Governmental Affairs & Public Policy

Health Care Financing Administration Resource-Based Practice Expense Final Rule

Attention: HCFA-1006-FC RIN 0938-AI52

Full Title: Medicare Program; Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1999; Final Rule

Introduction

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) has previously expressed concern that the Health Care Financing Administration's (HCFA) top-down approach to determining payments for physicians' practice expenses will allow inequities in payments to continue that exist under the current historical, charge-based methodology. We recognize that the top-down approach will be used for determining the initial practice expense relative value units (PE-RVUs) that will begin to be phased-in on January 1, 1999, however. The following comments provide the College's recommendations on issues that should be addressed by HCFA during the four-year refinement of the interim PE-RVUs.

Equity Issues

ACP-ASIM is pleased that HCFA recognizes in the final rule that the top-down approach to determining payments for physicians' practice expenses may allow inequities in payments to continue that exist under the current historical, charge-based methodology. HCFA states that it will accept comments on this issue during the refinement period.

Simply accepting comments on this issue during the refinement period is not sufficient, however. HCFA must work with specialty societies and other interested parties on developing a methodological approach that would allow for correction of inequities that persist under the top-down methodology. For instance, HCFA should provide guidance on alternative sources of data that commenters could provide to make a case that a service, or family of services, is systematically undervalued or overvalued under the top-down methodology.

HCFA should also consider funding an independent analysis of the extent by which the top-down methodology perpetuates historical inequities in payment. Such an analysis should also explore alternative methodological approaches and sources of data that could be used by commenters and the agency in making corrections in the interim PE-RVUs. Because the refinement period for PE-RVUs lasts the entire four-year transition period, HCFA has ample time to undergo an extensive analysis of this research question that underpins the credibility of the entire Medicare physician fee schedule. It is clear from HCFA's comments in the final rule that HCFA agrees with ACP-ASIM that the top-down methodology is imperfect and therefore must be viewed only as a reasonable starting point" for determining the final PE-RVUs. Improvements must be made during the transition that will meet the original intent of eliminating historical inequities in payment that
exist under the charge-based system and that are continued, to some extent, under the top-down approach.

**Base Year for Calculation of Transition Payments**

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. 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. The legislative history and statutory language support a conclusion that Congress intended for the PE-RVUs, *as adjusted by the down payment*, to be the basis for the blended transition payment rates that would occur during calendar year 1999, 2000, and 2001.

HCFA received comments on the proposed rule that advocated an alternative interpretation of the law and congressional intent. This alternative interpretation would use 1991 as the base year for determining the charge-based payments that would be blended with resource-based RVUs, instead of using the 1998 PE-RVUs. Some have suggested that as a "compromise" HCFA use 1997 as the base year, rather than 1991 or 1998.

**ACP-ASIM strongly supports the rationale for HCFA's decision to use 1998 as the base year for calculating transition payments, rather than reverting to either a 1991 or 1997 base year.** The College agrees with HCFA that there is nothing in the legislative history of the Balanced Budget Act of 1997 that suggested that Congress intended for the down payment to apply only in calendar year 1998. If the down payment were to apply only in 1998, the result would be in conflict with the goal of a resource-based practice expense (RBPE) methodology, by maintaining payment rates during the transition that are inconsistent with those that will occur when RBPEs are fully implemented.

We concur with HCFA that the reductions in overvalued procedures enacted by the BBA 1997 should not be treated any differently from the similar reductions enacted in Omnibus Budget Reconciliation Act of 1993 on practice expenses for 1994, 1995, and 1996. The College agrees that reverting to the PE-RVUs as they existed prior to the adjustments mandated by the 1993 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.

We also agree with HCFA that using 1991, or 1997, as the base year would create a yo-yo'ing' of practice expense RVUs between 1998 and future years. Practice expense RVUs for certain procedures explicitly decreased by Congress in OBRA '93 and the BBA '97 would be increased during the first two years of the transition, only to be reduced again when the practice expense is fully resource-based. ACP-ASIM also agrees with HCFA's assessment in the proposed rule 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." We agree that "this result would be at odds with the purpose of having a transition period and with transitions previously established for payment changes in Medicare."

ACP-ASIM believes that using 1991 or 1997 as the "base year" for calculating transition payments would have other unacceptable results, beyond those cited by HCFA in the final rule. **We recommend that HCFA include, in the record of its responses to the final rule, discussion of the following additional adverse**
effects that would result from using a 1991 or 1997 base year:

1. There would be a substantial increase in beneficiary co-insurance for hundreds of overvalued services that would temporarily and improperly receive higher Medicare payments during the transition. Many of the procedures that would receive higher payments--necessitating that beneficiaries be charged a proportionately higher co-insurance--are "big ticket" surgical procedures, such as cataract surgery. Higher co-insurance for such services could impose a financial hardship on lower-income beneficiaries, possibly forcing them to forgo needed care.

2. Effective on January 1, 1999, office visits are already being paid using 1998 PE-RVUs as the basis for the transition payments. If HCFA later changes its mind and decides that the law requires that it use the 1991 or 1997 PE-RVUs as the basis of calculating the transition payments, physicians who had been "overpaid" for their office visits during the interim may be required to refund the "excess" payments to the federal government. The law may also require that physicians refund to beneficiaries any "excess" co-insurance--and in the case of non-participating physicians, excess limiting charges--for office visits that had been paid using the 1998 PE-RVUs as the basis for calculating transition payments. Given the fact that office visits are among the highest volume services billed to Medicare, a demand that physicians refund "overpayments", co-insurance, and limiting charges for office visits will have a devastating impact on physicians and patients.

3. It could result in HCFA having to give physicians an opportunity to change their participating status for 1999, since participating decisions made on the basis of transition payments that use the 1998 base year would no longer be valid.

4. It could detract from the ability of carriers to reach Y2K compliance. HCFA has already stated in other forums that carriers will be unable to process any payment changes during a critical "window" of several months during which they will become Y2K compliant. Any requirement that carriers re-calculate transition payments and demand refunds from physicians for "overpayments" of office visits during this critical window will place at risk the ability of carriers to become Y2K compliant.

Volume and Intensity Offset

ACP-ASIM is pleased HCFA has decided to substantially lower the volume and intensity offset, although we believe that the adjustment should be eliminated in its entirety. Total elimination of the volume and intensity offset is appropriate because there is no evidence that physicians have increased volume and intensity to offset previous reductions in RVUs. HCFA has been provided with studies and analyses by the Physician Payment Review Commission and Medicare Payment Advisory Commission that support elimination of the volume and intensity offset. HCFA should heed these analyses, rather than relying on the flawed assumptions of its actuaries.

Other Issues to Be Addressed During the Refinement Process

1. In our comments on the proposed rule, ACP-ASIM questioned the validity of much the data utilized in the top-down methodology, including the accuracy of the SMS data for the purposes of developing
PE-RVUs, CPEP and time data refinements made by HCFA, and Medicare Part B frequency data.

In response, HCFA noted our comments on data problems (AMA SMS sample size, response rate, under-representation, and attempts to create a standardized work week) and responded that the AMA SMS was the best data source available and that such issues could be explored during refinement. HCFA gave the same reply to our suggestions for CPEP and time data refinement and to our suggestions for Medicare claims data refinement.

While ACP-ASIM is pleased that HCFA agrees that such issues can be addressed during the refinement process, HCFA's response provides little or no direction on how such issues will be reviewed and corrected during the refinement process. **ACP-ASIM strongly recommends that HCFA work with specialty societies, the RUC, and other interested parties on developing a clearer process for addressing concerns about the adequacy of the SMS data, the accuracy of Medicare frequency data, and service times during the refinement process.**

2. ACP-ASIM's comments also questioned the validity of the base relativity (the relative relationship of each service in the RBRVS to all other services) under the proposed PE-RVUs, because the values established by the top-down methodology appear to create distortions in the cross-service relationships between services. Under the 1997 proposed rule, an internist would have had to provide only 15 midlevel established patient office visits to obtain the practice expense reimbursement of a single coronary bypass graft, compared to 80 under the existing charge-based formula. Under HCFA's proposed rule "top-down" approach, an internist would have to provide 40 office visits to obtain the practice expense reimbursement of the coronary bypass, an improvement over the existing payment disparity but still far less of an improvement than would have occurred under last year's proposal, and far less than previous studies (Harvard, PPRC, HER, etc) suggest would occur under resource-based practice expenses. We continue to believe that the relative relationships of the practice expense for different categories of services might have been inappropriately altered due HCFA's decision not to edit out the clinical staff time for in-hospital procedures. We disagree with HCFA's view that such edits are unnecessary under the topdown approach since inclusion of the clinical staff time for in-hospital procedures does not increase the total pool of dollars for each specialty. While that may be true in terms of specialty impact, it greatly distorts the relativity across categories of services.

For instance, if the Clinical Practice Expert Panel (CPEP) estimates for a coronary artery bypass graft (CABG) include the costs of a surgeon's clinical staff assisting in the hospital, the PE RVUsen under the toddown approachfor the CABG will be higher than if those alleged costs are NOT included. (HCFA has received previous comments from ACP-ASIM, the General Accounting Office, and others that support a conclusion that is not a typical practice for surgeons to use their own staff to assist with surgery in the hospital setting. HCFA has also acknowledged that it is already paying hospitals for the costs of non-physician clinical staff who assist in surgical procedures, and that it precluded by law from paying both the hospital and the physician for such services. Yet when HCFA adopted the "top down" approach, it inexplicably decided to include such costs in the surgical PE-RVUs).

As a result, the ratio of CABGs to office visits will be higherin favor of the CABGthan if those costs were edited out as HCFA proposed last year. This may mean that some of the other procedures done by thoracic surgeons are lower as a result (since the higher RVUs for CABGs would reduce the pool available for their other services). But in terms of establishing a proper relativity between CABGs and office visits, HCFA's
methodology distorts the relationship. This same argument may apply to HCFA using the "raw" CPEP estimates as the basis for editing down the PE pools to individual procedure codes.

In response, HCFA noted our concerns regarding the fact that a physician would have to provide 40 mid-level office visits to obtain the practice expense reimbursement of a single coronary triple-bypass graft under the top-down proposal compared to the original bottom-up proposal and suggested that this issue could be addressed in the refinement period (FR 58818). HCFA did not specifically address our other comments on this issue. As discussed earlier in the comments on issues of equity, ACP-ASIM continues to believe that there are distortions in the relativity between families of services using the top-down methodology. We continue to question HCFA's decision to include clinical staff assisting in the hospital in the PE-RVUs for surgical procedures. ACP-ASIM strongly recommends that these issues be reconsidered during the refinement process.

3. ACP-ASIM suggested that the indirect allocation method using physician time and direct costs were biased towards services with higher physician time components. Administrative costs such as billing are not directly proportional to length of a physician service. For example, a 240 minute surgery does not necessarily require 12 times as much time to bill than a 20 minute office visit.

HCFA responded that the indirect allocation method may be reviewed during refinement. As an interim fix, HCFA will allocate indirect costs by using direct costs and work RVUs scaled using the Medicare conversion factor instead of a factor calculated using physician time data. HCFA indicates that this will give somewhat less weight to work values and avoids major methodological change until the issue is further evaluated (FR 58828).

It is unclear if HCFA's temporary fix adequately addresses the concerns expressed about the indirect cost allocation methodology. ACP-ASIM believes that like other issues left to refinement process, HCFA must work with specialty societies, the RUC, and other interested groups in developing a process that will allow for further evaluation of the indirect allocation method. Simply saying that the issue "will be further evaluated" does not provide sufficient direction or commitment on how, when, and by whom the issue will be re-evaluated.

Hours Worked Per Week

ACP-ASIM is aware that HCFA has received comments that the AMA SMS physician hours worked per week estimates used to create the practice expense pools should be standardized to a 40 hour work week. We are pleased that HCFA has not rescaled the hours worked per week to a standardized level. Most physicians do not work 40 hours a week. The SMS data clearly shows that many physicians spend well beyond 40 hours a week inpatient care activities and it does not make sense to standardize the number of hours worked. This suggestion may presume that the PE-RVUs should be based upon the number of hours that the physician office is open, or the number of hours that office personnel typically spend in the office, but the fact is that physicians incur practice expenses outside of the office setting.

Utilizing a 40 hour work week in the dominator used to develop practice expense per hour figures inflates the practice expenses per hour figures and artificially reduce the relative difference in practice expenses per hour for different physician specialties. The artificial use of a 40 hour work week severely distorts the relative
practice cost per hour relationships between different physician specialties. Acceptance of such arguments to alter the SMS data would largely maintain the status quo established under the non-resource-based practice expense RVUs, and not meet the legislative intent on the Medicare RBRVS.

The 40 hour a week construct simply does not make sense, particularly when physicians have historically recognized pre- and post- service work conducted beyond typical office hours and have built this work into their patient charges. Physician fees do not simply encompass the face-to-face patient encounter, but all work and practice costs associated with care delivered to the patient.

ACP-ASIM urges HCFA to continue to reject arguments that the interim PE-RVUs be refined by using a standardized 40 hour week.

Other Issues Relating to the Refinement Process

The BBA97 requires HCFA to develop a refinement process to be used during each of the four years of the transition period. ACP-ASIM agrees with HCFA that all practice expenses remain interim until the transition period ends. ACP-ASIM supports the RUC recommendation that a Practice Expense Advisory Committee (PEAC), based upon an expanded RUC composition, be created to provide practice expense recommendations regarding refinement and the creation of PE values for new codes.

The refinement process should also assure that any surveys conducted by physician specialty societies for purposes of the PEAC meet certain standards for validity and reliability. The survey instrument should be a uniformly designed instrument that uses common previously defined terms and neutral worded questions. The survey process should use a uniform survey technique, maintain minimum sample sizes, minimum response rates, and use common reporting methods.

The refinement process should also assure that sufficient input from non-physicians who bill for services reimbursed by Medicare and other practice cost experts would be considered.

Interim PE-RVUs for Evaluation and Management Services

ACP-ASIM believes that there should be an opportunity to further re-examine the interim PE-RVUs for evaluation and management services. The amount of time available in the comment period on the final rule precluded such an evaluation at this time. Issues relating to the interim PE-RVUs for evaluation and management services that may need to be addressed during the refinement process include:

1. **The relative relationship between E/M services and other services in the Medicare fee schedule.** ACP-ASIM continues to have concerns that under the top-down methodology, many E/M services are undervalued compared to inpatient procedures. HCFA is aware of studies by the PPRC, Harvard, Health Economics Research, and other analysts that support our view that a resource-based methodology should have narrowed the ratio of the practice expenses of office visits to many inpatient surgical procedures by a greater extent than has occurred under the top-down approach. There should be an opportunity during the refinement process to consider alternative or additional data, backed up by compelling arguments, that support a further narrowing in the ratio of the practice expenses of E/M services to inpatient surgical procedures.
2. **The PE-RVUs for new compared to established patient office visits.** ACP-ASIM questions why the resource-based PE-RVUs for established patient office visits increased by much less than those for new patient office visits. Although we concur that new patient office visits should have received a substantial increase over their charge-based PE-RVUs, established patient office visits arguably involve similar costs and should have been expected to have comparable increases in PE-RVUs. We hope that the refinement process will provide an opportunity to consider this question further.

3. **The degree by which the interim PE-RVUs undervalue the practice expenses of more complex E/M services.** For office visits, work RVUs increase in a linear fashion with physician time. This is not the case for the interim PE-RVUs. Instead, it appears that lower level visits received substantially higher gains in PE-RVUs, compared to their charge-based PE-RVUs, than higher level office visits. There should be an opportunity during the refinement process to evaluate the extent by which practice expenses for physician services correlate with physician time, physician work, or other factors that affect the cost of providing each E/M service.

ACP-ASIM expects to have recommendations for other issues relating to the interim RVUs for E/M services that should be addressed during the refinement process. We may also have recommendations for re-examination of the PE-RVUs for other non-E/M services provided by internists and internist-subspecialists. We urge HCFA to be open to further examination of these values, even though the comment period on the final rule and the interim PE-RVUs for 1999 may be closed.

**Summary**

ACP-ASIM believes that substantial improvements in the data and methodology used to develop the interim PE-RVUs will be needed during the refinement process. Although HCFA has indicated that it agrees that many of the concerns raised in comments on the proposed rule need to be addressed during the refinement process, the final rule is extremely vague on how and when those issues will be addressed. Considerable work still needs to be done to develop a fair and responsive process for considering the concerns that have been raised by ACP-ASIM and others. We urge HCFA to describe the process for involving the practice community and the RUC in the refinement process.

To summarize:

1. **ACP-ASIM is pleased that HCFA recognizes in the final rule that the top-down approach to determining payments for physicians’ practice expenses may allow inequities in payments to continue that exist under the current historical, charge-based methodology.** Simply accepting comments on this issue during the refinement period is not sufficient, however. HCFA must work with specialty societies and other interested parties on developing a methodological approach that would allow for correction of inequities that persist under the top-down methodology. HCFA should also consider funding an independent analysis of the extent by which the top-down methodology perpetuates historical inequities in payment.

2. **ACP-ASIM strongly supports HCFA's decision to use 1998 as the base year for calculating transition payments, rather than reverting to a 1991 or 1997 base year.** We recommend that HCFA include, in the record of its responses to the final rule, discussion of the adverse effects (in addition to those cited in the
final rule) that would result from using a 1991 or 1997 base year, including the higher cost-sharing that would be imposed on beneficiaries; the disruption that will occur if physicians must refund "overpayments" to Medicare; and the impact on Y2K compliance.

3. ACP-ASIM is pleased HCFA has decided to substantially lower the volume and intensity offset, although we believe that the adjustment should be eliminated in its entirety. Total elimination of the volume and intensity offset is appropriate because there is no evidence that physicians have increased volume and intensity to offset previous reductions in RVUs.

4. ACP-ASIM strongly recommends that HCFA work with specialty societies, the RUC, and other interested parties on developing a clearer process for addressing concerns about the adequacy of the SMS data, the accuracy of Medicare frequency data, and service times during the refinement process.

5. As discussed earlier in the comments on issues of equity, ACP-ASIM continues to believe that there are distortions in the relativity between families of services using the top-down methodology. We continue to question HCFA's decision to include clinical staff assisting in the hospital in the PE-RVUs for surgical procedures. ACP-ASIM strongly recommends that these issues be reconsidered during the refinement process.

6. ACP-ASIM believes that like other issues left to refinement process, HCFA must work with specialty societies, the RUC, and other interested groups in developing a process that will allow for further evaluation of the indirect allocation method. Simply saying that the issue "will be further evaluated" does not provide sufficient direction on how, when, and by whom the issue will be re-evaluated.

7. HCFA should provide an opportunity to re-examine the interim PE-RVUs for office visits, particularly issues relating to the relative relationship between office visits and other services in the fee schedule; the practice expenses of established patient office visits compared to new patient visits; and the practice expense RVUs for lower level visits compared to more complex visits.

ACP-ASIM is committed to working with HCFA to improve the interim resource-based RVUs and the methodology and data used to determine them. As the refinement process unfolds, we urge the agency not to lose sight of Congress' original objective in mandating implementation of resource-based practice expenses, which was (and continues to be) to correct historical inequities that undervalued the practice expenses of primary care and other office-based services compared to inpatient procedures. The interim PE-RVUs derived through the top-down methodology represent an initial step to meeting this objective. But further improvements will clearly be necessary before the Medicare fee schedule can truly be considered to be resource based.