The American Society of Internal Medicine (ASIM) appreciates the opportunity to share our perspectives on HCFA’s approach to developing resource-based practice expenses (RBPEs). We understand that HCFA is particularly interested in our views on how indirect practice expense relative value units (RVUs) should be developed. Given the fact that HCFA has proposed that the indirect practice expense RVUs be based in part on the direct PE-RVUs, it is important to also discuss today the process and methodology that HCFA proposes be used to develop the direct practice expense inputs.

It seems to us that there are at least seven fundamental questions that HCFA must answer as it refines its proposal:

First, is the objective to develop direct and indirect PE RVUs that pay physicians for the actual costs that they incur—or is the objective to develop PE-RVUs that determine how much more or less each service costs compared to other services on the same scale?

Second, is HCFA’s proposal to divide total PE-RVUs into separate pools of direct and indirect PEs a reasonable one, and do the data specifically support the proposed 55%/45% split between direct and indirect PE RVUs?

Third, should the numerical factor that scales the indirect PEs per service to the aggregate 55/45% split be uniform for all services, or should the factor vary based on specialty-based weighted averages of indirect PEs?

Fourth, should the “pass through” option of basing indirect expenses on the historical charge-based system be considered?

Fifth, is it reasonable to base the indirect PE RVUs on the sum of the direct PE RVUs, physician work RVUs, and medical liability RVUs, scaled to the total pool of indirect PE RVUs?

Sixth, are the process and methodology being used to develop the direct PE RVUs reasonable ones?

Finally, what additional data should HCFA collect on direct and indirect PE RVUs for the purpose of developing a new proposed rule, and new PE-RVUs, for publication by May 1, 1998 as mandated by the Balanced Budget Act of 1997?

ASIM offers the following perspectives on each of these questions.

1. Is the objective to develop direct and indirect PE RVUs that pay physicians for the actual costs that they incur—or is the objective to develop PE-RVUs that determine relatively how much more or less each service costs compared to other services on the same scale?
Perhaps the single greatest misconception that many physicians have is that the final RBPE rule should assure that physicians are adequately compensated for the actual costs that they incur in running their practices. But the purpose of a relative value scale is to determine how much more or less each service should be valued compared to all other services on the same scale, not how much each service should be paid in an absolute sense.

Under a resource-based relative value scale, the relative values cannot be based on historical charges. In the case of physician work, they must be based on the relative amount of physician time, mental and physical effort, judgment, and stress due to risk to the patient of each service compared to all others on the same scale. In the case of practice expenses, they must be based on the relative amount of clinical and administrative staff times, equipment, supply, utilities, rent, and other practice expenses the physician is typically responsible for, compared to all others on the same scale. Therefore, it can be expected that the relativity established by a resource-based relative value scale will be very different from what physicians were accustomed to under the charge-based methodology that is currently used to determine practice expenses.

Finally, whether or not the relative values that are established under a resource based relative value scale result in fee schedule payments that pay physicians for the actual costs that they incur is a function of the dollar conversion factor that converts the RVUs into payment amounts, not the RVUs themselves. If the total payments are insufficient to cover physicians’ costs, then the reason is that Congress has not provided an adequate conversion factor, not that the PE-RVUs themselves are flawed.

All of this may seem obvious to some in this room. But it is apparent that many physicians have a very different impression of what this whole exercise is all about. To them, the litmus test is not whether the relativity is correct, but whether or not the fee schedule payments will cover their actual costs or charges. If the objective instead is to develop a resource-based relative value scale, HCFA only needs to assure that the data and methodology it uses results in a reasonable relative relationship across all physician services based on the best available data on the resource costs involved in providing each service, not that the PE-RVUs cover the actual costs or charges of any given physician or specialty.

2. Is HCFA’s proposal to divide total PE-RVUs into separate pools of direct and indirect PEs a reasonable one, and do the data specifically support the proposed 55%/45% split between direct and indirect PE RVUs?

According to the October 31 notice of the intent to regulate, HCFA states that “indirect costs are generally defined as those costs not directly allocable to individual services, such as rent, utilities, maintenance, phones, general clerical staff, and office equipment . . . Costs attributable to billing, procedure-specific equipment maintenance, and other direct expenses should not be included since they were captured by the clinical practice expert panels or other means.”

ASIM believes that HCFA’s definition of indirect costs is a reasonable one. Some costs, such as billing and clerical costs, are inherently difficult to categorize explicitly as a direct or indirect practice expense. Although we have no conceptual disagreement with including billing costs in the direct cost RVUs for a specific procedure, we do have some concerns, as discussed later in this statement, that some of the clerical and administrative cost estimates from the CPEPs and validation panels are inflated.

Based on an analysis of the AMA’s Socioeconomic Monitoring Survey (SMS) data, HCFA concluded that in aggregate approximately 55 percent of the practice expenses that physicians incur involve direct practice expenses, and 45 percent indirect practice expenses. Based on this finding, HCFA proposed to divide the total pool of PE-RVUs into separate pools of direct and indirect PE-RVUs, with 55% of the total PE-RVUs representing direct PE-RVUs and 45% indirect PE-RVUs.

Based on a review by our own committee of physician experts on practice expenses, ASIM has concluded that HCFA’s percentage allocation of the total pool of direct and indirect PEs is valid and well-
supported by existing data on practice expenses. We have yet to see any credible data that suggests that this allocation is fundamentally flawed or inherently unreasonable.

3. Should the numerical factor that scales the indirect PEs per service to the aggregate 55/45% split be uniform for all services, or should the factor vary based on specialty-based weighted averages of indirect PEs?

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. It is premature for ASIM and other interested parties to unequivocally endorse this option without having more information on its potential impact compared to the option of applying the same multiplicative factor to all services, however.

4. Should the “pass through” option be considered?

No. The pass through option, which would base the indirect practice expense RVUs on the current charge-based PE-RVUs (after the new direct practice expense RVUs are subtracted from the total RVUs) is fundamentally inconsistent with resource-based payments and statutory intent.

5. Is it reasonable to base the indirect PE RVUs on the sum of the direct PE RVUs, physician work RVUs, and medical liability RVUs, scaled to the total pool of indirect PE RVUs?

ASIM believes that the basic formula proposed by HCFA for determining indirect practice expense RVUs is fundamentally sound.

A major element of the physician work RVUs is the time a physician spends in providing a service. A major element of the direct practice expense RVUs is the time that clinical and administrative staff spend that is directly related to the performance of a given procedure. In our view, there is a clear relationship between the amount of time that a physician and his or her staff spend in providing a service and the indirect costs associated with the service. Services that take more time to perform typically require more indirect costs—administrative salaries, utilities and rent—than services that take less physician and staff time.

Earlier, HCFA had considered basing the indirect PE-RVUs only on physician time or staff time. Basing the indirect practice expense RVUs only on physician time could undervalue services that have involve little physician time but extensive staff time, however. Basing the indirect practice expense RVUs only on staff time could undervalue services that involve substantial physician time, but relatively less staff time. Using physician time, as opposed to physician work, would undervalue highly work intensive services that involve substantial physician work but relatively less direct face-to-face physician time. Therefore, it
seems reasonable to base the indirect PE RVUs on both physician work and the direct practice expense RVUs, as proposed by HCFA.

Some have criticized HCFA’s proposal for relying on "proxies" to determine indirect PE-RVUs. Several studies support basing indirect PE-RVUs on formulas derived from extant data on physician time or physician work, however. Dunn and Latimer from Health Economics Research used extant data from the Hsiao study on physician time to develop indirect PE-RVUs. They concluded that:

♦ The formula-driven approaches employed in this study make use of existing data and can be implemented and updated on a timely basis at relatively low cost. The accuracy of these methods is an empirical question. Our impact simulations suggest that they address the biases perceived by many in the existing MFS practice expense RVUs. They also produce RVUs which are similar to those generated by more extensive accounting-based studies such as that conducted by PPRC. Given their design, these approaches are also likely to be more resistant to potential gaming and undue influence by those most influenced by the study results."

Similarly, extensive research by Harvard University, PPRC, and Pope and Burge also support a conclusion that extant data on physician time and/or work can be used to develop direct and indirect PE-RVUs. Attached to this statement is a summary of ten studies that supports the views that (1) extant data can be used to develop resource-based practice expense RVUs, including indirect PE RVUs and (2) existing data support a conclusion that office-based services, particularly E/M services, are undervalued based on the current charge-based formula.

It should be recognized that there are several different approaches that HCFA could take to determining indirect PE RVUs and that no matter what method is used, indirect practice expenses by definition will have to be allocated to specific services using a formula or proxy. If it was possible to directly link the costs to a given service, those costs would be included in the direct practice expense RVUs, not as indirect PE-RVUs. We concur with the views expressed by the Physician Payment Review Commission in its 1997 Annual Report to Congress:

♦ HCFA must choose among several alternative methods for allocating indirect costs . . . No one correct method exists, and no analytic tools are available that would dictate the choice. Instead, HCFA must consider factors like data availability and reliability, payment incentives, and policy goals. The method should be acceptable to physicians so that the resulting values are credible. It is also likely that no matter what method is used to determine direct and indirect practice expense RVUs, the results will still likely support a conclusion that office-based services are undervalued and most in-hospital procedures overvalued. In 1991, Dunn and Latimer concluded the following:

♦ First, whichever one of the four allocation methods is used, the high-intensity services tend to experience significant declines in fees, whereas the low-intensity services experience increases. Fees for office visits in particular increase substantially. This pattern agrees with the PPRC results, which are based on service-specific measures of direct expenses. Any resource-based method for incorporating practice costs into the RBRVS will narrow the gap in fees between high-intensity (primarily invasive) and low-intensity (primarily evaluation and management) services, increasing fees for office visits in particular. Second . . . using time as a basis for allocation results in an even smaller differential in fees between high-intensity and low-intensity services than using work. Third, our sensitivity analysis . . . shows that whether 100% of office expenses are counted as indirect, or 50% as indirect and 50% as direct, makes relatively little difference in the fees. The largest difference between a total fee among the services listed . . and the corresponding direct and indirect, is about nine percent. The imprecision with which this classification must be made appears not to have great practical importance. Fourth . . . an allocation method which is more resource-based than the current one can be simple.
Given the fact that assignment of indirect costs to direct services is inherently imprecise (Dunn and Latimer) and no one correct method exists (PPRC), we believe that HCFA’s proposal is a reasonable one, considering data availability and reliability, payment incentives, and appropriate policy goals (PPRC).

6. Are the process and methodology being used to develop the direct PE RVUs reasonable ones?

ASIM believes that the process of developing direct PE-RVUs based on the input of the clinical practice expert panels (CPEPS), as recently refined by the validation panels, is likely to result in reasonable estimates of the relative relationships of direct costs within families of similar services. We have less confidence in that this process will by itself produce appropriate direct PE-RVUs across families of services. Inconsistencies in how the CPEPs and the validation panels determined the amount of clinical and administrative costs associated with the services that they evaluated argue for the necessity of the data editing and linking methods proposed by HCFA in the June NPRM.

Over the past several weeks, the physician representatives from our organization that participated in the validation panel meetings early last month reported to us on their observations. With the exception of the validation panel for E/M services, they expressed similar concerns. Specifically:

1. The internists who served on the E/M validation panel felt that it had arrived at recommendations in which they have a high degree of confidence. They particularly felt that the estimates of direct clinical and administrative staff times were reasonable and appropriate. This panel may have been more successful in reaching a consensus on 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 group 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.

2. There seemed to be a consistent pattern in most, if not all, of the other validation panels inflating clinical and administrative staff times. Billing times, especially the time required to obtain pre-certification approval for surgical procedures, were viewed as excessive by the internist participants. Many surgical specialists also continued to argue that their clinical nursing staff were substantially involved in assisting in the performance of surgical procedures in the hospital setting, which was not supported by the observations of internists who are familiar with the way surgery is performed in their own hospitals. No independent data have been provided to support the view that the surgeon's own nursing staff are heavily involved in providing inpatient procedures. Primary care physicians and carrier medical directors attempted to challenge these inflated estimates, but the composition of the panels made it difficult for them to do so.

The observations of internists who participated in the validation panels therefore support two key elements of HCFA’s original proposed rule on practice expenses: linking and data editing.

By supporting linking, we do not necessarily argue that the specific mathematical formula proposed by HCFA in the June NPRM is the only way to establish the appropriate relative relationship between the clinical and administrative staff times for E/M services and those for other services. In our formal comments to HCFA, we urged that HCFA solicit comments on other ways to establish appropriate linkages. But we continue to believe that the clinical and administrative staff times developed by the non-E/M CPEPs and validation panels generally are too high compared to those for E/M services, and that HCFA must therefore establish linkages that will result in a more appropriate relative relationship between E/M services and non-E/M services. We also believe that HCFA needs to continue to apply data editing rules to the CPEP data as modified by the validation panels. We base these conclusions on the following:

First, although small group panels can come up with the proper relative relationship within a given family of services, a process of linking all of the clinical and administrative staff estimates to those for E/M
services needs to be applied to assure consistency across panels. If all the panels inflated the administrative and clinical staff times by an equal amount, then linking would not be needed. But if some panels’ estimates were consistently inflated compared to the estimates for E/M services, in the absence of linking, procedural services would continue to be overvalued at the expense of E/M services. Physicians who provide E/M services should not be penalized because the E/M panels were more conservative in their estimates of clinical and administrative staff times compared to the estimates from the other panels. The composition and decision-making rules made it impossible for internists and other primary care physicians to lower the time estimates for the other panels, even when they made their concerns known. Therefore, linking is essential to assure a proper relative relationship across families of services.

Second, in the absence of any independent data to support the contention that the nursing staff of surgeons typically accompany and assist the surgeon in providing a surgical procedure in the hospital, HCFA should continue to edit out clinical nursing staff time estimates for services provided in an inpatient setting, as suggested in HCFA’s proposed rule from June. Even if it could be shown that surgeons are bringing their own nurses into the hospital setting, HCFA needs to consider if the nurse is providing patient care services that otherwise would have been performed by the physician. If so, the nurse may be providing services that should be considered a work expense (i.e., checking on patients or doing preliminary information gathering, ordering, etc. that would otherwise have to be done by the physician, not a practice expense.

ASIM understands that HCFA may be giving consideration to dropping the linking formula proposed in the NPRM and replacing it with a multi-specialty panel that would reach consensus on specific codes that were reviewed by more than one CPEP and validation panel and given different clinical and administrative staff times. Given the experience to date with the validation panels, we are highly skeptical that a multi-specialty panel will be able to establish appropriate relative relationships between clinical and administrative staff times for E/M and non-E/M services. If the panel is working with three different estimates from the validation panels, but all three of the estimates are inflated, then it is likely that it would arrive at a "compromise" that would still overvalue the clinical and administrative staff times compared to those for E/M services.

It is also not clear how such a panel could establish appropriate relative relationships for over 7000 CPT codes. The decision-making rules and composition of the panel would also largely dictate the values that it produces. Therefore, we urge HCFA to exercise extreme caution in relying on a cross-specialty panel to determine the appropriate relativity of clinical and administrative staff times. A multi-specialty panel, such as the RUC, could play an important role in refining the PE-RVUs in the future, however.

7. What additional data should HCFA collect on direct and indirect PE RVUs for the purpose of developing a new proposed rule, and new PE-RVUs, for publication by May 1, 1998 as mandated by the Balanced Budget Act of 1997?

For all of the reasons presented in this paper, ASIM believes that the process HCFA is following is likely to produce reasonable resource-based practice expenses without the need to initiate a substantial new data collection effort. We specifically believe that a process that principally relies on extant data on direct and indirect practice expense is likely to produce reasonable resource-based practice expense RVUs.

Although ASIM has a good deal of confidence in the current process, we support efforts to obtain additional data as appropriate. Independent data should be sought before accepting the contention made by some surgeons that it is a common practice to bring nursing staff into the hospital to assist in performing a surgical procedure. Other data, such as that obtained by MGMA, could be used to compare the clinical and administrative staff times from the CPEPs, as refined by the validation panels, with data on the number of FTEs in a practice, using reasonable volume assumptions.

The BBA ‘97 requires that HCFA “utilize, to the maximum extent practicable, generally accepted accounting principles that recognize all staff, equipment, supplies and expenses, not solely those that can
be linked to specific procedures, and use actual data on equipment utilization and other assumptions." ASIM believes that the Notice of Intent to Regulate, published in the October 31, 1997 Federal Register, represents a good faith effort by the agency to solicit such data to the maximum extent practicable.

By specifying that HCFA utilize generally acceptable accounting principles and actual cost data only to the "maximum extent practicable," Congress made it clear however 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.

Cost accounting also does 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 vs. simpler ones that can do the job; expensive nurses vs. less expensive medical technicians, and other such variable costs.

ASIM believes that HCFA should consider verifiable 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.

We note that in HCFA’s October 31 notice of intent to regulate, HCFA expresses a willingness to consider special studies conducted by specialty societies to develop or validate resource-based RVUs for physician services. Although ASIM commends HCFA for seeking additional data, we caution the agency to look very critically at studies funded by groups with a vested financial interest in the outcome of the RBPE study.

Conclusions

To summarize, ASIM believes that HCFA’s definition of indirect costs is a reasonable one. We believe that extant data from the AMA Socioeconomic Monitoring Service can reasonably be used to determine the proportion of total practice expense RVUs that represent direct and indirect costs as the agency proposes. We believe that the number of indirect PE RVUs per procedure can reasonably be derived from the physician work RVUs and direct practice expense RVUs, scaled to the total available pool of indirect PE RVUs, possibly using the weighted averages by billing frequency of the indirect costs of the specialties that provide each service. We believe that HCFA must assure that the administrative and clinical staff time estimates from the non-E/M CPEPs and validation panels that are included in the direct cost RVUs are valued properly compared to those for the E/M codes, using a reasonable linking methodology. Finally, we have suggested that the statutory mandate that HCFA use generally accepted accounting principles "to the maximum extent practicable" does not require that HCFA conduct a cost accounting study of actual costs or that the PE RVUs cover the actual costs incurred by physicians.

Throughout our comments today, ASIM has repeatedly suggested that HCFA’s proposal be reviewed using a standard of reasonableness. There simply is no perfect method for determining direct and indirect PEs that will be endorsed by all of the experts in the field and that would enjoy the support of all physicians. The PPRC, in its 1997 report to Congress, said it best:

HCFA must choose among several alternative methods for allocating indirect costs . . No one correct method exists, and no analytic tools are available that would dictate the choice. Instead, HCFA must consider factors like data availability and reliability, payment incentives, and policy goals.
The test ultimately must be whether or not HCFA’s approach is a reasonable one, based on the available data, program policy goals and the statutory requirements. While final judgment must be reserved until a new proposed rule is published in the Spring of 1998, ASIM believes that the process HCFA is following to refine the methodology proposed this past June is more likely than not to produce direct and indirect resource based practice expense RVUs that will meet any reasonable standard of validity. Certainly, we have not heard any proposal that lays out a better process for achieving accurate resource-based relative value units.

Finally, it must be noted that the current charge-based system of allocating practice expenses is inherently unfair. To our knowledge, every independent study (i.e. a study not funded by a group with a financial interest in the outcome) has concluded that office-based services, particularly E/M services, are systematically undervalued, and many invasive procedures overvalued, under the current Medicare fee schedule. The approach that HCFA has taken to develop resource-based practice expenses will almost certainly result in payments that more closely reflect relative differences in practice expense inputs than the current charge-based formula. Refinements of the way that HCFA proposes to define and allocate direct and indirect costs are not likely change that basic conclusion that under a resource-based practice expense system, the total practice expense RVUs--direct and indirect combined--for office-based services will be substantially higher, and those for invasive procedures done in the hospital lower, than under the current Medicare fee schedule.

We’d be pleased to answer any questions.