Rebalancing the physician fee schedule towards ambulatory evaluation and management services

Ariel Winter and Kevin Hayes

January 12, 2018

MEDPAC

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

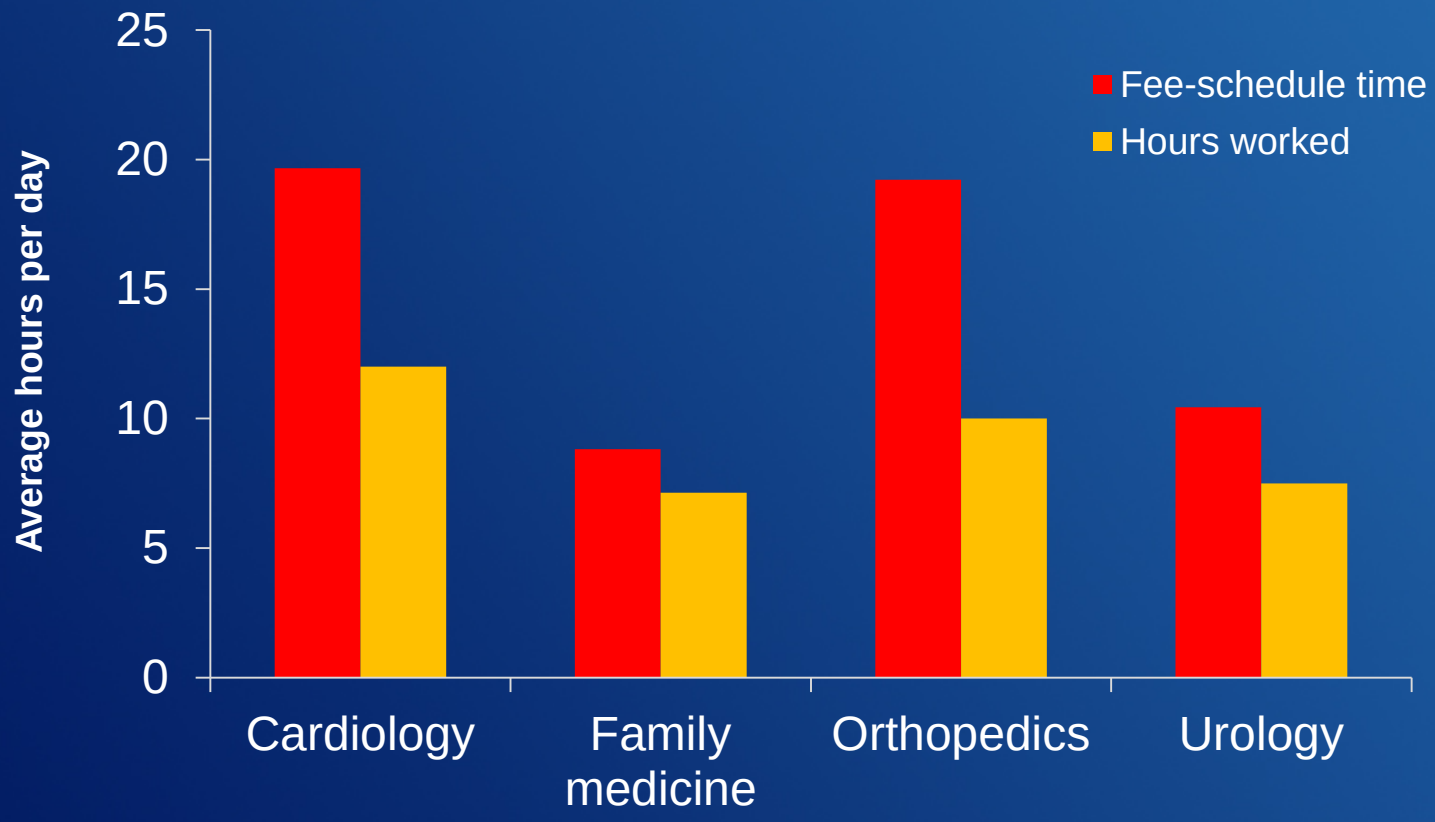
This year's agenda for clinician payment policy

- 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.

MEDPAC

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

	Number of services revised, 2008-2016	**Average percent change**
Work RVUs	607	-9%
Time estimates	607	-18

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.

MEDPAC

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

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

MEDPAC

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?