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Out of Whack:

Pricing Distortions in the Medicare Physician Fee Schedule

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It has become almost cliché to say that we need to move from “volume-based payment” to “value-based payment.” Medicare’s use of a physician fee schedule based on some 7,000 individual services is viewed (correctly) as the very prototype of volume-based payment, and most observers quickly conclude that this approach must be abandoned without delay. In fact, however, there are several reasons to improve Medicare’s fee-for-service (FFS) system in the short to medium term, even if the ultimate goal is to reduce its importance or eliminate it altogether.

First, migration to value-based payment will not be easy or quick. Not only are we still struggling to measure value well, significant differences of opinion exist about how to reorient payments to promote value most effectively. Should we use bundled episodes, global payments, shared savings or some other approach? Despite hopes for a faster track, it will take years for the new Medicare payment pilots to be developed, tested, refined and implemented on a more widespread basis. Second, fee schedule prices are building blocks for some of the newer aggregate payment approaches, most notably bundled episodes. Errors in setting individual fees in the Medicare Fee Schedule (MFS) would, therefore, be carried over into the bundled episodes. So we remain reliant on the fee schedule in the interim period and must get it right for the long term.

Third, entities like accountable care organizations will work best when formed around multispecialty group practices that can organize all needed care and accept the risk of global payment for their enrolled population. But specialties that have benefitted from distorted pricing under the current fee schedule, such as cardiology, seem more likely to continue forming the large single-specialty practices that give them the scale to purchase and operate highly profitable technologies and the clout to

attain lucrative buy-outs from hospitals seeking to capture significant ancillary service revenue. Perpetuating this trend through current MFS payment distortions will frustrate the transition to new delivery systems and global payments. Finally, since medical groups and hospitals currently use the MFS relative value units to assess physician productivity, errors in setting these values can skew assessments of physician productivity.

Given its role as a step toward a longer-run value-based payment strategy, it is important to understand the current fee schedule and work to mitigate its flaws. In this essay I explain how Medicare physician fees are determined, highlight the impact of current inaccuracies, and offer some thoughts on how these inaccuracies can be corrected.

High Hopes Initially for the MFS

When adopted twenty years ago, the so-called resource-based relative value scale (RBRVS) that became the basis for the MFS was considered to be a transformative approach that would establish objective payments reflecting only the underlying resource costs of providing each service. The end result was intended to reorient payments from specialists to primary care physicians to achieve specialty-neutral payments. The Physician Payment Review Commission noted at the time that many regarded the new payment system as “one of the most sweeping reforms of the U.S. health care system since the enactment of Medicare.”¹

The MFS is based on a long list of codes that describe thousands of discrete activities that physicians provide. The Centers for Medicare and Medicaid Services (CMS) assigns relative value units (RVUs) to each service by determining the amount of physician work, practice expenses, and malpractice liability costs associated with each service. The

values given to these resource components are adjusted for geographic variations in input prices, and the total relative value is multiplied by a standard dollar amount, called the conversion factor, to arrive at the final fee. Fees may be further adjusted for other factors, such as provider location in an underserved area.

The fee schedule is updated periodically to account for changes in relative resource costs, new services and new billing codes. While CMS is responsible for these updates, several committees housed at the American Medical Association play important roles. The CPT (Current Procedural Terminology) Editorial Board maintains the core coding system, and the RBRVS Update Committee (RUC), a group of 29 members representing different specialty societies, provides detailed data and recommendations on the work component for each service.²

Mispricing Under the MFS

Now, with the benefit of 20-year hindsight, the Medicare Fee Schedule is no longer viewed as rosy as when it debuted. While most concern has focused on the FFS incentive to increase service volume, close observers of the MFS are also concerned that the periodic updates have resulted in payments for some services that no longer reflect the underlying resource costs. Ample evidence shows that physicians have reacted to this variation in relative profitability by emphasizing services with higher profit margins, including many tests and imaging services, and shunning services for which payments are closer to costs, such as the core activities of office visits.

These payment distortions can also result in income distortions by specialty to the extent that higher- or lower-margin services are concentrated within particular specialties. Whereas a key objective of the RBRVS-based fee schedule was to reward all physician work equally, analyses

that colleagues and I recently completed show the MFS has fallen short of this goal. Using physician-level survey data on hours worked, annual compensation and services provided, we compared physicians' actual hourly earnings with the hourly earnings estimated as if all services had been paid using Medicare rates.³

We confirmed that radiologists, surgeons, and non-surgical proceduralists (e.g., cardiologists and dermatologists) earn much more per hour than primary care physicians and estimated that paying Medicare rates for all services would do little to change this picture (Figure 1). Such specialty payment distortions influence medical students' career choices and if left uncorrected will continue to disadvantage primary care specialties just when we anticipate needing more primary care clinicians.

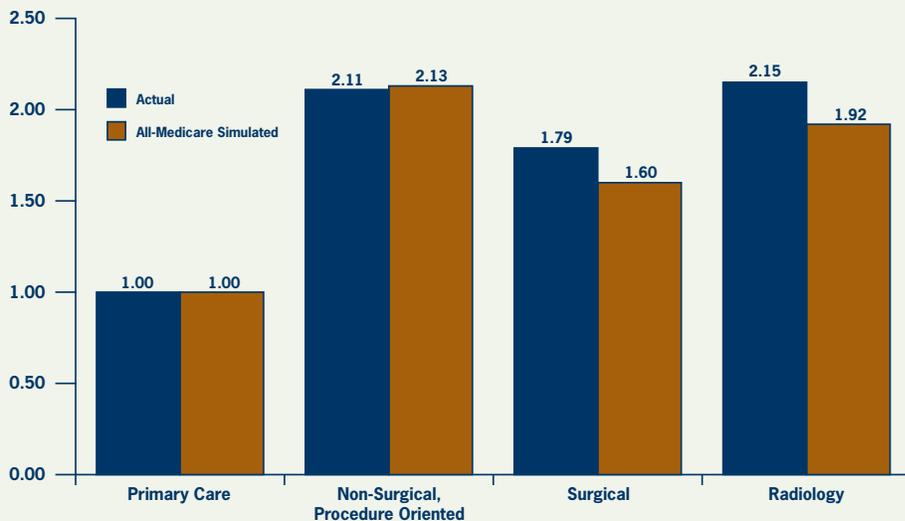
Most private health insurers have adopted the MFS as the benchmark for their own fee schedules, and the similarity between our all-Medicare simulation results and actual payment patterns underscores the pervasiveness of the MFS as the basis for all payments to physicians. Thus, flaws in the MFS affect the care provided to non-Medicare patients as well. A more accurate MFS would improve the derivative fee schedules developed by health plans, laying the groundwork for a more rational mix of services across the health care system and narrowing speciality income differentials.

Fixing the Distortions

Price distortions under the MFS are not inevitable – at least not to the degree now observed.⁴ To some extent, the MFS was put on “automatic pilot” after adoption while Congress, the Medicare Payment Advisory Committee (MedPAC), and CMS moved on to new issues. This was especially true after 1998 when the sustainable growth rate mechanism for updating the conversion factor was implemented. Because of the fiction that aggregate payments to physicians were being contained, little attention was paid to the actual fees or the signals that distorted prices were sending.

MedPAC began urging more active control over the fee schedule in 2006.⁵ In theory, one would expect many services to become “overvalued” over time as physicians gain experience and adopt other efficiency enhancements (reducing their required work) or as the per-unit costs of new technologies decline (reducing practice expenses). Revaluations of RVUs would lower fees for these services. But MedPAC's assessment of the RUC-driven review and update process found that it was disproportionately flagging potentially undervalued services,

Figure 1. Ratio of Average Hourly Earnings for Specialists Relative to Primary Care



Source: Berenson et al. “What if All Physician Services Were Paid under the Medicare Fee Schedule? An Analysis Using Medical Group Management Association Data.” Report No. 10-1 to MedPAC, March 2010.

leading to increased payment rates for many services without commensurate reductions in others. MedPAC concluded that CMS relied too heavily on self-interested specialty societies and the RUC to identify misvalued services and offered alternatives to improve the process.

Although CMS and the RUC rejected some of MedPAC's recommendations, they did implement new approaches to identify potentially overvalued services, and many more services have been reviewed in the past few years. The Affordable Care Act now requires the Secretary to continue this stepped-up review, make adjustments to RVUs as needed, and establish a process for validating RVUs. What is not yet known is whether this increased scrutiny will actually produce more accurate payment rates. MedPAC recently expressed renewed concern about basing the RVUs on estimates of work and practice expenses derived from speciality society surveys rather than using actual data from practices.⁶ For example, available data from operating room logs and appointment schedules demonstrate that service-specific time estimates provided by specialty societies are often inflated.⁷ MedPAC has urged CMS to consider ways to collect more objective data, and CMS recently sought public advice on how to do so.

This objective information about time spent on various services, practice costs and allocation of costs to specific services could be obtained from administrative data maintained by hospitals, group practices and health plans with their own delivery systems. While these entities would be in the best position to inform decisions on specific code-level valuations, health insurers

and self-funded employers also have an opportunity to improve the accuracy of payments by providing comments during the annual “notice and comment” rule-making process used to update fees. These comments might pertain to the RVUs proposed for specific services or be of a more general nature, such as offering insights on the type of data that should be used to make decisions about practice expenses and work. While appreciable time and resources would be needed to develop this input, this is likely to be an investment that more than pays for itself in a better mix of services and lower spending.

- 1 Physician Payment Review Commission, *Annual Report to Congress*. Washington, DC: PPRC. 1990.
- 2 National Health Policy Forum, *Medicare Physician Fees: The Data Behind the Numbers*. Issue Brief 838. <http://www.nhpf.org/library/details.cfm/2812>. July 22, 2010.
- 3 Berenson R, et al. *What if All Physicians Were Paid Under the Medicare Fee Schedule: An Analysis Using Medical Group Management Association Data*, Report No. 10-1 to MedPAC, March 2010. http://www.medpac.gov/documents/Mar10_Physician_FeeSchedule_CONTRACTOR_v2.pdf.
- 4 Bodenheimer T, Berenson R, Rudolf P. “The Primary Care-Specialty Income Gap: Why It Matters.” *Annals of Internal Medicine*, 146(4):301-6, 2007.
- 5 Medicare Payment Review Commission, *Report to The Congress: Medicare Payment Policy*. Washington, DC: MedPAC. 2006.
- 6 Medicare Payment Review Commission, *Report to The Congress: Medicare Payment Policy*. Washington, DC: MedPAC. 2010.
- 7 Cromwell J, et al. “Validating CPT Typical Times for Medicare Office Evaluation and Management (E/M) Services.” *Medical Care Research and Review*, 63(2):236-55, 2006; McCall N, Cromwell J, Braun P. “Validation of Physician Survey Estimates of Surgical Time Using Operating Room Logs.” *Medical Care Research and Review* 63(6):764-77, 2006.