intentionally increasing inequities. The tenets of standardization, high reliability, and a systems-level focus that are essential to safety can sometimes have this effect. We can counter this tendency by carefully designing solutions for our most at-risk patients.

We think patient safety is the pivot on which we can gradually turn the equity conversation — from ambivalence about reform to urgent action; from euphemisms to explicit conversations about racism, sexism, and other forms of discrimination; from passive academic descriptions of disparities to action supported by resources and infrastructure; from rationalization by good intentions to a comprehensive analysis of systems, human performance, and behavioral contributors leading to real improvement; and from lack of accountability to the active embrace of equity as a core mission.

An audio interview with Dr. Sivashanker is available at NEJM.org

Ultimately, we need to test this approach for integrating equity into quality and safety frameworks, recognizing that we are poking at a collective trauma that will be painful and uncomfortable when exposed. Things will seem worse before they get better. Mirroring the journey of patient-safety efforts, near-term measures of success in improving equity should paradoxically be more (not less) reporting of inequities, more (not less) discomfort as inequities are acknowledged and disclosed, and more (not less) complexity in balancing concerns for liability and public perception with a commitment to improvement by means of transparency. Such results are signs that we are moving toward addressing inequities and achieving our goal of delivering the highest-quality, safest care.

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

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Payment for Services Rendered — Updating Medicare's Valuation of Procedures

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For most surgical procedures, Medicare and many other insurers give physicians a single bundled payment that covers both the procedure itself and related postoperative care during "global periods" encompassing the 10 or 90 days after the procedure. Postoperative visits account for roughly 25% of Medicare payments for procedures with bundled postoperative care[1] — which totaled $9.9 billion in 2017. In 2015, the Centers for Medicare and Medicaid Services (CMS) proposed removing postoperative visits from bundled payments for procedures, in response to chart reviews by auditors that suggested that fewer postoperative visits were provided than the agency had assumed when setting Medicare payment rates.[2] This finding may be driven in part by postoperative care being shifted to hospitalists and intensivists who bill separately from the bundled payment.

After lobbying by the surgical community, Congress, in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), explicitly prohibited CMS from moving forward with this plan. Instead, Congress required CMS to collect more data on the number and level of postoperative visits provided and to use these and other data to improve the accuracy of the valuation of procedures. The data have been collected, and armed with this new information, CMS must now decide how to move forward.

Medicare payments for surgical procedures are based on calculations that take into account physician work, practice expenses, and malpractice expenses related to the procedure itself and associated postoperative visits. There are many steps involved in determining the valuation of specific procedures. In brief, estimates of work are based on physician sur-

veys fielded under the auspices of the American Medical Association and Specialty Society Relative Value Scale Update Committee (the RUC). In these surveys, respondents are asked to estimate the number and level of postoperative visits required to care for the typical patient who undergoes a given procedure. These visit counts, after any adjustment by CMS, are included in the work relative value units (RVUs) allocated to a procedure and also affect the number of practice expense and malpractice RVUs assigned. The estimated RVUs for the procedure are then used by Medicare and most other public and commercial insurers to set payment rates.

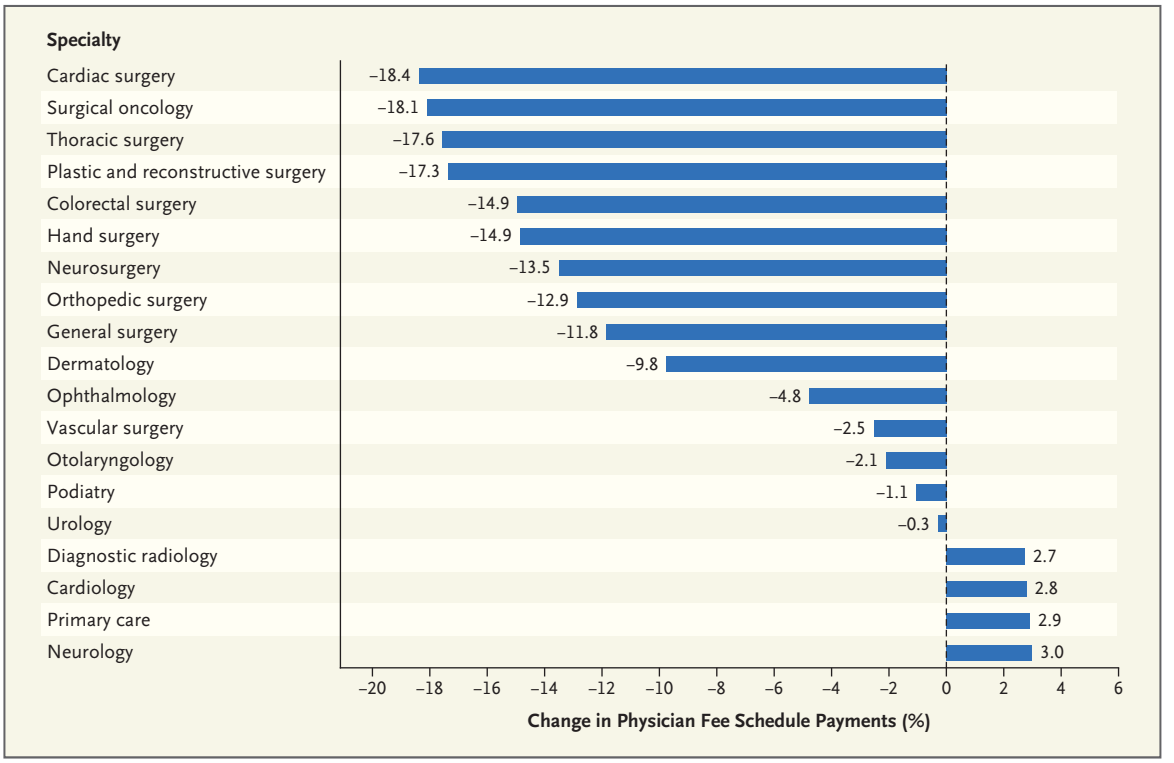
One glaring concern regarding this system has been that there is no way of confirming that the expected number of postoperative visits reported in physician surveys are actually provided. In response to this limitation and to Congress's mandate in MACRA, starting in July 2017, Medicare required certain physicians and other practitioners in nine randomly selected states to report their postoperative visits using a "no pay" code. The data from the first year of reporting are striking. Postoperative visits were reported during only 4% of 10-day global periods for more minor procedures (e.g., destruction of benign skin lesions), despite CMS's assumption that the payments for nearly all these procedures include a postoperative visit.[3] For more complex procedures with 90-day global periods (e.g., hip arthroplasty), only 39% of the visits that were assumed during the valuation process were reported to have taken place. These results were robust to analyses conducted in an attempt to address potential underreporting of postoperative visits.

These findings confirm earlier audits that revealed that the bulk of expected postoperative visits aren't taking place. How can CMS respond? In a project funded by the agency, we modeled what would have happened if RVUs associated with postoperative visits had been scaled back to match the number of such visits reported to CMS.[4] This calculation involved removing physician work and direct practice costs (such as rent, supplies, and clinical labor) associated with visits that were not typically provided and then reestimating practice expense and malpractice RVUs for all services in Medicare's 2018 physician fee schedule.

According to our models, these changes would have cut Medicare payments for procedures with 10- and 90-day global periods by 28% (or about $2.6 billion) in 2018. Total Medicare payments for all services to many procedure-focused specialties (e.g., cardiac surgery and surgical oncology) would have decreased by 15 to 20% (see graph). Because of Medicare's budget-neutrality policy, lower payments for surgical procedures would have resulted in across-the-board payment increases for all other physician services, including evaluation and management visits. The payment reduction for surgical services thus results in a net increase in payments to primary care and other nonproceduralist specialties.

But is this approach the best strategy? The complexity of the current valuation system leads to some ambiguity. The central issue is that the work involved in a procedure is not determined by tallying up the work involved in its constituent components (i.e., preparing for the procedure, performing the procedure, supporting a patient during recovery, and providing postoperative visits during the global period). In the RUC surveys, after answering questions about some of these individual components, respondents are asked a single, broad question that requires them to compare the total work involved in a given procedure with a reference procedure, a process called "magnitude estimation." It's common for the total work RVUs determined using magnitude estimation to conflict with the total work RVUs that result from summing the work RVUs for the individual components of a procedure. For example, in a few extreme cases — such as the treatment of foot dislocation — the valuation for the entire global period, which includes the procedure and postoperative visits, is exceeded by the work RVUs associated with just the assumed postoperative visits. This finding raises the concern that simply carving out work RVUs related to postoperative visits may not always be fair.

The size of the gulf between the number of postoperative visits that are assumed during valuation and the number that are actually provided under the global payment suggests that CMS must respond by lowering valuations to reflect these new data. The most practical path forward may be to carve out all or some fraction of RVUs related to postoperative visits that are not typically provided. CMS could also ask the RUC to revalue selected procedures for which the resulting valuations seem too high or too low. Alternatively, CMS could revisit its original plan to unbundle proce-



Estimated Change in Total Medicare Physician Payments for Selected Specialties after Revaluing of Procedures with 10- and 90-Day Global Periods.

"Change in physician fee schedule payments" is the percent change from current total relative value unit (RVU) valuations to updated total RVU valuations. Primary care includes family practice, general practice, and internal medicine. Data are from the authors' analysis of 2016–2017 claims data for reported postoperative visits and the Medicare CY 2018 Physician Fee Schedule and Time File.

dures and postoperative visits, but this approach goes against the general trend toward increased bundling of payments, and surgeons may react to reductions in payments for procedures by providing more services.

The issues raised by these new data highlight fundamental problems with the current system for valuing physician services. In the longer term, we believe that CMS should move to a system that does not depend solely on physician surveys and that uses a range of inputs, including data from billing claims, quality-improvement databases, and electronic health records.[1,5] Such a system would permit more direct adjustments to valuations on the basis of new, more objective data.

The stakes are high for CMS's decision. Cuts could have a major effect on surgeon revenue. But the current system results in inflated payments for surgical procedures relative to evaluation and management visits and other nonsurgical services that are the mainstay for many physician specialties. The discrepancy in income between procedural and nonprocedural specialties has many ripple effects, influencing the specialty choices of medical students and the number of students choosing careers in primary care. Ultimately, patients bear the cost of distortions in payment rates, which result in reduced access to underpaid services and an inflated cost-sharing burden for overpaid services.

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

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Healing as a Servant Instead of a Prophet

Michael Lee, Jr., M.D., J.D.

We had just completed a dramatic 3 hours in the emergency department: one patient in shock, another in status epilepticus, and a third with multiple traumas after having been hit by a car. I took one self-congratulatory moment before checking the board. Fortunately, there was only one new patient, and he was waiting to be seen for a less urgent problem. I shook off the stress of the past several patients and walked over.

The lights in J.'s room were off, and the room was quiet — eerie, almost. We could hear the soft beep of a pulse oximeter next door. Trying to muster some energy and put the patient at ease at the same time, I sat gently on the countertop to introduce myself and to hear his story. J.'s symptoms had started 6 months earlier with persistent nausea; he didn't vomit, but his appetite had steadily declined. He'd lost 15 pounds in the past 2 months, his schoolwork had deteriorated dramatically, and he'd withdrawn from his friends and hobbies. He'd made five previous medical visits — including visits to his primary care physician and two different emergency departments — and his mother fretted that everyone he'd seen had reported that his laboratory studies were normal and sent him on his way without a "real" diagnosis.

The first half of my response, shared while I examined his abdomen and pupils, was easy and automatic: we would check a few labs, evaluating J. for celiac disease or inflammatory bowel disease while screening quickly for a cancer. But then, having reached the heart of the issue, I paused. I spent a moment simply looking at J. His unshaven, teenage face looked haggard, and his thin, gangly frame was curled up on the corner of the bed. He was too withdrawn to make eye contact. I realized belatedly that he hadn't yet said a word; his mother had been speaking for him.

J. needed me to be honest with him — to tell him that I suspected his symptoms were manifestations of depression rather than a primarily gastrointestinal issue and that help was available — but I hesitated, knowing how often such conversations went poorly. Typically, I would recommend a behavioral health evaluation and outpatient follow-up for somatoform symptoms, and the patient and his family would resist. Usually, they saw my recommendations for low-intensity interventions as a sign that I didn't take their suffering seriously; in the face of that perception, my training and our institution's reputation meant very little to them. The seemingly ceaseless arguments about antibiotics for fatigue, magnetic resonance imaging for chronic abdominal pain, and subspecialty consultations for just about anything I could imagine usually left me exhausted and my patients dissatisfied.

Recently, weighed down by these ever-present conflicts, I had been contemplating the story of Naaman, from the Old Testament's Second Book of Kings. The Bible describes Naaman as a "great man" — a prominent, valiant general from the nation of Aram. But Naaman had leprosy. Seeing him suffering from this disfiguring, debilitating, and highly stigmatized illness,[1] one of his household servants — a young Israelite girl, kidnapped by raiders and held captive in Aram — spoke up. "If only my master would see the prophet who is in Samaria!" she said, referring to the famed Israelite prophet Elisha. "He would cure him of his leprosy."

Eager for a cure, Naaman loaded 10 talents of silver, 6000 shekels of gold, and 10 sets of clothing onto his horses and chariots and traveled to the door of Elisha's house in Israel. There, a messenger greeted him with an