July 20, 1998

Gail Wilensky, Ph.D.
Chair
Medicare Payment Advisory Commission
1730 K Street, N.W.
Suite 500
Washington, D.C. 20006

Dear Dr. Wilensky:

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) understands that MEDPAC will be meeting later this week to discuss HCFA's proposed rule on resource-based practice expenses (RBPEs), among other issues. There are several issues that we expect to raise in our comments on the proposed rule that we would hope will be considered by MEDPAC as you discuss this issue. Because ACP-ASIM is still developing its comments, the following observations should be viewed as being preliminary in nature.

Applicability of the "Down Payment" in Subsequent Transition Years

The Balanced Budget Act of 1997 (BBA 97) increased the 1998 PE-RVUs for office visits, while lowering them for procedures whose work RVUs exceeded their PE RVUs by more than 110 percent. Certain exceptions apply. The legislative history of this provision clearly demonstrated that Congress intended for the "down payment" to be the first step toward increasing the PE-RVUs of undervalued office visits, consistent with what would occur under RBPEs, and that the PE-RVUs *as adjusted by the down payment* would be the basis for the "blended" transition during CY 1999, 2000, and 2001.

HCFA correctly proposes to use the 1998 PE-RVUs in the manner intended by the BBA 97. HCFA proposes that the PE-RVUs that are *applicable in 1998* would be blended with the resource-based RVUs according to the increments specified by the BBA 97. HCFA received a comment stating, however, that the 1998 changes were for one year only and not intended to be included in the base practice expense used for the transition.

In rejecting this suggestion, HCFA notes that it cannot use the 1997 PE-RVUs because "we do not believe that we could treat the reductions enacted by the BBA 1997 any differently from the similar reductions enacted in OBRA 1993, 1995, and 1996." HCFA notes that reverting to the PE-RVUs as they existed prior to the 1993, 1995 and 1997 amendments would "create practical problems of requiring imputation of practice expense RVUs for the many new codes that have been established between 1991 and 1998; it would seem contrary to the statute's plain intent of moving toward a resource-based system."

Also, HCFA notes that "this alternative could also potentially result in a 'yo-yoing' of practice expense RVUs between 1998 and future years. Practice expense RVUs for certain procedures explicitly increased by Congress in 1998 could be reduced in 1999 only to be increased again when the practice expense is fully resource-based." Finally, HCFA states that "To adopt such a construction of the law would not gradually 'transition' payments to the new resource-based system, but instead would represent an abrupt change in direction, a result at odds with the purpose of

having a transition period and with transitions previously established for payment changes in Medicare. We find nothing in the legislative history to suggest that the Congress intended for such an atypical transition."

MEDPAC also noted that it would illogical to interpret the law as requiring such a "yo-yo" effect when it discussed the down payment issue in the context of preparing the March 1998 report to Congress. ACP-ASIM fully agrees with MEDPAC's previous discussion of this issue, and with HCFA's decision to use the PE-RVUs that are applicable in 1998 as the basis for the subsequent transition, and the agency's compelling rationale for this determination. We strongly urge MEDPAC to affirm its support for HCFA's decision and rationale on use of the 1998 PE-RVUs as the basis for the subsequent transition.

Top-Down Methodology

HCFA proposes a new "top-down" methodology that represents a substantial departure from the 'bottom-up" methodology proposed in last year's notice of proposed rule-making. In making the 11th-hour decision to substitute the top-down methodology, HCFA unfortunately did not have the benefit of consultation with specialty societies and other interested parties on the relative merits of this approach prior to publishing it in the June, 1998 proposed rule. Subsequent to publication of the proposed rule, serious questions have been raised by some about the fairness of the "top-down" methodology, and the appropriateness and reliability of the data used—questions that HCFA might have been better prepared to address had it consulted with specialty societies, including those representing primary care physicians—prior to publishing it in the Federal Register.

MEDPAC should consider the following issues as it reviews the "top-down" approach:

1. The degree by which the "top-down" approach may perpetuate some of the inequities in the existing charge-based methodology. Specialties whose services have historically been overvalued by Medicare are likely to have higher gross revenue from Medicare, allowing them to spend more on their practices as a result. Under the top-down approach, their pool of practice expense dollars as reflected in the AMA SMS survey is likely to be higher than those whose services have been undervalued.

2. Reliability of the SMS data, especially for under-sampled specialties.

3. Reliability of using Medicare Part B frequency data to determine the proportion of total PE dollars (from the SMS) per specialty that can be allocated to Medicare. The Part B frequency data, since it is based on self-reported specialty designation, may not accurately reflect the typical billing patterns per specialty. Geriatricians, for example, will often report themselves as being internists when billing for Part B services, rather than as geriatricians. Consequently, frequency of billings by geriatricians would be under-reported in the Part B frequency data.

4. Physician time data from the work RVUs have never been validated for the purpose of determining PE-RVUs. Given the importance of physician time in determining the total pool of PE-RVUs per specialty, it is likely that some groups will want to re-examine the time estimates used in the work RVUs. ACP-ASIM would be concerned if questions about use of physician times from the work RVUs, for the purpose of determining PE pools per specialty, results in the work RVUs themselves being re-examined. Given the fact that HCFA recently

completed a five-year review of the work RVUs, it is important that use of physician time for the purpose of determining PE pools not have the unintended effect of re-opening the entire RBRVS to re-examination.

5. Use of the "raw" CPEP data to allocate the pool of PE-RVUs to individual procedure codes. In last year's rule, HCFA made several adjustments or "edits" to the CPEP estimates, such as by capping administrative staff time, linking clinical times across CPEPs, and eliminating estimates for clinical nursing time in the hospital. ACP-ASIM is not persuaded by HCFA's argument that such edits and adjustments are no longer necessary under the "top-down" methodology. It seems to us that inflated estimates of nursing staff time, for instance, could still distort the relativity across categories of services, even under a top-down methodology.

ACP-ASIM would have preferred that HCFA also offer a "bottom-up" methodology, which directly responded to the comments it received on how last year's proposed rule might have been improved, rather than just proposing the top-down approach. Without such an alternative, it is difficult for ACP-ASIM and other interested organizations to consider the relative merits of the "top-down" versus an improved "bottom-up" approach.

Although the "top-down" approach, with improvements, may turn out to be an acceptable way to determine the *initial* PE-RVUs for 1999 (given the lack of a published viable alternative using the "bottom-up" methodology), HCFA must address in the final rule questions and concerns about the fairness of this methodology and the reliability of the data and methodology used. The subsequent transition and refinement period must provide an opportunity to make further corrections in the historical inequities in payments for practice expenses that may be perpetuated by use of a top-down approach. The refinement process should also be used to improve on the proposed data and methodology.

We urge MEDPAC to identify the specific questions about the "top-down" methodology, including those identified above, that must be addressed by HCFA in the final rule and the subsequent refinement and transition. Once our comments on the proposed rule are finalized, ACP-ASIM will be glad to share them with MEDPAC.

Sincerely,

Robert B. Doherty
Vice President
Governmental Affairs and Public Policy