MEDPAC Medicare Payment Advisory Commission

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Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Box 8013
Baltimore, Maryland 21244-8013

RE: file code CMS-1512-PN

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed rule entitled: *Medicare program; Five-year review of work relative value units under the physician fee schedule and proposed changes to the practice expense methodology.* [CMS-1512-PN] Federal Register, June 29, 2006. We appreciate your staff's ongoing efforts to administer and improve the payment system for physicians' services, particularly considering the agency's competing demands.

The 5-year review process

CMS recently completed its third five-year review of the physician fee schedule's work relative value units (RVUs) and has proposed changes to the work RVUs of 253 codes. As in past reviews, CMS relied heavily on specialty societies to identify codes that might be misvalued and to collect supporting data, and on the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) to evaluate the data and make recommendations. In previous five-year reviews, the RUC recommended far more increases than decreases in the relative values of codes. This was in large part because the specialty societies, which identified the vast majority of the misvalued services examined by the RUC, have financial incentives to pursue correction of undervalued services.

For the third five-year review, CMS continued to rely on specialty societies to identify misvalued codes, but also itself identified 168 codes for RUC analysis. Still, only a small number of these codes were identified as codes thought to be overvalued.

The Commission continues to be concerned by the overwhelming number of undervalued codes identified and corrected during the five-year-review process, as compared to the number of overvalued codes. CMS proposes to increase the work RVUs for 225 codes and decrease the

RVUs for only 28 codes. This suggests that overvalued services continue to be largely ignored by the current process. Such misvaluation can distort the market for physician services (as well as for other health care services that physicians order, such as hospital services). Services that are overvalued may be overprovided because they are more profitable than other services. In addition, because so many more codes would have their values increased than decreased, CMS would passively devalue all work RVUs by an estimated 10 percent, in keeping with the budget neutrality requirement.

In its proposed rule, CMS acknowledges that there is little incentive for physician specialty societies to identify codes that may be overvalued for review. Nevertheless, CMS has not yet proposed any alternative method for identifying such services in the next five-year review, and maintains that it is the responsibility of the specialties to present compelling evidence that a code is misvalued. However, CMS appears to have taken a more critical approach to its review of the RUC's recommendations, accepting only 71 percent, compared with more than 90 percent in previous years.

In our March 2006 Report to the Congress, MedPAC evaluated the five-year-review process and concluded that CMS itself must take a more central role in identifying potentially misvalued services, especially overvalued ones. We recommended that CMS reduce its reliance on physician specialty societies by establishing a standing panel that would provide expertise in addition to that provided by the RUC. This new panel would help CMS identify misvalued services and collect data to establish supporting evidence for the RUC to consider. The panel would also be useful in evaluating codes when no specialties express an interest in collecting the necessary data, as happened with the case of one code.

The Commission also recommended that the Secretary implement reviews of services based on analyses of Medicare data, institute automatic reviews of work RVUs for selected recently introduced services after a specified period, and establish a process by which all services are reviewed periodically. We recognized that these recommendations would increase demands on CMS and—since the goal was to improve the accuracy of Medicare's payments and achieve better value for Medicare spending—encouraged the Congress to provide the agency with the financial resources and administrative flexibility to undertake them.

Our recommendations were not intended to supplant the RUC but rather to augment it. The RUC and the specialty societies play an important role, which should continue. The RUC is currently in the process of reviewing its own procedures, including its composition, its role in the identification of misvalued services, and its processes for identifying and reviewing newly introduced services. It remains to be seen whether and how changes to the RUC's procedures will affect the review of services in the next 5-year review.

Other issues under the five-year review

As proposed, the work RVUs for many evaluation and management services would increase. We commend the RUC for recommending these increases and CMS for agreeing with the RUC. The Commission has expressed particular concern about primary care services, which have been found to be capturing a smaller portion of Medicare physician spending. If it continues, such a

shift in spending would have important implications for the future of the physician workforce necessary to meet the chronic care and other needs of Medicare beneficiaries.

The proposed rule also discusses the global surgical policy. Although it is not proposing any changes to the policy at this time, CMS voiced its interest in receiving comments concerning the current policy of including post-operative visits in the global surgical packages and what advantages or disadvantages might be associated with unpackaging these visits.

Compared to other payment systems, the unit of payment in the physician fee schedule is very narrow in that it consists of many discrete services—visits, imaging studies, laboratory and other diagnostic tests, and procedures. MedPAC has long been concerned that such a unit of payment might give physicians a financial incentive to increase payments by increasing the volume of services unnecessarily. Indeed, at the time the global surgical packaging policy was implemented, policy makers believed that some physicians were billing for unnecessary post-operative visits. In the absence of information suggesting that access to appropriate care is being compromised, the Commission continues to support packaging and bundling to encourage efficient and appropriate care.

Practice expense

CMS is proposing the first major overhaul of the method it uses to calculate practice expense payments since it implemented resource-based practice expense RVUs in 1999. Under the proposal, CMS will:

- Calculate direct practice expense RVUs using a "bottom-up" method instead of a "top-down" method,
- Modify the method it uses to allocate indirect costs to specific services,
- Use supplemental practice cost data from eight specialties to calculate indirect practice expense RVUs, and
- Eliminate the non-physician work pool and calculate the practice expense RVUs for all services using the same method.

Calculating direct practice expense RVUs

CMS proposes to calculate direct practice expense RVUs by summing the costs of the direct inputs for each service. In the Clinical Practice Expert Panel (CPEP) database, the agency maintains the types, quantities, and prices of the direct inputs—clinical labor, medical equipment, and supplies—required to provide each service paid under the physician fee schedule.

The proposed "bottom-up" method is more understandable and intuitive than the current "top-down" method in which CMS allocates total practice expenses to specific services using the direct inputs. Under the bottom-up method, it is not necessary to estimate the total direct costs of operating a practice and allocate these costs to specific services. However, moving to a bottom-up method will redistribute direct practice expense RVUs across services because the method relies solely on the cost of the direct inputs. Services that require costly equipment and supplies, such as some non-facility imaging services and procedures, will probably experience more gains on average than other services, such as evaluation and management services.

Therefore, it is important that CMS ensure that the inputs—types, quantities, and prices—are accurate and complete. Otherwise, the relative weights for practice expense will become distorted. Under CMS's proposal, the direct inputs play a greater role in determining both the direct and indirect practice expense RVUs than under the current method. CMS should address at least three issues to ensure the accuracy of the direct input estimates and their prices.

First, CMS, with the assistance of the medical community, should obtain estimates for services that are not currently valued as soon as feasible. Otherwise, Medicare's payment for these services may not reflect the resources that practitioners require to furnish them. For example, direct input estimates are lacking for the monthly capitated services that physicians provide to dialysis patients (codes G0308–G0327). Under the proposed bottom-up method, practice expense RVUs (fully implemented) for these services will decline by 22 percent to 64 percent compared with current (2006) values. In last year's proposed rule, CMS noted that they did not have estimates of the direct inputs for these services.

Second, CMS should revisit how it estimates the per service price of medical equipment, in particular the assumptions that all equipment is operated half the time that practices are open for business and that practices pay an interest rate of 11 percent when borrowing money to buy equipment. It is critical that CMS update these assumptions because it proposes to use estimates of clinical labor, equipment, and supplies to value services that are currently in the non-physician work pool (see discussion below). Until now, the practice expense RVUs for such services have been primarily based on historical charges. Many imaging and radiation therapy services that are currently in the non-physician work pool use high-cost equipment. If CMS overestimates the cost of such equipment, the RVUs for these codes under the proposed bottom-up method will be too high.

If providers use equipment more than 50 percent of the time, Medicare's prices for equipment are too high. We conducted a survey of imaging providers in six markets that indicates that providers in those markets use magnetic resonance imaging (MRI) machines more than 90 percent of the time and computed tomography (CT) machines more than 70 percent of the time (MedPAC, Report to the Congress: Increasing the value of Medicare, 2006). Our survey raises questions about whether CMS underestimates how frequently providers use MRI and CT equipment.

CMS could update its utilization assumptions for high-cost equipment by including questions about equipment use in a new multi-specialty survey of practice costs. (Inexpensive equipment is a lower priority because it represents a small fraction of a service's practice expense.) Alternatively, CMS could base the assumption of equipment use on an expectation of how frequently efficient providers operate expensive equipment. Such a standard would encourage more efficient use of high-cost equipment.

CMS also assumes that practitioners pay an interest rate of 11 percent per year when borrowing money to buy equipment, but more recent data from the Federal Reserve Board suggest a lower

interest rate may be more appropriate. A lower interest rate estimate would reduce payment rates for services that have high equipment costs. CMS has not updated the current estimate since it was developed in 1997.

The Federal Reserve Board conducts an ongoing survey that CMS could use to revise its interest rate assumption. The Board collects quarterly information on commercial and industrial loans made by commercial banks to different types of borrowers. One of the advantages of using this survey is that it is updated regularly, which would make it easier for CMS to keep its assumption up to date. Based on the Federal Reserve surveys conducted during the last five years (from the second quarter of 2001 to the first quarter of 2006), loans of more than one year had average annual interest rates over the last five years that ranged from 5.3 percent to 6.0 percent, depending on the risk of the loan.

Third, the agency should establish a reasonable time frame to periodically review and update the wage rates for clinical staff and the purchase prices of supplies and equipment. CMS should also review the prices of expensive supply and equipment items more frequently than other items. Staff wages and the prices of equipment and supplies have a greater impact on RVUs under a bottom-up method than a top-down method.

CMS last updated nonphysician clinical staff wages for the 2002 fee schedule and has not indicated when wages will be reviewed again. Because wages for different types of clinical staff increase at different rates, PE RVUs could become less accurate over time unless wage data are kept up to date.

Although CMS repriced supplies and equipment in the last few years, the agency has not indicated when it will next perform a comprehensive review. Moreover, the prices of new, high-cost supplies and equipment should be reviewed more frequently than other items to ensure that price changes are reflected in the relative values. Prices for new items are likely to drop over time as they diffuse into the market and as other companies begin to produce them.

Calculating indirect practice expense RVUs

Indirect practice expenses, which include office rent, utilities, and administrative staff, cannot be directly associated with specific services. Indirect costs are important because they represent more than half of most specialties' total practice costs. CMS currently uses a top-down approach to allocate aggregate indirect costs to individual codes based on each code's direct practice cost and work RVU. The agency proposes to continue using the top-down method for calculating indirect costs but changes how costs are allocated to specific services. We are concerned that these changes make the methodology less intuitive and understandable. In addition, CMS could describe its proposed method more clearly.

The current method allocates indirect costs to individual services based on the sum of the direct practice cost and physician work RVU for each service. The proposed method makes two changes:

- It adjusts the direct practice cost based on the ratio of indirect to direct practice costs for specialties that perform the service.
- Instead of using the physician work RVU, CMS proposes to use the higher of each service's physician work RVU or clinical labor RVU (e.g., the cost of a nurse's time).

The second change is designed to protect services with little or no work RVUs that might be disadvantaged by the current allocation approach. For example, codes that are currently in the non-physician work pool have no work RVUs. The problem with using clinical labor in addition to direct costs to allocate indirect costs for certain services is that clinical labor is a component of direct costs, which leads to double counting of clinical labor in the allocator. Although this approach seems reasonable for services that have no work RVUs, it is unclear why it should also be applied to services with small work RVUs.

Under the current method, CMS multiplies the indirect cost allocation for each service by a specialty-specific scaling factor. The scaling factor equals the specialty's aggregate indirect costs based on survey data divided by the specialty's total indirect cost allocation. It ensures that the indirect cost allocation for all services performed by a specialty (based on the direct costs and work RVUs for those services) equals the total indirect costs for the specialty based on survey data. Under the proposed method, CMS creates an indirect practice cost index that reflects the relationship between each specialty's indirect scaling factor and the overall scaling factor across all specialties. For example, if a specialty has a scaling factor of 1.0, and the overall average is 0.5, the practice cost index for that specialty is 2.0 (1.0 divided by 0.5). The practice cost index for each specialty is multiplied by the indirect cost allocation for the services it performs. The rule is unclear on whether the practice cost index differs from the current method.

It is difficult to evaluate the proposed changes to allocating indirect costs because there is no accepted standard for allocating such costs to specific services. Nevertheless, neither the current method nor the proposed method is very intuitive or understandable. We suggest that CMS explore alternatives for allocating indirect costs that would be more understandable. Such research could include:

- whether indirect costs should be allocated based on clinical labor and equipment, but not supplies (the current approach rewards services that use high-cost supplies although it is questionable whether they are associated with higher indirect costs); and
- the impact of allocating indirect costs based solely on the indirect expense ratio for each specialty.

The Commission also plans to examine alternative methods for indirect cost allocation.

CMS should strive to be as transparent as possible given the complexity of the method to calculate indirect practice expense RVUs. CMS could improve the transparency of its proposal by publishing the scaling factors and the indirect practice cost index values for each specialty. In addition, it would be helpful to show the impacts of changes to the indirect method by specialty and categories of services (rather than summarizing the impact of multiple changes to the practice expense methodology in a single table, as in the proposed rule).

Using supplemental data to calculate indirect practice expense RVUs.
CMS is proposing to use more current practice cost data submitted by eight specialties (allergy/immunology, cardiology, dermatology, gastroenterology, urology, radiology, radiation oncology, and independent diagnostic testing facilities) to calculate indirect practice expense RVUs. The Balanced Budget Refinement Act of 1999 (BBRA) mandated that CMS establish a process to consider supplemental data submissions when updating the physician fee schedule. For most other specialties, CMS uses practice cost data that the AMA collected between 1995 and 1999.

As the Commission noted in its June 2006 report, using more current practice cost data submitted by some (but not all) specialties raises several issues. Supplemental submissions do not provide a recurring source of information for all specialties. Although the BBRA gave providers the option to submit more current information, they are not mandated to do so. Since the BBRA, few groups have submitted newer data. Groups informed the Commission that collecting practice expense information is costly and time consuming, and they do so only when it is likely to increase their payment rates. Through 2006, the agency has accepted and used supplemental data from five specialties.

Using more current information from some but not all specialties could cause significant distortions in relative practice expense payments across services. If CMS uses the supplemental submissions from the eight specialties, a redistribution of practice expense RVUs will occur because it will implement the change in a budget neutral manner. Hourly practice expenses increased substantially for the eight groups with supplemental data, ranging from about 40 percent for urology to 125 percent for cardiology and 750 percent for independent diagnostic testing facilities. As a result, once CMS applies specialties' supplemental data in a budget-neutral manner, practice expense payments for services primarily furnished by them will increase while payments for services furnished by other groups will decrease. For example, the practice expense RVUs for destruction of a benign or premalignant lesion (CPT 17000) will increase by 42 percent (from 0.97 RVU to 1.38 RVU). Physicians specializing in dermatology primarily furnish this service, and this group is one of the eight specialties with supplemental data.

The most equitable goal is for the agency to collect comprehensive practice cost data for all practitioner groups on a regular basis. Using current total practice cost data from all specialties is important to ensure the accuracy of practice expense payments.

Eliminating the nonphysician work pool
CMS proposes to eliminate the non-physician work pool (NPWP) and calculate the practice expense RVUs for all services using the same method. CMS created this pool as an interim measure to allocate practice expense RVUs for services that are not performed by physicians, such as the technical component of most radiology services. Practice expense RVUs for NPWP services are primarily based on historical charges, rather than relative resource use. We have been concerned that this method may lead to overvalued RVUs for imaging services (Report to the Congress, March 2005). CMS's proposal to determine practice expense RVUs for codes in

the NPWP using the same resource-based methodology it uses for other services is more intuitive and promising than the current approach and fulfills the statutory mandate that RVUs be resource based.

Ensuring the accuracy of practice expense RVUs
CMS has not yet proposed a five-year review of practice expense RVUs. The agency fully implemented the resource-based values in 2002, which suggests that CMS should review them by 2007. However, the refinements of the direct input estimates continued through the end of 2005.

It is important for CMS to set a reasonable schedule for reviewing practice expense relative weights at least every five years as required and more often for services experiencing rapid changes. The statute requires the Secretary review and make adjustments to the relative values for all physician fee schedule services at least every five years. Periodic review of the RVUs is important because the resources needed to perform a service can change over time. CMS should adjust the value of the service accordingly. Otherwise, Medicare's practice expense payments will be too high or too low, relative to the resources needed to produce it. During the five-year review, CMS could also update the utilization data it uses to calculate indirect practice expense RVUs if it chooses to update the data periodically rather than annually.

A five-year review would give CMS the opportunity to review the estimates of the direct inputs in the CPEP database. The inputs required to furnish many—although not all—services can be expected to change over time. Currently, the RUC recommends the types and quantities of direct inputs for refined and new services to CMS. The agency has generally accepted the RUC's recommendations for most services.

CMS could focus its effort on high-volume services, particularly those for which the RUC based its direct input estimates on values estimated by consensus, not from surveys of physicians. Between 1999 and 2005, the RUC made recommendations to CMS to refine most of the direct inputs from resource estimates proposed by specialty societies. By contrast, for new services, the RUC used data gathered from physician surveys.

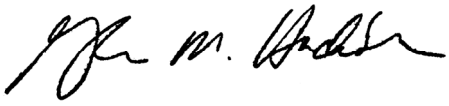
Updating practice expense data and CMS's workload
We recognize that the updating the practice expense data will substantially increase CMS's workload. There is a trade-off between improving the accuracy of practice expense payments and other demands on the agency's limited administrative resources. Therefore, we suggest that CMS focus its efforts on areas where the data are most out of date and the impact on RVUs is likely to be greatest. Although some time lag between relative weights and actual costs is unavoidable, CMS can still develop a reasonable time frame and approach to periodically update the data sources. The Congress should provide CMS with the financial resources and administrative flexibility to undertake the effort as it will improve the accuracy of Medicare's payments and achieve better value for Medicare spending.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

GMH/nr/w