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The Little-Known Decision-Makers for Medicare Physicians Fees

BY UWE E. REINHARDT
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Uwe E. Reinhardt is(was) an economics professor at Princeton. [Mr. R. passed 2017 – age 80 :: https://en.wikipedia.org/wiki/Uwe_Reinhardt *]*
…

Have you ever heard of the RUC?

If not, you are **not** part of the small circle of cognoscenti who know what makes the world go 'round – at least in Medicare.

To enter the circle, read on.

In my post last week, I described how Medicare pays physicians for the services they render Medicare beneficiaries.

In a nutshell, for a particular service (e.g., a routine office revisit or an appendectomy or a heart transplant) that we shall call Z, Medicare pays a fee calculated with this formula:

Fee_Z = (Work RVU_Z x Work GPCI + PE RVU_Z x PE GPCI + PLI RVU_Z x PLI GPCI) x CV

Fee_Z is the dollar amount of the fee paid for the service, Work RVU_Z denotes the relative value units for the physicians' work going into the production of service Z, PE_Z denotes the relative value units of the physician's practice expenses allocated to service Z and PLI_Z denotes the relative value units for the professional liability insurance premium allocated to service Z.

Each of these three relative cost factors is adjusted for its own geographic price index, GPCI in the equation. Thus, there is one GPCI for the physician's work, one for practice expenses and a one for malpractice premiums.

The sum of these three RVU components, adjusted by their GPCIs, is multiplied by CV, the conversion factor. This is the dollar amount that Medicare pays for one overall RVU.

This conversion factor is updated annually in a vaguely amusing ritual of which I shall write in the future. It currently stands at $36.0846. (For a history of these conversion factors, click here.)

The fee for service Z might be further adjusted by multipliers that reward physicians for working in an area with a shortage of physicians and other factors. (For more detail, click here.)

In response to my previous post, some commentators asked for a numerical illustration — so here it goes.

In "What Every Physician Should Know About the RUC," the American Academy of Family Physicians provides this example for a service defined as "level III established patient office visit," Code 99213:

Work RVUs: 0.92, Practice Expense RVU 0.72, Malpractice RVU 0.03. Assuming for simplicity that all geographic price

indices – the GPCIs – are 1 for this hypothetical physician's location, the total RVUs for this service are 1.56. It would be slightly different if the GPCIs were not all equal to 1.

The RVUs in this illustration are for 2008. If they have not changed since that time, and at today's conversion factor of $36.0846, the physician would be paid a fee of $36.0846 x 1.56 = $56.29 for that service (Code 99213).

By contrast, the total RVUs for a "left heart catheterization" (code 93510) are 40.54, of which 33.61 are related to practice expenses. The fee for that procedure at today's conversion factor would be $1,462.87.

In this example from the American Academy of Family Physicians, the Work RVU for a "level III-established patient office visit" (Code 99213) in 2008 was not 0.92, but only 0.8806, because the 0.92 had been adjusted for "budget neutrality reasons." What is that?

Here is where the mysterious RUC (pronounced RUCK) comes in.

Think about the RVUs underlying the Medicare fee schedule. They are thought to reflect total relative practice costs, including the physician's own time, for each of the 7,000 distinct physician services in the schedule. These underlying relative cost estimates were developed from carefully described medical-case vignettes submitted to groups of physicians who were then asked to tell the surveyors how much "physician work" each vignette entailed relative to some base vignette (e.g., a routine office revisit). This established the physician-work RVUs.

The Centers for Medicare and Medicaid Services, known within the health-care sector as the C.M.S., an agency within the Department of Health and Human Services that administers Medicare, then adds physician expense and malpractice RVUs to these Work RVUs to arrive at the total RVUs for a service.

Even if we assume that at some point the 7,000 or so RVUs in Medicare's relative value scale accurately reflected the true total relative practice costs, it must be the case that these RVUs change over time, because of rapid advances in medical technology.

Operations that may have taken two hours and required hospitalization in 1995, for example, may now be performed by physicians in half the time and in an ambulatory-care setting. Furthermore, entirely new services have come on line that did not exist when the fee schedule was established.

Who makes the required adjustments in the RVUs?

De jure it is the C.M.S.

De facto, it is the American Medical Association's Specialty Society Relative Value Scale Update Committee, otherwise known as — you guessed it — the RUC.

The RUC is a group of 29 physicians [now 31] drawn from a variety of medical specialties. It was established by the A.M.A. in 1991 to advise the C.M.S. on recalibrations of the relative value scale underlying the Medicare fee schedule.

In 1991, as a commissioner on the Physician Payment Review Commission of Congress, I thought the RUC was a useful institution. I continue to believe so.

There is, in my view, great merit in government's solicitation of the views of the profession whose economic affairs are being partially determined by the Medicare fee schedule.

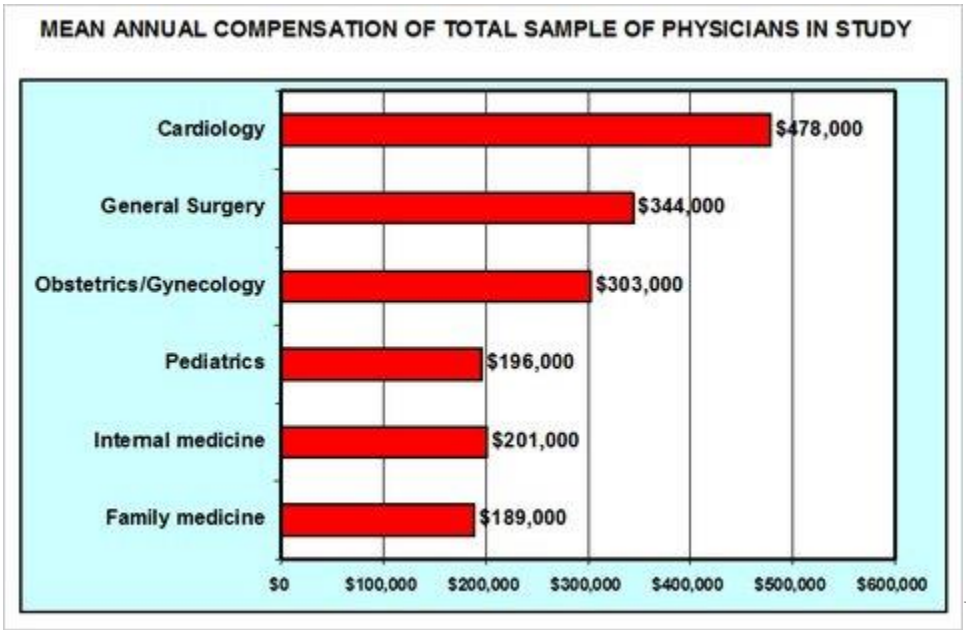
We should be thankful for the dedicated physicians who devote so much of their time to serving on the RUC Indeed, the C.M.S. recently wrote to the RUC, acknowledging its debt to these physicians.

As it happens, however, the C.M.S. tends to accept the RUC's recommendations on RVU changes more than 90 percent of the time, which effectively makes the RUC the final arbiter in these matters. I do not believe that slavish acceptance of the RUC's recommendations is a good thing, if only because the physicians on the RUC do labor under at least the appearance of a conflict of interest.

Medicare requires changes in the RVUs to be budget neutral overall, effectively forcing a zero-sum game on the RUC. This means that when the RUC recommends raising the RVU for some services, the RVUs of other services must be decreased. That adjustment has led to the "budget neutrality adjustment" in the American Academy of Family Physicians' numerical example shown above.

Primary physicians have long complained that they are outgunned by specialists on the RUC in this zero-sum game. They assert that the RUC has thus contributed to the relatively low pay of primary care physicians and to the shortage of primary care now being lamented all over the country.

To illustrate that these primary care physicians have a good case, consider a fascinating recent study of physician incomes produced for Medpac, the Medicare Payment Advisory Commission of Congress. Shown below is one chart from that study. The figures shown in this display are net income after practice expenses but before income taxes.



Urban Institute and the Medical Group Management Association Center for Research (for the Medicare Payment Advisory) Commission

Surely there is something absurd when a nation pays a primary care physician poorly relative to other specialists and then wrings its hands over a shortage of primary care physicians. Is it so hard to understand why young physicians, emerging as they do from long and arduous training, exhausted and deeply in debt, let expected future financial reward be a major factor in choosing their specialty?

In a highly critical article, The Wall Street Journal recently described the modus operandi of the RUC, as did the Center for

Public Integrity. These are well worth reading, as is the American Medical Association's brisk response to the criticism (and again here).

So what are we to make of it all?

I would prefer that the C.M.S. declare "Independence Day" when it comes to recalibrating the RVUs.

To be sure, the C.M.S. should continue to seek input from the RUC. But I concur wholeheartedly with the Medpac's recent recommendation that a truly independent body of experts (including economists and third-party payers) render a second opinion on RUC recommendations.

Specifically, this independent body should focus on frequently billed codes that, in the light of current medical technology, may be relatively overpriced in Medicare's relative value scale. The C.M.S. has already asked the RUC to do this. That task should be delegated instead to the truly independent body.

All of which requires, of course, that Congress properly fund the C.M.S. administrative budget for all that agency is asked to do. [end of copy]

https://en.wikipedia.org/wiki/Uwe_Reinhardt

Uwe Reinhardt

From Wikipedia, the free encyclopedia
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Uwe Reinhardt	
Born	September 24, 1937 Osnabrück, Germany
c	November 14, 2017 (aged 80) Princeton, New Jersey, United States
Scientific career	
Doctoral advisor	Richard Ruggles[1]

Uwe Ernst Reinhardt (September 24, 1937 – November 14, 2017) was a professor of political economy at Princeton University and held several positions in the healthcare industry.[2] [3] Reinhardt was a prominent scholar in health care economics and a frequent speaker and author on subjects ranging from the war in Iraq[4][5] to the future of Medicare.

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Biography[edit]

Reinhardt was born 1937 in Osnabrück, Germany, and later emigrated to Canada where he received his Bachelor of Commerce degree from University of Saskatchewan.[6] He later received a Ph.D. in economics from Yale University[6] in 1970, with a thesis titled "An Economic Analysis of Physicians' Practices" under the supervision of Richard Ruggles.[1] He taught courses in economic theory and policy, accounting, and health economics and policy. Reinhardt's scholarly work focused on economics and policy and included more far-reaching topics such as cost-benefit analyses of the Lockheed L-1011 TriStar[7] and the Space Shuttle.[*citation needed*] He died on November 14, 2017 in Princeton, NJ.

In July 2015 Reinhardt's 2013 syllabus and first lecture for a class titled "Introductory Korean Drama" received attention from several bloggers.[8] By way of explanation, Reinhardt introduced the class by stating

After the near-collapse of the world's financial system has shown that we economists really do not know how the world works, I am much too embarrassed to teach economics anymore, which I have done for many years. I will teach Modern Korean Drama instead.

Although I have never been to Korea, I have watched Korean drama on a daily basis for over six years now. Therefore I can justly consider myself an expert in that subject.[9]

It was not clear whether Reinhardt actually intended to teach the course.

Research[edit]

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Reinhardt's research focused on hospital pricing, systems of health care around the world, Medicare reform, and health care spending. His work appeared in *Health Affairs*, *The New England Journal of Medicine*, *JAMA*, and *The British Medical Journal*.[10]

In a recent paper, Reinhardt discusses the obstacles to success of consumer-directed health care in light of the lack of transparency in hospital pricing. He suggests several reforms that could lead to better information on hospital pricing for consumer decision-making, including a national set of Diagnosis-related group weights to which each hospital could then apply its own conversion factor. Reinhardt's previous work on hospitals examined the tax and cost of equity capital advantages of not-for-profit hospitals over for-profit hospitals.

Reinhardt's scholarship analyzed the U.S. health care industry in relation to systems around the world. He argued that higher U.S. health spending is a result of higher U.S. per capita gross domestic product (GDP) as well as intricate and disjointed payment systems. Reinhardt's work on foreign systems of health care includes a 2004 analysis of Switzerland that appeared in *The Journal of the American Medical Association*.[11] In it, Reinhardt argued that there is little correlation between the prevalence of consumer choice and the high quality of Swiss health care.

In 2003, Reinhardt, along with 14 other prominent health policy experts and private health care industry leaders, signed an open letter arguing that Medicare should lead the U.S. health care industry in paying for performance by tying financial reimbursement to quality measures.

Reinhardt's work on health care spending includes his argument that the aging of the U.S. population is not the primary cause of the growth in U.S. health care spending.

Private industry and advisory roles[edit]

In addition to his university duties, Reinhardt was active as an advisor for government, non-profit organizations, and private industry and held directorships in various for-profit companies in the health industry. Reinhardt served on the Governing Council of the Institute of Medicine of the National Academy of Sciences between 1979 and 1982, after election to the Institute in 1978.[12] At the Institute, he served on a number of study panels, including, the Committee on the Implications of For-Profit Medicine, the Committee on Technical Innovation in Medicine, the Committee on the Implications of a Physicians Surplus, and the Committee on the U.S. Physician Supply. In 1996, he was appointed to the Board of Health Care services of the Institute.

From 1986-1995, Reinhardt served three consecutive three-year terms as a Commissioner on the Physician Payment Review Commission (PPRC), established in 1986 by the Congress to advise it on issues related to the payment of physicians. Reinhardt serves as a Commissioner for the Kaiser Family Foundation Commission on Medicaid and the Uninsured.[13] Reinhardt was or is a member of numerous editorial boards, among them The New England Journal of Medicine, JAMA, The Journal of Health Economics, the Milbank Quarterly, and Health Affairs.

Reinhardt served as a trustee of Duke University and the Tekla Family of Funds.[6] He also served on the Boards of Directors of Boston Scientific Corporation,[6] a leading maker of medical devices, and Amerigroup Corporation, a large health insurer whose clients consist primarily of persons enrolled in Medicare. He served on the Board of Directors of Triad Hospitals, Inc, until that company was merged into Community Health Systems in 2007. He was a regular contributor to the *New York Times'* Economix blog, where he wrote about economic matters, particularly the economics of health care.[6]

Role in Taiwan's healthcare system and award[edit]

In 1989, as Taiwan was restructuring its healthcare system, Reinhardt persuaded its leaders to model it on those of Canada and Germany. Taiwan's system now provides universal care for 6.6% of GDP. For his contribution, in 2014 he was awarded the nation's Presidential Prize.[14][15]

Views[edit]

This section **needs expansion**. You can help by adding to it. *(August 2011)*

Administration[edit]

In the 2009 *Frontline* show "Sick Around America", Reinhardt criticized the United States for spending 24% of every health care dollar on administration, and pointed out that Canada spends less than half of the U.S. amount and Taiwan spends significantly less than Canada.[16] Reinhardt faulted the seeming U.S. preference for an unwieldy "mishmash of private insurance plans" for the inefficiency.[16] He said if the U.S. could spend half as much on administration, it would save more than enough money to cover all the uninsured.

Selected articles[edit]

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- Hambrecht and Quist Capital Investors official web site
- Boston Scientific official web site
- Reinhardt's posts on the *New York Times* Economix blog

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