A History of RBRVS as a Perspective on P4P — Part I

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Why Medicare Rates are Critical

How anesthesiology services are valued by Medicare has a pervasive influence on the economics of anesthetic practice. Indeed, in order that compensation from all payers in any particular practice be adequate to sustain that practice economically, contractual rates negotiated with commercial insurers (and even what might be deemed acceptable from cash-paying patients) must offset ("defray") the egregiously low payment rates from Medicare. Anesthesiologists have long understood that accepting commercial rates which are some percentage within proximity to Medicare rates is folly. In some circumstances, anesthesiologists have been forced to do so by political or economic forces much larger than their statutorily permissible collective bargaining, but much more often anesthesiologists have convinced insurers not to link their contractual rates to Medicare rates in any guise.

Primary care physicians or specialists in many practices are quite happy with commercial rates which are 120 percent of Medicare. The Workers Compensation System in California is not a government-financed program but actually a commercial one which is regulated by the government. WC contemplates, as part of its continuing reform process, a new rate structure in 2006, and a worst-case scenario would base payments on Medicare's Resource Based Relative Value System. A 120 percent multiple of Medicare rates for anesthesiologists would produce a conversion factor in the $22.50 range per unit, a 31 percent reduction from the already low WC rate of $32.78 per unit, which has been frozen for these past 18 years. On the other hand, a careful reading of the underlying WC Reform law establishes that physician procedure fees may be exempted from the limit of 120 percent of Medicare, at the discretion of the WC Administrative Director. Of course we hope that such an exemption will be the eventual outcome, but that we should even be discussing WC payments in some relationship to Medicare illustrates just how pervasive and pernicious RBRVS has become for anesthesiologists. If WC were to adopt a new payment system that would drastically reduce payments to anesthesiologists, one might characterize such a change as ill-advised, unfair, and unwarranted, and yet one might still be understating the reaction of a California anesthesiologist who

may well be forced economically to consider abandoning the elective care of these patients.

Moreover, as baby boomers reach Medicare age, the demographics of anesthetic care will change to reflect an ever-increasing percentage of Medicare patients and an ever-decreasing pool of commercially insured patients. For quite some time, the ASA has considered this issue in great detail, and even has *examined* (don't get nervous!) a proposal to eliminate actual time units, possibly developing a "case rate" system that incorporates average times with base values. This would bring the system for valuation of anesthesiologists' work into line with all other medical specialties and become a part of the RBRVS. We no longer would stand apart from all other physicians with our ASA Relative Value Guide. Your leadership, however, well understands that such a move would be a double-edged *sword*. The use of time for calculating reimbursement is appropriate in our specialty because we have no control over surgical time. Moreover, average time would benefit practices with healthy and uncomplicated patients and quick surgeons in stark contradistinction to the higher complexity and longer duration of cases typical in academic institutions. Furthermore, given the history of how anesthesiologists have been treated by Medicare, one can only assume that any kind of conversion at best will be cost neutral and more likely will produce further reductions in payments.

Abbreviations Key	
AANA	American Association of Nurse Anesthetists
CHAMPUS	Civilian Health and Medical Program for the Uniformed Services
CMS	Centers for Medicare and Medicaid Services
DHHS	Department of Health and Human Services
DRG	Diagnosis-Related Groups
HCFA	Health Care Financing Administration
HHS	Health and Human Services
HOD	House of Delegates
MAAC	Maximum Allowable Actual Charges
MEI	Medical Economic Index
MFS	Medicare Fee Schedule
PPRC	Physician Payment Review Commission
PPS	Prospective Payment System
RAP	Radiology, Anesthesiology, Pathology
RBRVS	Resource Based Relative Value System
RVG	Relative Value Guide
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
UCR	Usual, Customary and Reasonable
URVG	Uniform Relative Value Guide
WC	Workers Compensation System

To understand more fully this problem which is critical to the economics of anesthetic practice, this article seeks an exposition of how Medicare's RBRVS came about, how ASA's RVG is distinct from it, and how anesthesiologists' services came to be so undervalued by Medicare (even more so in academic

settings). There are some challenging questions to be tackled, especially whether we as a specialty devoted sufficient intellectual and political resources and insight at the time of the RBRVS proposal to protect our interests. Moreover, can any lessons be applied to—or analogies drawn from—what happened then to what is happening now concerning the establishment of Pay for Performance for Medicare services?

Payment Methodology in Jurassic Times

In the early part of the 20th century, anesthesiologists were paid through individual hospitals, but by the late 1940s, there had evolved a fee-for-service system with a flat fee, which typically was 20 percent of the surgeon's fee. The California Relative Value Guide is an early example of our modern billing methodology, in which there are base units and time units, as well as adjustments for anesthetic risk and an opportunity for geographic adjustments. Dr. Joseph H. Failing, an anesthesiologist from Los Angeles, developed this billing guide in the 1950s, and he nurtured it through the CSA and CMA, and then brought it to the ASA.

Some Feds Needed a Fee Schedule—
Other Feds Alleged a Conspiracy to Fix Prices

In the early 1960s, Congress passed a law establishing health benefits for military dependents, the Civilian Health and Medical Program for the Uniformed Services. This, as well as pressure from employers and insurers, seemed to require some sort of standard fee schedule for anesthetic services so that budgets could be generated. There was intense debate in the ASA House of Delegates concerning whether the establishment of a national RVG might further the cause of "socialized medicine." Debate also focused upon whether using "Usual, Customary, and Reasonable" fees, as had been developed by the rest of the House of Medicine, would be preferable because of a desire by anesthesiologists to be treated like other physicians. Concomitantly, deliberation also considered that because a national survey of UCRs was in process, if a uniform fee schedule were not adopted by anesthesiologists, then "one formulated by a third party [would be] forced upon us." In 1961, the HOD affirmed the principle of UCR fees, but in 1962, the HOD formally adopted the ASA RVG based upon time units, while emphasizing that this was a guide and that ASA members could use either the UCR or RVG systems.

The first ASA RVG in 1962 was merely a pamphlet of stapled mimeographed sheets, but by the second edition in 1967, many changes and additions had been incorporated, and the RVG had evolved into the form of a professional publication. Commencing with the relative value studies published by the

California Medical Association in the 1950s, other professional societies representing obstetricians, radiologists, pediatricians, and dentists had published their own guides. However, the Federal Trade Commission began challenging RVGs, alleging conspiracies to fix prices for medical services, clearly prohibited by antitrust laws including the Federal Trade Commission Act. The FTC obtained consent orders that terminated publication of these RVGs. For unknown reasons, the FTC did not challenge ASA's RVG. However, the Justice Department then brought suit under the Sherman Antitrust Act against the ASA in 1975! It was not until 1979 that the case was tried and the ASA prevailed, preserving ASA's RVG.

Medicare—The Early Years

In 1965, Medicare was enacted, and anesthesiologists then began to be paid in a discounted fee-for-service system, typically 90 percent of UCR charges. Early drafts of the Medicare law attempted to categorize anesthesiology services as hospital services, to be "reimbursable" on a reasonable-cost basis from Medicare Part A. This would have been a crippling blow for our specialty, and it was averted by Dr. Nick DePiero's (then a leader of the Ohio society and later ASA President) persuasion of Wilbur Mills, then Chair of the House Ways and Means Committee, that anesthesiologists should be treated like all other physicians and paid out of Medicare Part B. Current Procedural Terminology (CPT) codes were developed by the AMA and became the accepted method for billing Medicare and, later, other payers. The ASA changed the organization of its ASA RVG codes from physiologic systems to anatomical areas in 1977, hence reducing the number of codes required, and by 1980, there was an Anesthesia Section in AMA's CPT Codes which mirrored the ASA's RVG.

By 1973, Medicare expenditures had grown dramatically, and Congress authorized the Health Care Financing Administration—in recent years it was renamed the Centers for Medicare and Medicaid Services—to institute the Medical Economic Index, which sought to limit future Medicare payment increases to a ceiling established by the rate of increase in the costs of running a physician's practice. This MEI limited Medicare payment for anesthesia services, but it did not restrain UCR charges by physicians nor restrict what is now called payments for noncontracted services (also known as "balance billing").

Also by the mid 1970s, internists and other primary care physicians began to complain increasingly that their cognitive services were undervalued relative to technical or procedural services, and they lobbied the AMA and the DHHS—the government department with oversight over HCFA—to reconfigure the system of payment to pay them more, perhaps by paying surgeons and other "proceduralists" less. In the late 1970s, William C. Hsiao, Ph.D., and his group

at Harvard University became interested in trying to define the resources and costs associated with how a physician practices.

An Ill Wind Starts to Blow from the East

By the late 1970s, concerns arose in Congress about the perception of an excessive level of income that some anesthesiologists were being paid by Medicare, particularly 1) those who were paid on a "percentage billing arrangement" in which the anesthesiologist would receive a certain fraction of the gross billings of a hospital for all its anesthesia services, and 2) those maintaining a so-called "stable" of CRNAs. Limits on the number of procedures that could be medically directed simultaneously were also debated.

In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act of 1982, the first law intended to change how physicians delivered services under Medicare. It required that that a clear distinction be drawn between physicians services to an individual patient (to be paid from Part B) and those that serve patients in general (to be paid in a severely restricted manner under Part A). HCFA in 1983 promulgated additional new payment restrictions under Medicare Part B for anesthesia services. There were requirements for—and limits on—medical direction of anesthesia services: a maximum of four simultaneously directed procedures and prohibition of providing personal services concomitantly. Moreover, only two time units per hour for anesthesiologist-employed CRNAs, but four per hour for hospital-employed CRNAs, were allowed. Also in 1983, Congress established the Prospective Payment System for inpatient services, rewarding "efficient" care by establishing flat prices for specific procedures. This then would have produced an incentive for hospitals to "dump" CRNAs employed by them and paid from Medicare Part A, making it cheaper to use anesthesiologists paid from Part B. However, the American Association of Nurse Anesthetists flexed its political muscle to persuade Congress to make an exception for them to be paid outside this PPS and also to suspend the reduced time unit requirements, ultimately for six more years!

1984-1985 hosted the introduction of the notion of "participating" and "non-participating" physicians and a fee freeze for 15 months.

Except for the TEFRA rules, which were felt to incorporate ASA ethical principles into Medicare Part B payment policies, anesthesiologists had not been singled out for adverse treatment harsher than other specialties. However, AMA data continually showed anesthesiologists to be among the highest paid specialists and, also important, to have the lowest rates of acceptance of Medicare assignment. The Deficit Reduction Act of 1985 required that a balanced federal budget be achieved by 1990, set specific deficit limits for each year, and gave

rise to the notion of "budget neutrality," meaning that new expenditures must be balanced by reducing other expenditures.

In 1986, as part of the budget process, the Health and Human Services Inspector General argued to pay for Monitored Anesthesia Care cases with time units only, eliminating base units. The ASA was able to convince HCFA to reduce base units only—a compromise which ASA knew would affect some anesthesiologists more than others, but which was deemed to be needed to stave off more severe or broader cuts if ASA refused to negotiate.

RAP DRGs were first proposed in 1986, were an item in Reagan's 1987 budget, and were defeated by the ASA. (It was reintroduced by Clinton in 1993 and defeated once again.) Also in 1986, the federal government responded to the low rates of Medicare participation by subjecting nonparticipating physicians to MAAC limits on balance billing, refined in 1991 to 115 percent of the "reasonable" charge. The political power of the Gray Panthers was becoming apparent.

RBRVS Arises to Redistribute Medicare Dollars from Specialists to Primary Care Physicians

To produce a realignment of payment priorities, to encourage primary and preventive care, and to disincentivize what were perceived by the Congress as overpaid specialists, Congress, in 1985, awarded Harvard and the Hsiao group a multimillion dollar contract to develop a RBRVS. Then, in 1986, Congress mandated a study to use the RBRVS as the new Medicare Fee Schedule. In 1987, budgetary pressures put RAP DRGs back on the table and, as the negotiated "price" to avoid them, the ASA chose to accept significant percentage cuts in base units and time used to calculate payment for medical direction of CRNAs, as well as the imposition of strict limits on balance billing for nonparticipating physicians. There was a perception held by some who were familiar with the magnitudes of Medicare payments that some anesthesiologists who engaged in medical direction were gaming the system; therefore, ASA leadership chose to acquiesce in order to preserve the larger anesthetic picture. There was a subsequent firestorm of criticism from the affected anesthesiologists, who undertook an independent lobbying effort to stop the cuts, or at least to share them with anesthesiologists administering their own anesthetics. The scenario of two camps speaking with multiple contradictory voices almost unwound the negotiations and was close to plunging anesthesiologists into the darkness of an inclusion in a Medicare Part A DRG scheme. Fortunately, the political capital and credibility of ASA leadership averted the disaster. Mike Scott, former ASA Director of Governmental Affairs, explained this difficult negotiation:

> But in legislative matters, one often does not have a choice of defining the field of battle, nor the length of time over which the battle is fought, nor the alternatives if the tide of battle starts to turn.

This compromise, however, did serve ASA well the following year. In 1988, there was another crisis when HCFA realized that if payment for CRNAs was to be the same, no matter who employed them, severe cuts would be needed in payments to hospital-employed CRNAs to preserve budget neutrality. HCFA could have avoided these cuts by reducing medical direction payments even further, but the ASA and AMA, given the history of the 1987 compromise, persuaded HCFA to establish a budget-neutral CRNA fee schedule without further tinkering with payments for physician-directed anesthesia services.

In 1988, Congress decreed that, instead of using the UCR as the basis for payments, Medicare would be mandated to base Medicare payments to physicians on relative differences in work, practice expenses and medical liability insurance. After intense lobbying that used Hsiao's work as a basis for their deliberations, the PPRC recognized the ASA RVG as consistent with resource costs and as similar to the relative values in Hsiao's work (which in my opinion was, and remains, egregiously flawed), and recommended it as appropriate for use in the MFS, including the retention of anesthesia time units. The final rule on the URVG was published by the HCFA in 1990: the ASA RVG was retained, modifier units were eliminated, coverage of special types of monitors was left to carrier discretion, and certain eye procedures (like cataracts) were lowered by statute to four units base value.

Watch for Part II of this article in the Summer 2006 issue of the Bulletin.

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