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Unravelling the RUC Mystery

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AMA RUC Member for AAO

Disclosures

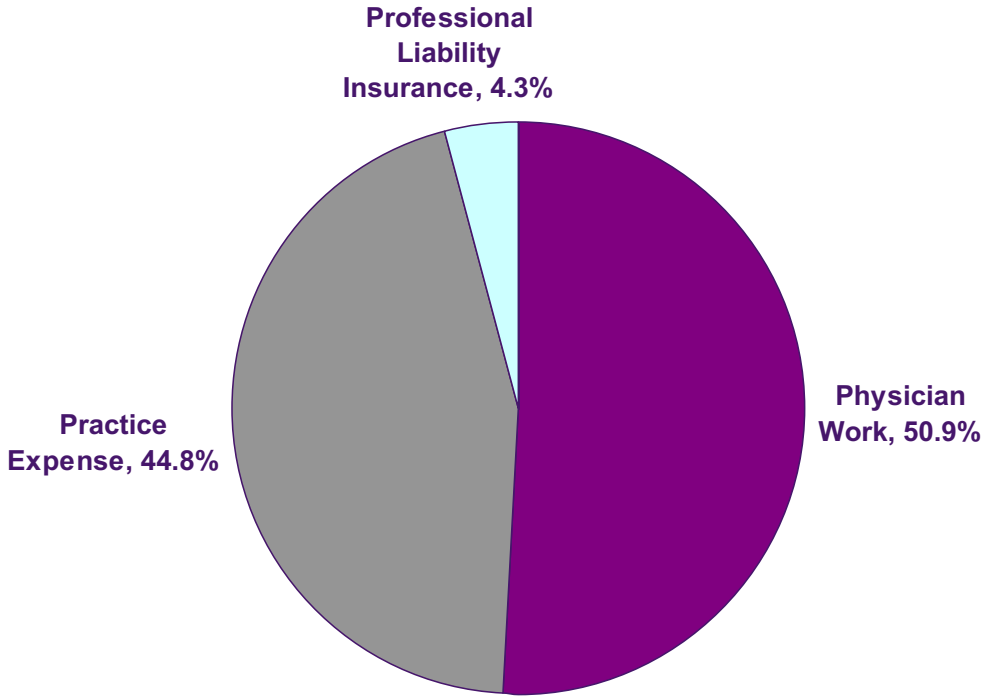
- I have no financial conflicts
- I am an AAO consultant
- I represent AAO at the AMA RUC

Medicare RBRVS

- Medicare implemented the Resource-Based Relative Value Scale (RBRVS) on January 1, 1992
- Standardized physician payment schedule where payments for services are determined by the **resource costs** needed to provide them

Components of the RBRVS

Percent of Total Relative Value

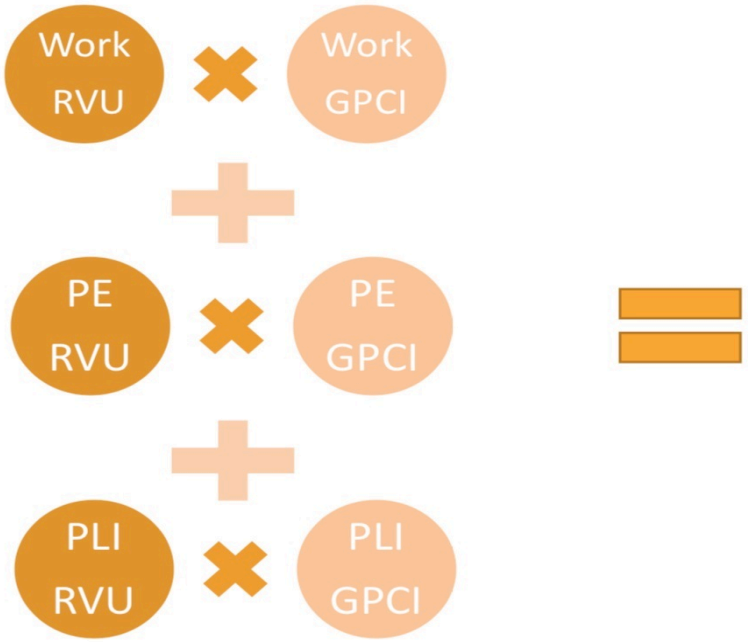


Physician or Qualified Health Care Professional Work

Determined by:

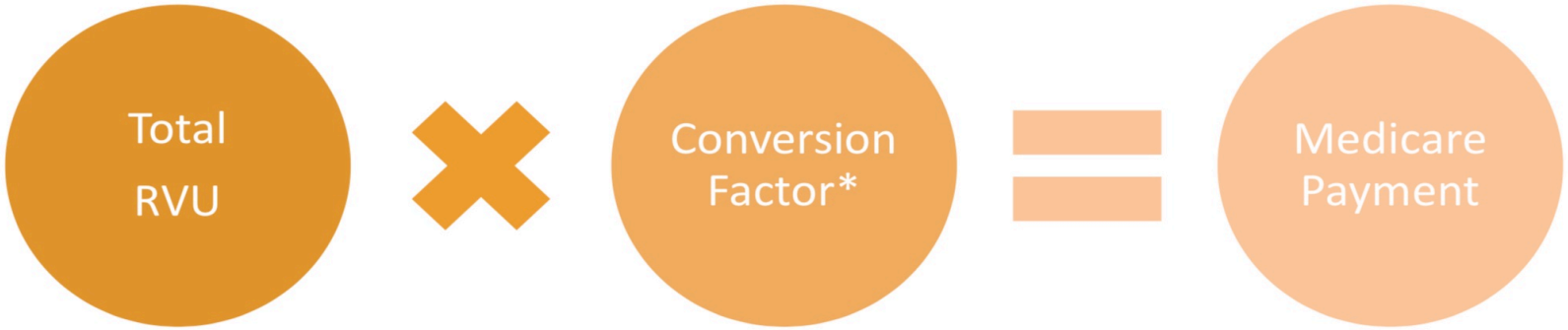
- The time it takes to perform the service
- The technical skill and physical effort
- The required mental effort and judgment
- Stress due to the potential risk to the patient

Calculating Payment- Step 1



Total RVU

Calculating Payment- Step 2



Conversion Factor is a monetary payment determined by Medicare each year.

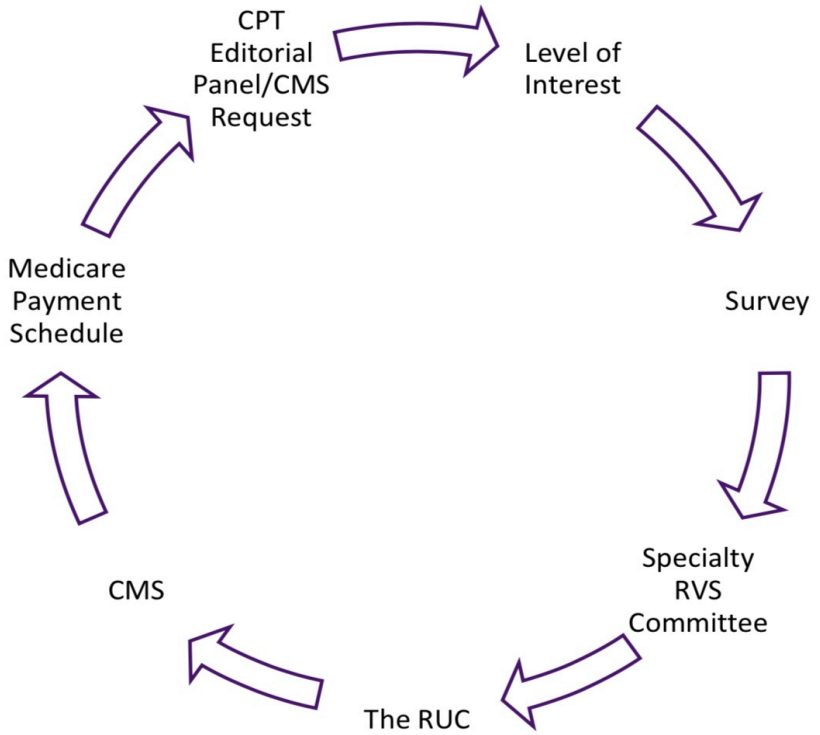
- Adjustments are typically based on three factors
  1. The Medicare economic index
  2. An expenditure target "performance adjustment"
  3. Miscellaneous adjustments including those for "budget neutrality"
- The Conversion Factor for 2018 = $35.9996

2019 = $36.0391

RBRVS Survey

- If you receive a request to survey a CPT code from AAO:
- Answer thoughtfully and honestly
- Any wildly aberrant inputs hurts the validity of the survey
- Please respond promptly

RUC Cycle


CPT Editorial Panel/CMS Request
Level of Interest
Survey
Specialty RVS Committee
The RUC
CMS
Medicare Payment Schedule

Confidentiality Agreement

All RUC materials are confidential and for RUC use only

Cannot publish RVU recommendations until CMS publishes *Federal Register*

All RUC participants registered for the upcoming meeting must sign the confidentiality statement

RUC Composition

RUC Chair
American Medical Association
CPT Editorial Panel

American Osteopathic Association
Practice Expense Subcommittee
Health Care Professionals Advisory Committee

Allergy and Immunology*
Anesthesiology
Cardiology
Cardiothoracic Surgery
Dermatology
Emergency Medicine
Family Medicine
General Surgery
Geriatric Medicine
Infectious Diseases*
Internal Medicine
Neurology
Neurosurgery
Obstetrics/Gynecology
Ophthalmology
Orthopaedic Surgery
Otolaryngology
Pathology
Pediatrics
Plastic Surgery
Primary Care*
Psychiatry
Radiology
Urology
Vascular Surgery*

**Indicates a rotating seat*

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AMA/Specialty Society Relative Value Scale Update Committee (RUC)

The RUC is an independent group of volunteer physicians exercising its First Amendment Right to petition the federal government.

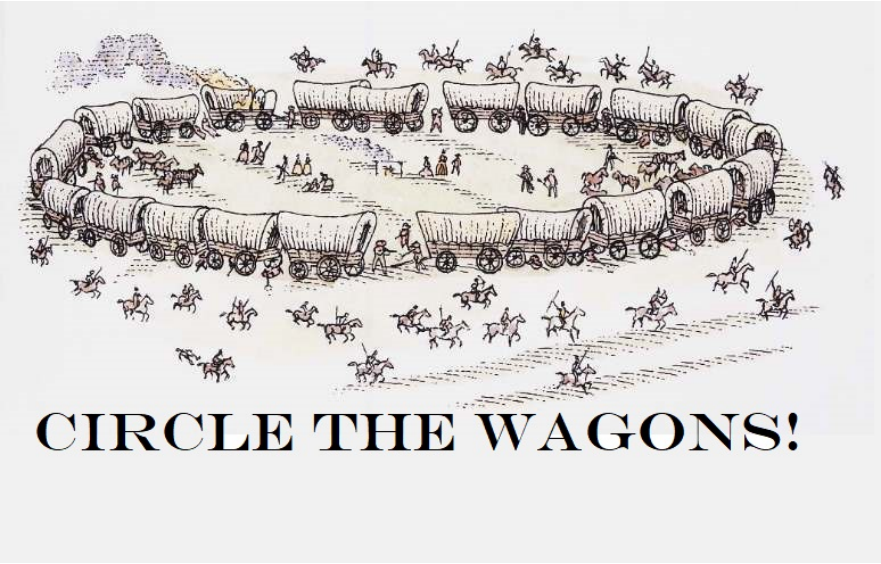
The RUC is comprised of 31 members, 28 voting members (16 of these 28 voting members are from specialties whose Medicare allowed charges are primarily derived from the provision of E/M services).

The RUC is an expert panel. Individuals exercise their independent judgment and are **not** advocates for their specialty.

The RUC is the worst form of valuation… except for all the others!

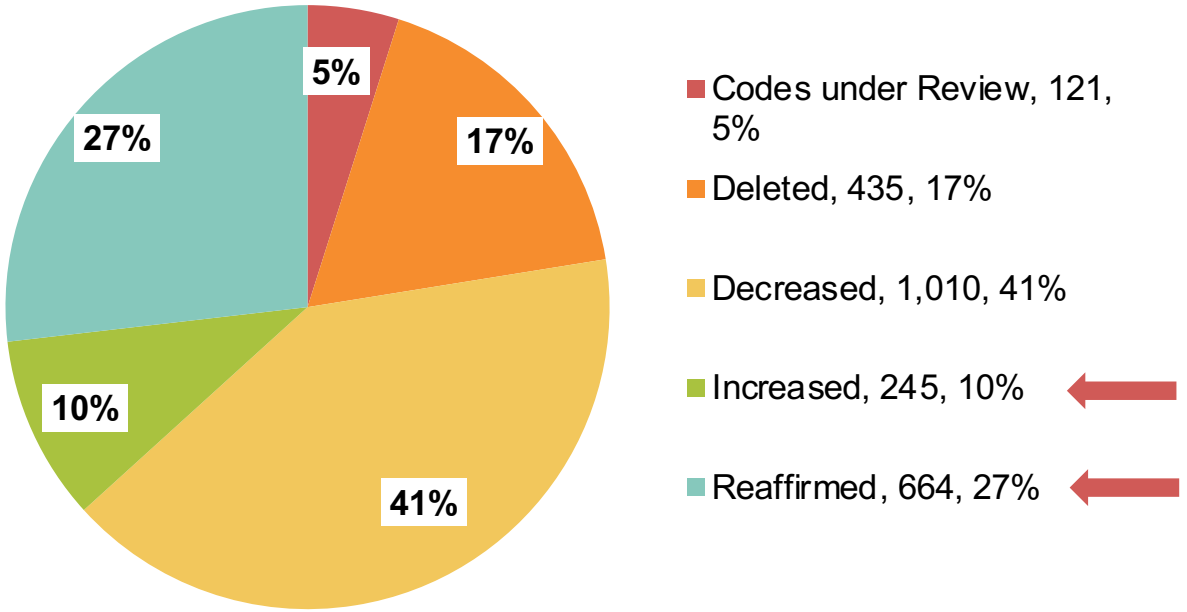
- Rand Corp
- Urban Instutute
- MedPac
- Independent Physician Advisory Board (Congress repealed 2018)

RUC is a physician driven process

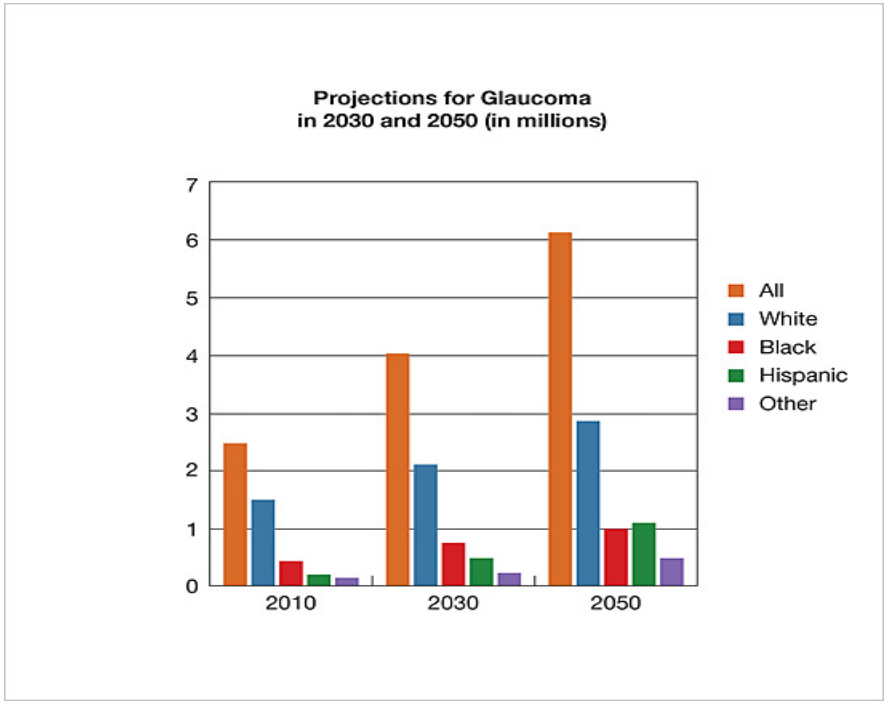


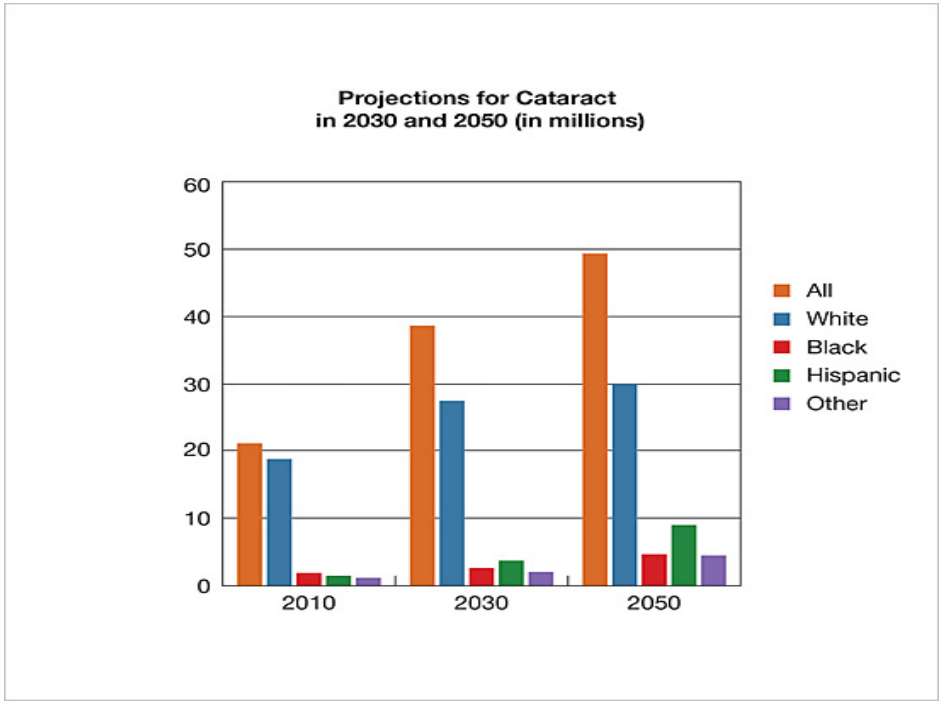
RUC Presentation: one small slip…

Potentially Misvalued Services Project (2006-18)



NEI Projections (2010 – 2050)





Empower your Biller

- Coding is the whole ballgame
- All the rules at your fingertips
- Bill it once, bill it correct
- Appeal denials with confidence

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Health Policy Update

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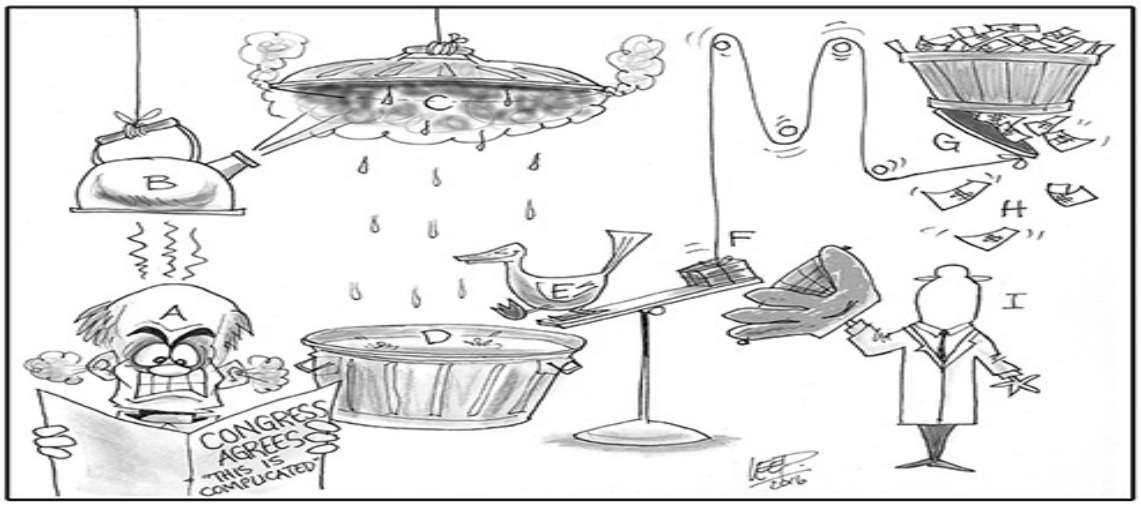
Payment Policy: a true story…

Often an illustration can help explain a complicated idea ...

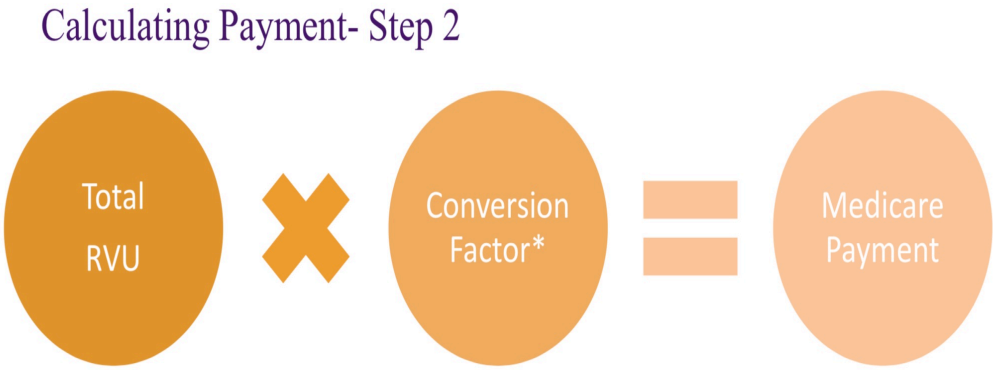


A. Thinking of "Congress" causes heat B. Kettle produces steam C. Vapor collects in garbage can lid, causes rain D. Tub fills with water E. Duck decides to swim F. Brick pulls on string G. Bushel basket bottom pulls open H. Money falls I. Doctor uses government-issued glove to catch money.

The Conversion Factor

- 1992 = $31.001
- 2019 = $36.0391

- CF = 4.31%
- S&P 500 = 9.06%



Conversion Factor is a monetary payment determined by Medicare each year.

•Adjustments are typically based on three factors

1. The Medicare economic index
2. An expenditure target "performance adjustment"
3. Miscellaneous adjustments including those for "budget neutrality"

•The Conversion Factor for 2018 = $35.9996

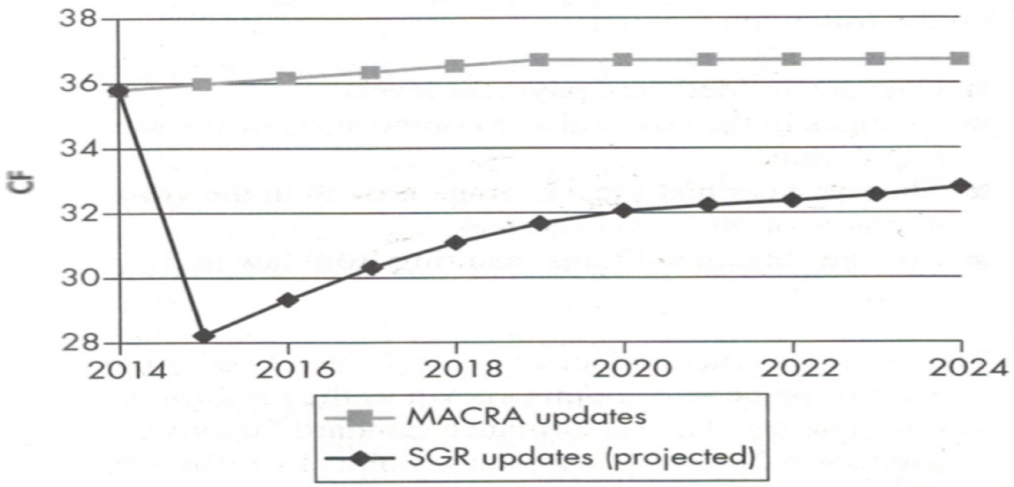
Medicare Physician Payment

- 1997: Sustainable Growth Rate (SGR) enacted
- 2002: SGR update turns negative
- 2002-2015: 17 Congressional SGR fixes
- 2015: -21.2% update blocked by MACRA

How did we get here? MACRA

- Medicare Access & Children's Health Insurance Program Reauthorization Act of 2015

Figure 10-1. MACRA Stabilizes Medicare Physician Pay



Note: MACRA and SGR updates exclude budget-neutrality and misvalued-code adjustments.

MACRA impact was enormous

- Medicare physician pay ~12% greater (2024) than SGR
- Physician fees average ~17% higher than SGR
- 2015-24: projected $150B increase compared to SGR

Merit Based Incentive Payment System (MIPS)

- A bargain with the devil

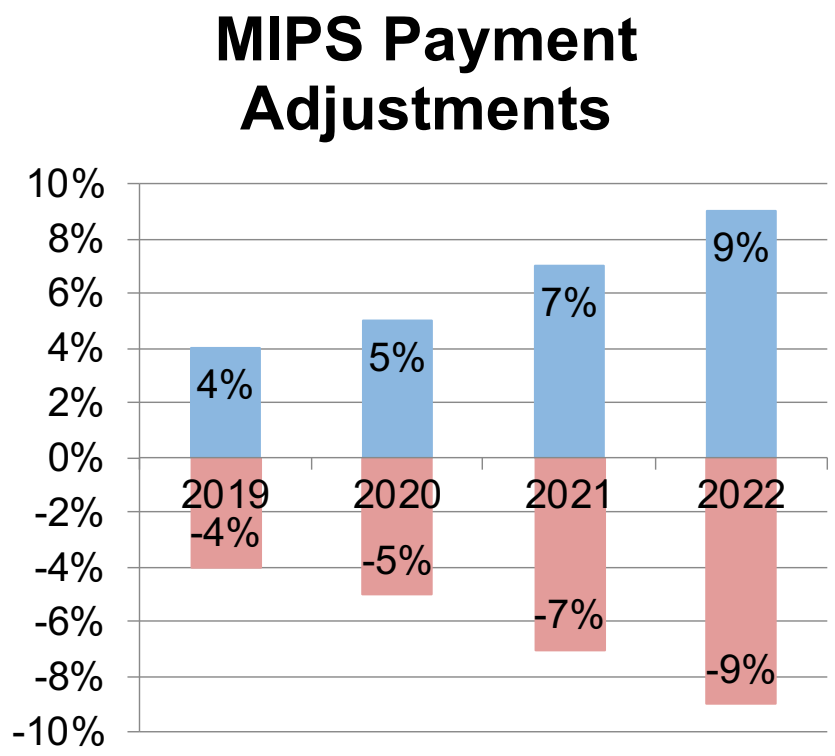
MedPAC + MIPS = Political Uncertainty

- MedPAC voted 14-2 advising Congress to **eliminate MIPS**; and
- Establish a "new" voluntary value program (VVP) in FFS Medicare
  - Clinicians can elect to be measured as part of a voluntary group
  - Qualify for value payment based on group performance on population-based measures
  - Payment increases offset by payment decreases (winners and losers)
  - $500MM yearly MIPS exceptional performance bonus funds available ($3B total)
  - Budget-neutral, assuming funds are reinvested in Medicare clinician payment
  - Administrative costs to create voluntary group
  - ***Reduced clinician reporting burden***
  - No impact on access to care

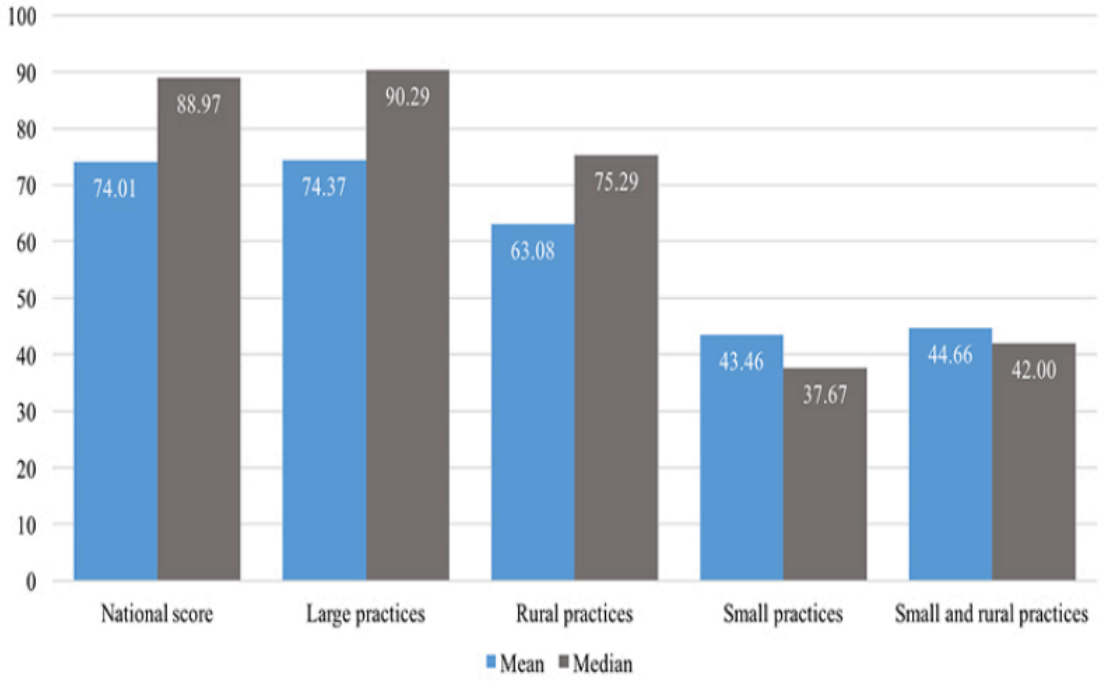
MEDPAC Medicare Payment Advisory Commission

MIPS Payment Adjustments

- Payment
  - Baseline: Standard FFS payments
  - Adjustment two years after measurement:
    - Upward/Neutral/Downward
    - Maximum adjustments (±4%, ±5%, ±7%, ±9%)
    - Partial or full adjustment, based on **Final Score**
  - MIPS payment adjustments are applied to services provided under Part B
- **Budget neutral: Losers$ = Winners$**
- Extraordinary performance pool
  - $500M for 5 years (2019-2023)



MIPS 2017 CPS Scores (by Size and Location)



2017 Max Bonus = 1.88%
…not published
4.00%

Navathe et al. Findings And Implications From MIPS Year 1 Performance Data. Health Affairs Blog, January 18, 2019

MIPS favors LARGE practices

SMALL

LARGE

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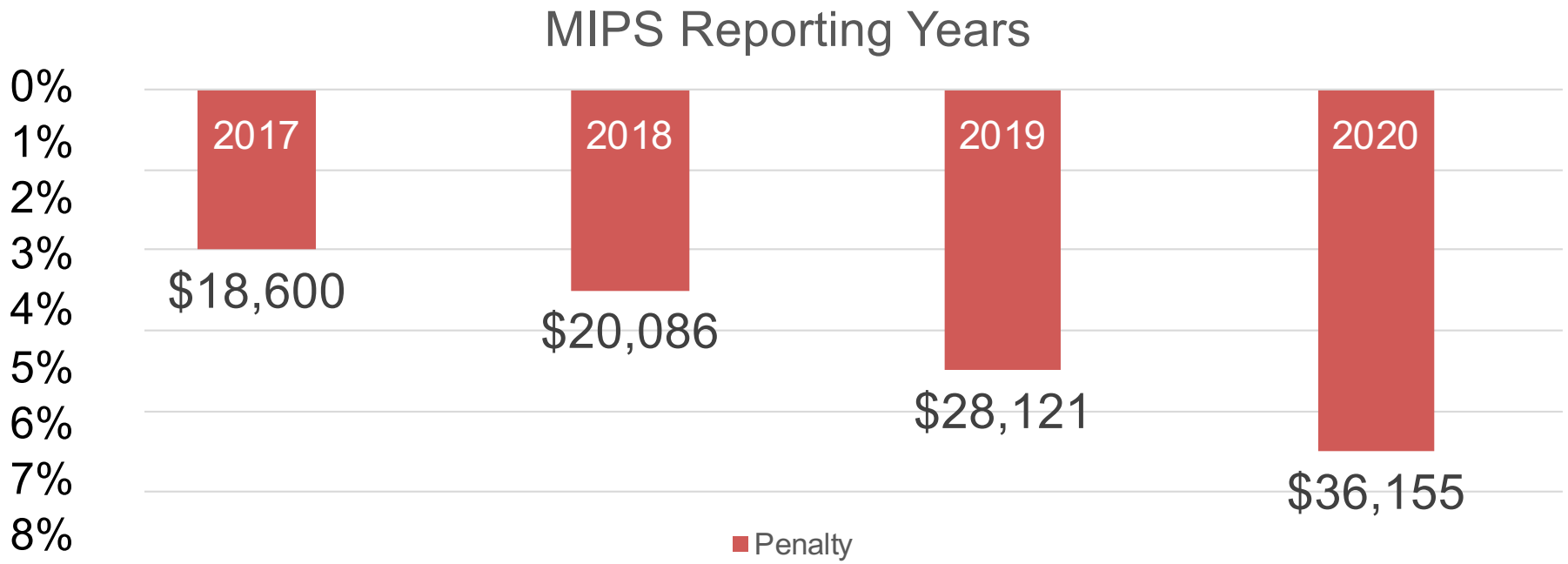
Photo courtesy of National Geographic

MIPS Penalties Per Physician



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MIPS: looking forward

- Year 2 (2018)
- Smaller bonuses anticipated in 2020 (per CMS)
    - **93% of ophthalmologists expected to be neutral or positive (1.4%) among the highest specialties ($82M – $6885 per eligible EyeMD)**
- Year 3 (2019)
- Maximum bonus estimated to be higher = 4.7%
    - similar to an APM (analysis in Health Affairs)

CMS – 5522 –FC
Navathe et al. Findings And Implications From MIPS Year 1 Performance Data. Health Affairs Blog, January 18,2019

2019 MIPS: How to avoid a 2021 Penalty

- **IRIS Registry** is the key to success!
- **MIPS 2019: failure is NOT AN OPTION!**
- 7% penalty in 2021 ($28,121 for average Ophthalmologist)
- No Ophthalmologist should receive a 2021 Medicare performance penalty!

Comparison:

IRIS Registry Results with Overall MIPS Results

CMS

IRIS Registry EHR	**91%**	**9%**	**0%**	**0%**
IRIS Non-EHR	**14%**	**76%**	**10%**	**0%**

IRIS Stats – Jan 1, 2019

Contracted

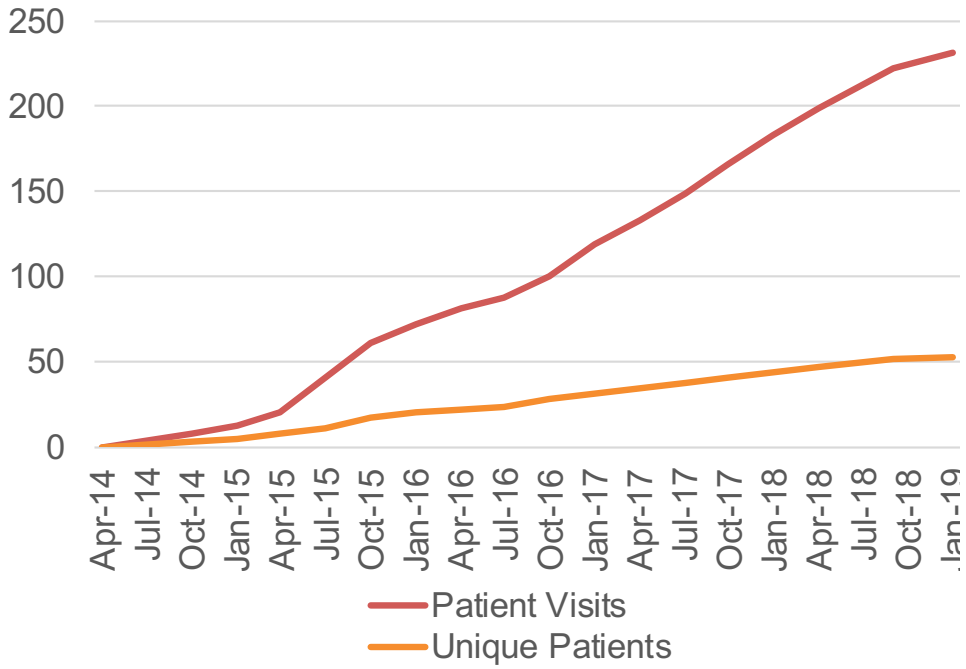
- **18,145** physicians from **5,216** practices

Contracted for EHR Integration

- **14,945** physicians from **3,120** practices

Number of patient visits

- **231.63** million, representing **52.97** million patients



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IRIS Registry

- MIPS reporting
- Analytics: clinical data mining
  - Real world outcomes, Clinical trials, Geographic variations
  - Retina, Glaucoma, Strabismus studies
  - CMS commends IRIS impact on meaningful data retrieval
- Non-Commercial applications
  - Patient benefit, AAO member benefit, education, research
  - Scientific inquiry, Health policy guidance, practice management

Academy Member Resources

- - Visit **www.aao.org/medicare** to find resources for 2019 MIPS:
- - Small Practice Roadmap
  - Large Practice Roadmap
  - Solo/Small Practice Survival and Quick Start Guide
- - *EyeNet's* MIPS Guide
  - IRIS Registry user guide
  - Glossary
  - Helpful CMS Websites
  - MIPS Help: mips@aao.org
  - IRIS Registry Help: irisregistry@aao.org

2019 Medicare Physician Payment Final Rule

- Streamlines office documentation requirements
- For 2021 suggestion to collapse E&M levels 2-3-4 into a single payment
  - AMA CPT/RUC revised EM coding: to be published in the Federal Register (?July, 2019)
- Increases coverage of Telehealth services
  - Electronic check in visit
  - Review of patient furnished images
  - Physician to physician consultation
  - More codes eligible for coverage with -95 modifier

2019 Medicare Rule from CMS

- **Change in direction**
  - Reinterpret the telehealth regulations in sec 1834(m) of the SS ACT to allow more telehealth services coverage if those services do not like face to face office visits
- Telehealth – To increase access to communications technology
  - Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code G2012) (~$13)
  - Remote Evaluation of Recorded Video and/or Images Submitted by the Patient (HCPCS code G2010) (~$15)
  - Internet Consultation (CPT codes 99451 ($37), 99452, 99446 ($18), 99447 ($38), 99448, and 99449 ($73)

Health Policy Future Trends

- Demographic Changes
- Consolidation
- AI/Telehealth
- Payment Models
- Cost

Photo courtesy Nat Geographic

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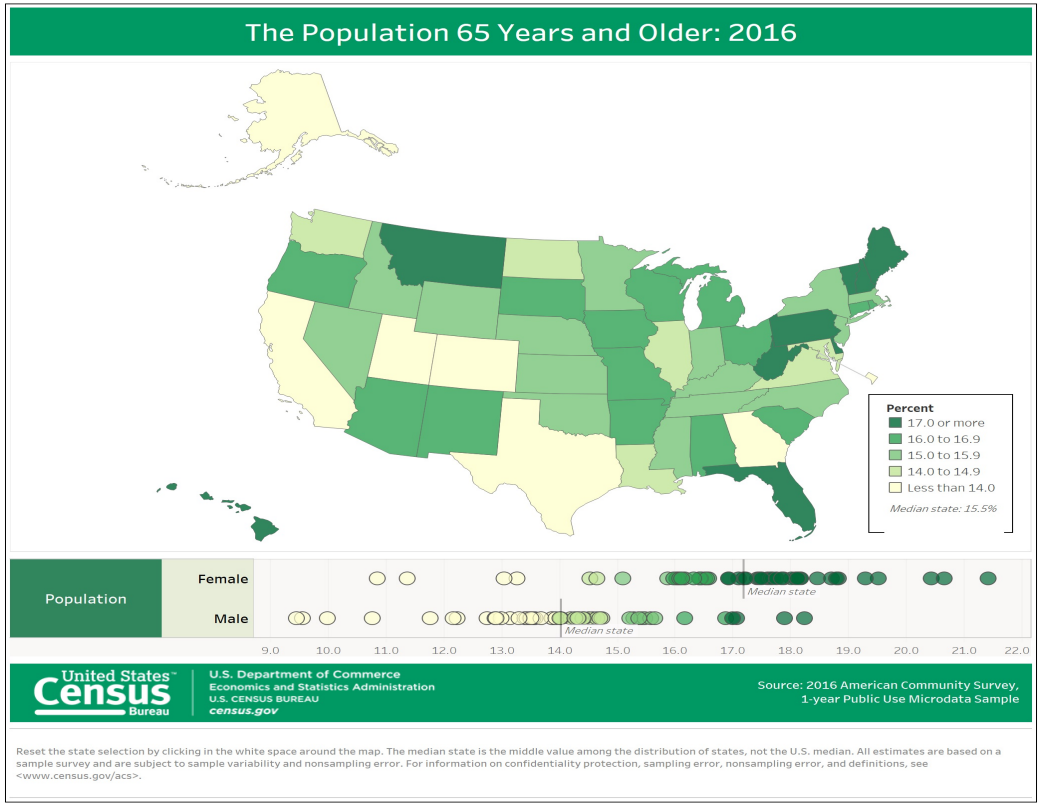
Demographics: Aging 65 and older

- US population is aging
- 2019 = 65M US seniors
- 2030 = One in five US seniors
- 2050 = 90M US seniors



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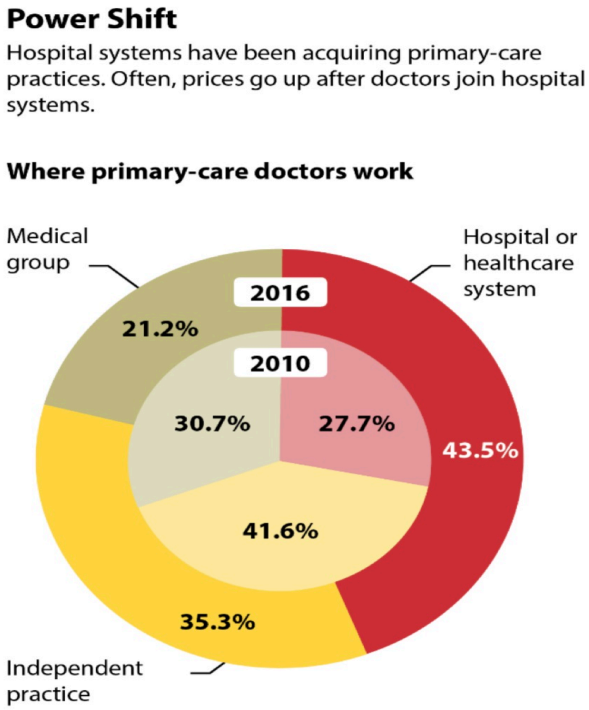
Health Policy Future Trends: Demographics

- Aging population with greater healthcare utilization
- Limited assets to cover home, health, assisted, memory care
- Less family support as caretakers
- Need:
  - Creative funding, policy innovation, Community outreach/support, technology

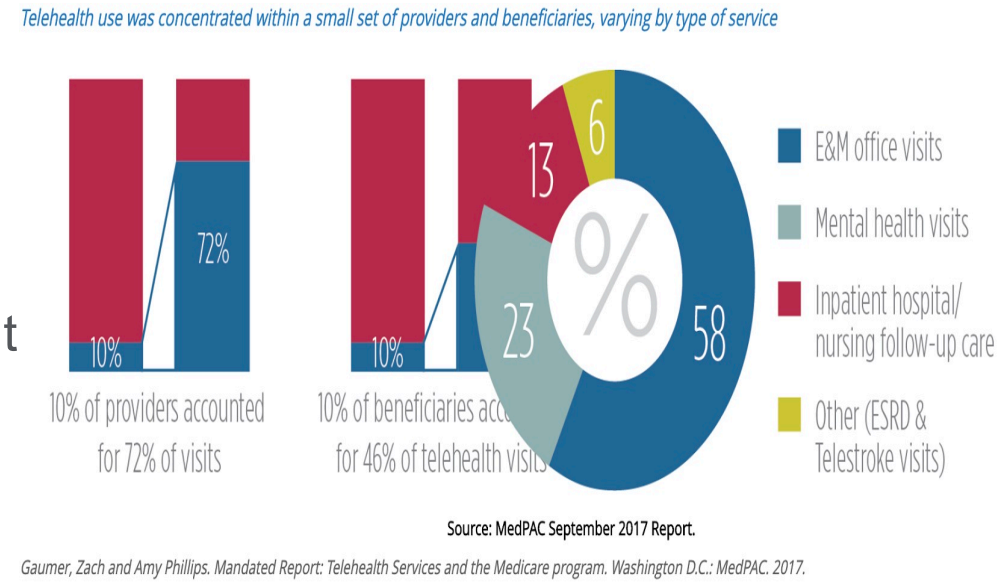
Health Policy Future Trends: Consolidation

- 2010 ACA/MACRA triggers consolidation of hospitals
- Positives:
  - economies of scale, elimination of redundant services
  - enhanced care coordination: ie. stroke intervention, care, rehab
  - less patient turnover
  - greater incentives for preventative care
- Negatives:
  - higher cost for younger patients
  - increased demand for care, wait times
  - reduced access to care and new treatments
  - uncertain manpower to provide the care



Health Policy Future Trends: AI/Telehealth

- Standardizing IT
- Interoperability
- Roles of IT for diagnosis and treatment
- Home health monitoring and reporting
- Robotic care
- Team care: who makes the call, 2nd opinions, liability, recourse



Health Policy Future Trends: Payment Models

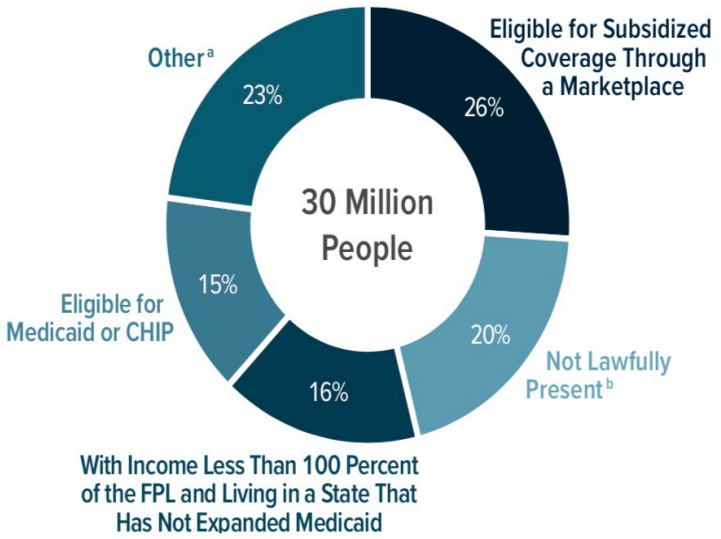
- Total coverage (single tier), 2 tier or more
- Private insurance opt out
- Supplemental insurance for dental
- Substitutive insurance for non-eligible citizens, visitors, opt-outs

Health Policy Future Trends: Cost

- Residency - eligibility
- Coverage levels
- New treatments and technology
- Long-term services
- Cost sharing:
  - (deductible, copay, coinsure, out of pocket max)

Figure 1-5.

Composition of the Uninsured Population, 2019



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

- Throughout history, physician's have always been respected for their knowledge and skills
- "Surgeon's have a special relationship when placing a knife into their patient's eye" –Randy Campo, MD
- The full value of your work will not change regardless of budget constraint's of CMS

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