 2016 and had a decrease in work RVUs, a decrease in the work-time estimate, or both.

Source: MedPAC analysis of physician time and RVU files from CMS.

**FIGURE
3-3**

Fee schedule's time estimates are most important factor in establishing work RVUs, 2017



Note: RVU (relative value unit), E&M (evaluation and management). The percentages for time estimates are from five regression analyses: one for each service type. In these analyses, the log of estimated time was the explanatory variable, and the log of work RVU was the dependent variable. The percentages for intensity are the differences between the estimated time percentages and 100 percent.

Source: MedPAC analysis of time data and work RVUs from CMS.

The data used to price services are inadequate

CMS's lack of comprehensive, current, and objective data on clinician work time and practice expense is a key reason the process for reviewing and revising mispriced services has been inadequate. Clinician work time is a key component of work RVUs. To estimate clinician work time for specific services, CMS relies on data from surveys conducted by specialty societies that are reviewed by the RUC. We have three main concerns about the objectivity and quality of these data. First, the specialty societies that conduct the surveys have a financial stake in the process of setting payment rates. Second, the survey data have weaknesses that include low response rates and low total number of responses, which raises questions about the representativeness of the results. For example, the Government Accountability Office found that, for services

surveyed by specialty societies for payment year 2015, the median response rate to surveys was only 2.2 percent, the median number of responses to surveys was 52, and 23 of 231 surveys had fewer than 30 respondents (Government Accountability Office 2015). Third, the respondents are generally aware of the purpose of the survey (to set payment rates), and therefore their responses may be biased in favor of higher time estimates.

To address this problem, the Commission recommended in 2011 that CMS use a streamlined method to regularly collect data from a cohort of efficient practices—including service volume and work time—to establish more accurate work and practice expense RVUs (Medicare Payment Advisory Commission 2011a). CMS's response has been to contract with researchers to develop models to validate the RVUs. These models attempt to validate the time estimates for services one by one (e.g., through time-and-

motion studies). The Commission's concern has been that this approach is time consuming, costly, and likely to be burdensome for providers and CMS. However, it may be useful for identifying specific services that are potentially misvalued.

The Commission has recommended a different, “top-down” approach to validate the RVUs (Medicare Payment Advisory Commission 2011b). This method looks at the amount of time that a physician worked over the course of a week or month and compares it with the time estimates in the fee schedule for all of the services that the physician billed over the same period. If the fee schedule's time estimates exceed the actual time worked, this finding could indicate that the time estimates are too high. In 2014, a contractor for the Commission explored the feasibility of the top-down approach by collecting data from a small set of physician practices on the services billed by their clinicians and the clinicians' actual hours worked (Medicare Payment Advisory Commission 2015). If CMS used a top-down approach to validate RVUs, it could identify groups of services that are likely overpriced, carefully review those services, and price them more accurately.

Evidence that estimates of clinician work time are inflated

Contractors working for CMS and the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services have gathered evidence that the fee schedule's time estimates for clinician work are inflated (Merrell et al. 2014, Zuckerman et al. 2016). While there was heterogeneity in the data and methods used by the contractors, the findings were consistent: The time assumptions for a broad range of services in the fee schedule—particularly imaging, procedures, and tests—are inflated when compared with ambulatory E&M services. Indeed, errors in some of the fee schedule's time assumptions were very large—multiples of the actual time spent by physicians. The Commission's position is that the time assumptions—and, therefore, the fee schedule's work RVUs—should be validated and corrected. In the meantime, a budget-neutral payment adjustment would appropriately rebalance the fee schedule toward ambulatory E&M services.

The contractors focused on estimates of the time that it takes clinicians to furnish services to a typical patient. These time assumptions are important because they are highly predictive of the work RVUs. Depending on the

type of service, time explains over 75 percent of the variance in work RVUs (Figure 3-3).

The contractors collected data from diverse sources: administrative data on service volume and physician hours worked, physician surveys, time-and-motion studies, and electronic health records. They analyzed the data using either a top-down approach or a bottom-up approach, which examines each service separately. Although a bottom-up approach is costly, the findings from this method illustrate significant distortions in the time estimates for common services.

Specialties other than primary care had the largest differences between time assumed in the fee schedule and actual time worked

The intent of the project for ASPE was to better understand whether there are systematic differences or errors in the fee schedule's time assumptions across specialties or groups of services. The contractor acquired data from three integrated delivery systems (IDSs): one located in the West, one in the Midwest, and one in the eastern United States (Merrell et al. 2014). To assess the accuracy of the time assumptions from a top-down perspective, the contractor collected administrative data on service volume by physician and billing code. These service volumes were multiplied by the code-specific time assumed in the fee schedule and summed for each physician to calculate “fee schedule time.” Data were also collected on “actual time worked,” calculated based on clinical practice days per year, clinical hours per year, or a full-time equivalent measure, depending on the IDS. The accuracy of the fee schedule's time assumptions was analyzed as the ratio of fee schedule time to actual time worked.⁷

Analyzing the differences between fee schedule time and actual time worked, the contractor concluded that the fee schedule's time assumptions may be distorted for some specialties. Specifically, their findings are consistent with the conclusion that primary care is disadvantaged by the current time assumptions (Table 3-3, p. 76). The median ratio of fee schedule time to actual time worked, when evaluated across all specialties, was 1.35. However, the ratio for radiology was higher, at 2.00; the ratio for cardiology was highest, at 2.08. By contrast, the ratios were lowest for pathology, general surgery, and primary care at 1.14, 1.16, and 1.25, respectively. Primary care specialties tend to concentrate on ambulatory E&M services.

**TABLE
3-3**

Primary care physicians' ratio of fee schedule time to actual time is below the median for all physicians

Specialty	Number of physicians	Median ratio of fee schedule time to actual time
Pathology	31	1.14
General surgery	53	1.16
Primary care	231	1.25
Orthopedic surgery	45	1.35
All other specialties	345	1.36
Radiology	57	2.00
Cardiology	44	2.08
All	806	1.35

Note: "Primary care" includes family medicine and internal medicine. "Fee schedule time" refers to the work time assumed in the fee schedule for the services provided by each physician. "Actual time" refers to the actual time worked by each physician, based on their clinical practice days per year, clinical hours per year, or a full-time equivalent measure.

Source: Merrell et al. 2014.

Findings suggest that the fee schedule's time estimates for services other than ambulatory E&M services are inflated

Two projects that examined each service separately suggest that the fee schedule's time assumptions for services other than ambulatory E&M services are likely too high. One study was a pilot project for CMS on validating the time assumptions for 60 services with data gathered from both electronic health records and direct observation of the care received by individual patients (Zuckerman et al. 2016). The other project, for ASPE, assessed the feasibility of validating the time assumptions for 26 services with data from a survey in which physicians were asked how many minutes they typically spend when furnishing each of the services (Merrell et al. 2014).

Pilot project for CMS The pilot project for CMS included developing empirical measures of physician service time for specific services (Zuckerman et al. 2016). The contractor measured time in one of two ways, depending on the service and data collection site.⁸ First, administrative data were extracted from electronic health records (EHRs) for some services. EHRs include time stamps for each recorded event (e.g., start of a procedure). The contractor calculated the service time in minutes with start and end time stamps, excluding minutes associated with any documented interruptions or pauses. The second

data source was direct observation—project or physician practice staff observing and documenting the time needed to provide services to individual patients. The direct observation data were collected at three sites in different regions of the U.S.: Mid-Atlantic, New England, and Pacific. EHR data were available from two of the sites.

In selecting services for the project, researchers considered a service's risk of being misvalued and its importance to Medicare because of total spending on the service or other policy reasons. Researchers also selected a mix of services that would allow them to test methods in a variety of clinical settings.⁹ The services were of four types: office-based procedures, outpatient department or ambulatory surgical center procedures, inpatient procedures with global periods, and imaging and other test interpretations. E&M services were not included.

In interpreting the results, the contractor concluded that the fee schedule's time assumptions were often high relative to the empirical time captured in their study. For 42 of the 60 services studied, the ratios of fee schedule time to empirical time were over 1.1, based on the data collected (Table 3-4). The largest discrepancies were in imaging and other test interpretations. Electrocardiogram report—the extreme case—had a fee schedule time of 5 minutes but a median study time of only 6 seconds, making the fee schedule time 50 times the actual time observed. Other

imaging and test interpretations had smaller discrepancies, but fee schedule times were still multiples of empirically based medians. Clinical expert reviewers consulted by the contractor attributed the discrepancies to automation and personnel substitution that has become prevalent since CMS and the RUC defined the content of the services and valued them.

Feasibility study for ASPE The contractor for ASPE surveyed physicians in five specialties: cardiology, family medicine, radiology, ophthalmology, and orthopedic surgery (Merrell et al. 2014). Each physician was asked about the time spent providing selected services relevant to their specialty. The 26 services selected—an average of 5 per specialty—were frequently provided, such as echocardiogram, office visits, computed tomography of the abdomen, cataract removal with lens insertion, and knee arthroplasty.¹⁰

A total of 625 physicians participated in the survey. Questionnaires were administered through mixed modes: mail and internet, with telephone prompts performed by interviewers trained to solicit participation. Some of the physicians were from random samples drawn from the American Medical Association Physician Masterfile.¹¹ Others were from multispecialty group practices that agreed to participate. Two of these practices were in the South, three in the West, one in the Midwest, and one in the Mid-Atlantic. The survey was administered from November 2013 through July 2014. Participants were offered a financial incentive to encourage adequate response to the survey. The response rate was 54 percent.

The contractor summarized the survey results as suggesting that, for the majority of the 26 services, the fee schedule’s time assumptions are high. At the time of the study, for example, photocoagulation of the retina had the highest ratio of fee schedule time assumption to median survey time estimate: 3.78. In other words, the fee schedule time assumption was almost four times the survey estimate. The service’s time assumption was 208 minutes, but its median time estimate from the survey was 55 minutes.¹² Another example is MRI of the brain, for which the fee schedule time assumption was more than twice the survey time estimate. By contrast, the ratios for the three ambulatory E&M services in the survey—Level III and Level IV office visits for established patients and Level IV office visit for new patients—were 1.05, 1.00, and 1.00, respectively. Overall, most services (20 of 26) had fee schedule time assumptions that were higher than their median survey time estimates.

**TABLE
3-4**

Ratios of fee schedule time to empirical measures of physician time were over 1.1 for most services reviewed

Ratio of fee schedule time to empirical physician time	Number of services
Under 0.9	8
0.9 to 1.1	10
Over 1.1	42
Total	60

Note: “Fee schedule time” refers to the work time assumed in the fee schedule. “Empirical physician time” is based on data from electronic health records or direct observation of the time needed to provide services to individual patients.

Source: Zuckerman et al. 2016.

To summarize the results by specialty, each physician’s response for a service was categorized as implying that the fee schedule’s time assumption for that service was too high, too low, or about right (Table 3-5, p. 78). Overall, the rate at which physicians said that fee schedule times were too high was almost 58 percent. However, by specialty, the rate ranged from a high of about 72 percent for radiologists to a low of almost 44 percent for family medicine. The rate for family medicine means that the survey participants in this specialty were more likely to say that fee schedule times were too low or about right than they were to say that those times were too high.

Evidence that RVUs for global surgical services are inflated

Currently, the payment rate for many surgical services is a bundled payment that includes the procedure itself and certain services that are provided immediately before and after the procedure; CMS calls this group of services the global package. There are three categories of global billing codes based on the number of postoperative days included in the global package:

- 0-day global codes, which include the procedure and preoperative and postoperative physician services on the day of the procedure;

**TABLE
3-5**

Specialties other than family medicine physicians were more likely to report fee schedule times that were too high

Specialty	Total number of service-level responses	Percent of survey responses that suggest fee schedule time is:		
		Too high	About right	Too low
Family medicine	582	43.8%	10.7%	45.5%
Cardiology	469	50.5	14.9	34.5
Orthopedics	530	59.1	8.1	32.8
Ophthalmology	443	66.1	2.7	31.2
Radiology	496	72.4	3.4	24.2
All	2,520	57.8	8.1	34.1

Note: Fee schedule time was defined as “too high” if the fee schedule time exceeded the survey time estimate by more than 5 percent. “About right” means that the fee schedule time was within 5 percent of the survey time. “Too low” indicates that the fee schedule time was lower than the survey time by more than 5 percent. Each specialty’s shares may not sum to 100 due to rounding.

Source: Merrell et al. 2014.

- 10-day global codes, which include the same services as the 0-day global codes plus physician visits related to the procedure during the 10 days after the procedure; and
- 90-day global codes, which include the same services as the 0-day global codes plus preoperative services furnished one day before the procedure and postoperative services during the 90 days after the procedure.

In general, the Commission supports moving Medicare in the direction of bundled payments to counter the volume incentives intrinsic to FFS Medicare. However, it is essential that the individual services that make up a bundle have accurate values and that there is a mechanism to ensure that the services that are part of the bundle are not paid separately (unbundling). Otherwise, the payment rate for the entire bundle will be inaccurate.

CMS has raised several concerns with the 10-day and 90-day global packages for surgical services (Centers for Medicare & Medicaid Services 2014):

- The number and type of visits needed in the package for a given service are likely to change over time as medical practice and the patient population changes.
- There is a lack of consistency in how the work RVUs for global codes are constructed (e.g., services may have work RVUs that are the sum of each component

of the global package or just a single value for all components of the package).

- The global codes contribute to payment disparities among specialties.
- The global packages are inconsistent with current medical practice (e.g., care has been shifting from individual practitioners to larger practices and teams).

CMS also cited evidence from the Office of Inspector General (OIG) that the RVUs for global codes may not reflect the typical number and level of postoperative visits (Office of Inspector General 2012a, Office of Inspector General 2012b). OIG reviewed a sample of medical records for several types of global surgical codes and counted the number of postoperative E&M visits provided by the physicians. In many cases, OIG found that physicians provided fewer E&M visits during the postoperative period than were included in the payment for the global package. OIG recommended that CMS adjust the number of E&M visits in the global package to reflect the number that are actually provided.

The global payment assumes that the same physician who performs the procedure also provides all the postoperative care. However, a study by the RAND Corporation for CMS observed that postoperative care is shifting from the physician who performed the

procedure to other clinicians, such as hospitalists and nonphysician practitioners, who bill separately for each postoperative visit (Mehrotra et al. 2016). This change suggests that physicians who bill for the global payment may be receiving payments for postoperative care that is provided by other clinicians.

CMS proposed to convert all 10-day global codes to 0-day codes in 2017 and convert all 90-day codes to 0-day codes in 2018. With these changes, providers would bill separately for all preoperative visits and postoperative visits that occur after the day of the procedure. However, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) directed CMS to not transition all 10-day and 90-day global codes to 0-day codes. Instead, MACRA mandated that CMS develop and implement a process to gather the necessary data to appropriately value postoperative care. CMS is currently collecting the data.

The available evidence from CMS, OIG, and RAND suggests that 10-day and 90-day global surgical services are overvalued. It may take CMS several years to collect data and revalue these services. In the meantime, a budget-neutral payment adjustment for ambulatory E&M services—excluding the ambulatory E&M services currently considered when valuing global packages—would rebalance the fee schedule toward ambulatory E&M services.

Problems with the accuracy of practice expense RVUs

In addition to the shortcomings with the data used to estimate clinician work time, there are also major problems with the accuracy of the data used to set practice expense RVUs. Practice expense includes the cost of nonphysician clinical and administrative staff, medical equipment and supplies, office rent, and other expenses. First, CMS does not have a comprehensive data source with current information on the prices of medical equipment and supplies; consequently, the price estimates for these items are often outdated (Medicare Payment Advisory Commission 2006a). Second, practice expense RVUs are also based on data from a survey of total practice costs incurred by nearly all specialty groups. Because this survey was conducted in 2007 and 2008, the data are unlikely to reflect current practice costs. CMS has not developed a strategy for updating this information. However, CMS could collect data on total practice costs along with data on service volume and work time from a cohort of efficient practices, as the

Commission recommended in 2011 (Medicare Payment Advisory Commission 2011a).

An approach to rebalance the fee schedule toward ambulatory E&M services

Despite efforts made by CMS and the RUC over the last several years to review potentially mispriced services and adjust their payment rates, there is evidence that certain types of services—such as procedures—are still overpriced. Because the fee schedule is budget neutral, ambulatory E&M services become underpriced through a process of passive devaluation. One approach to rebalance the fee schedule toward ambulatory E&M services is to increase payment rates for these services and to maintain budget neutrality by reducing payment rates for other services (e.g., procedures, imaging, and tests). Because these services are essential for both primary care and specialty care, the higher payment rates should apply to all clinicians who bill for an ambulatory E&M visit, regardless of specialty. This change would be a one-time price adjustment to the fee schedule to address several years of passive devaluation of ambulatory E&M services. This adjustment could be phased in over multiple years to reduce the impact on other services. To reduce the need for future significant price changes and to address the mispricing of individual services, CMS should accelerate its efforts to identify overpriced services and adjust their payment rates. To do so, CMS should regularly collect data from a cohort of efficient practices and use this information to validate payment rates and establish accurate RVUs.

Design issues

A key design issue is which ambulatory services should be included in the payment increase. For the purpose of this approach, we included E&M billing codes for office visits, home visits, and visits to patients in certain non-inpatient hospital settings (nursing facility, domiciliary, rest home, and custodial care). We excluded newer E&M services that were added to the fee schedule in recent years because they have not been subject to several years of passive devaluation. For example, we excluded annual wellness visits (added to the fee schedule in 2011), transitional care management services (added in 2013), and chronic care management services (added in 2015 and 2017). We also considered whether to include

ambulatory psychiatric visits in the payment increase. Like ambulatory E&M services, many ambulatory psychiatric services are time-based services that do not lend themselves to efficiency gains (e.g., HCPCS code 90834 is for a 45-minute psychotherapy visit). However, we excluded them from the payment increase that we model below because the payment rates for most of these services were updated in recent years. Nevertheless, policymakers could consider applying a payment increase to the newer E&M and ambulatory psychiatric services in addition to ambulatory E&M services.

Another important design issue is the size of the payment increase for ambulatory E&M services. Although these services have become passively devalued, we were not able to precisely quantify how much these services are underpriced. We considered an increase in the range of 5 percent to 30 percent. If policymakers decided to make a one-time price adjustment to ambulatory E&M services, they would need to make a policy judgment about the appropriate increase. One precedent to consider is the Primary Care Incentive Payment program, which, from 2011 through 2015, provided a 10 percent bonus for certain E&M visits provided by eligible primary care practitioners (see text box, p. 71). To illustrate the impact of a budget-neutral payment increase for ambulatory E&M services, we modeled a 10 percent increase. However, a smaller or larger adjustment could also be considered. Our model assumes that the increase would apply to both Medicare program payments and beneficiary cost sharing so that cost sharing would continue to equal 20 percent of the total payment amount for a fee schedule service, which is the current policy. As a result, beneficiary cost sharing would increase for ambulatory E&M services but decline for all other services. Total cost sharing across all services would remain about the same.

CMS could increase payment rates for ambulatory E&M services in a budget-neutral manner by raising total RVUs for these services while reducing RVUs for all other services.¹³ Alternatively, CMS could create two different conversion factors: a higher one for ambulatory E&M services and a lower one for all other services.¹⁴ Currently, CMS uses a single conversion factor to calculate payment rates for all fee schedule services. The first approach is consistent with CMS's current method for adjusting practice expense RVUs; if RVUs for some services go up, RVUs for other services decline by a corresponding amount. This approach also makes it simpler to apply the same update to all fee schedule

services because there is a single base payment amount. Moreover, it would increase the reach of the policy beyond Medicare because many commercial plans use the fee schedule's RVUs to determine their payments to clinicians. The second approach would make it easier for policymakers to establish payment updates for ambulatory E&M services that are different from updates for other services in the future. Under either approach, the end result is the same: Clinicians would receive a higher payment rate for ambulatory E&M services and a lower rate for other services. The results of our illustrative model, described below, would be the same under either approach.

Another critical design question is how to offset the increase in fee schedule payments for ambulatory E&M services in a budget-neutral manner. We describe three options:

- an automatic reduction to the prices of new services (after a certain amount of time) and services with high growth rates,
- an extension of the annual numeric target for CMS to reduce the prices of overpriced services, and
- an across-the-board reduction to all fee schedule services other than ambulatory E&M services.

Under the first option for budget neutrality, there would be an automatic adjustment to the prices of new services to ensure that prices declined over time, consistent with the expectation that the amount of time and effort required for new services should decline over time because of advances in technology, technique, and other factors (Medicare Payment Advisory Commission 2006b). Because the payment rates for new services are not updated frequently enough to reflect reductions in time and effort, these services tend to become overpriced. An automatic reduction triggered after a certain number of years would ensure that payment rates did not remain too high. Services that were recently reviewed by the RUC and CMS and had their RVUs reduced could be exempt from an automatic reduction. An automatic reduction could also apply to services that experience high volume growth because the dynamic of learning by doing that applies to new technology should also apply to services that are being provided more frequently. Savings from this automatic reduction could be used to offset increased payments for ambulatory E&M services.

Under the second option for budget neutrality, there would be an extension of the annual numeric target set by the Congress for CMS to reduce the prices of overvalued services. The Congress set this target for a three-year period (2016 through 2018). The target was set at 1 percent of fee schedule spending for 2016 and 0.5 percent for 2017 and 2018. (CMS did not meet the target in any of the three years, which meant that payment rates for all fee schedule services were reduced by the difference between the target and the actual aggregate reduction to the RVUs of overpriced services.) The annual numeric target was based on a Commission recommendation from 2011 (Medicare Payment Advisory Commission 2011a). Under this option, the target would be extended beyond 2018 and the cumulative target amount would be based on the total amount of money to be redistributed to ambulatory E&M services. For example, a cumulative target amount of 4 percent of fee schedule spending could be phased in through an annual 1 percent target over four years. Savings achieved by reducing the prices of overpriced services would be redistributed to ambulatory E&M services.¹⁵ If CMS did not meet the target, payment rates for *all* fee schedule services other than ambulatory E&M services would be reduced by the difference between the target and the actual reduction to the prices of overpriced services. These savings would be redistributed to ambulatory E&M services.

Under the third option, the payment increase for ambulatory E&M services would be offset by an across-the-board payment reduction to all other fee schedule services (procedures, imaging, tests, and other E&M services such as those provided in emergency department and inpatient hospital settings). To fully offset a 10 percent payment increase for ambulatory E&M services, for example, there would need to be a payment decrease of 3.8 percent for all other fee schedule services. These payment changes could be implemented in one year or phased in gradually over multiple years. This estimate assumes that there would be no changes in service volume as a result of the changes in payment rates.

Modeling the net effect of a payment increase for ambulatory E&M services

To illustrate the impact of a budget-neutral payment increase for ambulatory E&M services, we modeled a 10 percent increase that would be offset by a 3.8 percent across-the-board payment reduction to all other fee

schedule services (the third budget-neutrality option described above). Other alternatives could be considered for the size of the payment increase and how to offset the increase. Our model assumes that the payment changes would occur in a single year, but the changes could instead be phased in over multiple years. The net effect of these changes on specialties would vary based on each specialty's mix of ambulatory E&M and other services. Specialties that focus on ambulatory E&M services would receive a net increase in payments, while specialties that mainly provide other services would receive a net decrease, assuming there is no change in volume due to changes in payment rates.

The increased payments for ambulatory E&M services would total \$2.4 billion (based on 2016 data). To determine the total amount of the additional payments for ambulatory E&M services by specialty, we summed the fee schedule payments for ambulatory E&M services in 2016 for each specialty and multiplied this amount by 10 percent. Table 3-6 (p. 82) shows the increase in payments for ambulatory E&M services and the net effect of the 10 percent payment increase for these services and the 3.8 percent reduction to other services, by specialty, for the 20 specialties with the highest share of total fee schedule payments in 2016. Online Appendix 3-A, available at <http://www.medpac.gov>, displays these impacts for all specialties.

Internal medicine and family practice would receive the largest amount of additional payments for ambulatory E&M services (\$435 million and \$378 million, respectively) (Table 3-6, p. 82). The three specialties that would receive the highest percent increase in their total fee schedule payments (on net) are endocrinology (6.6 percent net increase in fee schedule payments), rheumatology (5.5 percent increase), and family practice (4.9 percent increase) (see online Appendix 3-A, available at <http://www.medpac.gov>). These specialties concentrate on ambulatory E&M services. Specialties that perform procedures but also provide a significant number of ambulatory E&M services—such as urology, obstetrics/gynecology, and otolaryngology—would also experience a net increase in fee schedule payments.

Several specialties would experience reductions in their fee schedule payments of 3.8 percent because they provide very few ambulatory E&M services. These specialties include diagnostic radiology, pathology, physical therapy, and occupational therapy (see online Appendix 3-A, available at <http://www.medpac.gov>).

**TABLE
3-6**

Impact of a 10 percent payment rate increase for ambulatory E&M services offset by a 3.8 percent reduction for all other services, for specialties with highest share of total fee schedule payments, 2016

Specialty	Current payments for ambulatory E&M services (in millions)	Amount of payment increase for ambulatory E&M services (in millions)	Share of total payment increase for ambulatory E&M services (across all specialties)	Net change in fee schedule payments as a result of payment increase for ambulatory E&M services and payment reduction for all other services
Family practice	\$3,782	\$378	15.7%	4.9%
Nurse practitioner	1,650	165	6.8	4.1
Hematology/oncology	689	69	2.9	2.8
Physician assistant	824	82	3.4	2.5
Neurology	658	66	2.7	2.0
Urology	745	74	3.1	1.9
Internal medicine	4,349	435	18.0	1.7
Podiatry	744	74	3.1	1.4
Cardiology	1,681	168	7.0	0.3
Pulmonary disease	507	51	2.1	0.2
Gastroenterology	495	49	2.1	0.1
Orthopedic surgery	933	93	3.9	-0.4
Dermatology	841	84	3.5	-0.5
General surgery	341	34	1.4	-1.5
Nephrology	356	36	1.5	-1.6
Ophthalmology	505	50	2.1	-2.6
Emergency medicine	177	18	0.7	-3.1
Radiation oncology	83	8	0.3	-3.2
Diagnostic radiology	14	1	0.1	-3.8
Physical therapy	<1	<1	0.0	-3.8

Note: E&M (evaluation and management). Table includes the 20 specialties with the highest share of total fee schedule payments. "Ambulatory E&M services" includes office visits, home visits, and visits to patients in certain non-inpatient hospital settings (nursing facility, domiciliary, rest home, and custodial care). The payment increase is applied to allowed charges for ambulatory E&M services. Estimates assume there would be no changes in service volume as a result of changes in payment rates. Analysis includes services billable under the fee schedule for physician and other health professional services.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries, 2016.

Conclusion

We describe an approach to address the problem of passive devaluation of ambulatory E&M services that would rebalance fee schedule payment rates in a budget-neutral manner. It would also help reduce the risk of beneficiaries experiencing problems accessing these services and send a more favorable signal to medical students and residents contemplating careers in specialties that provide a large share of E&M services. Even if this approach is adopted, we urge CMS to accelerate its efforts to improve the accuracy of the data used to calculate payment rates and

the process for reviewing mispriced services. To support these efforts, CMS should regularly collect data from a cohort of efficient practices and use this information to validate the payment rates. Improving the accuracy of prices for ambulatory E&M and other services going forward could reduce the need for future significant adjustments to rebalance the fee schedule. ■

Endnotes

- 1 In this chapter, the term *clinicians* is synonymous with *physicians and other health professionals*.
- 2 These RVUs are the national average nonfacility RVUs.
- 3 The full list of practitioners eligible for the bonus, as recommended by the Commission, was family medicine, internal medicine, geriatric medicine, pediatric medicine, nurse practitioner, and physician assistant.
- 4 When CMS reviews the work RVUs for a code, it also reviews the practice expense RVUs.
- 5 The RUC examined a total of 2,220 services from 2009 to 2017. Work RVUs were reviewed for 1,652 services, practice expense RVUs (but not work RVUs) were revised for 158 services, and billing codes were deleted for 410 services.
- 6 Although CMS has accepted most of the RUC's prior recommendations, we do not have information on whether CMS accepted the recommendations for these specific services.
- 7 The analysis used the fee schedule's payment modifiers (e.g., assistance at surgery) to adjust service volumes.
- 8 Both types of data were based on intraservice time, the largest component of the RUC's time assumptions. Intraservice time includes the time the clinician spends on treatment/therapy and documentation of services. The other two components of the time assumptions are preservice time—preparing to see the patient, reviewing records, and communicating with other professionals—and postservice time—arranging for further services and communicating (written or verbal) with the patient, family, and other professionals.
- 9 Services at risk of being misvalued included those with the fastest growth, substantial changes in practice expenses, and new technologies.
- 10 Physicians in three specialties were asked about time spent providing a Level IV office visit for an established patient (HCPCS 99214): cardiology, family medicine, and orthopedic surgery. Family medicine physicians were also asked about a Level III office visit for an established patient (HCPCS 99213) and a Level IV office visit for a new patient (HCPCS 99204).
- 11 The American Medical Association Physician Masterfile includes current and historical data for more than 1.4 million physicians, residents, and medical students in the United States.
- 12 CMS has since reduced the service's time assumption from 208 minutes to 81 minutes.
- 13 Total RVUs include work, practice expense, and professional liability insurance RVUs.
- 14 There is precedent for a fee schedule with more than one conversion factor. Under the volume performance standard policy that was replaced by the sustainable growth rate formula in 1997, the fee schedule had separate conversion factors for surgical services, primary care services, and other nonsurgical services.
- 15 In extending the target, the Congress would need to specify that the savings would be redistributed only to ambulatory E&M services. Under the target that expires at the end of 2018, savings are redistributed to all fee schedule services.

References

- American Medical Association. 2017. *RUC Relativity Assessment Workgroup progress report*. Updated October 2017. Chicago, IL: AMA.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014. Medicare program; revisions to payment policies under the physician fee schedule, clinical laboratory fee schedule, access to identifiable data for the Center for Medicare and Medicaid Innovation Models & other revisions to Part B for CY 2015. Proposed rule. *Federal Register* 79, no. 133 (July 11): 40318–40540.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010. Medicare program; payment policies under the physician fee schedule and other revisions to Part B for CY 2011. Final rule. *Federal Register* 75, no. 228 (November 29): 73169–73860.
- Ginsburg, P. B. 2012. Fee-for-service will remain a feature of major payment reforms, requiring more changes in Medicare physician payment. *Health Affairs* 31, no. 9 (September): 1977–1983.
- Government Accountability Office. 2015. *Medicare physician payment rates: Better data and greater transparency could improve accuracy*. GAO-15-434. Washington, DC: GAO.
- Laugesen, M. J. 2016. *Fixing medical prices: How physicians are paid*. Cambridge, MA: Harvard University Press.
- Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2015. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2011a. Moving forward from the sustainable growth rate (SGR) system. Letter to the Congress. October 14.
- Medicare Payment Advisory Commission. 2011b. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2008. *Report to the Congress: Reforming the delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2006a. *Report to the Congress: Increasing the value of Medicare*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2006b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 1998. *Healthcare spending and the Medicare program: A data book*. Washington, DC: MedPAC.
- Mehrotra, A., C. Gidengil, L. Hilborne, et al. 2016. Developing codes to capture post-operative care. Santa Monica, CA: RAND.
- Merrell, K., C. Schur, T. Oberlander, et al. 2014. *Analysis of physician time use patterns under the Medicare fee schedule*. Report prepared for the Assistant Secretary for Planning and Evaluation. Washington, DC: Social & Scientific Systems and the Urban Institute.
- Office of Inspector General, Department of Health and Human Services. 2012a. *Cardiovascular global surgery fees often did not reflect the number of evaluation and management services provided*. No. A-05-09-00054. Washington, DC: OIG.
- Office of Inspector General, Department of Health and Human Services. 2012b. *Musculoskeletal global surgery fees often did not reflect the number of evaluation and management services provided*. No. A-05-09-00053. Washington, DC: OIG.
- Zuckerman, S., K. Merrell, R. Berenson, et al. 2016. *Collecting empirical physician time data: Piloting an approach for validating work relative value units*. Report prepared for the Centers for Medicare & Medicaid Services. Washington, DC: The Urban Institute.