

American Society of Internal Medicine

Testimony to the Ways and Means Committee
Subcommittee on Health
on the
Results of the General Accounting Office's
Examination of Physician Practice Expenses

March 3, 1998

Introduction

I am Alan R. Nelson, MD, Executive Vice President of the American Society of Internal Medicine (ASIM). ASIM represents physicians who specialize in internal medicine, the nation's largest medical specialty and the one that provides care to more Medicare patients than any other specialty. I am pleased to provide the Ways and Means health subcommittee with internists' perspectives on the current state of HCFA's efforts to develop resource-based practice expenses (RBPEs). Our testimony will address the following questions:

1. Is HCFA meeting the spirit and intent of the provisions in the Balanced Budget Act of 1997 (BBA) relating to practice expenses?
2. Are the basic process and methodology being used by HCFA for developing RBPEs fundamentally sound, and if so, are there improvements that still should be considered by HCFA as it develops the proposed rule?

My testimony will refer to the findings and recommendations of a draft report by the General Accounting Office (GAO), which ASIM had the opportunity to review on February 11. ASIM's testimony also refers to recommendations that the Medicare Payment Advisory Commission (MEDPAC) is expected to include in the Commission's March 1 report to Congress. The MEDPAC report, and the final versions of the GAO recommendations, were not available to ASIM when this testimony was prepared, so there may be some revisions in each of those reports' findings and recommendations from those that served as the basis for our testimony. Quotes attributable to the GAO report are based on our notes and recollections of the exact words used in the draft report.

ASIM's testimony today will explain why we believe that:

1. HCFA is meeting the spirit and intent of the BBA relating to practice expenses, particularly the requirements that it consult with physicians and consider data on actual costs to the maximum extent practicable.
2. HCFA's basic methodology and data are valid, although some improvements are appropriate.
3. It is not necessary for HCFA to start over and use an entirely different approach to develop resource-based practice expenses, which would needlessly increase costs and lead to further delay.

The GAO's draft report concurs with ASIM on each of these conclusions.

Requirements of the Balanced Budget Act of 1997

ASIM supports the practice expense provisions of the BBA. We believe that they represent an eminently fair and balanced approach to addressing the concerns that many physicians expressed last year. The BBA provided another year for physicians to consult with HCFA prior to implementation of RBPEs, and gave direction to HCFA on how its proposal might be improved. At the same time, though, it recognized the concerns of physicians whose services have historically been undervalued by the existing charge-based practice expenses, by beginning the process of redistributing payments in 1998. We appreciate the leadership shown by this subcommittee on this issue.

More specifically, the Balanced Budget Act of 1997 directs the Secretary of the Department of Health and Human Services to:

1. phase-in implementation of resource-based practice expense (PE) payments over four years, beginning on 1/1/99;
2. use generally accepted accounting principles and "actual cost" data to the "maximum extent practicable";
3. consult with physicians and other experts.
4. publish a new proposed rule and new practice expense relative value units (PE-RVUs) by May 1, 1998, with a 90 day public comment period;
5. begin moving payments to resource-based practice expenses, effective on January 1, 1998, by implementing a "down payment" that increased practice expense RVUs for undervalued office visits and reduced them for procedures whose current PE-RVUs are overvalued (based on a comparison of PE-RVUs to work RVUs).

In addition, the law directed the General Accounting Office to submit a report to Congress, within six months of enactment of the BBA, on the data and methodology being used by HCFA to develop the new proposed rule.

Consultation with Physicians

The record shows that HCFA has fully met the law's requirements that it consult with physicians and other experts on the development of the proposed rule. The actions that HCFA has taken since enactment of the BBA include the following:

- ◆ A 60 day comment period was provided on a HCFA notice of intent to issue a proposed rule on practice expenses, published in October, 1997. The notice invited comments on how to use generally accepted accounting principles, utilization rates of equipment, and actual cost data in the development of the proposed rule.
- ◆ The RVS Update Committee (RUC), which consists of specialty society representatives and the American Medical Association (AMA), was asked by HCFA in September of last year to participate in a "mock" validation panel. This provided specialty societies with an opportunity to advise HCFA on how to structure the validation process, and helped them prepare for the subsequent validation panel meetings. The RUC had another opportunity to question HCFA staff on methodological issues relating to the development of the proposed rule at its February, 1998 meeting.
- ◆ Specialty societies nominated physicians, practice administrators, and other experts to participate in panels that met this past Fall to validate the data on direct practice expenses.
- ◆ Specialty societies, accountants, health services researchers, and other experts participated in a conference held on November 21 that discussed how to apply generally accepted accounting principles to the development of indirect PE-RVUs. (Indirect costs are the general costs of running a physician practice that cannot be specifically allocated to a particular procedure).
- ◆ Specialty societies nominated physicians to serve on a cross-specialty panel that met in December to advise HCFA on how to develop direct practice expense RVUs for a list of high volume, high cost physician services.

- ◆ HCFA staff have regularly solicited advice from specialty societies, the AMA, and others on methodological issues relating to development of the proposed rule.

It should be noted that the above actions to solicit the views of physicians are *in addition* to the extensive consultation that occurred prior to enactment of the BBA. The physicians, practice administrators, nurses and other experts who were selected to serve on the Clinical Practice Expert Panels (CPEPs) that developed the initial direct PE-RVUs were selected from nominations made by specialty societies. Specialty societies and the AMA were given an opportunity to review preliminary data from HCFA as early as January, 1997. They were also given an opportunity to submit comments during a 90 day comment period on the proposed rule on RBPEs that was published in June, 1997.

Physicians were also consulted by the General Accounting Office as it prepared its report to Congress on HCFA's data and methodology. ASIM was invited on three separate occasions to meet with the GAO to discuss internists' views on the process, data and methodology being used by HCFA. The AMA and other specialty societies were given similar opportunities. Since HCFA will likely give great weight to the GAO's recommendations, the GAO report provided another vehicle for physicians to have input into HCFA's decision-making.

It should also be noted that physicians will have another opportunity to comment on the *new* proposed rule and PE-RVUs that will be published by May 1, 1998. It is likely that the 1998 PE-RVUs will also be published as *interim* PE-RVUs that will be subject to yet another comment period. The BBA also requires that HCFA make further refinements in each of the transition years, which will provide physicians with additional opportunities to advise HCFA on any improvements that are needed. The RUC will soon be developing a proposal to HCFA to participate in the refinement process, which if accepted by HCFA, will provide an ongoing means for HCFA to consult with the medical profession on refinements of the PE-RVUs.

By the time that the PE-RVUs *begin* to be implemented on January 1, 1999 physicians will have had far more opportunity to advise HCFA on data and methodology than was the case when resource-based *work* RVUs began to be implemented on January 1, 1992. As a result, the medical profession should have a higher degree of confidence that their views were considered in developing the PE-RVUs than may have been the case when the resource-based relative value scale (RBRVS) for physician work was first implemented. (It should be noted that many in the medical profession expressed the same kinds of concerns about implementation of the RBRVS that Congress is now hearing about practice expenses, but that over time the RBRVS has become almost universally accepted by physicians). The subsequent refinements that will occur during the four year transition should give the profession an even higher degree of confidence in the final PE-RVUs that will be implemented on January 1, 2002.

Use of Actual Cost Data and Generally Accepted Accounting Principles

ASIM also believes that HCFA is in the process of fully meeting Congress' intent that it consider use of actual cost data and generally accepted accounting principles to the maximum extent practicable. As noted previously, HCFA solicited comments on actual cost data, equipment utilization rates, and generally accepted accounting principles in its October notice of intent to issue a proposed rule. The November 21 conference on indirect costs invited further discussion of this issue. Witnesses who provided comments at the conference offered a wide range of opinion on the extent by which the data being used by HCFA was consistent with generally accepted accounting principles, with several of the witnesses concluding that HCFA's approach is consistent with generally accepted accounting principles.

HCFA is also using actual cost data from the CPEPs and validation panels. Data from the AMA's Socioeconomic Monitoring Survey (SMS) can also be used to determine specialty-specific proportions of direct and indirect practice expenses. Independent sources of data on the pricing of labor and equipment costs are also being used by HCFA to develop the direct PE-RVUs.

Despite HCFA's efforts to consider data on actual costs, some physician groups have repeatedly argued that HCFA's data are so fundamentally flawed that the agency needs to start over and conduct a new cost accounting analysis of physician practices, either through on-site studies or through a survey process. They claim that the CPEP and validation panel process was based on speculation, not actual cost data, and that the requirements of the BBA will not be satisfied unless HCFA undergoes a new study of the actual costs of physician practices.

ASIM firmly believes, however, that with some improvements, HCFA's data and methodology will prove to be valid, and that it is not necessary or desirable to conduct on-site studies or surveys of physician practice costs, except possibly on a limited basis as part of a refinement process.

Acceptability of HCFA's Basic Data, Methodology

It is not only ASIM, however, that reached the conclusion that HCFA's basic methodology is fundamentally sound.

The draft GAO report specifically concluded that the use of expert panels is an acceptable method for estimating direct labor and other direct PEs. It also concluded that alternative methods (including new surveys of physician practice costs or an activity-based accounting methodology) have their own practical limitations that preclude their use in developing the proposed rule.

The GAO's draft report dismissed the argument that the CPEPs were not representative of the physicians that provided the services whose direct costs were being estimated, or that the panel members engaged in "best guesses" that had no factual validity. The GAO found instead that many CPEP participants reviewed practice cost data on their own practices prior to the CPEPs and came to the meetings prepared to discuss the issues, using actual cost data, rather than basing their estimates on pure speculation.

The GAO also concluded that mail out surveys, use of existing data, and on-site gathering each has "practical limitations that preclude their use as reasonable alternatives" to the expert panel approach. The limitations it saw in the other methods include low or biased response rates and high cost (the GAO noted that it cost the PPRC \$135,000 to survey one single multi-specialty practice). The draft report also specifically says that activity-based accounting, one of the alternatives favored by critics of HCFA's current methodology, "does not provide the specificity needed to adjust the MFS" because it allocates costs to broad categories of codes, not specific procedures.

Most importantly, in reference to cost accounting surveys and other approaches that have been recommended by the Practice Expense Coalition, the draft GAO report stated that *"starting over and using one these approaches as the primary means for developing direct PE estimates would needlessly increase costs and further delay implementation."*

ASIM fully concurs with the GAO's draft conclusion that the CPEP process is an acceptable method of developing labor and other direct practice expenses, although some additional work still must be done to validate the CPEP (and validation panel) estimates and to link and standardize the labor cost estimates across families of services. *We strongly agree with the GAO that starting over and using mail surveys of physician practices, on-site cost accounting analyses, or activity-based accounting would needlessly increase costs and further delay implementation.*

Use of Survey Data in Future Refinements

The GAO draft report suggested that gathering data from a limited number of practices could be useful in pinpointing problems that should be addressed during the refinement process, and in validating some of the CPEP results for key procedures. It also suggested that gathering such data might be useful in the subsequent refinement processes.

ASIM does not disagree that it may be appropriate to gather data from a limited number of physician practices as one source of information to be used in future refinements. We believe, however, that HCFA would first need to decide, in consultation with physician groups, on how such data should be collected and used. A poorly designed survey could be prone to the same limitations, such as poor response rates and under-representation of small primary care practices, that led the GAO to preclude using such data in the development of the proposed rule. The CPEP data should not be thrown out based on data from a survey of a limited number of practices on the costs of a few procedures.

The AMA has suggested that HCFA attempt to validate and refine the CPEP data by comparing it with other data from other independent sources, such as data from billing companies and transcription services. ASIM concurs that such data should also be considered by HCFA as it validates and refines the CPEP data.

The GAO's draft findings on the acceptability of the CPEP process, and on the practical limitations of alternative approaches, should put to rest the argument that HCFA has failed to meet the BBA's mandate that it consider actual cost data and generally accepted accounting principles to the "maximum extent practicable." The discussion should no longer be over whether an entirely new approach, requiring further delay, is needed. Rather, the discussion now should be directed to what improvements in HCFA's methodology are appropriate, as well as on how the refinement process should be conducted.

Suggested Improvements in HCFA's Methodology, Data

Linkages

One of the most important--and potentially controversial--recommendations in the draft GAO report concerns the formula used by HCFA to link the labor costs of physician services. The GAO suggests that HCFA consider other approaches to the statistical regression formula proposed in the June 18 notice of proposed rule making.

HCFA's rationale for applying the regression formula was that the relative relationships with the CPEPs are generally correct, but the absolute time estimates need normalization. HCFA noted that absolute numbers within some of the CPEPs may have reflected duplicate counting of tasks that can be performed simultaneously, and that different CPEPs may not have calculated absolute labor costs in the same manner. As a result, HCFA observed that there was considerable variation in the CPEP absolute estimates for the clinical and administrative staff times, including variation in the estimates for services that were evaluated by more than one CPEP.

It is essential that such variation be corrected. To illustrate, if one CPEP came up with absolute estimates of clinical and administrative staff times that are 20% higher than those derived by another CPEP for services that in fact involve comparable labor costs, the result of using the "raw" CPEP estimates--without statistical linking--would be that the services rated by the former CPEP would be overvalued compared to those rated by the other panel. In other words, since the purpose of a relative value scale is to place all the relative value units on a common relative scale, use of the

"raw" CPEP estimates would not produce a common scale of the costs of providing one service compared to another *as the law requires*.

Therefore, ASIM believes that it is absolutely necessary that HCFA standardize the data to create a relative value scale that appropriately values the relationships between all services and that not doing so would fail to meet Congressional intent.

More specifically, ASIM is concerned that with the exception of the panel that evaluated evaluation and management services, the CPEPs generally came up with absolute labor costs estimates that were too high, especially compared to those for E/M services. HCFA implicitly recognized this, since the regression formula had the effect of lowering the labor cost estimates of non-E/M services.

The GAO draft report accurately quotes ASIM as believing that linking is appropriate because some of the CPEPs uniformly assigned higher labor time than the E/M CPEP. The draft report suggests, however, that HCFA's regression formula may have created anomalies that are not supported by the CPEP data. As an alternative to the regression formula, the GAO states that HCFA is looking at "assigning uniform administrative staff times across broad categories of codes", such as the time required to schedule an appointment. It also suggests that shifting billing costs into the indirect cost formula may reduce the need for statistical linking.

ASIM is not opposed to considering whether, as an alternative to the regression formula, there are other approaches to establishing appropriate linkages between the labor costs of E/M services and non-E/M services. However, *we strongly believe that any alternative linking method must correct the continued problem of non-E/M codes having excessively high administrative cost estimates compared to E/M services*. The validation panels, and the cross specialty panel meeting that HCFA held in December, did not correct the misalignment of the labor costs of non-E/M services compared to E/M services. Therefore, it is essential that HCFA establish an appropriate linkage in the new proposed rule.

In our discussions with the GAO staff, the GAO staff assured ASIM that by asking that HCFA consider alternative approaches to the regression formula, it was not suggesting that it was unnecessary to establish an appropriate relationship between the labor costs of E/M and non-E/M services. Rather, the GAO only intended to suggest that HCFA *consider* other approaches that would appropriately link the labor costs of E/M and non-E/M services, such as by standardizing certain costs and shifting administrative costs into the indirect cost category. The GAO also did not rule out making such adjustments through a statistical formula. The draft report also states that the GAO cannot yet evaluate other approaches that may be considered by HCFA.

Although it is unlikely that Congress would want to get involved in the technical deliberations on linkage, Congress needs to be aware of the impact this issue will have on whether or not the new proposed rule satisfies the law's intent that practice expenses be based on the resources involved in providing each physician service. *If an alternative to the statistical linking formula perpetuates the over-valuation of the clinical and administrative labor costs of in-hospital surgical procedures compared to office visits and other E/M services, the new practice expense payments will still not accurately reflect the resource costs of providing one physician service compared to another.*

ASIM is committed to working with HCFA on developing an approach that will assure that the labor costs of non-E/M services are appropriately aligned with non-E/M services. If there is a better way to achieve this than the statistical formula proposed in June, then we have no objection to considering such an alternative. But without knowing what alternative may be offered by HCFA, it is premature to conclude that statistical linking is not necessary.

Scaling

The GAO draft report recommends that HCFA eliminate scaling of the CPEP data to the national survey data (AMA SMS data).

Scaling means adjusting the proportion of direct costs from the CPEP data so that they are consistent with the AMA SMS data. The SMS data suggests that the direct costs can be divided as follows: labor cost, 73 percent; medical supplies, 18 percent; and medical equipment, 9 percent. The CPEP estimates, in aggregate, came up with different shares of direct costs: labor, 60 percent; medical supplies, 17 percent; and medical equipment, 23 percent. Thus, HCFA adjusted the CPEP expenses for labor, medical supplies and equipment by scaling factors of 1.21, 1.06, and .39 respectively.

Eliminating scaling would tend to help specialties with a higher proportion of equipment costs, and disadvantage those with a higher proportion of labor costs. Since the direct expenses of primary care physicians typically have high proportions of labor costs, and lower proportions of equipment costs, than surgical and medical specialists, the GAO's recommended change likely would disadvantage primary care physicians. ASIM has not, however, made a decision yet on whether or not elimination of scaling is appropriate. We will be examining this further and providing our recommendations directly to HCFA.

Indirect Costs

The draft GAO report recommends that HCFA consider using specialty-specific adjustment factors to determine the ratio of direct and indirect costs; and consider moving administrative costs into the indirect cost category. *It also concludes that the basic approach of allocating indirect costs based on physician work RVUs, direct PE RVUs and malpractice RVUs, as proposed by HCFA, is acceptable.* Some physician groups had argued that the indirect costs should not be allocated using such a "proxy" formula. ASIM agrees with the draft GAO report's conclusion that HCFA's method for allocating indirect costs based on the proposed formula is acceptable.

ASIM does not have any conceptual problems with moving billing and other administrative costs into the indirect cost category, but we believe that this would necessitate treating those costs differently than would be the case if they were allocated based on the physician work+direct cost+malpractice RVU formula. Use of the formula used to determine other indirect practice expense would inappropriately allow surgical procedures with higher work RVUs to get substantially higher billing costs than E/M services, even though the costs of billing for a surgical procedure are not much different than for an office visit.

We support using specialty-specific ratios of direct to indirect costs, provided that there are adequate and valid data for each specialty to accurately calculate specialty-specific ratios.

Use of Physician Nurses

The draft GAO report concluded that "HCFA appropriately disallowed nearly all expenses related to staff that accompany physicians to the hospital since there is no available evidence that these expenses are not already being reimbursed or are a common practice."

Some surgical groups have argued that surgeons often bring their nurses into the hospital and that these costs should be reimbursed by HCFA. The draft GAO report disagreed. In ASIM's meeting with the GAO staff to review the draft report, we were advised that they had been told by surgical

groups that there was some new evidence given to HCFA in response to the October rule-making notice that supports the claim that this is a widespread practice. GAO staff said it planned to examine the evidence and determine if it should modify its conclusion. ASIM recommends that the GAO ask HCFA to independently validate any such evidence, to determine if it is the usual practice for a typical Medicare patient, before agreeing that such expenses should be allowed.

Draft GAO Recommendations

Based on its overall analysis and findings, as discussed previously in this testimony, the draft GAO report concludes with several recommendations. ASIM's specific reaction to each recommendation is as follows:

1. HCFA should document how it intends to adjust the CPEP data, the basis for the adjustment, and the effects on physician practices. HCFA should also describe the process for future refinements and updating.

We concur with this recommendation. ASIM believes that HCFA should describe the elements that are needed in a future refinement process, but should leave the door open for the RUC to submit a proposal on how it might participate in such refinements.

2. On a limited basis, HCFA should collect actual PE data to identify significant problems that should be addressed in the refinement process.

ASIM concurs with this recommendation, provided that HCFA also look at other sources of data, such as from billing companies and transcription services. Any survey of physician practices or on-site gathering needs to be carefully designed to minimize response bias and other problems inherent in a survey process.

3. HCFA should revise the linking methods and eliminate scaling to the national survey data.

We concur with looking at alternatives to the regression formula used in the proposed rule, *as long as the revised linking method properly aligns all services on a common scale, and specifically addresses the problem of inflated labor costs for non-E/M services compared to E/M services.* We support using specialty-specific ratios of direct and indirect costs. ASIM has not adopted a position yet on the proposal to eliminate scaling to the national survey data.

4. HCFA should collect data from a limited number of practices to test assumptions that underlie the other adjustments or the limitations on direct costs.

ASIM concurs, but with the same caveats on the use of survey data that were discussed earlier.

5. HCFA should evaluate assigning indirect PEs based on specialty-specific data.

ASIM concurs.

6. HCFA should monitor the impact of RBPEs on access, focusing on procedures with the largest cumulative reduction.

ASIM concurs that the impact on access should be monitored. Congress should understand, however, that there are inherent limitations in any study that attempts to link changes in access (which may be due to a myriad of factors) to specific payment changes. Improvements in access to primary care services should also be monitored.

Application of the "Down Payment" to the Transition Years

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The BBA began the process of moving payments in the direction of resource-based payments, by mandating a "down payment" in 1998 that improved the practice expense RVUs for office visits, while lowering them for some procedures. The legislative history of this provision, which originated in the Senate Finance Committee but was also accepted by the House conferees, shows that the intent was to increase the PE-RVUs of office visits in 1998 as a first step toward the expected increases that will occur when RBPEs are implemented on 1/1/99. Congress clearly intended for the PE-RVUs, as adjusted by the down payment, to be used in the subsequent years of the transition that begins in 1999 (i.e. the down-payment adjusted PE-RVUs would be blended with the resource-based PE-RVUs). Since other provisions in the BBA postponed implementation of RBPEs for one year (followed by an additional four year transition) the down payment was viewed by Congress as being an essential first step to helping physicians whose practice expense payments for office visits are undervalued.

In its notice of intent to issue a rule, HCFA indicated that the 1998 PE-RVUs, as adjusted by the down payment, would be the basis for the subsequent blended transition. Some physician groups are now trying to influence HCFA to re-interpret the law in such a way as to apply the down payment only to the 1998 PE-RVUs. They argue that the charge-based RVUs, which would be blended with the resource-based PEs beginning in 1999, should revert back to the 1997 PE-RVUs that were in effect prior to the down payment mandated by the BBA.

ASIM strongly opposes any such re-interpretation of the law and congressional intent. If HCFA agreed to apply the down payment only in 1998, but not the subsequent transition years, this would not only violate congressional intent, but would break faith with the members of ASIM and other primary care groups that supported the compromise on practice expense that was adopted last year. (We accepted a delay in implementation and a four year transition, conditioned on the requirement that HCFA begin making improvements in 1998 in PE payments for office visits, with the understanding that such improvements would carry into the transition years). It will also re-open the divisive debate in Congress and within the medical profession on an issue that Congress intended to settle last year. Finally, it could have the effect of raising PE payments for office visits in 1998, then lowering them in 1999--a "ping pong" effect that makes no rational sense.

It must be remembered why Congress mandated resource-based practice expenses in the first place, and why it decided to begin the process of making improvements--through the down payment--in 1998. Congress concluded--correctly--that the historical charge basis for determining practice expense payments undervalued office-based services. Even with the "down payment", the practice expense RVUs of a coronary bypass procedure that is performed in the hospital are more than 81 times that of a mid-level established patient office visit--even though the hospital picks up most of the costs of the bypass procedure. For many office-based services, Medicare payments now barely cover the costs of providing those services. Improved payments for the practice expenses of office visits and other undervalued services will therefore help improve access for those services. The down payment was a good first step to correcting the existing inequities, and Congress should not go along with any attempt to reverse the progress that is being made.

ASIM does not believe that it will be necessary for Congress to enact legislation to clarify the intent of the down payment provisions, since we believe that the intent of the BBA provisions are clear. But if this issue is re-opened by HCFA, then we will urge Congress to step in and enact a technical correction that makes it clear that the 1998 PE-RVUs, as adjusted by the down payment, will apply in the transition years.

MEDPAC Recommendations on Practice Expenses

It is our understanding that MEDPAC will recommend that HCFA not adopt its proposal to reduce payments for procedures provided in conjunction with an office visit or other E/M service. ASIM strongly concurs with the MEDPAC's recommendation. HCFA's proposal to reduce PE-RVUs for such procedures by 50% would result in payments that do not reflect the resource costs of providing each procedure. There is no basis for HCFA to arbitrarily assume that the costs of providing procedures in conjunction with an E/M service are reduced by 50% from the costs of the original procedure.

We also understand that MEDPAC will oppose HCFA's proposal to include a volume and intensity adjustment--otherwise known as a behavioral offset--in its calculations of the PE-RVUs. In its June 18, 1997 propose rule, HCFA stated that it intended to assume that 50% of the reductions in payments for specific procedures will be offset by an increase in volume and intensity. The effect of this assumption is to increase the amount of reductions for some procedures, and reduce the expected gain from others. ASIM agrees with MEDPAC's view that HCFA's experience with implementation of the RBRVS does not support the need for such a volume and intensity adjustment. Further, MEDPAC argues--correctly--that the sustainable growth rate for physician services, also mandated by the BBA, already corrects for any increase in the volume and intensity of physician services. ASIM strongly urges Congress to advise HCFA that application of a volume and intensity offset to the PE-RVUs is inconsistent with requirement that resource-based practice expenses be implemented in a budget neutral manner.

Conclusion

ASIM is pleased that the draft GAO report fundamentally supports our assessment that HCFA is satisfying the intent of the BBA and that it is not necessary or desirable for HCFA to start over with an entirely different approach. We are pleased that the GAO recognizes the validity of the CPEP process and HCFA's formula for allocating indirect costs. We agree with the report's assessment of the practical limitations of the cost accounting surveys and other alternatives that have been advocated by others. We concur with the GAO that HCFA was correct in disallowing the costs associated with nurses who accompany a surgeon into the hospital, barring *independently verifiable data* that this is a typical practice.

None of the GAO draft report's recommendations for improvement are fundamentally inconsistent with the way HCFA is going about developing RBPEs. ASIM believes that the GAO's suggestions for improvement are for the most part appropriate, although we have some concern about supporting alternatives to statistical linking until we are certain that there is a better approach that would correct the misalignment of labor costs for non-E/M services compared to E/M services. None of the suggested improvements would result in what the draft report rightly calls the "needless" increase in costs and further delay that would be required if HCFA was forced to use cost accounting studies or some other alternative methodology to develop RBPEs, as the critics of HCFA's current process and methodology have long advocated.