A History of RBRVS as a Perspective on P4P

Part III of III: Lessons Learned and Suggestions for Future Action

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Part I, published in the Spring 2006 issue of the *CSA Bulletin*, detailed the history of how Medicare's RBRVS evolved. We elucidated early methods of billing for anesthesia services, painted the political landscape concerning payment for medical services in the 1980s, described the government's machinations to redistribute federal dollars to effect change, and examined ASA's role in shaping the Medicare Fee System, up to the adoption of the final rule on the Uniform Relative Value Guide, published by the HCFA in 1990. In Part II, published in the Summer issue of the *Bulletin,* we examined in detail the little-understood details of how HCFA constructed the RBRVS as the new MFS, including the debate over anesthesia time, how cross-links were actually set, how the conversion factor was distorted, and what ASA did and did not do on our behalf, both during the initiation of RBRVS and thereafter with outside expert consultants and the RUC. In Part III, we will draw an analogy to the current climate in Washington, explain how all the P4P business is informed by the history of RBRVS, and thereby be forewarned and potentially guided by an appreciation of what happened to anesthesiologists two decades ago.

Did We Devote Sufficient Resources Then to Protecting Our Resources?

I would say no, that it seems to me in retrospect that we were perhaps a bit politically naïve, perhaps a bit too passive in how we voiced our objections. On the other hand, some of our leaders involved at the time would say that we had all the resources we needed, but that we were just unable to get those making the judgments to listen to logic. Certainly we are now considerably more aware of the treachery and trappings of the political system and have a manifestly more noticeable presence in Washington. The ASA Political Action Committee was formed in 1991, and it appears to be highly effective, but it needs to be fed. More resources (read that as **money**) are required. California anesthesiologists need to understand that although we are always near the top of total dollars raised for ASAPAC, this misleading fact is the consequence only of the numbers of

contributors from our state. This false perception, however, belies the more important fact that we have one of the lowest per capita rates of participation of any state society. Furthermore, it is astonishing that across the nation, a mere one of 10 ASA members contributes to ASAPAC! Achieving the real potential effectiveness of political action begins *after* the checks are cut. We assuredly need more ASA members to lobby their own federal legislators and to participate in this representative democracy, just as do the lawyers and the CRNAs whose levels of participation should make us ashamed. AANA members are trained to lobby as part of their education, and CRNAs work at the local level to get to know and support their candidates. One of our own, Robert Hertzka, a recent CMA president, has been able to accomplish this crucial task for medical students at UCSD and other California medical schools. He should be encouraged by his own specialty to establish such a model curriculum for our residents. The ASA ought to encourage those who determine the curriculum for the Residency in Anesthesiology to move beyond basic science and its clinical applications and include study of the system of American medicine, the importance of political activism to the survival of our specialty, and the practical skills required to lobby legislators.

In the 1980s, the ASA was disadvantaged by not having a strong political influence either on Capitol Hill or within the AMA. The ASA has addressed and corrected these weaknesses, which, had they been in place in the 1980s, might have brought about something substantially better for our specialty, although "it still would have required Congressional override of HCFA's preplanned outcome."

Did We Miscalculate?

My opinion is that we did miscalculate a bit, perhaps, in how much time and effort we devoted to preserving anesthesia time. Although we celebrated this preservation as a great success, we later were shocked by how little we were able to influence the actual development of the anesthesia conversion factor itself. That being said, the preservation of actual time did not in itself lead to the dramatic payment reductions. There never was an "either-or" proposition, nor was there an offer concerning the preservation of anesthesia time (average or actual) versus the use of case rates like the rest of the medical specialties. Unquestionably we were highly focused on the anesthesia RVG and our system of base units and time units, but all that was negated to a large degree by HCFA basically deciding that they were going to "get us," and they used their overwhelming power to deploy whatever figures and data were needed to do the job. We were one of HCFA's targets, and, despite our important and rather remarkable success in preserving anesthesia time, we still were hosed at the end of the day.

Some of our leaders there at the time have a different take on what occurred. They still do not believe that our specialty was specifically targeted, but rather conclude that we suffered the consequences of inertia, almost like an inconsequential side effect of a train—the metaphor of the train leaving the station has been used repeatedly concerning P4P—steaming to a new place. As detailed in Part I, given the history of issues with anesthesiologists in the years leading up to RBRVS, our plight did not stimulate any sympathy in HCFA, nor any special reconsideration of how the theory of relative value—a concept born in our specialty—was being transformed and perversely applied to our specialty.

To this day, our leaders may not have fully grasped how a series of relatively minor erroneous estimates by HCFA, when taken together, may have compounded the economic disadvantage that befell anesthesiologists. Surely few practicing anesthesiologists today understand how RBRVS came to be, despite how central it has become to the economics of the practice of anesthesiology.

Stephen "Butch" Thomas, M.D., Chair of the ASA Committee on Economics during the development of RBRVS, feels that he and the ASA as an organization were "asleep at the wheel" and did not appreciate the consequences of what was about to befall our specialty. However, he also observes that because anesthesiologists stand apart from true RBRVS—both because of the inclusion of time and because of egregiously low Medicare anesthesia conversion factors—most anesthesiologists have been able to negotiate contracts that avoid having their compensation tied to the MFS. He opines that, overall, our specialty has fared far better economically in the last 16 years than it would have if anesthesiologists had been paid flat rates based upon some fraction or even some multiple of a Medicare-determined fee schedule.

Were There Forces at Work Beyond Our Control?

Absolutely yes! There were complex forces at play, but we were at times our own worst enemy. Pogo's Axiom, "We have met the enemy and it is us," was an apt description used by Michael Scott to characterize what happened. "We" spoke with more than one voice. Curiously, some academicians from New York lobbied for average times, perhaps with an additional academic adjustment factor. Some academicians pursued their own advocacy in Washington, undermining the single voice of our specialty, while criticizing ASA for not being more effective. Those on the losing end of a compromise were sometimes unwilling to take the resultant hit themselves (e.g., those employing large numbers of nurse anesthetists), although a large part of the responsibility for the perceptions of those paying the bills could be laid at their feet. The government we now realize is not a coherent, logical, predictable machine, and there are currents at play, inertial forces, changing opinions, and evolving circumstances at work, which

collectively dwarf our own little piece of medicine's vast pie. Economics, control, perception, political capital, and just plain old dumb luck all contribute to the final outcome.

Why Could We Not Prove the Flawed Logic of the Cross-Links?

Insofar as setting the work value of anesthesiology procedures on the common scale of MFS, it would have been obvious to anyone open to a logical argument that the whole process (i.e., the mechanisms by which the underlying theory of relative values were applied to produce the end product, the new RBRVS) was a house of cards constructed on a flimsy and unstable base, and that HCFA was not forthcoming or transparent in how exactly it constructed the final version of RBRVS. To this day, the complete story of all the maneuvering that went on behind the scenes remains untold, as does much of the underlying data used to construct the relative values and the cross-links. However, other factions within the House of Medicine had their own specialty-specific issues, and each was—and has been—focused on protecting its own turf and optimizing its own economic position. The House was divided by the government and has remained so. Moreover, although using anesthesia time was eventually mandated by law—and hence separated anesthesiology from the rest of RBRVS—anesthesia time itself was not used appropriately to set anesthesia work on the common scale.

Furthermore, perhaps the ASA did not state vigorously enough, or loudly enough, or disruptively enough our unequivocal and absolute rejection of the HCFA final rule. Indeed, in a letter to HCFA dated February 6, 1995, commenting on the Five-year Refinement of RVUs, ASA President Dr. Bernard Wetchler wrote:

> Despite our concerns with the original methodology to link anesthesiology to other physician services and with the resulting reductions in the conversion factor, we have no major problems with the methodology used to place anesthesiology on [the] MFS scale.

That letter otherwise was an excellent summary of the issues relating to how anesthesiology services were valued initially with the institution of RBRVS, and it also described in detail a study by Abt Associates which concluded that the final rule undervalued anesthesia work by 35 percent. But why would the ASA president make the statement quoted above? Glenn Johnson, esteemed former executive director of the ASA, suggests that "the intent of the letter was to state that the methodology 'concept' was acceptable to ASA but the implementation was terribly flawed, and these flaws were substantiated by Abt's study showing anesthesia work undervalued by 35 percent." This is not to suggest that vigorous attempts to change things were not made, but it does suggest that how

we expressed ourselves may not always have been clear and coherent, at least as far as government officials might be concerned. However, it has become abundantly clear that "HCFA had ulterior motives and our arguments fell on deaf ears."

Furthermore, Dr. Hannenberg observes that, in trying to argue against the logic of the cross-links, "these were Harvard 'scientists,' not bureaucrats nor politicians, and the usual lobbying and persuasion dynamics don't work in the same way."

Why Have We Not Sued CMS?

One might think that the inconsistencies of the facts—(1) that intra-operative anesthesia time was not used to set the cross-links and (2) that actual time was later mandated by legislation in 1993—should be sufficient to overturn legally how the system was constructed. However, the law establishing RBRVS specifically prohibited legal and administrative challenges to work valuations, and so we have been left with the curious situation of a law apparently defining itself as being above legal challenge. This provision has been contested several times, using varying legal theories, but two Circuit Court opinions (*Painter v. Shalala,* 97 F. 3d 1351, and *American Society of Cataract and Refractive Surgery et al. v. Tommy Thompson,* 279 F. 3d 447) found that the intent of Congress prevails because physicians do not have a "property interest" and also do not have to "participate" in Medicare. Glenn Johnson notes that "there was fairly strong interest in bringing suit. ASA sought considerable legal advice from outside counsel and was persuaded that a challenge would not prevail."

Is There Any Untested Cause of Action Against CMS?

The American health care system has continued to evolve since 1992 in a way that essentially requires anesthesiologists who work at hospitals to participate in Medicare (either as participating or nonparticipating providers) and, in practical terms, can no longer have the option of being private contractors. Medicare will pay neither the physician nor the patient for services rendered by a private contractor. This provision is unique among insurers and is a club wielded by the federal government on behalf of Medicare activists. Physicians in other specialties can decide to reject Medicare entirely and, as private contractors, bill patients outside of the system, but this does not apply to physicians who are required to care for emergency patients (Emergency Medical Treatment and Active Labor Act of 1986—EMTALA—regulations), nor those who work in hospitals. It appears that there will be no negotiated resolution to how we have become disadvantaged by Medicare. Therefore, one

wonders if the unique circumstances of anesthesiologists—and their unique interaction with RBRVS without truly being a part of it—might now suggest some novel and as yet untested legal theories for at least investigating anew whether the ASA could or should bring legal action against CMS to redress our grievances.

What Happened to the ASA Task Force on Medicare Payment Methodology?

There was considerable discussion at a special 2004 ASA Reference Committee on the work of an ASA task force that was studying whether we ought to try to become more like other specialties in our payment system—perhaps adopting a case rate system with average times built in, but with a high degree of "granularity" to separate coding for surgeries more minutely—with perhaps more than a thousand different anesthesia codes. However, eventually everyone came to understand that there would be no guarantee that sacrificing actual time would make Medicare payments more reasonable and that, at best, we could only expect such a change to be cost-neutral for CMS.

Are There Analogies to Our Current Situation Vis-à-Vis P4P?

Without a doubt! RBRVS was prompted by a perception that certain folks were gaming the payment system from Medicare or were just overpaid and earned too much. It was an attempt to redistribute dollars from overpaid specialists to primary care and preventive medicine. P4P seeks to reward quality or efficiency and, in so doing, to reduce costs and incentivize improvements in care. Businesses, insurers, patients, and the government want just two things—to pay less and to get more, in that exact priority. Just below the surface, the performance stuff seems fundamentally to be an excuse to reduce costs, and a bit of a bait-and-switch gimmick at that. It seems not unlike the bait-and-switch tactic employed with RBRVS, when anesthesiologists were all on board with employing a relative value scale essentially invented and championed by us, and then ported to other specialties; but, with the calculation of the conversion factors, it actually turned out to be about saving money rather than paying rationally. By the way, why were we ever considered to be proceduralists rather than cognitive doctors? We do both, but it is the intellectual aspects of what we do that produce the value to our patients.

The government is very clear that it wants "value," and that is quality divided by cost. Increased value can be created either by increasing quality or by reducing cost, or both, but it can also be "created" by reducing cost more than it reduces quality.

So How Should We Rethink Our Current P4P Strategy in Light of the History of How RBRVS Came About?

We made no glaring errors then, and we employed a lot of very smart people who worked very hard. However, our specialty was going to be abused from the outset. Glenn Johnson reflects, "I don't believe we expected it. I think we naïvely believed it was an honest process and did not recognize that 'budget neutrality' and pushing medical students into primary care specialties was the administration's agenda." Given the road that anesthesiologists have traveled with Medicare so far, it takes very little political acumen to realize that we are still the target and that compromises will be needed to forestall some very bad things. Dr. Jim Arens articulates to Dr. Alex Hannenberg this lesson from RBRVS: "If one does not participate, bad things happen; and when one does, equally bad things occur."

We should not mistake the intentions of those who then created RBRVS and now are pushing P4P. We as a specialty must address the issues that have given rise to and are driving P4P, but we will be further harmed economically unless we are determined to be willing to either "just say no" or somehow change the debate. The former is a risky political gamble, while the latter might still be our last best shot. Perhaps it is time for us to help craft a new payment system, as we did with the relative value scale before RBRVS, one which incentivizes neither too little care (like HMOs) nor too much care (like fee-for-service). Or perhaps it is time for us to produce data which shows that anesthesiologists already serve as guardians of patient safety, that our practice is the continual balancing of risk and benefit for our patients, that on a fundamental level we truly are a unique specialty, and that we have data to show that we provide the same care, no matter the payment system, and therefore that P4P is not necessary in our specialty except as a way to pay us less.

Unfortunately, the drivers in the present game may not respond to the facts in a logical manner. A disturbing example of politically driven but clearly illogical thinking by the federal government is the CMS anesthesiology teaching rule, initiated as a part of RBRVS. Academic anesthesiology teaching programs have been crippled by this rule, which CMS could change by administrative fiat but has declined to do apparently because of the shortsighted anesthesia-bashing lobbying program of nurse anesthetists. Recall from Part 2 that the AANA lobbied for this teaching rule when the MFS based upon RBRVS was being built, ostensibly to protect its own teaching programs. Unless the current payment muddle concerning academic anesthesiologists is solved promptly, the collapse of anesthesiology as a profession will loom on the horizon. Do you suppose that this is fundamental to the theory that motivates the actions of the AANA?

Eventually, we will have to decide if we need to roll the dice to try to preserve our profession. A critical point here is to appreciate that, until now, we have not found effective tactics or means to reject unsatisfactory governmental decisions. We did not make the call to "go to the mat" with RBRVS. This is an area that deserves further measured study by the ASA, then a pronouncement and mobilization of the forces, then strong and effective action.

Final Thoughts

At the time RBRVS was debated and then "negotiated," and in the RUC process that has followed every five years since, the other medical specialties and the AMA have shown very little understanding and support for the unique issues that anesthesiologists have had with Medicare. With our dramatically increased visibility within the AMA—the anesthesiology specialty delegation is now the third largest in the AMA House of Delegates—anesthesiologists now "have a seat at the table." One of our own, Dr. Rebecca Patchin, is an AMA Trustee and just recently was elected Secretary of the AMA Board of Trustees. Dr. Joseph Annis, from Austin and a member of the Texas delegation to the ASA, is also a newly-elected AMA Trustee. Make that "two seats at the table." Just as in contract negotiations with insurers—where it is desirable for individual anesthesiologists to make themselves "bigger" by forming larger integrated negotiating entities (of course within the constraints of the federal antitrust laws)—so it may be that anesthesiology as a specialty should try to make itself "bigger," allying with other specialties that can also be devastated by the application of misguided attempts by the federal government to force P4P into settings where it has no logical place.

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A table of chronology covering Parts I through III is available on the CSA Web Site at www.csahq.org.