

Physician Practice Expenses: What Does the Independent Research Show?

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Introduction

Dating back to 1990, every major independent study and analysis of physician practice expenses has concluded that the current charge-based method undervalues office-based services and overvalues most services provided in an inpatient setting. (Independent studies are those that are funded and conducted by researchers with no financial interest in the outcome). The studies used different methods to determine practice expenses: accounting based analysis of direct costs of specific services (PPRC); allocating costs on the basis of time (Hsiao, Braun, Becker, Latimer, Chen, Dunn); and allocating costs on the basis of physician work (Pope and Burge). Remarkably, all concluded that existing data may be used to construct practice expense relative values that are more resource-based than those used in the current Medicare fee schedule. All reached similar conclusions on the impact of resource-based practice expenses on payments per service and payments per specialty; under all approaches, office visits and other office-based services gain, while invasive procedures done in the hospital lose. The overall aggregate estimates from each study do not differ substantially from those that would result from HCFA's proposed rule on resource-based practice expenses. Taken together, the studies strongly support a conclusion that HCFA's proposed methodology produces practice expense relative values that are fundamentally valid, recognizing that further refinements and improvements are necessary.

Policy-makers should assign more credence to these independent studies than those funded by interest groups with a vested financial interest in the conclusions of the study. Excerpts from the independent studies are presented below:

Hsiao, Braun, Becker et. al. A National Study of Resource-Based Relative Value Scales for Physician Services, Phase II, Final Report to the Health Care Financing Administration, September 30, 1990, pp. 738-740.

"The current method of allocation [of practice costs] specified in the law would distribute the practice cost according to current charges. This approach would not be in accord with the fundamental principle that the Medicare fee schedule be closely related to the resource costs required to deliver the service. This dissonance results from the fact that the practice costs are not necessarily related to the current charges. The deficiency of this allocation method can be clearly illustrated with an example. Under the government's proposed approach, a 20-minute office visit would be allowed \$11 for the practice cost portion of the service. Since the typical family physician or general internist sees 5000-6000 patients a year, this translates to an allowance of \$50,000-60,000 for the practitioner's practice expense. Actual aggregate practice expenses, however, are much higher.

Other anomalies and inequities will also be created by the proposed allocation method. As the model MFS table illustrates, the practice cost allowance for a repair of inguinal hernia or appendectomy would be \$200, and for a three-vessel coronary bypass it would be \$1,300. These results clearly indicate that the allocation of practice costs to each service are not in conformity to their actual expenses. If practice costs are not allocated appropriately by service, the Medicare fee schedule could create unintended financial incentives for physicians to perform more of the procedures that produce the greatest net revenue. A better allocation method must be developed."

Latimer, Becker, Chen, Toward a Rational Method for Incorporating Overhead Expenses into the RBRVS, Harvard School of Public Health, 1991

"Four significant conclusions emerge from our analysis. 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. Some measurement of direct expenses for selected services would improve further on the approach used here, at low cost."

Physician Payment Review Commission, Practice Expenses Under the Medicare Fee Schedule; A Resource-Based Approach, 1992.

"By relying on average allowed charges, the OBRA89 method anchors a large share of Medicare Fee Schedule payments on the CPR [customary, prevailing and reasonable] payment system. Services that have had historically high payment levels will continue to have relatively high practice expenses, regardless of the practice expenses physicians incur when they provide these services. For example, 54 percent of the Medicare Fee Schedule payment for a coronary artery bypass graft in the Federal Register represents payment for practice expenses. However, this service is provided in hospital operating theaters that are equipped and staffed by the hospital, not the physician. In this case, the Medicare Part A payment includes the costs of virtually all of the direct inputs required to provide the service besides the physician's work. The practice expense payment for this service is one of the highest in the Federal Register, despite the fact that many of the other services, when furnished in a physician's office, require the physician to provide more medical staff time, supplies and equipment." (page 6)

"The estimated resource-based practice expense payments and total payment amounts [based on the PPRC's resource-based framework and clinical data] differ substantially from those that will obtain under the OBRA89 method . . . The estimated payment for an office-based mid-level visit for an established patient is \$35.28, 23 percent higher than under the OBRA89 method. This implies that practice expense data suggest that physicians incur relatively more practice expenses when providing this service than the OBRA89 method allows. Conversely, the estimated payment for a coronary artery bypass graft is 32 percent lower than under the OBRA89 approach. The estimated resource-based amount is presumably sufficient to cover the relative billing and occupancy costs that the physician incurs when providing this inpatient service, as well as any additional resources used to provide office-based follow-up visits included in the global package. Other resources required to provide this service, such as operating room staff and equipment, are included in the Part A diagnosis related group (DRG) payment to the hospital, since it is financially responsible for these resources. The estimated total payment for this service is \$1,396, compared to an OBRA89 payment level of \$2054." (page 22).

Hsiao, Dunn, Verrilli, Assessing the Impact of Physician-Payment Reform, The New England Journal of Medicine, April 1, 1993

"The low net income the Medicare fee schedule generates for some specialties is due largely to its inadequate reimbursement of practice expenses . . . We found that many specialties are inadequately reimbursed for practice costs. In general, these shortfalls are greatest for the primary care specialties.

"Our findings suggest that Medicare's practice expense payments understate actual expenses. Furthermore, because practice expenses are allocated in accordance with historical physicians' charges, the allocation formula systematically favors invasive procedures. Since surgical procedures have

historically involved more generous compensation than other services, charge-based allocation favors these services and reimburses more for expenses than is actually spent." (pages 931-932)

Pope and Burge, Allocating Practice Expense Under the Medicare Fee Schedule, Health Care Financing Review, Spring 1993, pp. 139-162

"Many believe that the physician fees that evolved under the customary, prevailing and reasonable (CPR) payment method were distorted by insurance coverage and other factors. Historical CPR physician fees often greatly exceeded the cost of providing services . . . especially for invasive procedures . . . A primary goal of the Medicare fee schedule is to bring payments for Medicare physician services more in line with the relative resource costs of providing services. To this end, relative values for physician work were established through surveys of physicians (Becker, Dunn and Hsiao, 1988). MFS payments for physician work, however, account for only 54 percent of total MFS payments . . . Practice expense and malpractice RVUs are established by multiplying the historical Medicare allowed charges for services by the percentage of total practice revenues accounted for by these costs. Thus, the MFS is a mixture of resource-based fee schedule (for physician work, and a charge-based fee schedule (for practice expense and malpractice costs). Any benefits from resource-based fees--less incentive to overprovide some services and underprovide others--are attenuated in the MFS . . .

In . . . this article, we present approaches to allocating practice expenses in the MFS, we describe the proposed resource-based method of allocating practice expenses and how it compares with other methods . . .

The biggest winners among physician specialties from the Specialty Resource Based Fee Schedule (SRBFS) are general practice, family practice, and internal medicine. The non-physician specialties of chiropractic, optometry, and podiatry are also big winners. The biggest losers are thoracic surgery, pathology, ophthalmology, neurological surgery, and gastroenterology.

The [SRBFS] method could be used to replace the current charge-based allocation of such expenses, which seems inconsistent with the goals of the MFS. We compared our simulated specialty resource-based fees with the preliminary service-specific resource-based fees developed by the PPRC. The two fees are similar for many high volume office services, and with an office or non-office site of service differential, it appears that they would be similar for many non-office services as well."

Becker, Adams, Physician Practice Cost Payments in the Medicare Fee Schedule: What Are the Implications for Primary Care Specialties of Not Being Resource-based, Journal of General Internal Medicine, January 1995.

"One cornerstone for a good relationship between physicians and the federal government is the fairness and accuracy of payments for services rendered under Medicare. Physicians as well as their patients are entitled to a payment system that is reasonable and unbiased. With the current Medicare fee schedule this is still not the case; nearly half of the Medicare payment--the portion paying for practice expenses--is inaccurate and biased . . .(page 36)

. . . Since the 'true' average cost for a particular physician may vary from his or her colleague because of differences in overhead resource utilizations and overhead allocation methodologies, any final allocation legislation passed by Congress will always be arbitrary and intended to achieve certain policy goals. All of these allocation issues need to be understood and fairly resolved. If practice costs are not allocated appropriately by service, the MFS will continue to create unintended financial incentives for physicians to provide some services more than others. (page 38)

Finally, because a reallocation of practice cost payments will favor internists and other primary care specialists who receive a substantial portion of their revenue from visits and consultations and will hurt specialists who have the preponderance of their revenue derived from surgical procedures and diagnostic and/or laboratory testing, movement to a fully resource-based payment schedule will result in further

friction between surgical and nonsurgical specialties. Coupled with the decline in Medicare revenue already experienced by surgical specialties under the MFS, reforming practice expense cost payments will be even more difficult and contentious . . .(page 38)

While in the short run the practice cost problem may appear most serious to internists and other primary care physicians; in the long run, it will continue to undermine and discourage prudent, rational and cost-effective medicine."

Dunn, Latimer. Derivation of Relative Values for Practice Expenses Using Extant Data, A Research Project for the Health Care Financing Administration, Final Report, April 1, 1996.

"The objective of this research was the development of more resource-based relative values for service and procedure codes using existing data and a formula-based approach . . .(page I)

Using these methods and an extensive data base assembled for the purposes of this research, we produced estimates of direct, indirect and total practice expense RVUs for approximately 7000 physician services. Including non-physicians services and site-of-service variants, we produced these values for more than 12,000 services . . . (Page ii).

Simulations on the impacts of the practice expense RVUs produced by each method on Medicare Part B payments indicated that in general, RVUs under each of the methods would increase for evaluation and management (E/M) services and decrease for invasive services. . . Consistent with the findings for services, in general, surgical specialties would experience decreases in payments, while medical specialties would realize gains . . .(page ii)

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." (page iii)

Pope and Burge, Executive Summary. Final Report on the Specialty Resource-Based Method to the Health Care Financing Administration, Spring, 1996.

"In general, visits, consults, and other evaluation and management services experience increases in RVUs under the Specialty Resource-Based (SRB) method. For example, an office visit for an established patient (99213) has 0.38 practice expense RVUs and 0.96 total RVUs under the 1996 MFS if performed in the office. Under the SRB method, practice expense RVUs increase to 0.59 (55 percent gain versus MFS) while total RVUs increase to 1.17 (22 percent gain versus MFS).

Major surgeries and diagnostic procedures tend to have reduced RVUs under the SRB method with the new site-of-service differential. For example, CABG [coronary artery bypass graft] (33533) practice expense RVUs fall from 30.45 to 12.62 (-58 percent) under the SRB method, while total RVUs decline from 59.81 to 41.98 (-29 percent."

Physician Payment Review Commission, Annual Report to Congress, 1997.

"The Commission continues to recommend that HCFA develop direct cost relative values based on data on service-level direct costs, and that indirect costs be allocated by one of the available valid methods. The evidence described [in this report] implies that it would be difficult to develop practice expense relative values that capture service-level differences in resource use without service-level direct cost data. Although the Commission had previously envisioned a widescale data collection effort from

physician practices, the small group process used by Abt Associates to develop direct cost relative value units should have been able to capture service-level differences in practice costs. These data were made available in time for HCFA to use in developing proposed regulations in 1997.

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.

That the Commission, Harvard, and Health Economics Research derived generally similar effects has led the Commission to conclude that existing data are sufficient to begin the process of implementation in 1998. If a multi-year transition and a refinement process are used, then launching the process in 1998 based on these gross estimates will move most relative values in the correct direction toward their final resource-based values. Such an approach mirrors the overvalued procedure reductions that preceded implementation of the Medicare fee schedule. It would start to remedy the longstanding inequities caused by the continued use of charge-based practice expense values." (page 275)

"Because alternative data sources and analytic methods are not currently being developed, nothing would be gained through a delay. In addition, delay would perpetuate the inequities that underlie the current method. Even if the new values were imperfect, they are likely to reflect resource use more accurately than the current values do. . . ." (page 277).

Physician Payment Review Commission, HCFA Proposes New Practice Expense Relative Values: A First Look by PPRC, PPRC Update, No. 20, July, 1997

"HCFA's estimates of the effects of the new values on payment by specialty are fairly similar to those found in the PPRC's earlier work on practice expense relative values. Under HCFA's proposed values, cardiology and thoracic surgery would experience larger reductions in payment than those predicted by the PPRC's analysis. This may reflect the fact that the PPRC studied a limited number of services. HCFA estimated that lower-income specialties will experience gains while losses will occur in the higher-income specialties. PPRC has begun to analyze the differences between HCFA's proposed relative values and those from PPRC's earlier practice expense study. Among 140 office-based services common to both, the correlation in direct costs in the two studies was fairly low, but the correlation in indirect costs is quite high. PPRC is now conducting more thorough analyses to learn why the two sets of values differ. These analyses will address both the CPEP data and the decision rules applied to these data as potential causes of the different results." (page 2)

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