Misvalued clinician services: Current status and next steps

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Overview

- Context and background
- Commission recommendations to correct mispricing of services in the clinician fee schedule
- Developments since the Commission made the recommendations
- Remaining issues
- Potential next steps

Context: MACRA and the fee schedule

- MACRA repealed the SGR
- Established two new paths for payment updates
  - Advanced Alternative Payment Models (APMs)
  - Merit-based Incentive Payment System
- Still important to ensure accuracy of fee schedule
  - Basic mechanism for paying for clinician services, including under APMs
  - Impact on delivery system

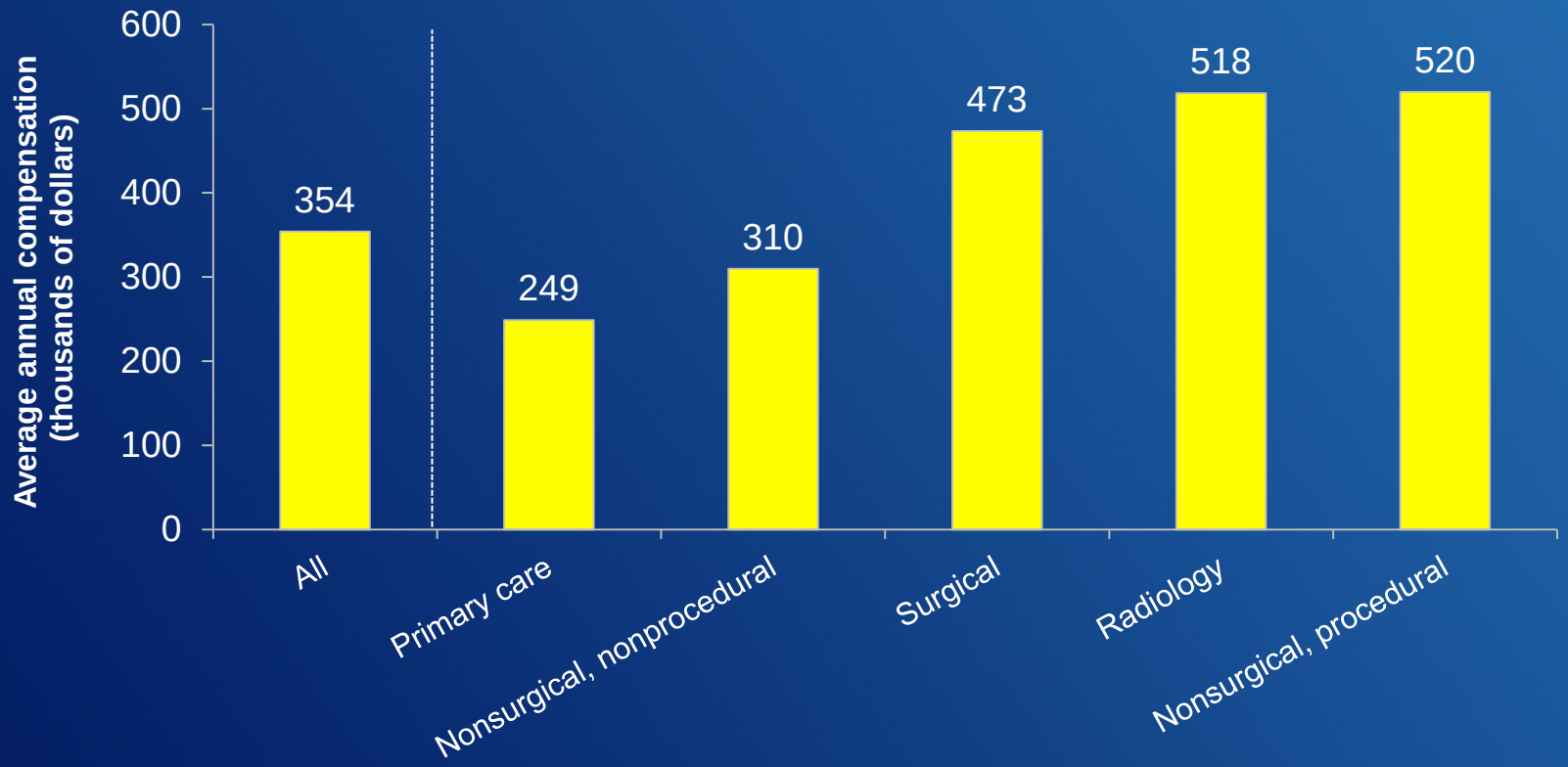
Background: Medicare's payments for clinician services

- Medicare spent $69 billion for physician and other health professional services (2014)
- Medicare's fee schedule lists payment rates for 7,000 codes
- Payment rates based on relative value units (RVUs) for clinician work (51% of spending), the cost of maintaining a practice (45%), and professional liability insurance (4%)

Issues with the fee schedule

- Mispriced services
  - Primary care undervalued
  - Lack of focus on overvalued services
  - Inadequate data
- Paying for 7,000 CPT codes creates opportunities for upcoding, makes it harder for CMS to maintain accurate payment rates
- Leads to fragmented care

Wide income disparities between primary care and certain specialties, 2014



Source: MedPAC analysis of data from Medical Group Management Association's Physician Compensation and Production Survey, 2014.

Issue #1: Primary care is undervalued

- Primary care is labor intensive, which limits the potential for efficiency gains and volume growth
- For services other than primary care, efficiency gains are more likely due to advances in technique, technology, and other factors
  - RVUs should decline for these services over time
  - Under budget neutrality rule, RVUs should go up for other services, including primary care
- Some specialties can increase the volume of services more readily than primary care clinicians

Recommendations: Rebalance fee schedule toward primary care

- Payment adjustment for primary care services billable under the fee schedule (2008)
- Repeal SGR and replace it with specified updates that favor primary care (2011)
- Per beneficiary payment for primary care, to replace the Primary Care Incentive Payment program (2015)

What's happened: Primary care

- Primary Care Incentive Payment
  - Started in 2011
  - Expired in 2015 (not replaced)
- New billing codes in fee schedule
  - Transitional care management, 2013
  - Chronic care management, 2015
- CMMI models
- No per beneficiary payment for primary care

Issue #2: Valuation process should focus on overvalued services and be simpler

- Resources needed for a service can change over time due to
  - Productivity gains
  - Changes in clinical practice
- Review process relies heavily on the specialty groups with financial stake in process
- Large number of codes makes maintenance of fee schedule difficult

Recommendations: Valuation process

- Establish standing panel of experts to help CMS identify mispriced services (2006)
- Apply criteria to identify overvalued services (2006)
- Expand multiple procedure payment reduction (2005, 2011, and 2013)
- Set annual overvalued-services target (2011)

What's happened: Valuation process

- Review of potentially mispriced services
  - CMS and RUC report reviewing 1,700 to 1,800 services as of 2016
  - CMS: Contracts to develop validation models
  - RUC procedural and other changes
- MPPR implemented for certain diagnostic imaging and outpatient therapy services
- Target set for adjusting misvalued services

Remaining issues: Valuation process

- No standing panel of experts to help CMS identify overvalued services
- MPPR could be expanded to all imaging services and to additional types of diagnostic tests
- Stakeholders have expressed concerns about RUC's composition
- Misvalued services target expires in 2018

Issue #3: Data available to maintain the fee schedule are inadequate

- Secretary lacks current, objective data to validate relative values
  - Work and practice expense values depend on time assumptions from specialty society surveys
  - Practice expense values often based on outdated prices for equipment and supplies
  - Data collection can be costly, burdensome, and biased if service-by-service
- No ongoing data collection activity to maintain fee schedule overall

Recommendation: Data collection and validation of relative values

- Secretary should regularly collect data—including service volume and work time—to establish more accurate work and practice expense RVUs (2011)
- The data should be collected from a cohort of selected practices rather than a sample of all practices (2011)
- If necessary, practices should be paid to participate (2011)

What's happened: Data collection and validation of relative values

- CMS contracts
  - Urban Institute: Time estimates from direct observation and electronic health records
  - RAND: Claims-based reporting of post-operative care
- No data collection of type recommended
- Commission has worked with a contractor to develop an alternative method for data collection

Commission's data collection method

- Collect data to identify services with inaccurate time assumptions
  - Unit of analysis: Clinician
  - Data on service mix and total time worked
- Feasibility study showed mispriced services
  - Cardiology practice: Services provided had time assumed that exceeded actual hours worked by 60 percent (on average)
  - Cardiologists with largest difference furnished more imaging services than others in practice

Potential next steps: Revisit prior recommendations

- Establish expert panel to help CMS identify mispriced services
- Expand MPPR to additional services
- Collect data from cohort of selected practices to validate payment rates, establish more accurate rates

Potential next steps: New directions

- Paying for primary care: Partial capitation approach
  - Issues: Size of capitated payment, risk adjustment, beneficiary attribution, practice requirements
- Combine CPT codes into families of codes
  - Examine typologies for grouping codes
  - Explore ways to price families of codes

Discussion

- Questions or clarifications
- Potential next steps