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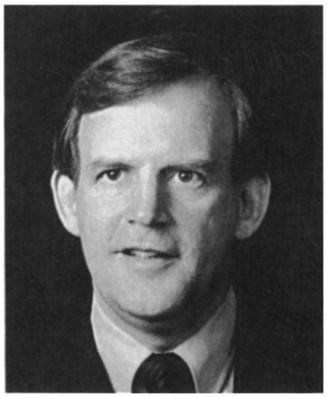

President's Page: Reaction to the Harvard-American Medical Association Resource-Based Relative Value Scale

ANTHONY N. DEMARIA, MD, FACC
President, American College of Cardiology

Shortly after the implementation of the Diagnosis Related Groups (DRGs) for payment of hospital costs by Medicare, the government embarked on an effort to revise methods of physician reimbursement. Although a variety of approaches were considered, including physician DRGs and capitation, attention has centered on a study to establish a resource-based relative value scale (RBRVS). The results of this study, conducted by William Hsiao, PhD of Harvard University in conjunction with the American Medical Association (AMA), were widely anticipated and discussed. These results have recently been reported and, not surprisingly, have received various responses.

The Harvard-AMA RBRVS study represented the first major attempt to apply objective quantitative criteria to the work performed by physicians. The results of this study indicated that, in the 13 disciplines evaluated, physician reimbursement was disproportionately large for the work calculated for some specialties and disproportionately small for others. Of significance to cardiovascular medicine and surgery, implementation of the findings indicated that fees for cardiac surgery might be adjusted downward by as much as 50%. In general, so-called cognitive services appeared undercompensated and "procedural" services appeared overcompensated. Although the Harvard RBRVS was constructed under the premise that it would be budget neutral, the need to devise a multiplier by which the relative values for individual services can be converted to actual dollars provides a relatively simple potential mechanism for reducing reimbursement across the board.

College evaluation of the project. The College has carefully monitored this project from its onset. Discussions of the Harvard-AMA effort were held among multiple College committees as well as the Board of Governors and Board of Trustees. Despite these preparations, we were somewhat surprised to be asked by the American College of Physicians and the American Medical Association to render our opinion of the study just weeks after its initial publication. Although the College is still preparing a formal position, which will be placed before the Board of Trustees for their consideration at the next meeting, there are a number of aspects regarding the RBRVS study that I believe will dictate our posture.

A factor of cardinal importance in determining the position of the College regarding the Harvard-AMA RBRVS is that cardiology was not one of the specialties that was modeled in this study. Cardiology has been included in the second round of this project, and the initial aspects of this exercise are currently underway. We were asked by the AMA and Dr. Hsiao to nominate Fellows of the College to assist with the cardiology modeling and I am pleased to say that all of our nominees were invited to serve on the cardiology advisory panel.

The results of a work-based approach to reimbursement for cardiovascular services should be of great interest because these activities clearly straddle the line between the cognitive and the procedural. I suspect that the number of members of the College who spend a majority of their time in patient evaluation and treatment is nearly equal to the number of members who spend a majority of their time performing procedures. Obviously, as a College we should be unwilling to take any final position regarding this study until the modeling of all aspects of cardiovascular medicine is completed and can be evaluated by appropriate ACC committees.

Limitations of the study. A variety of limitations of the Hsiao study have been delineated by outside observers as well as by the Harvard investigators themselves. Of great

Address for reprints: Anthony N. DeMaria, MD, Division of Cardiology, University of Kentucky Medical Center, 800 Rose Street, Lexington, Kentucky 40536.

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importance, quality of care was not factored into the calculation of reimbursement. Potential variation among patients with a given problem was also not assessed. Major questions exist as to how work performed before and after the rendering of a service should be factored into reimbursement. The study did not measure all 100 of the most frequently rendered services. It has been pointed out that difficulties will be encountered in attempting to translate the services considered into existing current procedural terminology (CPT) codes. An acknowledged shortcoming in the assessment of practice costs also exists. In terms of the physicians participating in the study, approximately 30% were nonresponders and it is uncertain whether all of the physicians who rated services were fully qualified to do so. Thus, in light of these significant limitations, it would appear that considerable refinement of the current study is required before a definitive evaluation can be made.

The response to the Harvard-AMA RBRVS has been mixed, with surgically oriented physicians focusing on the limitations of this study and primary care physicians emphasizing the merits. William Roper, MD, Director of the federal Health Care Financing Administration, pointed out that, in its current format, the RBRVS will not significantly address the increasing cost of health care delivery. It is now well recognized that the volume of services delivered is of equal or of greater importance than the type of service in determining the cost of health care. Accordingly, a variety of mechanisms for controlling the volume of services delivered, such as expenditure caps in the Canadian system, continue to be developed. Nevertheless, it is likely that estimates of the relative work involved in individual services, such as has been evaluated in the Harvard-AMA project, will play an important role in any future restructuring of the physician reimbursement system.

Appropriate responses to the study. Given the current state of affairs, it seems to me that a number of reactions to the Harvard-AMA RBRVS are appropriate. I believe that Dr. Hsiao and the AMA should be applauded for their efforts to measure physician work, and it should be acknowledged that such measurements provide a potential mechanism by which to achieve the desirable end of reducing the cost of health care. Nevertheless, it must be recognized that significant limitations are present in the existing study and that important additional corrections and refinements are necessary before the validity and utility of such an approach can be determined. It would seem inappropriate for the American College of Cardiology to render any final approval or disapproval of the Harvard-AMA RBRVS study until the modeling of cardiovascular medicine is completed. However, in light of the existing national budget deficit and the pressures on our society to reduce the cost of health care, there can be little doubt that some revision of the current method of physician reimbursement will be implemented. Given these circumstances, although a system based on a resource-based relative value scale clearly will not address many of the important determinants of health care costs, it appears to be the best of the alternatives that have been considered for revised physician payment. If, after suitable revision and refinement, a new RBRVS approach to physician payment is instituted, it would seem mandatory that the mechanism include a gradual transition with careful evaluation along the way.