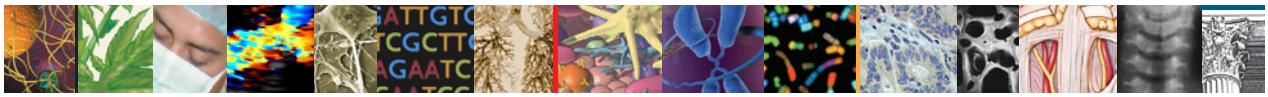

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Perspective

The CMS Proposal to Reform Office-Visit Payments

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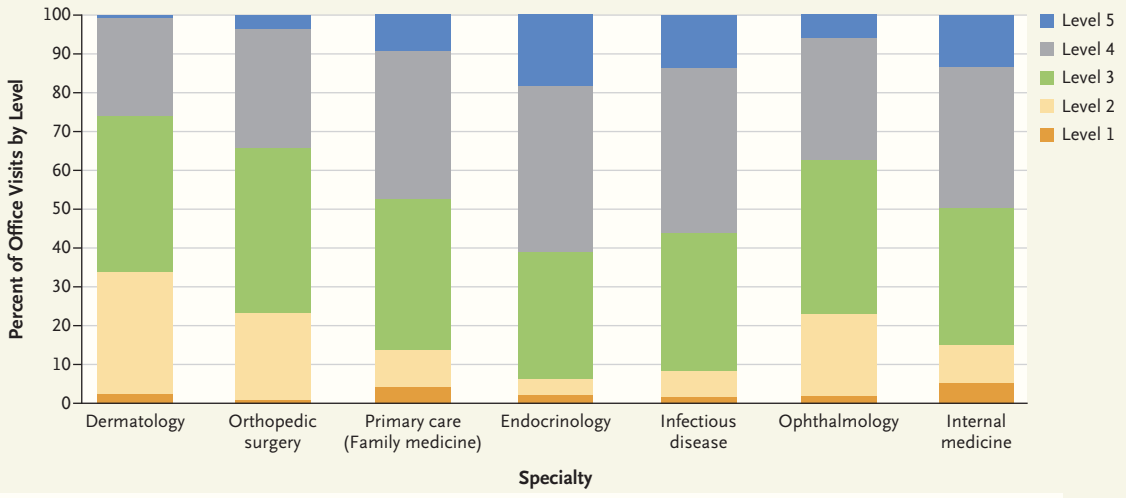
The Medicare payment policy for evaluation and management services — the most commonly billed type of physician services in the United States — has long attracted scrutiny. Tasked with rewarding cognitive work by physicians that is commensurate with patients' needs while minimizing the potential for fraud, Medicare pays for office visits using five levels of codes based on clinical complexity, medical decision-making complexity, and time. For visits with established patients, physicians are currently paid $22, $45, $74, $109, and $148 for levels 1, 2, 3, 4, and 5 visits, respectively; for new patients, they receive $45, $76, $110, $167, and $172. This pricing structure in the Medicare Physician Fee Schedule, established by Congress in 1989, is the basis for physician payment by both public and private payers.

In July 2018, the Centers for Medicare and Medicaid Services (CMS) proposed revamping Medicare payments for office visits. CMS plans to collapse Medicare fees for levels 2 through 5 office visits into a single price beginning in 2019.[1] For visits with established patients, physicians would be paid $93; for new patients, $135. There would be an add-on payment of about $5 for visits with primary care providers, and a $9 add-on payment for visits with certain specialists. A separate add-on fee of about $67 would be available for a 30-minute prolonged visit. Simultaneously, CMS would reduce the documentation requirements for this uniform fee to those of a current level 2 visit — brief history, single-system physical examination, minimal decision making, or 10 minutes of physician time. In addition, physicians would be allowed to update only what has changed, carrying over remaining documentation from prior notes. A visit code between levels 2 and 5 would still have to be chosen, but it would not affect payment.

This policy embodies the CMS commitment to reducing administrative burden — a key goal of its "Patients Over Paperwork" initiative. It attempts to address widespread concerns that documentation requirements contribute to physician burnout and distract from patient care.[2] In addition, CMS would create payments for telehealth services, non–face-to-face check-ins, and assessments of patient-submitted photos and videos.

Despite the admirable intention of reducing burden, the policy poses risks for Medicare beneficiaries with the most complex needs and may exacerbate workforce deficiencies. Collapsing fees for levels 2 to 5 office visits, which account for essentially all physician visits billed to Medicare, effectively removes physi-



Variable							
Medicare office-visit payments per physician ($)	49,441	30,150	30,975	45,611	10,977	19,126	31,684
Share of Medicare payments from E&M codes (%)	22.4	23.1	70.8	70.3	80.2	5.3	74.9

Medicare Payments and Levels of Service for Office Visits for Established Patients, 2015.

Data are from the Centers for Medicare and Medicaid Services public use files for 2015. E&M denotes evaluation and management.

cians' incentive to spend time with patients who have complex needs. The physician effort required for a level 2 visit is minimal. In contrast, working with patients who have multiple coexisting conditions, psychosocial challenges, and language or other barriers requires additional effort that would no longer result in a larger payment. The incentive to conduct shorter, repeated visits would be heightened.

Physicians who disproportionately care for patients with complex needs would face a fee cut for levels 4 and 5 visits, despite the add-on payment. Physicians in nonprocedural specialties whose revenue derives largely from these visits (see graph) could find this cut untenable. To maintain their income, they would need to reduce visit time and bring patients back more often for shorter visits, potentially compounding patients' burden and increasing care fragmentation. Concretely, the $67 that would be added to a physician's reimbursement for a 30-minute prolonged visit pales in comparison to the $279 ($93 per visit) he or she could earn by using that time to conduct three level 2 visits. Such pressure to churn patients could prove antithetical to the goal of burden reduction for some specialties and consequently exacerbate physician burnout. Conversely, specialties whose visits are disproportionately level 2 or 3 would receive relative payment increases. But insofar as CMS aims to reduce physicians' documentation burden, requiring level 2 documentation would have less of an effect on these specialties.

Over time, such a policy might worsen shortages in the U.S. physician workforce. In specialties that are already lower-paid — such as infectious disease, in which 18% of fellowship slots and a third of training programs were unfilled in 2018, and geriatrics, in which 54% of fellowship slots and three fourths of programs were unfilled[3] — the prospect of having to generate more visits or incur an income reduction is probably unappealing to future medical graduates. Fundamentally, this policy would maintain the disparities in revenue per unit of physician time between specialties that derive a larger share of revenue from procedures, tests, and imaging and specialties that depend on evaluation and management. Specialties that rely on levels 4 and 5 office visits are especially disadvantaged by preserving these disparities (see graph).

In projecting that the policy would be budget-neutral, CMS assumes that visit volume would

remain unchanged. Moreover, it does not consider potential offset effects on other services. Evidence shows that physicians typically respond to fee cuts by changing the volume of affected services provided (an "income effect") or using their time for higher-margin services ("substitution effect").[4] Thus, physicians who perform procedures could recoup losses in office-visit revenue more easily than those who do not. Such unintended effects on both office visits and other services could increase total spending.

Moreover, in reality, administrative burden may not be easily mitigated. For patients with complex needs, reducing documentation could be a false promise, since a physician's reasoning through a challenging differential diagnosis or nuanced decisions made amid uncertainty probably cannot be left unexplained. Documentation is also necessary to justify payment for services such as medical equipment (e.g., home oxygen supplies) and Medicare's Annual Wellness Visit. It remains critical, too, for pay-for-performance programs such as those created by the Medicare Access and CHIP Reauthorization Act (MACRA). Documentation of diagnoses — a related aspect of physician burden — will continue to be consequential for providers participating in risk-adjusted alternative payment models, such as Medicare's bundled or global payment programs. Such documentation demands also apply to Medicare Advantage, in which risk-adjusted payments depend on diagnosis codes. Private payers might or might not adopt this policy, potentially limiting its effect among physicians who must document adequately for multiple payers. If some payers maintained existing payment levels, there could be unintended shifts in access to care for Medicare beneficiaries.

CMS considered alternative policies, such as combining levels 2 through 4 visits while retaining level 5 for patients with complex needs. This approach, however, was considered inconsistent with the priority of minimizing documentation requirements. Moreover, CMS predicted that specialties that bill for higher-level visits would see less income from keeping their level 5 visits than loss from the effective fee cut in level 4 visits.[1]

Policymakers and stakeholders could consider alternative strategies that might reduce documentation burden while protecting specialties that depend on complex office visits as a chief source of revenue.[5] First, reducing documentation requirements need not be coupled with collapsing prices across levels of work intensity. Uncoupling these reforms would allow the agency to reduce burden without discouraging efforts to care for patients with complex needs.

Second, CMS could design separate office-visit codes for cognitive and procedural specialties, analogous to psychotherapy codes for psychiatry. Such codes could then be priced to dampen unintended consequences from changes in volume, while documentation requirements are simplified as much as possible. Third, burden reduction may be achieved in other ways, such as by revising the existing visit definitions from the 1990s, perhaps taking greater account of how physicians' time is used.

We believe that CMS should be commended for this effort to reduce administrative burden. However, potential unintended consequences and persistent incentives or needs for documentation may blunt the impact of the proposed policy and render it undesirable for patients and providers. If professional societies, researchers, and policymakers collaborate to develop a more robust understanding, based on contemporary evidence, of what constitutes various levels of work intensity for the cognitive care required by patients, such data would inform efforts to more reasonably define service codes, valuations, and documentation requirements.

Disclosure forms provided by the authors are available at NEJM.org.

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