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Valuation of Internal Medicine Services: Reimbursement

As noted in the first installment of this five-part series, internal medicine is the largest specialty among physicians and an understanding of the various environments in which these physicians operate is crucial in determining their numerous value drivers. In particular, healthcare reimbursement, the process by which private health insurers and government agencies pay for the services of healthcare providers (including internists), is perhaps one of the most important environments to understand, as it comprises a provider's expectation of future return on investment.[1] This second installment will discuss the reimbursement of internal medicine services.

The U.S. government is the largest payor of medical costs, through Medicare and Medicaid, and has a strong influence on physician reimbursement. In 2019, Medicare and Medicaid accounted for an estimated $799 billion and $614 billion in healthcare spending, respectively.[2] The prevalence of these public payors in the healthcare marketplace often results in their acting as a price setter, and being used as a benchmark for private reimbursement rates.[3]

Since 1992, Medicare has paid for physician services under Section 1848 of the Social Security Act (SSA).[4] The SSA mandates that physician fee schedule payments be calculated according to Medicare's Resource Based Relative Value Scales (RBRVS) system, which was designed with the intent of bringing medical practice payment more in line with a prospective payment system and away from a purely fee-for-service (FFS) system. The RBRVS physician payment system is updated annually by the Centers for Medicare & Medicaid Services (CMS). In assigning the relative values to procedures and in making yearly updates to these levels, the government has deliberately shifted payment levels to primary care specialties such as internal medicine in order to redress what they believe are historic inequalities perceived to cause medical students to over specialize and thereby raise healthcare costs (as specialists and surgeons generally command higher fees and compensation). These adjustments in reimbursement levels have historically, and are forecasted to continue to have, significant impacts for the internal medicine specialty.

As mentioned above, the RBRVS system assigns relative value units (RVUs) to individual procedures based on the resources required to perform each procedure. Under this system, each procedure in the Medicare Physician Fee Schedule (MPFS) is assigned RVUs for three categories of resources: (1) physician work (wRVUs); (2) practice expense (PE RVUs); and, (3) malpractice (MP RVUs) expense.

Further, each procedure's RVUs are adjusted for local geographic differences using Geographic Practice Cost Indexes (GPCIs) for each RVU component. The GPCI accounts for the geographic differences in the costs of maintaining a practice. Every Medicare payment locality has a GPCI for the work, practice, and malpractice component,[5] which is determined by taking into consideration median hourly earnings of workers in the area, office rents, medical equipment and supplies, and other miscellaneous expenses.[6] There were 89 GPCI payment localities as of 2018.[7]

Once the procedure's RVUs have been modified for geographic variance, they are summed, and the total is then multiplied by a conversion factor (CF) to obtain the dollar amount of governmental reimbursement. The formula for calculating the Medicare physician reimbursement amount for a specific procedure and location is as follows:[8]

> Payment = [(wRVU x work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI)] x CF

The wRVU component represents the physician's contribution of time and effort to the completion of a procedure. The higher the value of the code, the more skill, time, and work it takes to complete.

The PE RVU is based on direct and indirect physician practice expenses involved in providing healthcare services. Direct expense categories include: clinical labor, medical supplies, and medical equipment. Indirect expenses include: administrative labor, office expenses, and all other expenses. To determine the direct PE, CMS uses a bottom up methodology by adding costs of resources typically required to provide each service, based on recommendations by the American Medical Association's (AMA's) Relative Value Update Committee (RUC). To determine the indirect portion of the PE RVU, CMS uses actual PE survey data indicating the indirect practice expenses incurred per hour worked (PE/HR).

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MP RVUs correspond to the relative malpractice practice expenses for medical procedures.[9] These values are updated at least every five years and typically comprise the smallest component of the RVU.[10] Due to the variation in malpractice costs among states and specialties, the malpractice component must be weighted geographically and across specialties.[11]

The CF is a monetary amount that is multiplied by the RVU from a locality to determine the payment amount for a given service.[12] This CF is updated yearly by a formula that takes into account: (1) the previous year's CF; (2) the estimated percentage increase in the Medicare Economic Index (MEI) for the year (which accounts for inflationary changes in office expenses and physician earnings); and, (3) an update adjustment factor.[13] All physician services, except anesthesia services, use a single CF.[14] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) contains a predetermined schedule of updates to the CF. However, these annual updates are relatively small, with an update of 0.5% from 2016 to 2019, and an update of 0% for years 2020 through 2025.[15] It should be noted that, although the annual updates to the MPFS will be stagnant for the next several years, MACRA includes several provisions related to financial rewards for providers who furnish efficient, high quality healthcare services.

In recent years, payors have attempted to reduce healthcare expenditures and raise the quality of healthcare services that beneficiaries receive through payment models that tie physician compensation to the "value" of care delivered. Typically, the "value" of healthcare services refers to the cost and quality associated with those services.[16] Notably, MACRA introduced the Quality Payment Program (QPP), under which physicians' reimbursement for Medicare Part B services may be increased, decreased, or kept neutral, based upon quality performance under one of two models: alternative payment models (APMs) or the Merit-based Incentive Payment System (MIPS),[17] which consolidated several historic VBR programs into a singular quality program beginning in 2019.[18]

The QPP allows for modifications to a given physician's "base payment rate" based on an individual provider's participation in an APM or MIPS.[19] From 2019 to 2024, providers utilizing APMs are eligible for a bonus payment in the amount of 5% of their estimated aggregate payment amounts for services furnished to Medicare beneficiaries during the preceding year.[20] Further, beginning in 2026, the annual update to Medicare payments to providers who do not qualify as APM participants will be 0.25%, while the annual update to Medicare payments for qualifying APM participants will be 0.75%.[21]

In addition to provider incentives based on APM participation, MACRA also incentivizes providers through MIPS, which increases, keeps neutral, or decreases payments to providers based on certain performance metrics in the fields of: (1) quality; (2) promoting interoperability; (3) improvement activities; and, (4) cost.[22]

An estimated 95.3% of eligible clinicians qualified for neutral or positive payment adjustments beginning in 2020.[23] Notably, the bonus payments and penalties under MIPS will be budget neutral, i.e., the total bonus payments paid out to high-scoring providers will be funded by the total penalties withheld from low-scoring providers.[24]

In addition to the above VBR initiatives, CMS has also focused specifically on primary care in its transition to VBR. In 2019, for example, CMS and the U.S. Department of Health and Human Services (HHS) announced the CMS Primary Cares Initiative.[25] This model built on past, similar models and aimed to reduce administrative burdens and leverage primary care for better health outcomes and lower costs.[26] It offers five payment options under Primary Care First (PCF) and Direct Contracting (DC) paths.[27] The two PCF payment models incentivize providers to reduce hospital utilization by making performance-based payments based on quality of care, patient experience, and key clinical outcomes.[28] The DC path provides a fixed monthly rate, which allows for predictable revenue and reduces burdens commensurate to financial risk.[29]

While Medicare reimbursement base rates for all physician services are expected to be fairly stagnant in the near term (notwithstanding the aforementioned VBR initiatives) due to MACRA's predetermined schedule of updates to the CF, recent efforts by CMS may encourage those specialties that provide more preventative services. For example, in the 2021 MPFS, CMS increased the wRVUs for common evaluation and management (E&M) office visits, which in turn bolstered reimbursement for those primary care specialties where E&M visits comprise a significant portion of the provider's case mix. Indeed, the 2021 MPFS increased internal medicine reimbursement rates approximately 6%.[30] This acknowledgement by CMS that primary care services are vital in shifting the U.S. healthcare industry to value-based care may serve to motivate more physicians to enter into primary care specialties such as internal medicine.

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(Continued on next page)

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