Improving Data and Methods Related to Indirect Practice Expense in the Medicare Physician Fee Schedule:
Read-ahead materials for the virtual Town Hall

Town Hall Agenda for June 16, 2021

1:00 PM – Welcome and Background

1:15 PM – Topics 1 & 2

3:00 PM – Topic 3

Attendee Comments

CMS wants to hear from stakeholders and get their input on potential future reforms to the Practice Expense (PE) data and methodology. We have designated time to allow registered attendees the opportunity to provide verbal feedback on any of the three topics and related questions described in this document.

Registered attendees who would like the opportunity to provide feedback during the town hall need to email CMSPETownHall@rand.org no later than 11:59 PM EDT on June 14, 2021 to indicate their desire to provide verbal feedback and to indicate which topic(s) and questions they would like to address. The sessions are described below in this PE Town Hall Preparation Guide. Given time limitations, not all who desire to provide verbal feedback may be able to do so. However, any interested party is welcome to provide written feedback by June 23, 2021 at 11:59 PM EDT to CMSPETownHall@rand.org on the topics and questions described below in lieu of verbal remarks.

Commenters should limit their feedback to topics that are discussed in this document. Overall Medicare payment rates (as determined by the RVU-to-dollar conversion factor), outlier services that require special attention, and RAND's investigation of using information from the Outpatient Prospective Payment System in PE rate-setting are out of scope for this town hall.

General Background

Payment for the indirect PE associated with delivering Medicare services accounts for roughly a third of total payments made under the Medicare Physician Fee Schedule (MPFS); however, the main source of data that informs how these payments should be distributed across services is approximately 15 years old, and there is currently no strategy for updating these data. Additionally, the process that determines how PE rates are set has not been substantially changed since 2005. In response to concerns that these aspects of the PE valuation data and methodology contribute to potentially misvalued payment rates, RAND has been helping CMS review the data and methodology used to establish PE relative value units (RVUs) and identify potential improvements in how indirect PE is allocated to services (CMS, 2018). (Publicly available

reports on this work can be accessed on RAND's website [Burgette et al., 2018; Burgette et al., 2020].) Stakeholder input on several topics would advance CMS' understanding of these matters. CMS has set up a virtual Town Hall to discuss three areas of potential change: establishing a system of ongoing data collection, collecting PE data by specialty, and improving indirect PE allocation.

This document contains background information on each of the three areas of potential change and includes related questions about which we are soliciting feedback. For participants who would like additional background on the data and methods underlying the Medicare Physician Fee Schedule (MPFS), the text box below includes a general overview.

Overview of the MPFS

Medicare bases its payment rates under the MPFS in part on estimates of the resources used in furnishing each service to a typical patient. The resources that are required to deliver each service in the fee schedule are quantified (or "valued") in terms of relative value units (RVUs), which are determined annually by CMS. There are separate valuations for physician[1] work, PE, and malpractice liability RVUs; together they comprise the core elements of how services are valued. After adjustments for geographic and other sources of variation, payments are then determined through a conversion factor that converts RVUs to a dollar amount for payment (Figure 1).

Figure 1. How payment is determined for services in the MPFS
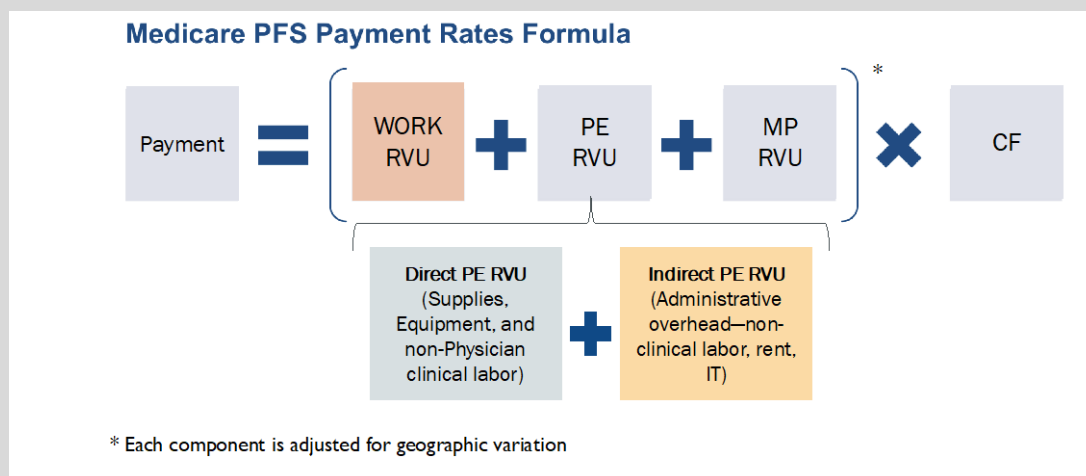
Since the 1990s, when the methods for resource-based PE valuation methods were established, CMS has followed the principle that PE RVUs should be "incentive neutral" so that a physician does not have an incentive to choose to provide one service over another or to practice in one setting over another (PPRC, 1992b). To be incentive neutral, payment rates should be proportional to the resources needed to provide each service. In other words, profitability should be roughly constant across services. If a procedure is overvalued—if its payment rate is out of proportion to the resources required to furnish the service to a typical Medicare beneficiary—Medicare could be wasting resources by paying more than it should and inadvertently creating an

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[1] Here and elsewhere in this document we use the term "physician," though this may include other non-physician practitioners who independently bill Medicare.

incentive for the provision of potentially unnecessary services. Moreover, systematic overvaluation or undervaluation of services furnished by particular specialties could affect physicians' willingness to provide services to Medicare beneficiaries, the income levels of specialties, and by extension the choices of specialty made by new physicians.

In the current system, PE is broken into direct and indirect components. Direct PE includes non-physician clinical labor, disposable medical supplies, and medical equipment that are typically used to provide a service. Indirect PE relates to expenses such as administration, rent, and other forms of overhead that cannot be attributed to any specific service. Indirect practice expenses constitute a substantial portion of the RVUs allocated across the MPFS, accounting for roughly one-third (approximately $30 billion) of MPFS payments in fiscal year 2019, and it plays a significant role in how overall PE is distributed across services.

Direct PE for each service is determined through a bottom-up approach where component costs (e.g., equipment and supply costs) are aggregated at the service level. By definition, indirect PE cannot be directly attributed to particular services, so instead the pool of total indirect PE across all MPFS services is allocated using a top-down approach. The pool of total indirect PE is allocated across most services using a complex, multi-step process that includes a formula that takes into account the physician work associated with the service and the direct costs associated with that service adjusted by a ratio that reflects the cost structures of the specialties that tend to bill for that service (Figure 2). (Modified methods are used for global services and for services with relatively little physician work.)

Figure 2. Allocation of indirect PE
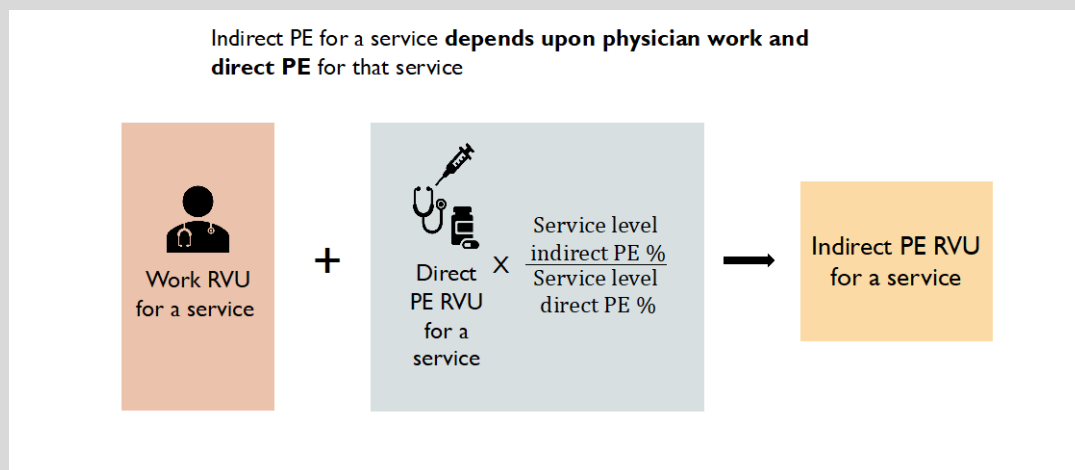
The current process for updating PE RVUs across services relies on a wide variety of sources, some of which are historical and some that are revisited regularly. The American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) reviews information concerning the direct PE inputs submitted by specialty societies and recommends direct PE to CMS for new and potentially misvalued services. Through a similar process, the RUC also provides recommendations on the work RVUs associated with services. A major data source used to determine the distribution of indirect PE comes from the Physician Practice Information (PPI) Survey, most recently conducted in 2007–2008 and reflecting 2006 data, from self-employed physicians and selected non-physician practitioners. This survey largely determines the relative sizes of the overall direct and indirect PE pools, further influencing how PE is distributed.

Topic I. A system of ongoing data collection

Because the data inputs currently used to determine relative indirect PE were last collected through the PPI Survey in 2007 and 2008, they are likely obsolete and inaccurate. Changes in the practice of health care, including ownership structures, affiliation agreements, technology, and regulations, suggest that these data likely no longer reflect physician practice cost structures overall or their distribution across specialty and other practice characteristics. If relative valuation of services is indeed incorrect, it would not only undermine incentive neutrality between services but may also distort patient access to services and physicians (Hsiao et al., 1988; Pope and Burge, 1993; PPRC, 1992a; PPRC, 1992b).

No strategy is in place for keeping these inputs up to date. The PPI Survey and the Socioeconomic Monitoring Survey that preceded it were each used for approximately a decade without significant updates. Additional negative consequences of this beyond potentially misvalued payments include 1) the use of supplemental data for some specialties that felt that their PE values were either inadequately or inappropriately measured, creating inconsistencies in the timing and methods of data sources used, and 2) potentially disruptive specialty impacts when data are updated, necessitating lengthy phase-in periods. ***These deficiencies have yielded ongoing public comments and numerous methodological reviews recommending that CMS establish an ongoing system of data collection to ensure current and accurate inputs to determine PE RVUs*** (HCFA, 1998; GAO, 2001; GAO, 2004; Hackbarth, 2012; MEDPAC, 2011).

Approaches

The goals for a new system of collecting PE data would likely include that the data be accurate, representative, consistent across specialties, and updated frequently enough to avoid disruptive fluctuations in payments from year to year. As PE data are updated, they should reflect market-level changes caused by practices entering or exiting the market as well as changes that occur within practices over time, as both may be important to the cost of delivering care. Another goal may be to collect data, such as on practice characteristics and patterns, that enable methodological improvements to the MPFS system. Whichever goals are chosen, they must be balanced with limiting the burden of data collection on the community of practices.

Using these and other considerations, RAND investigated several approaches to recurring data collection of detailed expense data from Medicare practices, ranging from a system of universal cost reporting to survey-based approaches (Figure 3). Recurring, survey-based approaches would avoid the burden that universal cost reporting would impose and were therefore investigated in greater depth.

Figure 3. Approaches to a system of ongoing data collection
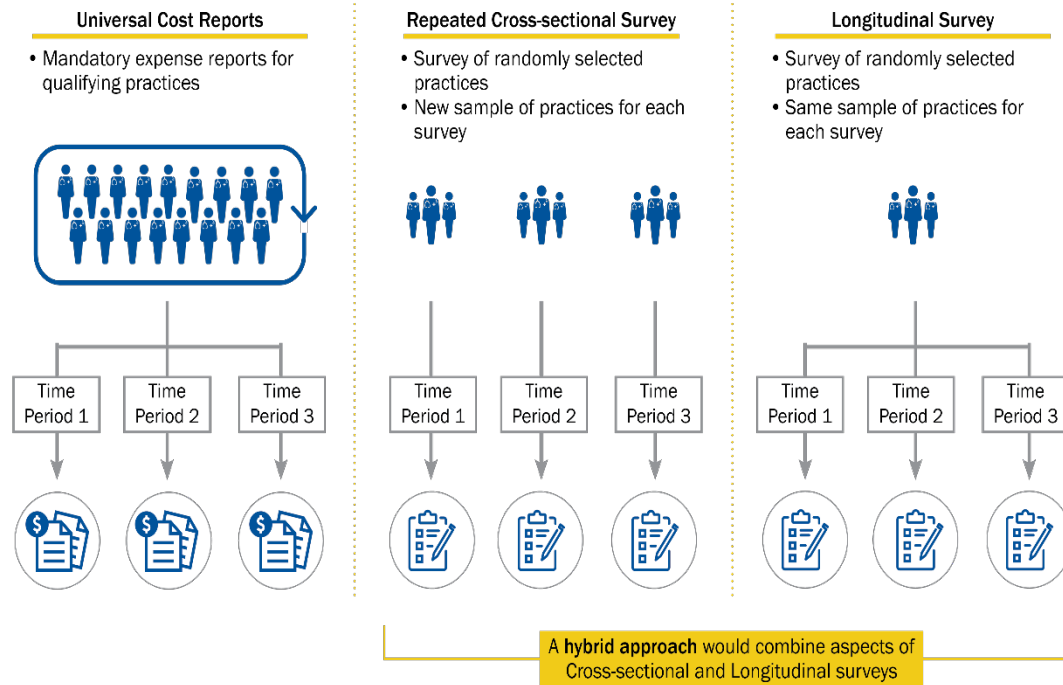
Possible approaches investigated for an ongoing PE survey include repeated cross-sections in which a new sample of practices is selected during each wave of data collection; longitudinal surveys that track individual practices over time; and a hybrid approach that combines aspects of the two. The general capabilities of each include:

- *Repeated cross-sectional survey.* Cross-sectional surveys are capable of generating point-in-time market-level statistics but are not capable of tracking practice-level changes over time. Data from repeated cross-sections are less useful than data from the other approaches for causal inference regarding observed changes, i.e., understanding what causes PE to increase or decrease.
- *Longitudinal survey.* Longitudinal data are capable of tracking practice-level changes but may have difficulty tracking market-level changes and maintaining representativeness. Longitudinal data collection is more useful than other approaches for making causal inferences and likely better suited to efforts to understand how and why PE is changing. This may be useful in evaluating the effects of policy and programs on practices. In addition, if responding to repeated surveys for individual practices becomes easier over time, longitudinal designs will have comparatively low survey burden across the population compared to repeated cross-sections.
- *Hybrid survey.* Hybrid approaches can capitalize on the advantages of both longitudinal and cross-sectional approaches and are well-suited for data collection efforts with needs for both respondent-level and market-level statistics. However, hybrid approaches are more complex to implement and analyze and can present tradeoffs that can limit some benefits of the other "pure" cross-sectional and longitudinal options.

An example of a hybrid survey design that may be well suited for updating PE and tracking physician practices is the rotating panel design, which is used by the Medicare Current Beneficiary Survey and Medical Expenditure Panels Survey. In a rotating panel, respondents are enrolled for a fixed term in panels that overlap and can be combined to efficiently produce representative statistics of market-level changes in PE (Figure 4). This approach would produce gradual updates in inputs over time to keep them current and could serve as a vehicle for rapidly collecting information from practices on an as-needed basis. A practice panel or similar system of data collection could also provide a formalized channel of communication between CMS and a representative sample of practice managers and physicians.

Figure 4. Hybrid approach: rotating panel illustration
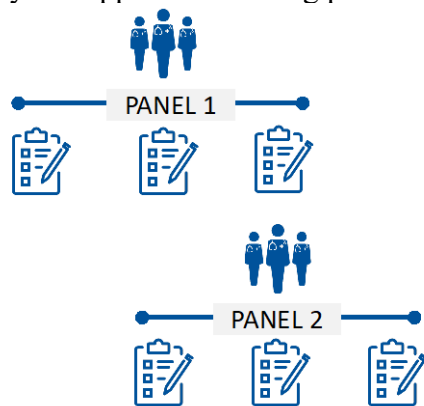
Encouraging participation

A challenge to collecting new PE data on a voluntary basis will be achieving adequate participation. Past efforts to update indirect PE data have often struggled to achieve representation across specialties that all stakeholders found acceptable. Even in efforts where sample targets were met, response rates have been low. The response rate for the PPI Survey was 12 percent, with only half of those having provided responses used to calculate PE inputs (Kane and Emmons, 2013). Surveys of physicians that inform valuation of work RVUs and direct costs had a median response rate of just over 2 percent in 2015 (GAO, 2015). The prospect of low response rates or resulting small sample sizes on a future data collection effort may cause concern among stakeholder groups that the practices that participate are not representative.

Generally speaking, incentives and outreach can be effective in boosting survey participation. Although CMS is often limited in its options to incentivize reporting activities, some approaches to improve participation could include:

- Involving stakeholder groups in data collection and effectively communicating the importance of accurate PE data
- Financial compensation for staff time
- Credits toward trainings or assistance in business and accounting methods
- Personalized benchmarking reports to provide participants with feedback on how their practice compares with peers

- Non-monetary incentives, such as credit toward MIPS requirements or certifications.

Participation for a survey that targets practices may also depend upon identifying and reaching an appropriate point of contact. This person may need to gather responses from several members of the practice and understand where to access information on practice expenses, labor force, and other characteristics.

Questions

- Planned, recurring updates to data collection could allow for timely, more accurate PE valuation. In what timeframe would you say the components of PE for your specialty change in ways that are important for rate-setting? Yearly? Every other year? Every five years? Every ten years?
  - Have disruptions related to COVID-19 affected how you think about this?
- What approach would you recommend that CMS take to update PE data on a regular basis? What is most important to you in how such a system would be designed?
- Historically, PE survey contractors have struggled to find physicians willing to participate. How could CMS and a future survey contractor best encourage participation, without resorting to punitive measures?
  - Which incentives discussed thus far would be most appealing to you?
- Who in your practice would be the best point of contact to complete a survey on practice expenses?

Topic II. Collecting PE Data by Specialty

Although all specialties are paid the same amount for a particular service, the current PE algorithm uses specialty-specific inputs in the valuation process. A ratio that reflects the cost structures of the specialties that tend to bill for that service adjusts some of the inputs that determine how indirect PE is allocated across services, and specialty-level measures define pools of indirect PE. To allocate indirect PE to a particular service, PE statistics from the specialties that bill Medicare for that service are combined and weighted by utilization for use in the indirect PE allocation formula (Figure 5). In this way, specialty is used as a mechanism to adjust the indirect costs associated with a service to more closely reflect the relative indirect costs of the setting in which that service is typically performed. To be able to calculate these adjustments, the PPI survey collected data from 42 specialty strata to estimate specialty-specific cost structures (Kane and Emmons, 2013). Using the PPI and data from prior supplemental surveys, current policy recognizes 52 unique PE per hour measures across 72 billing specialties. As new specialty groups form, public commenters often urge CMS to recognize more distinct specialties for rate-setting purposes (CMS, 2018).

Figure 5. The role of specialty in the allocation of indirect PE
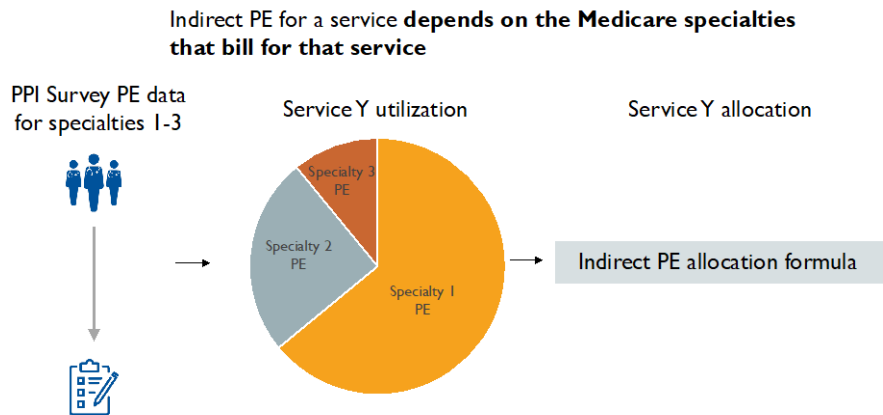
However, the number of specialties that are currently treated as distinct in the PE algorithm presents several issues, particularly if data are to be updated. First, sample sizes and precision targets for many specialty-specific statistics have in the past fallen well short of goals, despite considerable efforts to reach them, and a broad trend toward declining survey response rates may make this challenge even greater. Inconsistent precision in inputs across specialties differentially exposes specialties to error in both their own data and in the data of *other* specialties. (In an illustration using real specialty-level PPI data for hypothetical Service Y, Figure 6 shows how poorly estimated cost structures of a single specialty can negatively impact allocation of services billed by other specialties. Here, the low-precision estimate from Specialty 2 would be bringing down the indirect PE allocated to a service also billed by Specialties 1 and 3.) Second, collecting data from many distinct specialties, particularly those whose data would be largely swamped by specialties with overlapping service distributions, is burdensome relative to any increases in precision that could be attained with fewer specialty groupings.

Figure 6. Illustration of how imprecise data in one specialty affects payment in other specialties
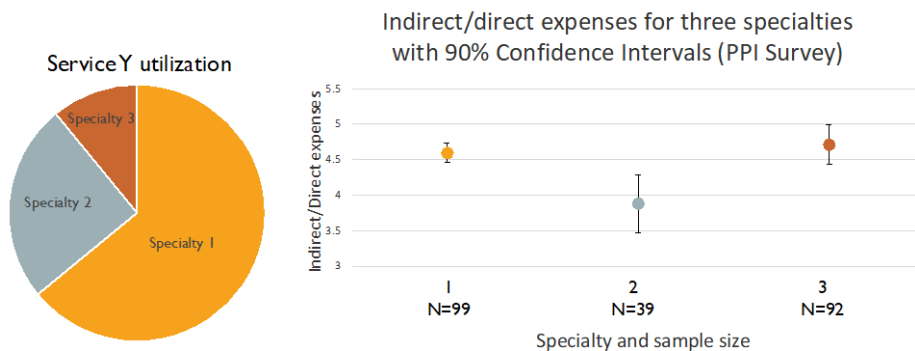
Note: Illustrative example using data from the PPI Survey applied to a hypothetical service. 90% Confidence Intervals on transformed statistics approximated based upon SE of PE/HR

Approaches

Issues leading to imprecise PE data could be addressed under alternative methods of allocation that do not rely exclusively on specialty-level inputs. One such method is explored under Topic III of this document. However, assuming that specialty is retained as the basis for adjusting the indirect costs of particular services, specialty-level surveys will continue to be necessary to update MPFS inputs. In this case, if one or more specialties does not produce enough completed survey responses to provide precise estimates, CMS could:

1. <u>Use only the reported values that meet acceptable precision targets.</u> This approach could potentially throw out informative data and leave many specialties without estimates that would need to be cross-walked from similar specialties. There could also be pressure on CMS to relax acceptable precision thresholds for groups that do not reach them.
2. <u>Combine data from specialties that do not meet precision targets with those of similar specialties.</u> Insufficiently precise specialty data might be grouped on the basis of pre-identified specialties that likely share similar cost structures based upon observable criteria.
3. <u>Use a weighted average of the values reported by similar specialties.</u> Specialties that do not achieve target precision could use PE per hour measures that incorporate information from specialties with similar PE structures. The level of imprecision in a specialty's data would dictate how much it would rely on data from other specialties. Thus, specialties with relatively worse precision in PE data would "borrow" more heavily from other specialties than specialties whose own data falls just short of target precisions. Specialties that achieve target precisions could retain PE per hour measures based entirely on their own data.

An advantage of approaches that allow combining or sharing of data across specialties, such as options 2 and 3, is that it would be more feasible to regularly update practice expense inputs with a substantially smaller survey effort than what would be necessary if the current specialty-level inputs are retained. These approaches may also reduce false precision by assigning shared specialty-level inputs to groups of similar specialties rather than attempting to produce specialty-specific values that may reflect substantial statistical noise due to small sample sizes.

Questions

- What process would you recommend CMS use to identify groups of specialties with similar cost structures?

Topic III. Improving Indirect PE allocation

Since the resource-based relative value scale system was first implemented, the appropriate method of allocating indirect PE among services has been debated, but the methods used to

allocate indirect PE have not been substantially changed since calendar year 2007 (CMS, 2006). Requirements for a new or updated allocation method might include that it should, when possible, reflect relative differences in indirect PE among services and be standardized across common PE components. It must also not be needlessly complex.

There are a number of potential flaws in the current indirect PE allocation. In the current system, indirect PE—expenses such as administration, rent, and other forms of overhead that cannot be attributed to any specific service—is allocated across most services using a formula that takes into account the physician work and direct PE associated with each service (See Figure 2 in the MPFS overview for further detail). This methodology assumes that indirect costs scale linearly with physician work and direct costs, but the appropriate relationship may be more complicated. All else being equal, a service that is assigned twice as many work RVUs and twice as much direct PE as another service would also be allocated twice as much indirect PE. However, some types of indirect costs do not necessarily vary with the level of work and direct practice expense inputs. For example:

- Services with substantial direct costs, such as high equipment costs, may get a large amount of indirect costs allocated even if the overhead and administrative costs are no more costly than for services that do not require expensive equipment. This may result in overvaluation of some services using expensive equipment and therefore, because of budget neutrality, contribute to an undervaluation of other services.
- Billing and other administrative costs are not likely to vary across broad classes of services. The costs are more likely related to service volumes than to direct input costs and physician work. Not appropriately accounting for these kinds of expenses may contribute to an undervaluation of high-volume services with low direct costs or work.
- Portions of what is currently classified as indirect costs may be related more closely to physician time than work. Use of work RVUs to allocate indirect costs may overstate the indirect practice expense used to furnish high-intensity services and therefore, because of budget neutrality, contribute to an undervaluation of other services.

Moreover, new types of services may not be well accounted for in the current methodology. For instance, artificial intelligence (AI) tools are starting to be used in clinical settings, e.g., to interpret images from eye exams. When practices pay for these tools on a per-use basis, there are questions as to whether the fee should be considered a direct or indirect expense. The current methodology currently considers IT expenses as part of indirect costs, but like other direct expenses, the per-use cost of AI tools can be easily and exclusively tied to a specific patient encounter. However, an issue with treating AI tools or similar services as a direct expense under the current methodology is that indirect PE would also be paid with each use even though little additional indirect PE may actually be incurred. Transitioning away from classifying expenses into indirect/direct pools and updating the methodology could provide flexibility for these new expense types.

Approaches

The current system of PE allocation assumes that, within a specialty, a service with twice the work RVUs and twice the direct costs should be allocated twice as much indirect PE. Imagine two practices within a particular specialty, one of which performs a higher volume of services

that require expensive equipment. If running the practice with higher a volume of services that depend on the expensive equipment does not result in proportionally higher indirect PE, that would suggest that the allocator should be revisited for the sake of fairness.

Breaking the current indirect pool into less aggregated expense categories may provide a path forward to address this issue. Rather than assuming that all components of indirect PE scale consistently, it may be possible to specify allocation rules for sub-components of indirect PE such as scheduling and billing, physician office space, and information technology.

Considering the indirect components individually may also make it possible to identify types of indirect PE that are generally similar across specialties, when allocated on an appropriate basis. If, for example, the cost of obtaining and maintaining electronic medical records (EMR) systems does not vary substantially by specialty, EMR expenses could be removed from the current indirect pool and allocated separately. Taking such action could provide at least two advantages. First, it could improve fairness: If there truly are no systematic differences in the expense across specialties, a PE allocation system that recognizes this fact will eliminate the risk that one specialty is disadvantaged due to the vagaries of data collection. Second, survey data on expense types that are common across large collections of practices would not need to be collected from all practices, since a sub-sample could provide an adequate sample size to yield precise estimates.

A system that better recognizes common expense types across broad groups of specialties could also be used to improve PE measurement for practices that deviate from the broad groups. For example, certain services may require a room with lead shielding. An allocation system that focuses more on variation in PE across services than across specialties could measure the excess costs of building and maintaining such a space.

One barrier to improving the allocator is that good data to lend evidentiary support to specific reforms do not currently exist. While some stakeholders have advocated collecting the minimum information required to update inputs to the current methodology to limit survey burden, more detailed PE or other information that goes beyond these purposes—such as practice, patient, or payment characteristics—could be useful to develop and supply methods that allow for more nuance in how PE data are allocated.

Questions
- Would you support a movement away from specialty-based PE allocation to a system that focuses on indirect PE requirements for specific types of services?
- If the current system based on direct and indirect PE is maintained, do you recommend any changes in which expenses are classified as direct versus indirect? How should new expense types be incorporated in PE rate-setting?
- Do you feel that CMS should collect data to facilitate the development of an updated PE allocation methodology? Or do you think the current indirect PE allocation system would be adequate if the PE per hour inputs were updated?

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