What is the Future of Reimbursement?
The Future is Now

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Disclosures

- No financial disclosures
- AVLS Advisor to the AMA's RUC Committee
- Member, RUC Practice Expense Subcommittee

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Outline

- How reimbursement is determined
- Present challenges
- Physicians' expectations

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Reimbursement Determination

- Physician process

  AMA - RUC

- Political process

  CMS and Congress

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AMA, RVU's and RUC

- CMS only determines payment for Medicare
  - but other insurers follow
- AMA contracted to provide payment advice
  - RVU's and the RUC

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RVUs: How did we get here?

- Physician payments based on charges
- 1986-1988: Health Care Financing Agency, predecessor to CMS, awards contract to Harvard University to develop a method to assign value to medical services - the future RBRVS (Resource-Based Relative Value Scale)
- Budget Act of 1989 mandates new system of payment based on RBRVS – fully implemented in 2002

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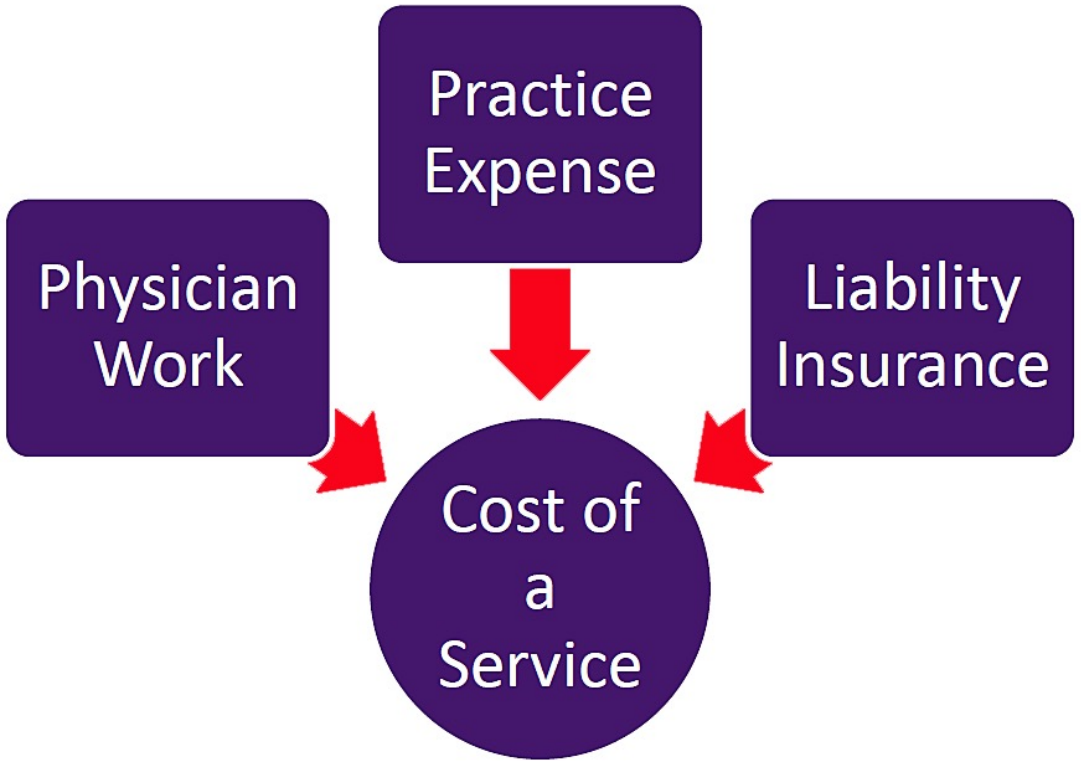
Medicare RBRVS

Cost for each medical service divided into 3 components



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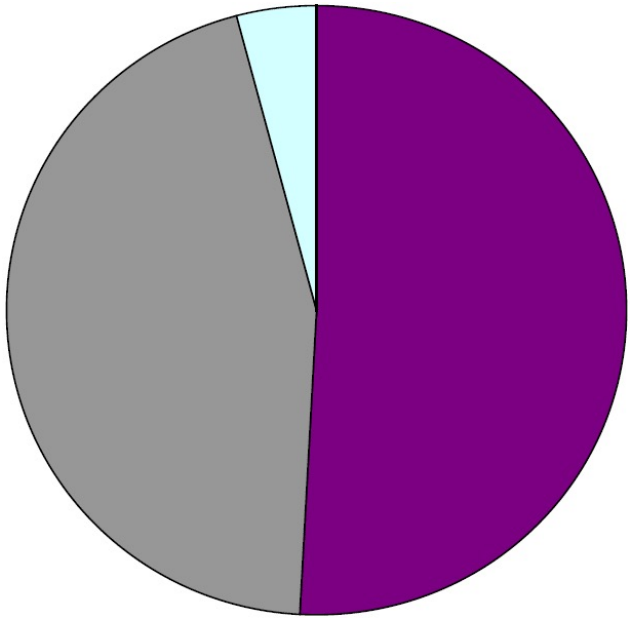
Components of RBRVS

Percent of Total Relative Values

Liability Insurance
4%

Practice Expense
45%



Physician Work
51%

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Practice Expense

Practice Expense

- Direct expense: clinical non-physician labor, disposable medical supplies, devices and fixed equipment
- Indirect expenses: administrative and nursing staff, office expenses

Calculated

- Specialties make recommendations to the Practice Expense subcommittee, approved by RUC
- Actual paid invoices is what RUC (CMS) want to see to establish pricing

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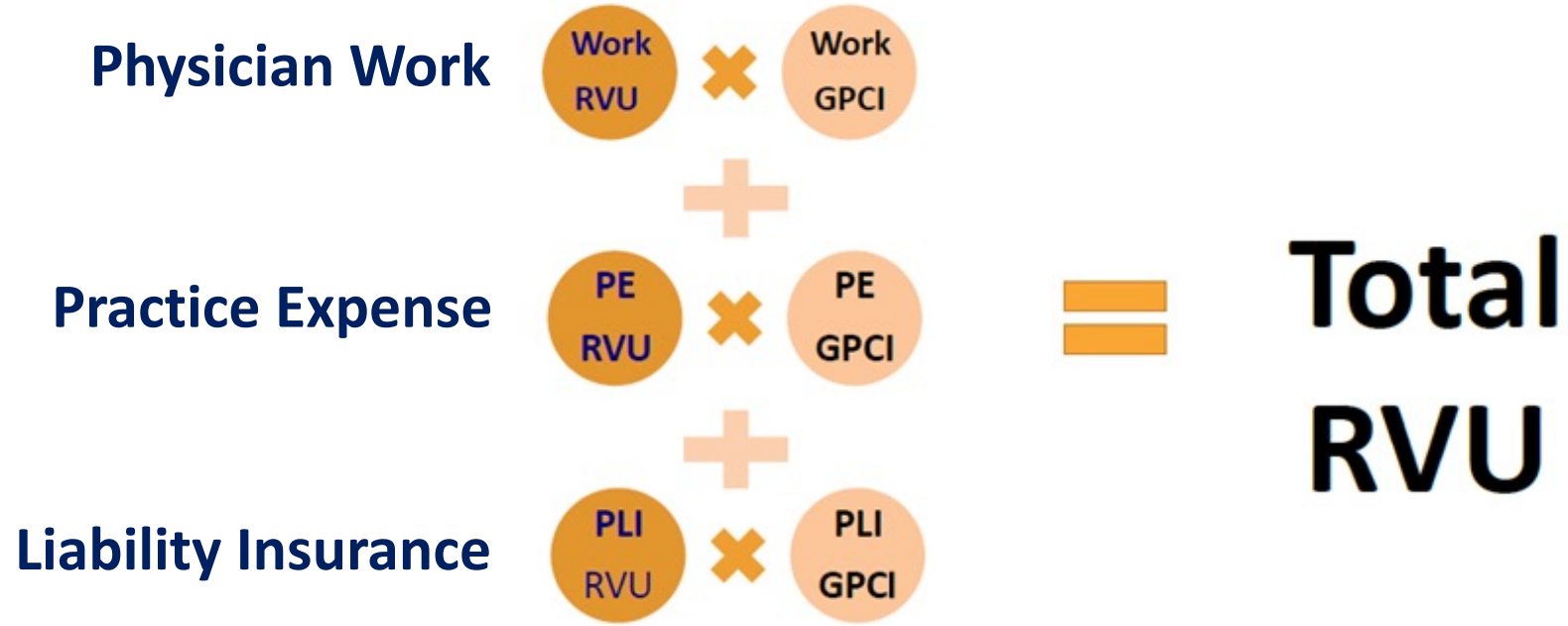
Calculating Payment – Step 1

Calculating RVU



GPCI = geographic practice cost index

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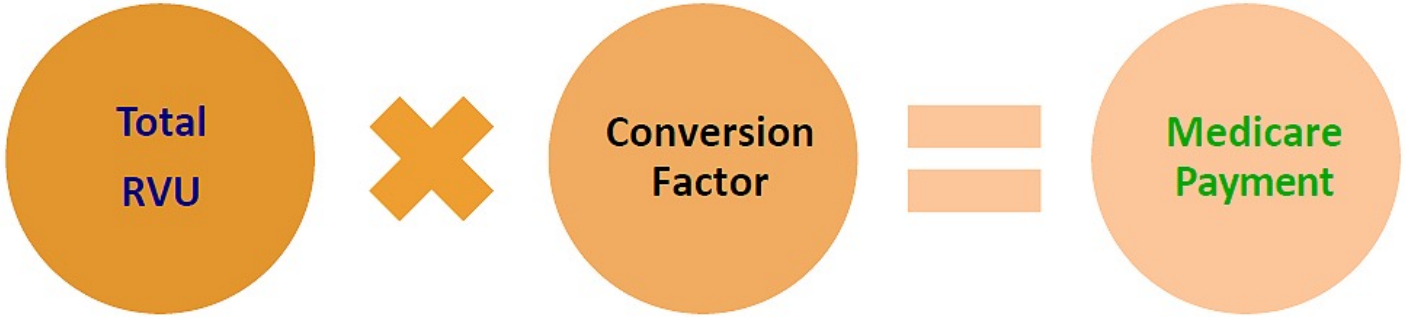
Calculating Payment – Step 2

Conversion Factor



Conversion Factor determined by Medicare each year, required to maintain total cost of Medicare Part B fixed = **"budget neutrality"**

Conversion Factor for 2020 = $36.09

Conversion Factor for 2021 = $34.89 ⬇ **3.3%**

2022 = $34.61 ⬇ **0.75%**

?2023 = $33.08 ⬇ **4.4%**

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Relative Value Scale Update Committee (RUC)

- AMA establishes in contract with CMS in 1992
- Comprised of 31 members - assign component values for Current Procedural Technology (CPT) codes

Appointed by Major Medical Specialties

Anesthesiology
Cardiology
Dermatology
Emergency Medicine
Family Medicine
General Surgery
Geriatrics
Internal Medicine
Neurology
Neurosurgery
Obstetrics/Gynecology
Ophthalmology
Orthopedic Surgery
Otolaryngology
Pathology
Pediatrics
Plastic Surgery
Primary Care*
Pulmonary Medicine*
Psychiatry
Radiology
Rheumatology*
Thoracic Surgery
Urology
Vascular Surgery*

* Indicates rotating seat

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Relative Value Scale Update Committee (RUC)

- Closed meetings – not public forum
- Over 3,000 CPT codes have been reviewed at RUC meetings
- New /changes in CPT codes requires RVU updates
- Recommendations sent to CMS
- Generally, CMS accepts RUC recommendations, but not always
- Values approved by CMS become default values used by all payers

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RUC Reviews

CMS Required to Review RVUs

- No less than once every five years
- Review potentially misvalued codes annually
- Periodically identify and adjust potentially misvalued codes

Budget Neutrality

- Any revisions of any RVU causes change of total Medicare physician payment of >$20 million, adjustments need to be made so total expenditures do not increase >$20 million

How can just 31 people do all of this?

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RUC Advisory Committee

- One physician representative from each of 119 specialty societies in AMA House of Delegates
- Assist in the development of RVUs
- Represent their specialties' recommendations
- Comments on recommendations made by other specialties
- Society involvement critical to maintain appropriate reimbursement

AVLS Representatives

John Blebea MD MBA / Marlin Schul MD

Director, Health Care Policy & Advocacy: Robert White

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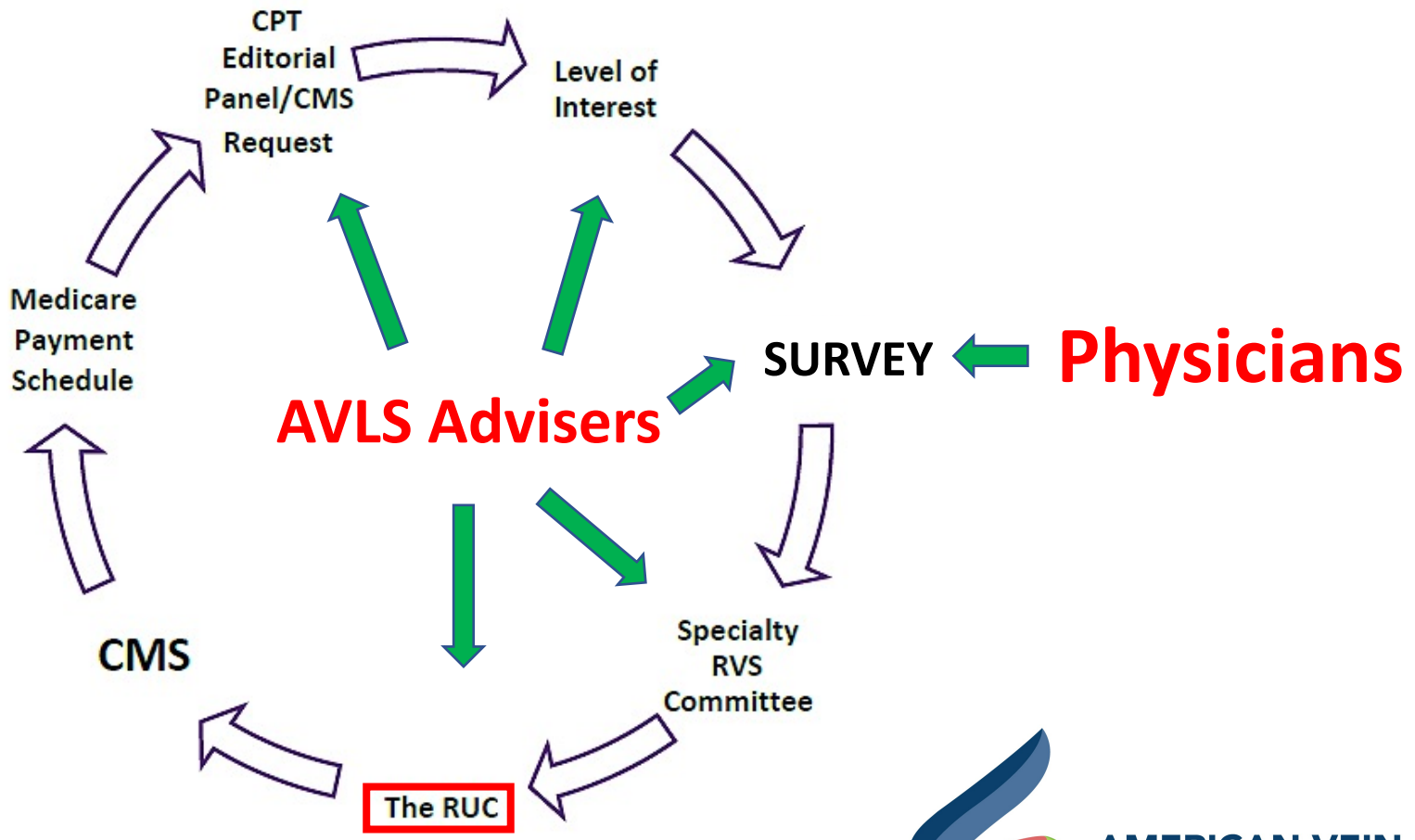
RUC Cycle & Physician Work



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Purpose of Surveys

Evaluate Potentially Mis-valued Services

- High utilization codes
- Rapid volume growth
- High expenditure procedures
- Procedures done together (bundling)
- New technology / procedures

Purpose: Obtain data on the amount of physician work involved in a service

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Survey Development

Survey Vignettes

- Specialties debate/propose vignette to Research Subcom of RUC

Survey Sample

- Societies decide on participation

Survey Instrument

- Sent to random members

Specialty Advisors

- Review results of survey
- Present and make relative value recommendations to RUC

AVLS is only society primarily representing venous specialists

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Survey Response Thresholds

RUC established thresholds for required number of surveys:

- Codes with >1 million Medicare claims = 75 respondents
- Codes with 100,000 to 999,999 claims = 50 respondents
- Codes with <100,000 Medicare claims = 30 respondents

Critically important to have sufficient survey respondents

Surveys below the established thresholds will need to resurvey

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Physician Work

Determined by:

- Time it takes to perform the service
- Technical skill and physical effort
- Required mental effort and judgment
- Stress due to the potential risk to the patient

Does not include work done by nurses and other staff

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Physician Procedural Work

PRE-service time (minutes)	
INTRA- service time (minutes)	
POST- service time (minutes)	

Pre-service period
The pre-service period includes physician work provided before the onset of the procedure and may include review of records and any discussions with other physicians or the clinical staff.

Intra-service period
The intra-service period begins at the onset of the examination and ends after the examination is interpreted. Activities in the intra-service period may include performing the procedure; communications with the clinical staff performing the examination; review of preliminary images or data and/or processing of images and data; and interpretation and report of the examination. Only the physician's time spent during the procedure should be considered. Time spent by the technologist and other clinical staff is NOT included.

Post-service period
Activities in the post-service period may include signing off on the report for the medical record, and discussions with the patient and referring physician if performed.

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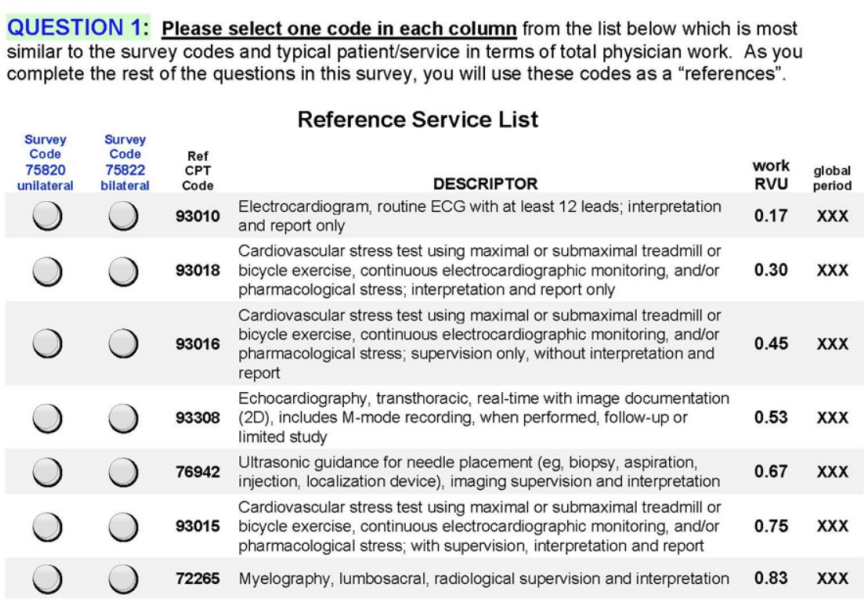
Key Reference Service



QUESTION 1: **Please select one code in each column** from the list below which is most similar to the survey codes and typical patient/service in terms of total physician work. As you complete the rest of the questions in this survey, you will use these codes as a "references".

Reference Service List

Survey Code 75820 unilateral	Survey Code 75822 bilateral	Ref CPT Code	DESCRIPTOR	work RVU	global period
○	○	93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	0.17	XXX
○	○	93018	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only	0.30	XXX
○	○	93016	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report	0.45	XXX
○	○	93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	0.53	XXX
○	○	76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	0.67	XXX
○	○	93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report	0.75	XXX
○	○	72265	Myelography, lumbosacral, radiological supervision and interpretation	0.83	XXX

- Provided a list of CPT codes that the specialty feels are broadly similar to the code being surveyed - the Key Reference Service list
- Usually, recently validated and with same global period, but may not be a procedure you do regularly
- Which is most similar to the survey code descriptor and typical patient/service that is being surveyed?

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Intensity Comparison

QUESTION 3: **Compare intensity components of each survey code relative to the corresponding reference code you selected in Question 1.** Using your expertise, consider how each survey code compares directly to the reference code you chose in Question 1. For example, if you find the technical skill for the survey code is identical when compared to the corresponding reference code you chose in Question 1, select "identical" in the table below.

INTENSITY COMPONENTS	75820 compared to 75710	75822 compared to 75716
Mental Effort and Judgment Necessary • The range of possible diagnoses and/or management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, or other information that must be analyzed • Urgency of medical decision making		
Technical skill required		
Physical effort required		
Psychological Stress • The risk of significant complications, morbidity and/or mortality • Outcome depends on skill and judgment of physician • Estimated risk of malpractice suit with poor outcome		

QUESTION 4: **Compare OVERALL intensity/complexity** of all physician work for each survey code relative to the corresponding reference code you selected in Question 1. Using your expertise, consider how each survey code compares directly to the reference code.

OVERALL INTENSITY/COMPLEXITY	75820 compared to 75710	75822 compared to 75716
OVERALL intensity/complexity of all physician work		

- Rate Intensity and Complexity (time, mental effort and judgment, technical skill, physical effort, psychological stress)
- Compare to Reference procedure

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Propose RVU Value

QUESTION 5: **Based on your review of all previous questions, please provide your estimated Work RVU for each survey code (to two decimal places).** For example, if the survey code involves the same amount of physician work as the reference service you choose, you would assign the same work RVU. If the survey code involves less work than the reference service you would estimate a work RVU that is less than the work RVU of the reference service and vice versa. This methodology attempts to set the work RVU of the survey service "relative" to the work RVU of the reference services.

Work RVU **Survey Code**

[ ] **75820 Venography, extremity, unilateral, radiological supervision and interpretation**

CPT	REFERENCE CODES (XXX global)	Work RVU
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	0.17
93018	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only	0.30
93016	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report	0.45
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	0.53
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	0.67
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report	0.75

Propose RVU value using the Reference Codes as guide

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Why is this so important?

RUC process is perhaps the single most important factor in payment policy

Example: Phlebectomy 37765 (10-20) 37766 (>20 sites)

Total Non-Facility RVU

	2019	2020	
37765	18.52	12.68	↓ 32%
37766	22.02	14.82	↓ 33%

National Payment in Office

2019	2020	
$667	$458	↓ 31%
$794	$535	↓ 33%

"You live and die by the Survey...at the 25th percentile"

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Implications for AVLS

ALVS has RUC Advisors

- present at all meetings
- access to deliberations and data
- PE subcommittee member
- Lead presenter at RUC – vein treatments

But we are not a recognized specialty!

- Never lead society on any issue
- Lead presenters at RUC dependent on relationships

We need to become recognized specialty!

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Reimbursement – Political Process

RUC makes recommendations to CMS

- most, but not all, accepted
- CMS decisions are final
- CMS also constrained by Congressional laws/regulations
- Only Congress can mitigate decisions

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CMS Process

CMS publishes a Proposed rule in July
Open to public comment
Final rule published in November

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CMS Proposals in 2021

Practice Expense Update - Clinical Labor Rates

- Last updated 2002
- Increases using Bureau of Labor Statistics 2019 data:

Examples

Medical assistant	increase **50%**
Registered Nurse	increase **67%**
Radiology tech	increase **68%**
Vascular tech	increase **98%**

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Clinical Labor Update Issues

- Increases have nothing to do with what is actually being paid to office staff
- Medicare does not pay any office staff, it is the physician that pays his office personnel
- No office staff was being paid at 2002 levels!

Because of separate budget neutrality for Practice Expense, increasing labor costs (by 30% of PE = $3.5 Billion) necessarily decreases equipment and supply reimbursement for proceduralists

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Practice Expense Scaling

To maintain budget neutrality for Practice Expense,

Direct scaling factor for practice expense decreases -24% from 0.5916 in 2021 to 0.4468.

Medicare would then reimburse 44 cents on the dollar instead of 59 cents on the dollar for supply and equipment costs. An unsustainable payment rate for any business

[55 cents on the dollar in 2022 as now to be fully implemented over 4 yrs]

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Specialty Effects

Redistribution of payments to primary care specialties

CMS: "Specialties with a substantially higher direct costs attributable to labor would experience significant increases"

Family Practice **increase 2%**

Vascular Surgery **decrease 4%**

Interventional Radiology **decrease 5%**

AMA was officially neutral and did not lobby against this change, nor surgery as a whole. IM and FM lobbied in support.

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2021 CMS Proposed Cuts

Labor costs	**(new rule)**	**-4%**
Conversion Factor	**(E/M changes)**	**-3.75%**
Sequestration	**(Budget Neutrality Act 2011)**	**-2%**
PAYGO	**(unfunded Covid funding)**	**-4%**
	TOTAL	**13.75%**

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Advocacy Results

Clinical Labor Update costs (4% over 4 years) -1%

Conversion Factor (E/M changes; 3% deferred to 2023) -0.75%

Sequestration (Budget Neutrality Act 2011; 2% delayed)

April 1, 2022 -1%

July 1, 2022 -1%

PAYGO (unfunded Covid funding; 4% delayed for 1 year)

2022 TOTAL -3.75%

(instead of 13.75)

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2022 Specialty Specific Effects

Decreases for Office Venous Procedures

	January	April	July
RFA 1st vein (36475)	**-12%**	**-13%**	**-14%**
Laser 1st vein (36478)	**-5%**	**-6%**	**-7%**
MOCA 1st vein (36473)	**-9%**	**-10%**	**-11%**
Adhesive 1st vein (36482)	**-7%**	**-8%**	**-9%**
Varithena 1st vein (36465)	**-9%**	**-10%**	**-11%**
Phlebectomy 10-20 (37765)	**-2%**	**-3%**	**-4%**
Stent, venous (37238)	**-6%**	**-7%**	**-8%**

Specialty-specific effects are most relevant

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Braid-Forbes Research 2021

Status in 2022

"Déjà vu all over again"

FEDERAL REGISTER

Public Inspection :: Tomorrow's Documents Today

PR Public Inspection :: Proposed Rule

Special Edition – Thursday, July 7, 2022

CMS Proposes Physician Payment Rule to Expand Access to High-Quality Care

Decrease in Conversion Factor from $34.61 to $33.08 4.4% cut !

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Total Effects for 2023

Conversion Factor	**-4.4%**
Conversion Factor (E/M changes)	**-1.5%**
Clinical Labor Update costs (Year 2 of 4)	**-1%**
PAYGO (unfunded COVID expenses from 2022)	**- 4%**
2023 TOTAL	**-10.9%**

Superimposed on -3.75% cut in 2022

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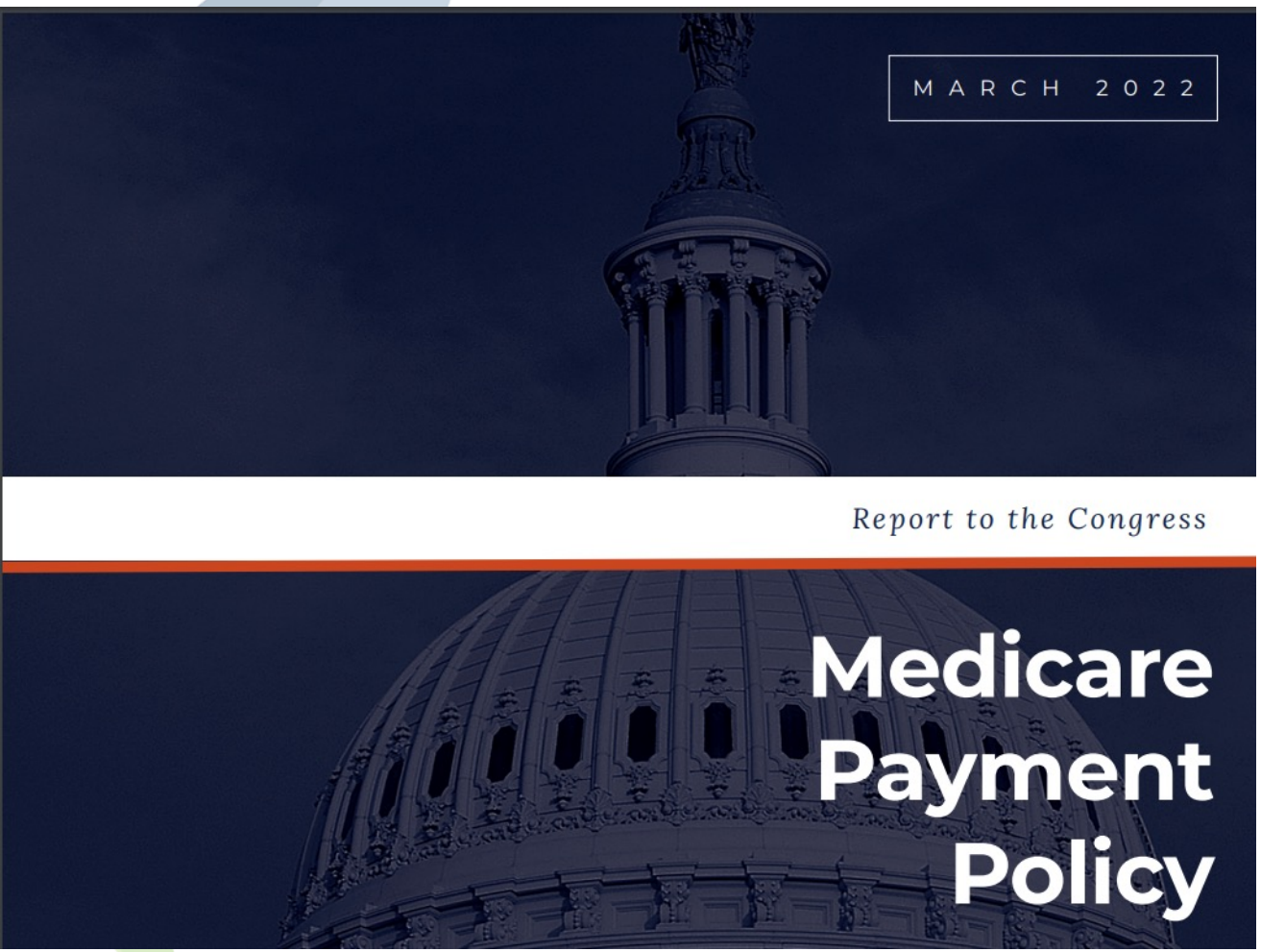
MedPAC



Medicare Payment Advisory Committee Commission Report to Congress – March 15, 2022

Recommended a continued freeze on Medicare physician payment rates = budget neutrality.

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Non-Physician Payment

CMS finalizes 8.5% rate hike for Medicare Advantage, Part D plans in 2023

By **Robert King** • Apr 4, 2022 06:20pm

FIERCE Healthcare

Hospitals decry CMS pay bump 'woefully inadequate' amid rising labor rates

By Robert King

Apr 19, 2022

"3.2% increase isn't enough"

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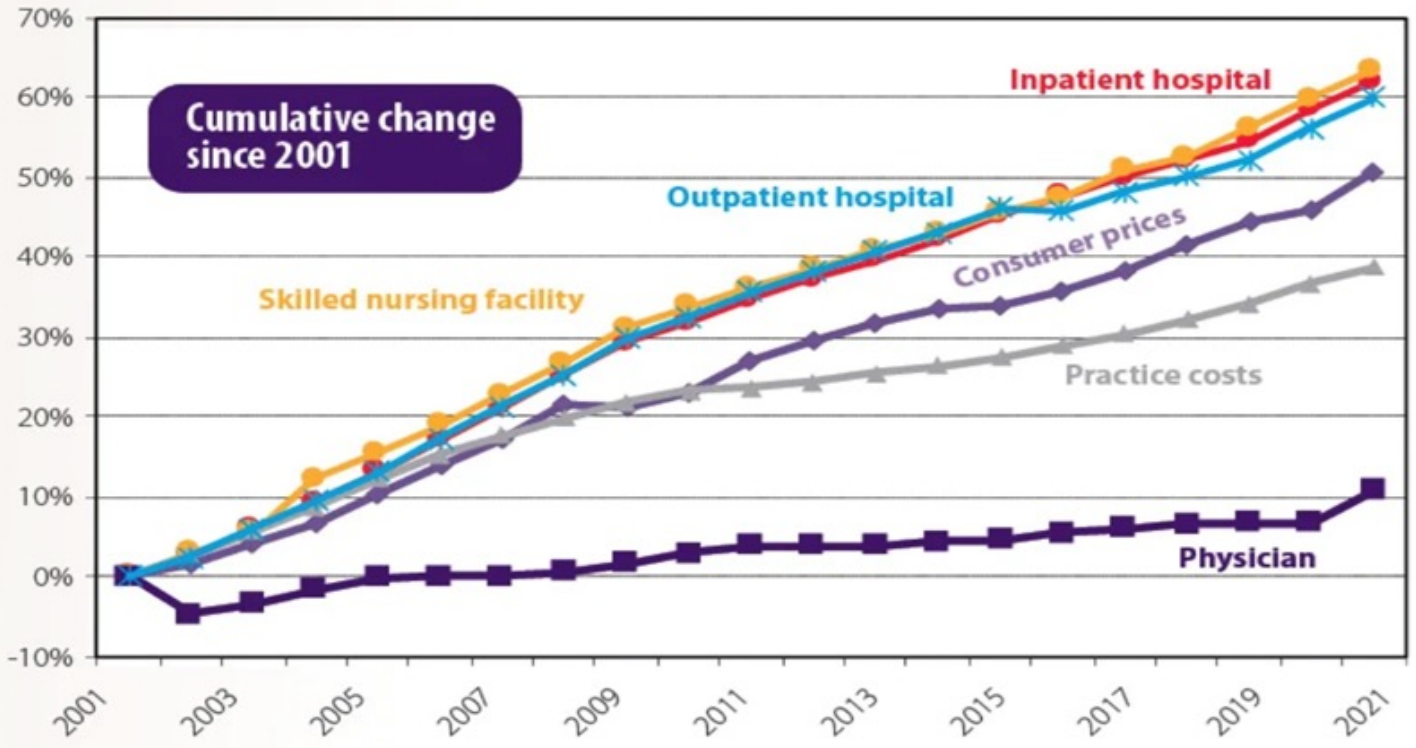
Effects of Inflation

Medicare physician payment is not keeping up with inflation

Medicare updates compared to inflation (2001–2021)

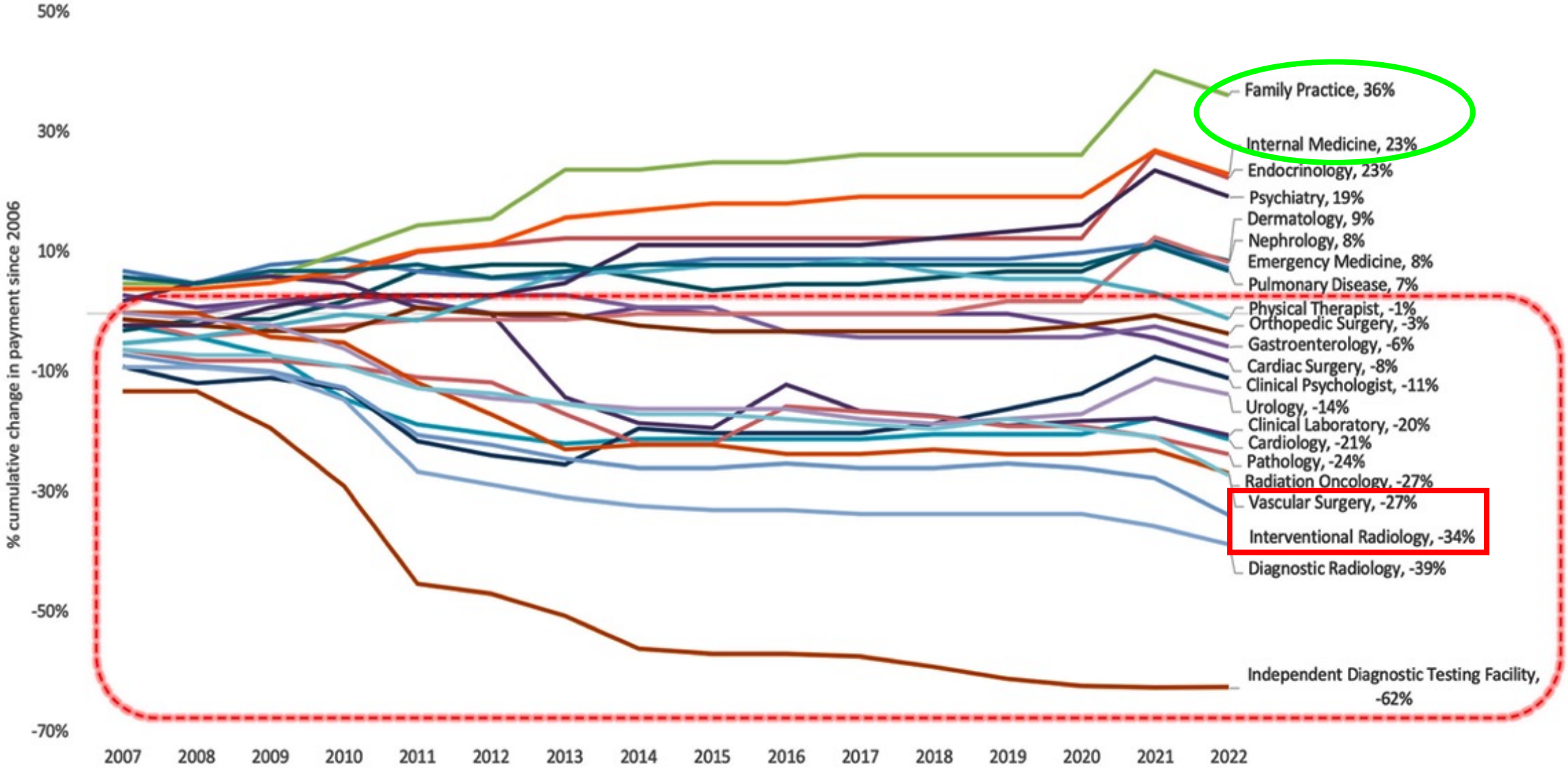
Adjusted for inflation in practice costs, Medicare physician pay declined 20% from 2001 to 2021.

AMA
AMERICAN MEDICAL ASSOCIATION



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics, American Medical Association, Economic and Health Policy Research, October 2021

Significant Specialty Variation in Estimated Payment Changes since 2006



Source: HMA analysis 2007-2022 Medicare Physician Fee Schedule Final Rule Impact Tables.
2021 and 2022 values adjusted for effects of Consolidated Appropriations Act of 2021, including the delayed effect of G2211 until 2024 which, if implemented as proposed, will reduce payments to many specialties that are already at zero percent or lower and increase payments to many specialties that are above zero percent.

Inflation - Venous

Table III. Average adjusted percent change in reimbursement rate from 2011-2021 by procedure type. All values adjusted for inflation to 2021 USD

Procedure type	2011 Mean reimbursement (Adj to 2021 USD)	2021 Mean reimbursement (2021 USD)	Percent change 2011-2021	Mean 2021 (2021 USD)	Average % change from 2000-2020
Open	$841.97	$723.53	-13.9%	$841.97	-13.9%
Endovascular	$734.18	$595.34	-20.1%	$734.18	-20.1%
Venous	$495.07	$279.84	-42.4%	$495.07	-42.4%

It has not been a good trend for venous treatments

Ann Vasc Surg 2021; 000: 1–7
https://doi.org/10.1016/j.avsg.2021.04.001

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Inflation – Venous Procedures

Procedure Reimbursement, Inflation, and the Declining Buying Power of the Vascular Surgeon (2011-2021)

Jack M. Haglin,[1] Victoria S. Edmonds,[1] Samuel R. Money,[2] Victor J. Davila,[2] William M. Stone,[2] Ina Y. Soh,[2] and Andrew J. Meltzer[2]

Table II. Adjusted reimbursement trends from 2011 to 2021

CPT Code		2011 Reimbursement (In 2011 USD)	2011 Reimbursement (Adj to 2021 USD)	2021 Reimbursement (In 2021 USD)	% Change in Buying Power (Change in Adjusted Reimbursement)
36475	RFA	$372.16	$431.70	$283.68	-34.3%
37765	Phlebect	$481.41	$558.44	$276.00	-50.6%

Ann Vasc Surg 2021; 000: 1–7
https://doi.org/10.1016/j.avsg.2021.04.001

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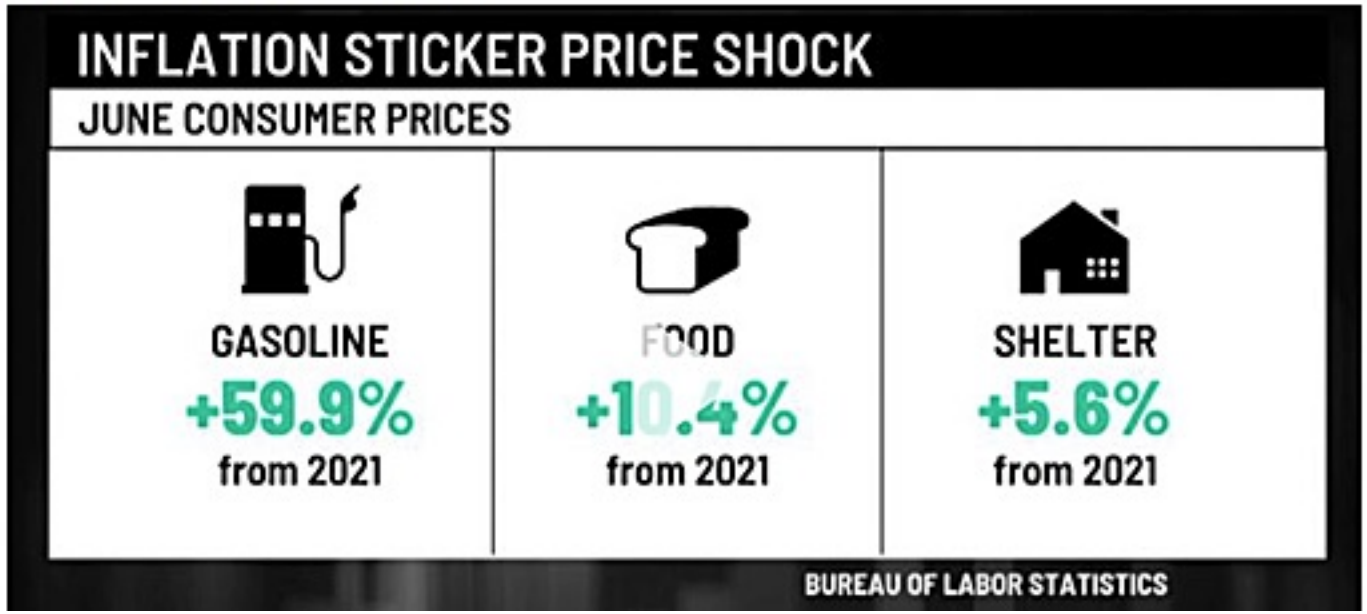
Inflation Today

CNN BUSINESS

US inflation hit 40-year high in June, driven by record gas prices

By Lucy Bayly and Alicia Wallace, CNN Business

Updated 10:29 PM ET, Wed July 13, 2022



9.1%!!

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What is the Future of Reimbursement?

The Future is Now !

Progressive decreases in payment by largest government payer, increasing supply costs, staff salary increases, and inflation threatens viability of medical private practices!

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Past as Predictor of Future

20% access centers closed

39%

In 2017 payments to a key vascular access code were cut by 39%

30%

Medicare claims data has confirmed a decrease in office-based vascular access services of more than 30% since 2017

DIALYSIS VASCULAR ACCESS COALITION

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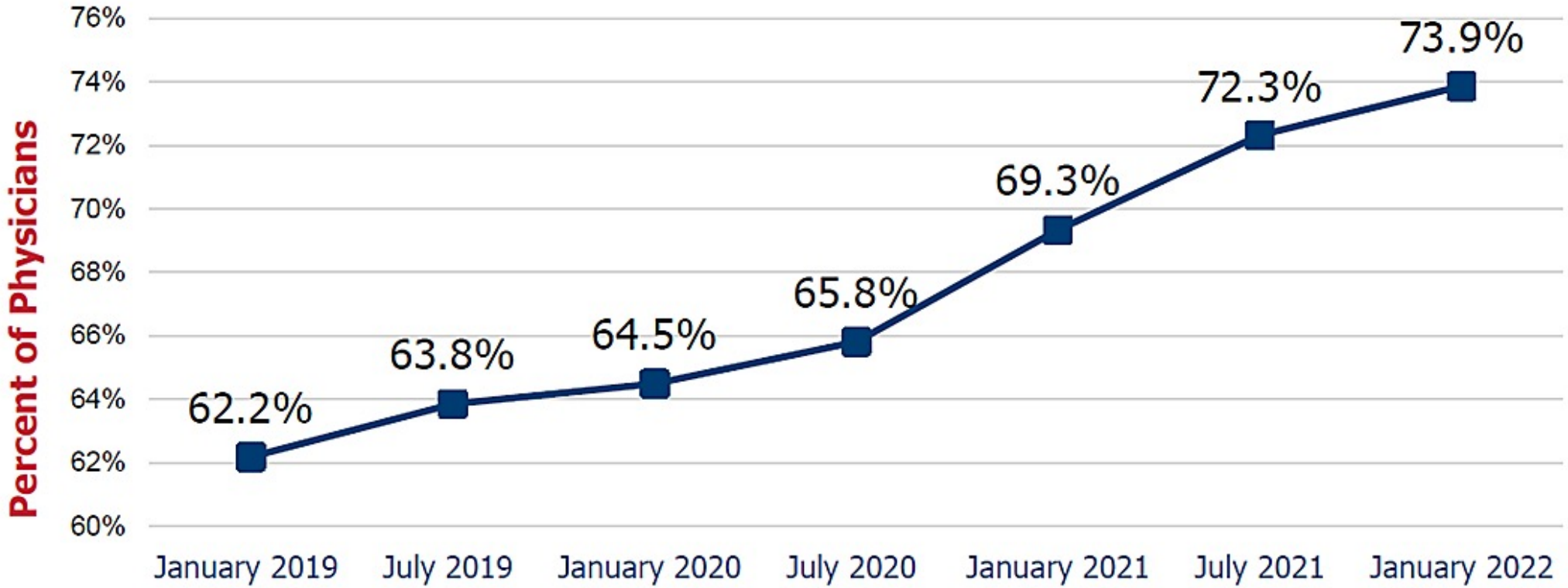
PERCENT OF U.S. PHYSICIANS EMPLOYED BY HOSPITALS OR CORPORATE ENTITIES IN 2019-21



- **74%** of physicians were hospital or corporate-employed by January 2022
- Over the three-year study period, the percentage of employed physicians **grew by 19%**

http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20

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AVLS – OEIS Member Survey

Expected Changes in Physician Outpatient Interventional Practices as a Result of COVID-19 and Recent Changes in Medicare Physician Fee Schedule

John Blebea MD, MBA[1]
Krishna Jain MBBS[2]
Chin-I Cheng PhD[3]
Chris Pittman MD[4]
Stephen Daugherty MD[5]

20 question survey
February 2022
165 respondent physicians

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Demographics

	Number	Percentage
Highest Interventional Practice Type*		
Office-based Practice	90	55%
OBL	46	28%
Hybrid OBL/ASC	24	15%
Hospital Outpatient	4	2%
ASC only	0	0%
Physicians in practice		
1	81	53%
2	25	16%
3	11	7%
4	6	4%
5	8	5%
6	22	14%
Clinical Practice		
Venous - Superficial	164	99%
Venous - Deep	63	38%
Peripheral Arterial	60	36%
Cardiac	12	7%

98%

69%

Employment Model		
Practice Owner	125	76%
Private Practice, but not the Owner	23	14%
Multi-specialty Group Employee	9	5%
Hospital Employee	8	5%
Years since training		
1-5 years	9	5%
6-10 years	7	4%
11-15 years	29	18%
16-20 years	23	14%
20+ years	96	59%
Years in interventional		
1-5 years	16	10%
6-10 years	24	15%
11-15 years	37	23%
16-20 years	30	18%
20+ years	56	34%

90%

75%

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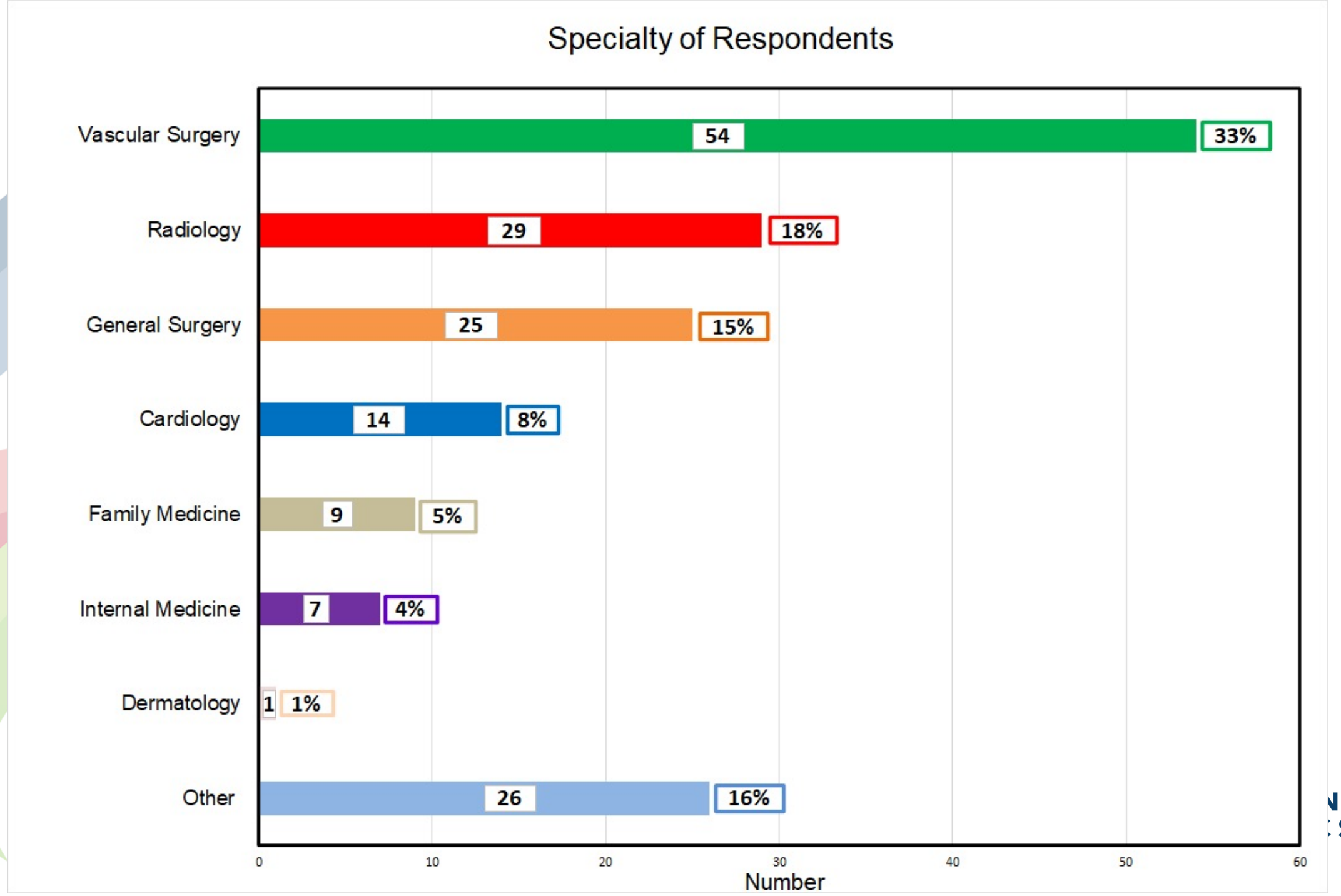

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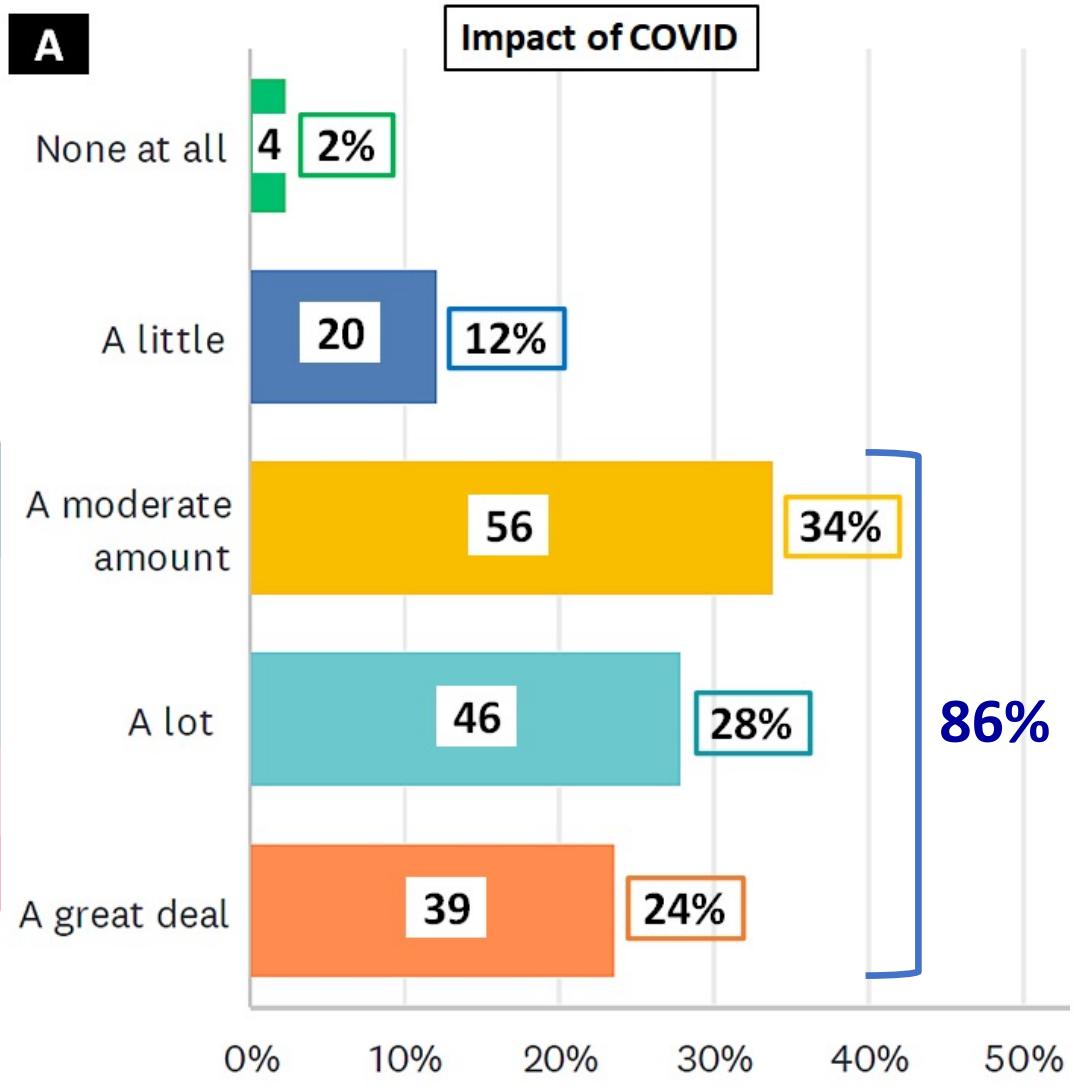

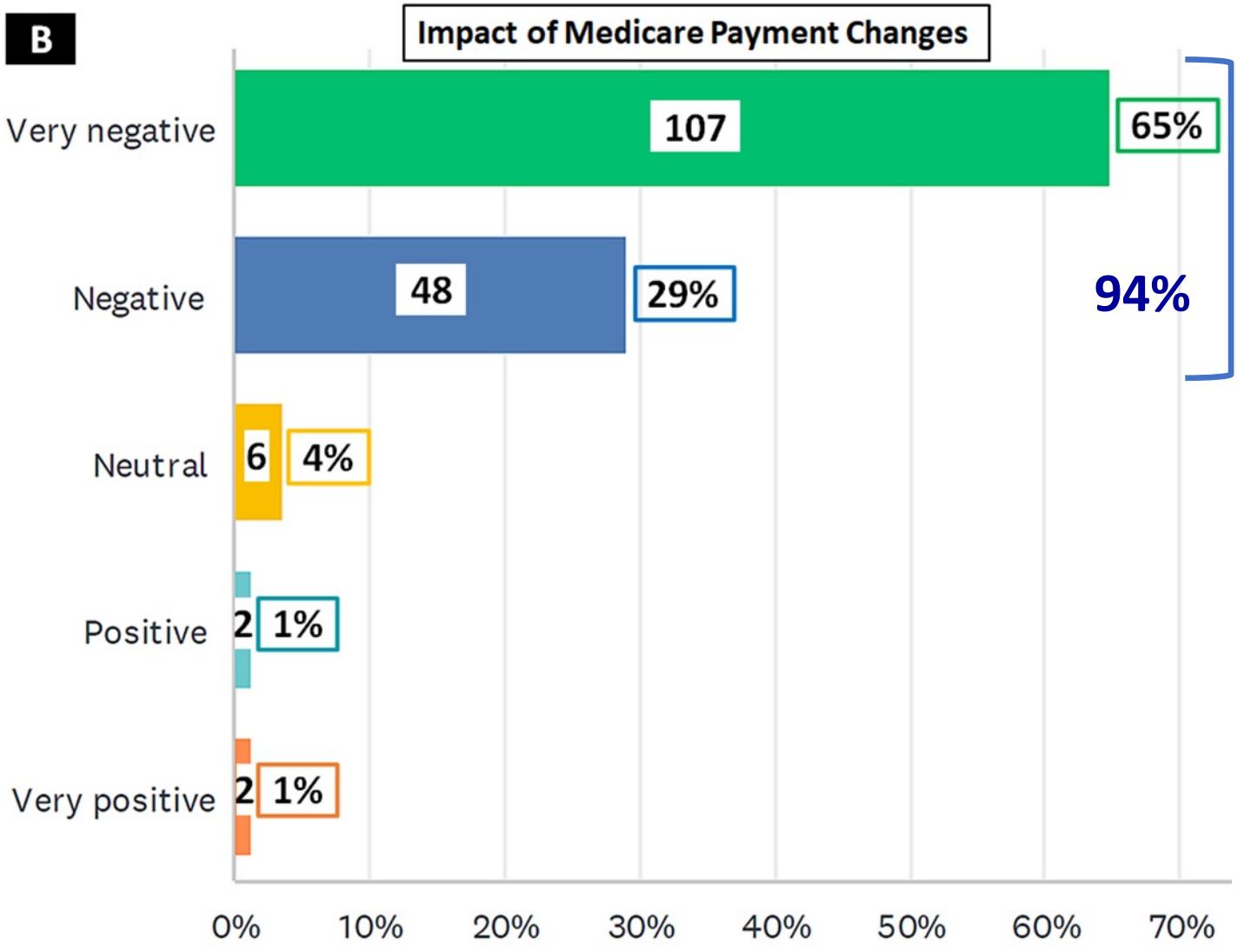

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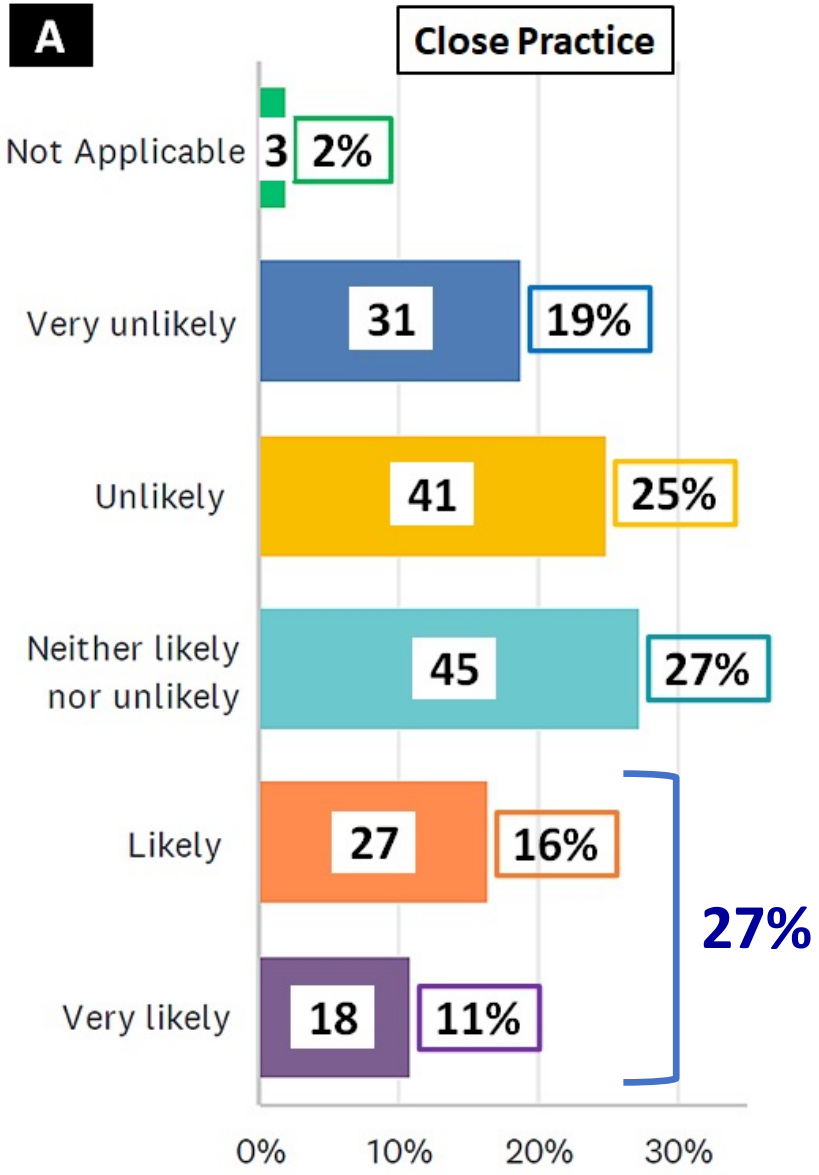

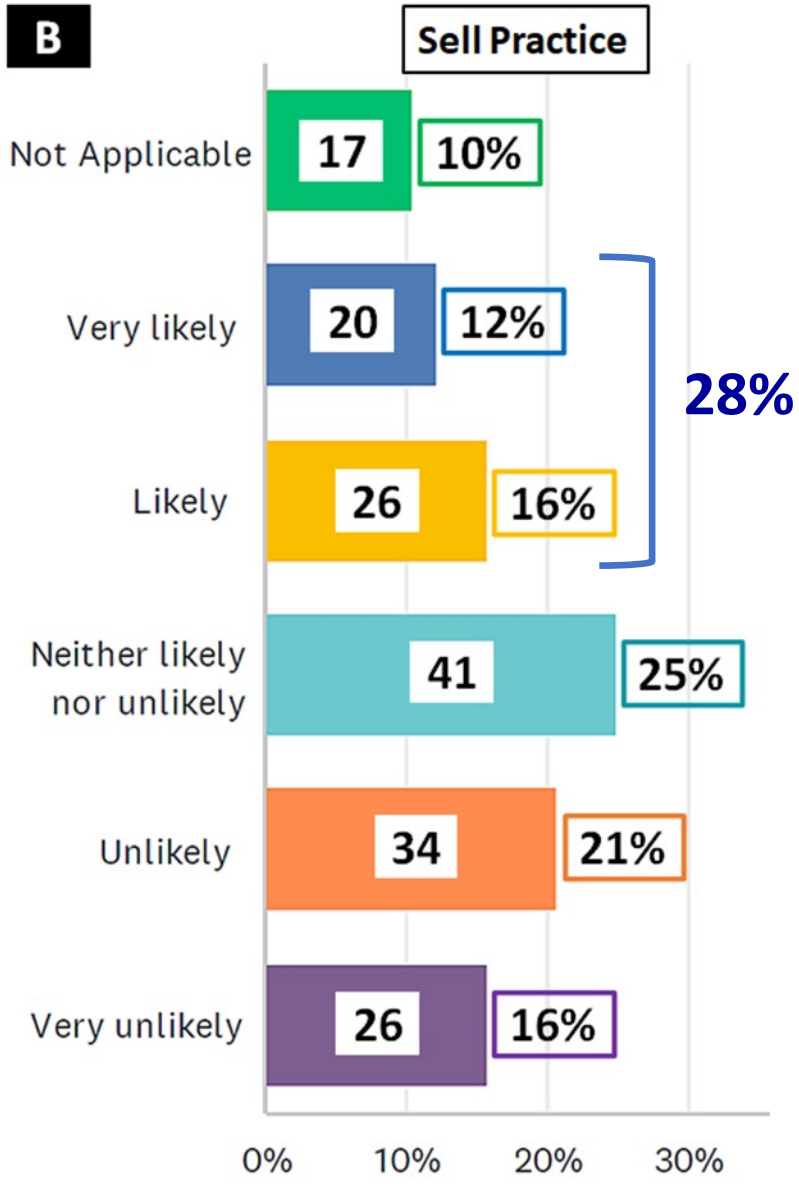

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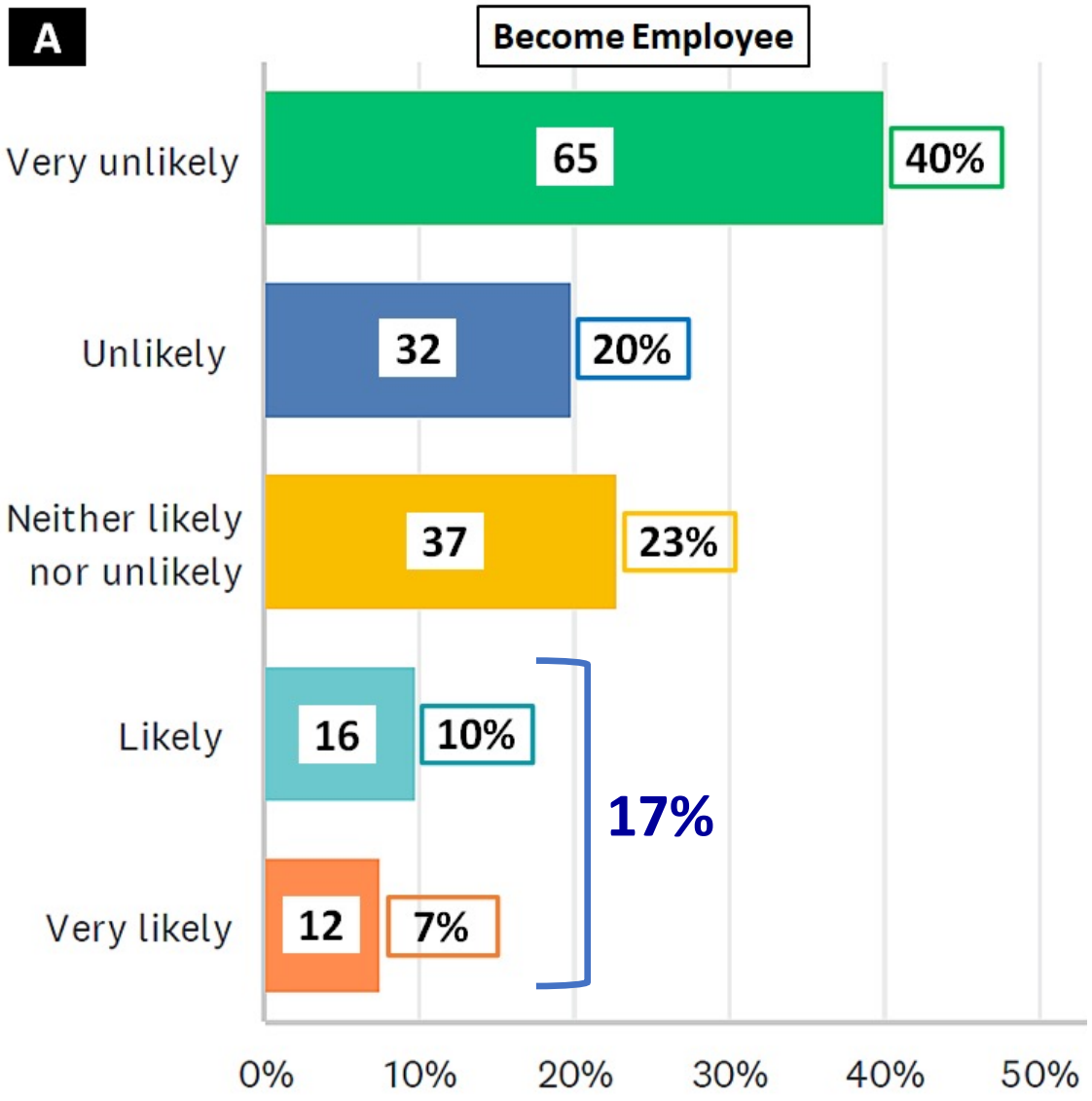

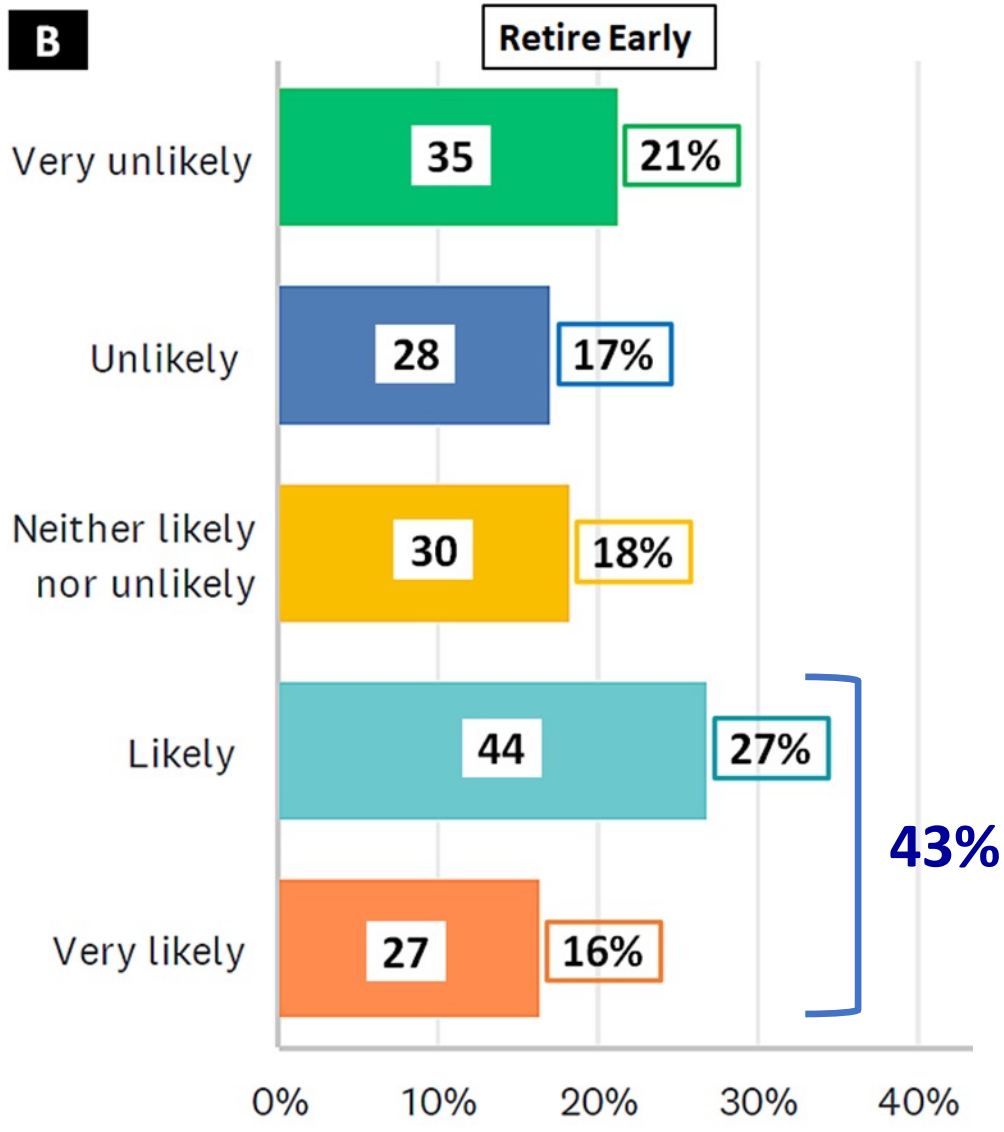

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Study Conclusions

- COVID and cuts in Medicare reimbursement have challenged the financial viability of office practices
- Large number of physicians expect to retire, sell or close their practices in the next two years
- Further Medicare cuts may cause irreparable harm and limit patient access to private practice care of patients with vascular disease

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Summary Thoughts

Increasing supply costs, salary increases, and inflation, on top of progressive decreases by Medicare, threatens viability of private venous practices.

Physicians will choose to retire early, close or sell practices in areas of unfavorable payer mix.

Patient access to care will decrease, especial in rural areas.

Total health care costs will increase.

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Summary Thoughts

Budget neutrality for physician reimbursement is no longer tenable if private practice to survive in U.S.

Congressional action is needed

Now, more than ever, support of AVLS and Advocacy is needed – for physicians and their patients

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