

A Chronology of the Evolution of RBRVS and P4P

Date	Event	Comment
Early 1900s	Paid through hospitals	
Late 1940s	Fee for Service flat fee	20% of surgeon's fee
1950s	CA RVG CMA RVS	Dr. Joseph Failing, anesthesiologist from Los Angeles Other guides by OBs, Rads, Peds, Dentists
Early 1960s	CHAMPUS	Feds need fee schedule
1961	ASA HOD affirms UCR	
1962	ASA HOD adopts RVG First ASA RVG	Base plus time
1965	Medicare and Medicaid	Discounted FFS, 90% UCR, avoided inclusion in Medicare Part A, paid out of Medicare Part B
1967	ASA RVG 2 nd Edition	
Late 1960s	FTC challenges RVGs, alleging price fixing	Consent orders stop publication, except ASA
1973	Medical Economic Index instituted	Limits Medicare payments but not UCR, nor noncontracted payments
Mid 1970s	PCPs complain	Allege cognitive undervalued relative to procedural
1975	DOJ sues ASA	Claims ASA RVG violates Sherman Anti Trust Act
1977	ASA RVG reorganized	Now anatomical, fewer codes
1979	ASA prevails over DOJ	ASA RVG preserved
Late 1970s	Congress concerned	Gaming and excessive income alleged
1980	AMA CPT has Anesthesia Section	Codes mirror ASA RVG
1982	TEFRA	1 st law changing Medicare MD pay—Parts A vs. B
1983	HCFA restrictions Congress establishes PPS for inpatients	Limits on medical direction Flat fee pricing for procedures rewards "efficient" care

1984-1985	<p>“Participating” and “Non-Participating” MDs</p> <p>Fee freeze</p>	18 months
1985	<p>Deficit Reduction Act</p> <p>Congress awards multimillion dollar contract to Hsiao and Harvard</p>	<p>Required balanced budget by 1990, specific yearly deficit limits, “budget neutrality”</p> <p>To develop RBRVS</p>
1986	<p>Congress mandates study</p> <p>RAP DRGs proposed</p>	To use RBRVS as new MFS
1987	<p>RAP DRGs in Reagan budget</p> <p>Proposal to pay MAC with time only, no base units (cataracts)</p> <p>MAAC limits</p> <p>CRNA Medical Direction</p>	<p>Defeated by ASA at a “price”****</p> <p>*** ASA convinces HCFA to reduce base units only</p> <p>***In response to low rates of “participation”</p> <p>*** Cuts in base and time units</p>
1988	<p>HCFA suggests cuts to hospital-employed CRNAs to preserve budget neutrality</p>	<p>ASA negotiates budget-neutral CRNA MFS and no more cuts in medical direction fees (uses political capital from 1987 compromise)</p>
1988	<p>Congress mandates MFS based upon RBRVS</p>	<p>HCFA stated intention to redistribute Medicare payments from specialists/proceduralists to primary care/cognitive/prevention</p>
1988-1991	<p>Hsiao et al. develop RBRVS</p> <p>ASA policy to preserve anesthesia time as primary objective</p>	<p>Intra-specialty surveys to create relative work scales, what to do with anesthesia time, cross links (? base units only and anesthesia time excluded), practice expense and insurance components</p> <p>ASA representatives to specialty panels, attempts to lobby Hsiao and HCFA</p>
1990	<p>HCFA publishes the “Final Rule” on URVG</p>	<p>ASA RVG retained, modifier units eliminated, carrier discretion on certain types of monitoring, cataract base value reduced</p>

1991	National average anesthesia conversion factor was \$19.27 Hsiao develops new MFS anesthesia conversion factor	Some anesthesiologists paid in mid \$40s Uses data from Medicare claims 1990-1991, only 3 anesthesia specific cross links, average case times for 19 CPT codes, straight arithmetic averaging ignores frequency distribution, extrapolation to 252 anesthesia codes
October 1991	ASAPAC formed by ASA HOD, ratifying BOD	Dr. Tom Joas authored the ASA Resolution, First ASAPAC Chair was Dr. Roger Litwiller
?October 1991	HCFA announces national average anesthesia conversion factor for new MFS in 1992, \$13.68	Conversion factor reduced by 29%, inputed anesthesia work values reduced by 41.7%, onerous academic anesthesia teaching rule
Mid 1992	S. 2643 (Bentsen, D-Texas)	Intends to prevent HCFA from using average anesthesia times
1993	RAP DRGs proposed by Clinton Omnibus Budget Reconciliation Act	Defeated by ASA Incorporates S. 2643, enshrines in law that anesthesiologists uniquely stand apart from RBRVS
1995-1996	RUC meets	ASA presents Apt study
1997	First (every 5 year) MFS Update SGR replaces MEI and MPVS	
2001	IOM publishes <i>Crossing the Quality Chasm</i>	Hospital performance measures thereafter tied to institutional rate increases
2002	Second RUC MFS Update	Obviously a zero sum game
2002-2004	P4P programs for PCPs begin and grow	
2003-2004	ASA Committee on Economics studies Flat Fee methodology	
2004	Report to ASA by Curt D. Mueller, Ph.D.	No "critical" mathematical errors at initiation of RBRVS

	ASA Special Reference Committee on Flat Fee methodology	No consensus in ASA HOD
2004-2005	Negative MFS Updates loom from SGR formula	Congress passes "one-time fixes" in 2004 and 2005
2005	P4P Medicare legislation in Congress	AMA says not doable until fix SGR; debated and defeated
2005	ASA debates P4P	ASA CPOM creates 5 potential performance measures, ASA sees P4P as an opportunity, argues to position members to benefit from P4P, vocal group rejects P4P as insidious budget axe
February 2006	National Summit on P4P	Planners congratulate each other on P4P reaching "critical mass," some want to reform MFS to use only P4P, specialist measures not yet created
2006	Medicare accepts only some of proposed performance measures in demonstration project, voluntary reporting program AMA agrees to develop performance measures within Consortium	