Comments of the American Society of Internal Medicine

December 30, 1997

RE: Medicare Program; Delay in Implementing the Adjustments to the Practice Expense Relative Value Units Under the Physician Fee Schedule for CY 1998; Notice of Intent to Regulate (42 CFR Part 414)

Introduction

The American Society of Internal Medicine, representing the nation's largest specialty society--and the physicians who treat more Medicare patients than any other specialty--appreciates the opportunity to provide comments on HCFA's notice of intent to regulate on practice expense relative value units (PE-RVUs). Although our comm ents provide some suggestions on additional data that could be utilized in developing the proposed PE-RVUs, ASIM believes that HCFA's efforts to date already are well on the way to fully satisfying the requirements and intent of the Balanced Budget Act of 1997 (BBA '97).

Requirement that HCFA Consult with Physicians

We commend HCFA for soliciting formal comments before publishing a proposed rule next Spring. For the record, it should be noted that the opportunities being provided to physicians and other interested parties to comment on the proposed rulemaking far exceed those that were available prior to implementation of resource-based work RVUs on January 1, 1992. Only one formal comment period preceded implementation of the work RVUs. A second comment period was subsequently provided on the interim final work RVUs.

By contrast, physicians will have had the following opportunities to formally advise HCFA and Congress of their views prior to implementation of resource-based PE-RVUs:

In response to the preliminary data released by HCFA in January, 1997.

During the official comment period on the notice of proposed rulemaking (NPRM) published on June 18, 1997.

During the official comment period on this notice of the intent to regulate.

In response to the report from the General Accounting Office on the data and methodology used by HCFA, which must be submitted to Congress no later than February 5, 1998. The GAO has actively solicited views from physician organizations as it prepares its report.

In response to the March, 1998 report to Congress from the Secretary on the data and methodology being utilized to develop PE-RVUs, as mandated by the BBA '97.

During the official comment period on the new proposed rule on resource-based practice expenses (RBPEs), which by law must be published no later than May 1, 1998.

During a comment period on any interim PE-RVUs that will begin to be phased-in on January 1, 1999.

During the refinement process that by law must occur during each year of the subsequent transition.

Further, *physicians have actively participated in the actual development of RBPEs* through every stage of the process: including participation in the original Clinical Practice Expert Panels (CPEPs), in the validation panels conducted this Fall, and the multispecialty panel meeting that was convened this past month. HCFA has also provided numerous other forums for physician groups to convey their opinions to the agency.

We note this record of responsiveness to physician input because we believe that the agency's actions to date--and the plans for future opportunities to submit views--already fully meet the mandate in the BBA '97 that HCFA "consult with organizations representing physicians regarding data and methodology to be used.

In this notice of the intent to regulate, HCFA requests information on several specific data issues that must be considered by the agency as it develops new practice expense RVUs as required by the BBA '97. ASIM's comments on those requests are as follows:

<u>Generally Accepted Accounting Principles</u>

HCFA requests comments "on generally accepted accounting principles that recognize all staff, equipment, supplies and expenses, not just those that can be tied to specific procedures. We particularly solicit comments on aspects of the cost accounting methodology used in the June 18, 1997 proposed rule that were not consistent with statutory intent.

ASIM believes that the cost accounting methodology used in the June 18, 1997 proposed rule is consistent with statutory requirements. We believe that allocating indirect costs based on the physician work RVUs and direct PE-RVUs is consistent with generally accepted accounting principles. Further, by specifying that HCFA utilize generally acceptable accounting principles and actual cost data only to the "maximum extent practicable," Congress made it clear that it did not intend for HCFA to initiate a major new cost accounting study, since it is not practicable to expect that such a study could be initiated, and reliable data made available, in time to be used in developing the proposed rule that Congress directed must be published by May 1, 1998. Nor, in ASIM's view, is it necessary that such a study be initiated in order to produce reasonable resource-based practice expense RVUs. It is clear that Congress did not intend that the practice expense RVUs cover actual costs, only that such cost data be considered to the maximum extent practicable in determining the*relative* relationships between each physician service.

Further, there is support in the independent literature on allocating indirect costs based on extant data, rather than conducting new studies of actual costs. Attached to these comments are the summaries of ten independent studies, including the most recent report to Congress of the Physician Payment Review Commission, that support the view that indirect practice expense RVUs can reliably be calculated using extant data--such as existing data on physician work and the percentage of direct and indirect PEs from the AMA's Socioeconomic Monitoring Survey, as proposed by HCFA. By also basing the indirect PE-RVUs on the direct PE-RVUs, HCFA is not relying solely on extent data on physician work, however. HCFA appropriately is considering new data--the data on direct PE-RVUs from the CPEPs, validation panels, and other sources--in determining the indirect PE-RVUs.

Cost accounting studies do not address the issue of resource inputs, only costs which can vary widely from practice to practice. Examples include rent in fancy buildings versus low budget buildings; fancy computers versus simpler ones that can do the job; expensive nurses versus less expensive medical technicians, and other such variable costs. HCFA should *not* be basing *resource-based*practice expenses on variable costs that are due to personal preferences of physicians, since those preferences are themselves influenced by historical inequities in payments (i.e. physicians in specialties that have historically earned more because of Medicare's charge-based practice expense methodology can afford to spend more money on office space, staff and other practice amenities--even though those variable costs may exceed the actual resource inputs that are *truly* required to provide a service). Rather, HCFA should base the PE-RVUs on the equipment, supplies, and administrative and clinical staff times that are *actually* needed to provide a service to a *typical* patient.

HCFA expresses a willingness to consider special studies sponsored by physician organizations to develop or validate resource-based PE-RVUs for physician services. ASIM does not object to considering such analyses, but we believe that the agency must be cautious in accepting the conclusions of studies that were funded by physician groups with a vested financial interest in the outcome of the study. Presumably, if a study did not support the sponsoring group's views on the practice expense issue, the results would not be provided to HCFA in the first place. We concur with HCFA that the complete studies must be provided to HCFA, including the underlying surveys supporting those studies, actual copies of the survey instrument, sample design, general and item response rates, and characteristics of non-response rates. It is our understanding that some physician specialty organizations have only selectively reported out certain results from their studies, rather than providing the entire study, since some of the findings in their own studies suggest that the current-charged based methodology overpays them for some services.

<u>Equipment Utilization</u>

ASIM believes that HCFA should consider additional data on the actual utilization rates for equipment. The 50 percent utilization rate should be considered the default estimates in the absence of better data on equipment utilization, however. HCFA should attempt to validate any additional data on utilization rates before agreeing to use a different estimate.

<u>Direct and Indirect Costs</u>

ASIM agrees that HCFA should consider data on the percentage of direct and indirect costs on a specialty-specific basis. In our comments on the proposed rule, we asked that HCFA consider varying the percentage allocation of indirect PEs per service based on the weighted average by frequency of the indirect costs of the specialties that provide each service. HCFA proposed to base the indirect PE-RVUs on the sum of the direct practice expense RVUs, the physician work RVUs, and the malpractice RVUs, multiplied by a factor of .219 to scale the indirect PEs to the total available pool of indirect PE-RVUs. Under ASIM's suggested alternative, the multiplicative factor would vary based on the proportion of indirect practice expenses of the specialties that perform each service, weighted by the frequency by which each specialty billed for each service. For specialties for which there are insufficient data on billing frequencies, the .219 multiplicative factor would be the default.

ASIM continues to believe that this option deserves consideration by HCFA. If a particular specialty has a higher proportion of indirect practice expenses than is the average for all specialties, and that specialty provides a given service more frequently than any other, it seems only fair that the higher proportion of indirect PEs that typically are involved in providing the service be reflected in the factor used to determine the total number of indirect PE-RVUs.

We suggest that HCFA present this option, along with estimates of its potential impact on payments per specialty and per service, as part of the new proposed rule for public comment that will be published by May 1 of next year.

We understand that the cross specialty panel that met in December voted to recommend that billing expenses be moved from the direct practice expense category to indirect costs. If HCFA decides to move billing from a direct cost to an indirect cost then it must revise the 55/45 direct/indirect cost split accordingly using the AMA SMS data. Based upon consultation with our physician representatives, we believe that if billing is moved from direct to indirect costs then billing cannot be handled in the same manner as other indirect costs. Billing costs are not a linear function of direct costs and physician work, but are more static than other indirect costs. Consequently, it would not be correct to assume that billing costs should increase in a linear fashion with direct costs and physician work RVUs. For instance, the billing costs for most evaluation and management services are not significantly different than those for lengthy surgical services.

We also believe that the administrative expenses associated with billing should be based on the expenses that are typically incurred in billing for *Medicare*beneficiaries. Some of the billing staff time estimates from the CPEPs and validation panels were based on the staff time required to comply with pre-authorization requirements from managed care plans. Medicare, however, has no preauthorization requirements. Therefore, the staff time associated with pre-authorization approval cannot be considered to be typical for Medicare patients. Although we understand that the relative value units in the Medicare fee schedule are used by other payers, HCFA's statutory responsibility is to assure that the Medicare fee schedule pays appropriately based on the resources involved in treating Medicare patients. Therefore, any consideration of the costs incurred in complying with the requirements of other payers should be given less weight than the costs incurred in treating Medicare patients. This would require that the billing time estimates be

adjusted based on the proportion of the claims that are billed to Medicare compared to other payers.

Use of Physician-Employed Staff in Hospitals and Other Facility Settings

The internists who participated in the CPEP and validation panels question the premise that it is a common and widespread practice for a physician's employees, for example, nurses, to accompany the physician to the hospital, ambulatory surgery center, and other facilities. Their personal observations do not support the conclusion that this practice is typical.

ASIM recently asked four hospital administrators if this practice is typical in the institutions in which they have worked. Two of the administrators are Vice Presidents of Quality Assurance, one is a Vice President for Medical Affairs, and one is a hospital CEO. They work or have worked in the Northeast, Midwest and the South. None of these people were familiar with the RBPE project, so we can be assured that their comments were unbiased.

The hospital administrators indicated that a surgeon's own nurse will sometimes assist in surgery in community-based hospitals where there is no surgical residency program. However, they indicated that this occurs only for a minority of the procedures provided in the community-based hospital (and never at teaching institutions with a surgical residency program). Therefore, their observations would suggest that the practice of bringing the surgeon's own personal staff into the operating room is not typical, but is confined to only a minority of procedures performed in some, but not all, community-based hospitals.

ASIM believes that HCFA should not rely solely on comments and information from physician groups on how common and widespread this practice is, but also should attempt to solicit views from other parties on the extent of this practice. The American Hospital Association and American Nurses Association may be excellent sources of data on this question.

Refinement Process

ASIM believes that HCFA should consider using the RVS Update Committee (RUC), or a similarly structured group, to conduct the refinements that must be made for each of the four years of transition. The RUC has shown that it has been able to fairly and capably carry out this function for the work RVUs. ASIM has confidence that the RUC could carry out a similar function for the PE-RVUs, assuming certain changes are made in its composition and decision-making rules.

For the RUC to carry out this function on practice expense, a way must be found to incorporate the views of non-physician practice expense experts, such as nurses and practice administrators, into its consideration of resource-based PE-RVUs. Rules will need to be established on what data needs to be submitted to the RUC to support a change in PE-RVUs, including survey instruments and response rates. We also believe that the RUC may be more suited to refining the direct PE-RVUs rather than the indirect PE-RVUs.

ASIM suggests that HCFA invite the RUC to consider making a proposal to carry out this function. If the RUC is unable or willing to do so, a similar process that would involve group decision-making by physician and other experts, based on survey and compelling arguments presented by specialty societies, should be considered. We believe that whatever process is initiated should be convened under the umbrella of the American Medical Association, assuming that the AMA wishes to take on this role.

Data on Clinical and Administrative Staff Times

With the exception of the request for comments on the extent that surgeons bring their clinical staff into the operating room to assist in the performance of a surgical procedure, the notice of the intent to regulate did not specifically request comments on the appropriateness of the other data derived from the CPEPs and validation panels on clinical and administrative staff times. ASIM believes that it is essential that HCFA re-examine the accuracy of the CPEP and validation panel on clinical and administrative staff times. We are concerned that: many of the original CPEP estimates of clinical and administrative staff times appear to be unjustifiably high (a conclusion that HCFA supported in the June 18 NPRM when it proposed data editing rules and a statistical linking formula that had the effect of lowering inflated time estimates from the non-E/M CPEPs) compared to those for evaluation and management (E/M) services; the validation panels failed to correct the unjustifiably high estimates, and in some cases came up with even higher estimates than the CPEPs; and the cross specialty panel that met on December 15-16, 1997 was unable to hold those estimates to the scrutiny that is needed for them to be accepted by HCFA and the profession.

We were especially disappointed by the unwillingness of the cross specialty panel members to test the rationales behind the estimated staff times that came out of the validation panels. The internists who participated in the validation panels felt that many of the estimated times for non-E/M services were excessive. They tried to question them at the validation panel meetings, but the panel composition and voting rules established by HCFA made it difficult for them to successfully challenge those estimates. Any hope that the cross specialty panel might hold the estimates to a more critical analysis was dashed by the apparent willingness of most panel members to accept--without question or discussion--the estimates of the validation panels, no matter how unjustifiably high some of those estimates appear to be.

We believe that HCFA must take steps on its own to assure that the clinical and administrative staff time estimates used to develop resource-based practice expense RVUs are reasonable ones. Although it would have been preferable for the medical profession to take responsibility for making sure that the estimates are credible, the experience with the multispecialty panel suggests that it will not be possible for the profession to achieve consensus at this time. We therefore believe that HCFA must take the following steps:

We recommend that HCFA evaluate the clinical and administrative staff time estimates from the validation panels and CPEPs compared to (1) physician time per procedure code and (2) independent survey data on the number of full-time equivalent staff (FTEs) per physician in each specialty.

By establishing separate ratios of clinical staff times and administrative staff times (from the validation panels or CPEPs) to physician time from the RBRVS, HCFA can identify procedure codes that have an unusually high estimated clinical staff time compared to the physician time required to provide the procedure. While there may be instances when it might be reasonable for a particular service to require far more staff time per minute of physician time, there appear to be extraordinary and unexplained variations in the ratios of clinical and administrative staff time to physician time per procedure code (see attachment B). (Attachment B is based on analyses prepared by the American Osteopathic Association, American College of Physicians, and ASIM). Such variations are particularly surprising, since data from an Medical Group Management Association (MGMA) survey show that there is far less variation in the number of clinical and administrative staff FTEs per physician in each specialty (attachment C). If it truly took far more clinical and administrative staff time than physician time to provide the highest volume services in some specialties, compared to the average for all services, one might expect that this would result in those physicians employing substantially more FTEs. This does not appear to be supported by the MGMA data, however.

HCFA can take this analysis a step further, by multiplying the CPEP and validation panel estimates of clinical and administrative staff times per procedure, by the frequency (from the B-MAD file) by which the procedure is billed by Medicare in a calendar year, and then by the reciprocal of the percent of Medicare billings by that specialty, to arrive at the total minutes required to perform the procedure over an entire year. By dividing the total minutes by the number of physicians in each specialty that bill for the procedure, HCFA could determine the amount of clinical and administrative staff minutes per physician, per week, required to provide each procedure. If the total clinical and administrative staff minutes per physician for all billed procedures exceed the number of FTEs per physician as determined by the MGMA data, HCFA would have strong evidence that the CPEP and validation panels estimates are too high.

Should further analysis support our contention that many of the administrative and clinical staff times for invasive procedures, as determined by the CPEPs and validation panels, are too high, HCFA should apply data editing rules and a statistical linking formula to those estimates to establish appropriate relativity across families of services.

In the June 18 NPRM, HCFA argued that data editing and statistical linking was needed to establish appropriate relativity across families of services. Had more of the cross specialty panel members been willing to critically examine the CPEP and validation panel estimates, then it might not have been necessary to apply the data editing rules and the statistical linking formula.*Given the failure of the multispecialty panel to engage in such a re-examination, HCFA must be prepared to use its regulatory authority to establish appropriate linkages and to edit out excessive estimates, as proposed in the June 18 NPRM.*

ASIM is open to suggestions for improving the statistical linking formula used by HCFA. But we firmly believe that the overall validity of the practice expense RVUs is dependent on HCFA adopting policies and rules to establish an appropriate relativity between the staff time estimates for E/M services and those for non-E/M service. Physicians who provide a substantial amount of E/M services should not be penalized because the E/M CPEP and validation panels were conservative in developing the estimates of clinical and administrative staff times, while the

other panels were far less conservative in their estimates of clinical and administrative staff times.

We should note for the record that we are not necessarily concluding that the higher--and in our view, unjustifiably so--estimates for many of the non-E/M services was due to deliberate "gaming" by the participants in those panels. Although it would be naive to expect that economic considerations played no role in the estimates developed by each panel, there may be other factors that led the other panels to err on the side of assigning higher clinical and administrative staff times than may be justified. Some of the panelists may have been influenced by anecdotal stories of instances when billing for a particular procedure required unusually high amounts of staff time due to pre-authorization requirements; such instances may not reflect what occurs for the typical patient, yet such examples may have influenced the panelists to accept higher values than are appropriate. Many of the panelists also seemed to be reflecting their experiences in a managed care plans, which also are not typical of the costs involved in caring for Medicare patients.

Similarly, many of the panelists seemed to accept the view that it is a common practice for a nurse to assist a surgeon in the operating room--as noted previously, this practice appears to be limited to a minority of patients in some community hospitals without surgical residency programs; therefore, it does not reflect the clinical staff times associated with treating the *typical*>patient. The panelists also did not adequate explore whether or not some of the work being provided by clinical staff represent services that reduce the amount of physician work involved; if this is the case, then any allowance for the practice expenses associated with clinical nursing staff must be accompanied by a re-examination of the physician work RVUs of those procedures. The panelists also did not adequately explore the extent by which clinical and administrative staff may be performing several functions contemporaneously; i.e. a billing staff person who is placed on hold by a managed care plan may be working on filling out other claim forms in the meantime. Finally, many of the panelists appeared to be unfamiliar with the actual times that there staffs typically incur in billing for services.

In other words, we are suggesting that in many instances, the clinical and administrative staff times for non-E/M services that came out of the non-E/M CPEPs and validation panels are too high because:

The panelists were influenced by anecdotes of unusually high (staff) time-intensive cases, which do not reflect what occurs with the typical patient

The estimates were based on experiences with managed care organizations' requirements, particularly pre-authorization requirements, that are not typical for Medicare beneficiaries;

The panelists assumed that the practice of nurses accompanying a surgeon into the operating room was typical, when there is evidence to suggest that this practice is confined to a minority of patient encounters in certain regions in some community-based hospitals that do not have surgical residency programs;

The panelists may have not taken into consideration that some of the work being provided by the clinical staff may be substituting for physician work;

The panelists did not adequately take into account the ability of non-physician staff to provide multiple functions contemporaneously with each other;

Many of the physician panelists appeared to be relatively unfamiliar with the billing times typically expended by their staffs.

The panels may have been partially influenced by economic considerations (i.e. panelists who are anticipating large payment reductions from implementation of RBPEs may have been more likely to err on the side of accepting unusually high estimates of clinical and administrative staff times.

The composition and voting rules of the panels (with the exception of the E/M panel) did not provide sufficient opportunity to challenge inappropriately high estimates.

The cross specialty panel failed to engage in a rigorous examination of the rationale--and supporting data, if any--behind the estimates from the CPEPs and validation panels, and specifically did not critically assess whether the estimates were based on the *typical* Medicare patient.

Why was the E/M validation panel more conservative in its staff time estimates? This panel may have been more conservative in its estimates of clinical and administrative staff times due to the fact that the composition of the panel assured balanced representation from primary care physicians, medical specialists, and surgical specialists. No one specialty or type of practice dominated the panel--there were six primary care physicians, five surgeons (including obstetrics and gynecology), one emergency physician and one internal medicine subspecialty (cardiology) that performs a substantial number of invasive procedures in the hospital setting. As a result, the panel was more successful in developing time estimates that truly reflect the typical patient seen in primary care, surgical, and medical specialty practices.

Conclusion

The process that HCFA has established can still result in reasonable, credible, and defensible practice expense RVUs. The estimates produced by the CPEPs and validation panels may have established appropriate relativity within families of services. For the reasons discussed above, however, ASIM remains concerned that the clinical and administrative staff times for many non-E/M services that were developed through the CPEP and validation panel process are excessive compared to those for E/M services. Correcting these estimates, so that there is an appropriate relationship between E/M services and non-E/M services, is the most critical data issue still facing HCFA. If the estimates from the CPEPs and validation panels can not be validated using other sources of data, then it will be essential that HCFA apply a statistical linking formula and appropriate data editing rules, similar to those proposed in the June 18 notice of proposed rule-making.

It is also essential that HCFA seek independent data on the use of physician-employed staff in hospitals and other facilities.

Notwithstanding ASIM's concerns about the clinical and administrative staff times that came out of the CPEPs and validation panels, ASIM continues to believe that the current process can produce valid and credible resource-based practice expense RVUs by May 1, 1998, as mandated by Congress. HCFA has the means and data to correct excessive staff time estimates so that there is an appropriate relativity established between E/M and non-E/M services, without having to initiate a new survey on practice expenses. Indeed, it is not realistic to expect that any data from a new survey process would not be biased by the same economic considerations that have affected the validation and multispecialty panels discussions.

List of attachments:

A. Physician Practice Expenses: What Does the Independent Research Show?
B. Comparison of CPEP and Validation Panel Clinical and Administrative Staff Times to Physician Time
C. MGMA Survey Data on Number of FTEs per Physician, by Specialty