Published on *American Council on Science and Health* (https://www.acsh.org)

Are Surgeons Providing Care They Promised? RAND Corporation Says No.

By Chuck Dinerstein, MD, MBA — January 28, 2020

Bundling surgery and surgical fees into one payment for a so-called episode of care is the goal of CMS. It's meant to reduce costs. But what if physicians don't deliver all the expected services? Should they reimburse some of the money? The RAND corporation says yes -- and estimates the savings at nearly $10 billion annually.

Image courte of Gerd Altmann on Pixabay [1]

Surgeons, receiving fee-for-service payments, obtain a global fee to cover the care involved before surgery, the surgery itself, care during the hospitalization, and out-patient follow-up care for 10 or 90 days depending on the extent of the surgical procedure. For comparison, an internist treating a patient with pneumonia receives payment for every day of care provided, as well as for follow-up care. Surgical fees are more bundled, and approximately 25% of that global payment is attributed to post-operative, out-patient follow-up. A "Perspective," from the RAND Corporation, in the New England Journal Of Medicine, wants to lower that part of the global fees, which they estimated to cost Medicare $9.9 billion in 2017.

Global fees and how to pay physicians for their work is not a new issue. It surfaces every few years. Let me take a moment to remind you how these fees are established. CMS using its contractor, the American Medical Association, and the Specialty Society Relative Value Update

Committee (RUC), survey surgeons for the time they spend on those aspects of care covered by the global fee. After some deliberation and tussling, relative value units (RVUs, the bitcoin of medical care) are assigned to each aspect of the care, and the total is the global RVU. Medicare sets a conversion rate every year for what that RVU is worth, currently $36.09. For example, to explore an artery by open surgery, without the need for any repair or correction is valued at 7.5 RVU or roughly $270.

You can imagine the fighting over how much physician work is worth, especially when the committees are considered bias towards specialists and away from primary care providers. And the fight is made more intense by CMS's rules that payment changes be cost-neutral – that is, my increase in payments is someone else's lower payments. As other writers and I have reported, the short stick goes most frequently to the least represented and influential, primary care.

When this issue came up previously in 2012, a report by the Inspector General's office, which looked at only 300 cases, suggested that surgeons didn't provide as much post-operative care as they indicated. (About a third of cases provided less follow-up, and a quarter provided more post-operative care). Given the small sample size, there was a lot of pushback from the surgical community, and fee changes were deferred as CMS sought better data. The better data would come from surgeons, in 9 randomly selected states, reporting all post-operative visits to get a more accurate count. The initial data is in.

- For minor procedures with a 10-day post-operative care window, 4% of patients received follow-up care
- For major interventions with a 90-day post-operative window, 39% of patients received follow-up care.
- The savings from adjusting RVUs would amount to $2.6 billion in 2018, money that would be now available to give to primary care. That would, of course, require that these savings were directed to them because, in the current process of deciding payments, they do not have enough "juice" to get it done on their own.

The RAND authors raise a good question, is the methodology we are using to apportion payment the most useful? I think most physicians would say no. Simplifying surgery into components is not nuanced, especially when you fail to account for the frailty or resilience of the beneficiary being treated. The same operation on a 40-year old and an 80-year old requires much different pre and post-operative care. That is part of why a third of patients received less post-operative care and a quarter received more; the health of the patient at the time of surgery, or medical care, makes a big difference, not only in terms of physician work but hospital spending.

The dilemma for CMS is whether to take a knife to those post-operative visits, or they might unbundle post-operative care, paying for it separately. Cutting payments across the board will be met with stiff resistance from surgeons; unbundling goes against the CMS trend of containing costs by connecting them.

The RAND study may well have missed some other difficulties in apportioning care. When a patient is hospitalized for surgical care overnight or longer, it is assumed, in the payments that the operating surgeon will be responsible for other aspects of the patient's care, e.g., managing their

diabetes, hypertension, or coronary artery disease. Some physicians feel comfortable providing the basics of this care, only requesting a consultation with hospitalists, internists, or specialists as needed. Other physicians who feel their expertise begins and ends with surgery, routinely ask for assistance. And in all these cases in the fee-for-service world, that assistance is an additional cost. In bundled care, that assistance is part of the global fee; physicians and hospitals are left to fight out payments. Employed physicians have their income determined by their health system employer, who may apportion the money as they see fit, rewarding the revenue centers, i.e., surgeons, and not always recognizing the contribution of their consultants. Of course, the health systems take a cut from both.

One last thought, based on many years of experience. Legislators will not resolve the problem quickly, the more they dither, study and defer, the more specialty societies contribute to political action committees, that lobby for their viewpoint. With short election cycles, politicians need campaign funds almost continuously. What better source than PACs with legislation before them? Why would they make a decision, when not deciding can be so helpful to their political needs?

Source: Payment for Services Rendered — Updating Medicare's Valuation of Procedures NEJM DOI: 10.1056/NEJMp1908706
