

IMPROVING DATA AND METHODS RELATED TO INDIRECT PRACTICE EXPENSE IN THE MEDICARE PHYSICIAN FEE SCHEDULE

A VIRTUAL TOWN HALL MEETING

RAND Corporation, 6/16/21

TOWN HALL AGENDA

- Welcome and background
 - Meeting objectives
 - Overview of indirect PE determination in Medicare Physician Fee Schedule (MPFS)
- Topic I. Establishing a system of ongoing data collection
- Topic II. Collecting PE data by specialty
- Topic III. Improving indirect PE allocation

OBJECTIVES

- **Inform:** CMS is interested in improving the data and/or methodology for allocating indirect PE in the MPFS.
- **Involve:** RAND is engaging stakeholders to provide input while CMS considers data or methods improvements.
- **Build a Common Understanding:** Stakeholders can work toward establishing agreement on a fair process for yearly updates to the fee schedule.

OUT OF SCOPE

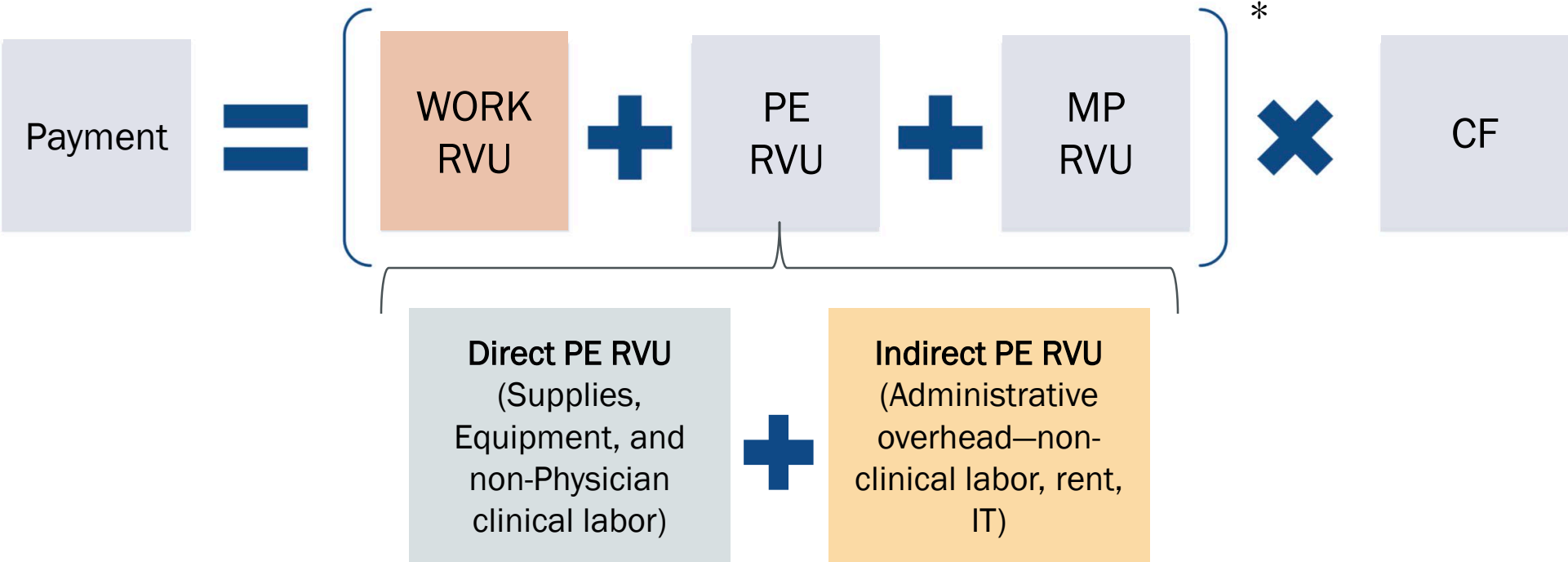
- **Overall Payments:** RAND has not been charged with investigating whether physicians are over- or under-compensated on average.
- **Outlier services:** This discussion is not focused on service payments that will need special consideration in how they are set, only on the standard data and methodology.
- **OPPS:** RAND has been investigating use of information from the Outpatient Prospective Payment System in PFS rate-setting. This is not our focus today.

GENERAL DISCLAIMER

The content presented here was developed by the RAND Corporation under contract HHSM-500-2014-00361, Task Order HHSM-500-T0004 and does not necessarily reflect the views or agenda of CMS.

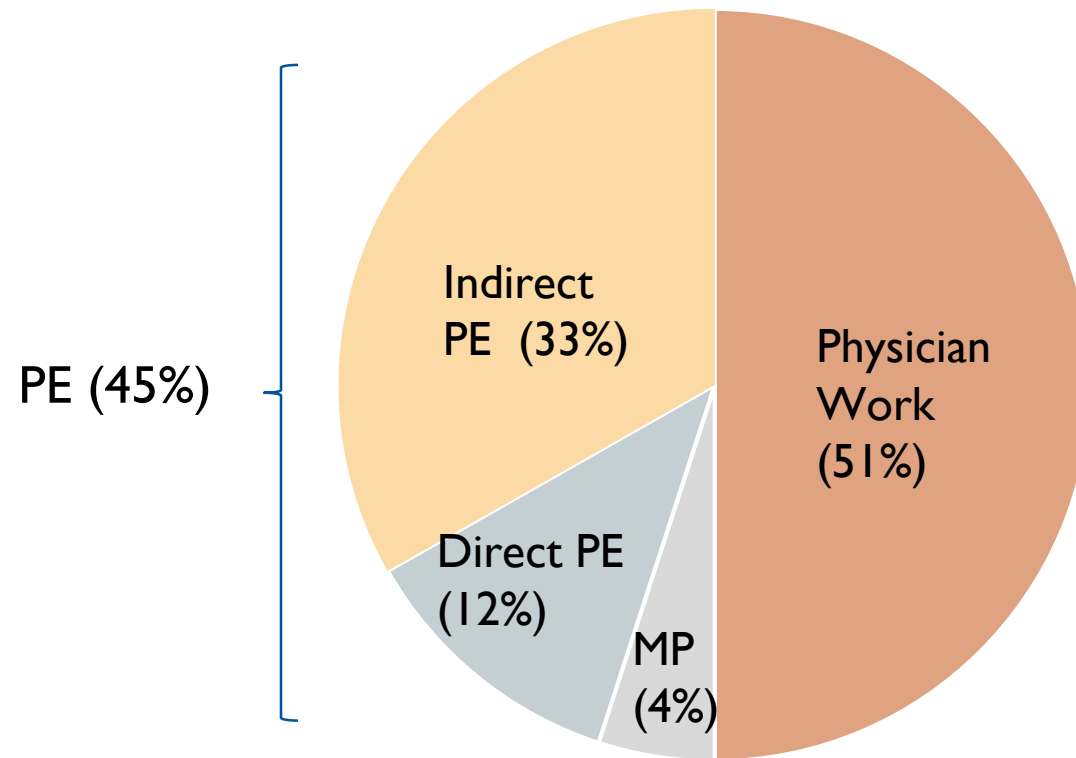
HOW PAYMENT IS DETERMINED FOR SERVICES IN THE MPFS

Medicare PFS Payment Rates Formula



* Each component is adjusted for geographic variation
Graphic adapted from Medicare Learning Network Booklet, MLN901344, March 2021

INDIRECT PE IS A SUBSTANTIAL PART OF NATIONAL PAYMENTS

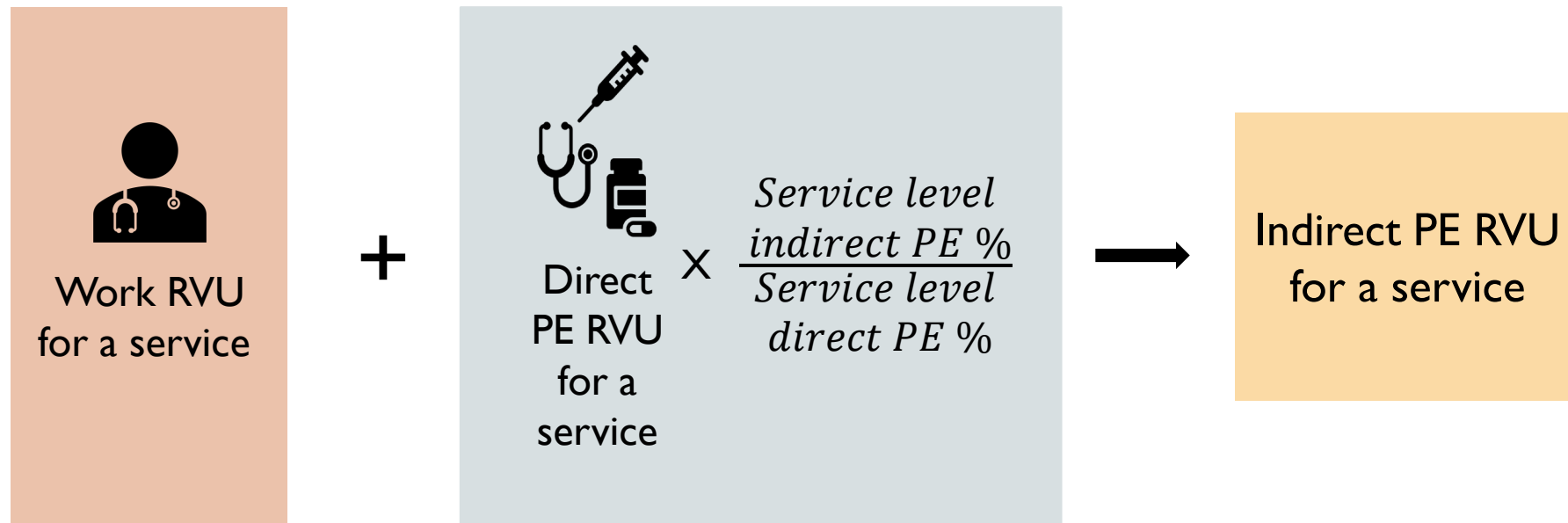


KEY CHARACTERISTICS OF HOW INDIRECT PE IS DETERMINED

- 1 Like other MPFS components, the amount of total **indirect PE is fixed**
- 2 Indirect PE for a service **depends upon physician work, direct PE**, and the Medicare specialties that bill for that service
- 3 A major source of **data** used to determine the relative size of total indirect PE and how it is distributed across services **comes from the PPI Survey of 2007-2008**

ALLOCATION OF INDIRECT PE

Indirect PE for a service **depends upon physician work and direct PE** for that service



ISSUES WITH INDIRECT PE DATA AND METHODS

1) Data

- Outdated and no mechanism for updating
- Not equipped to inform methodological revisions
- New data collection is likely to be difficult

2) Methods

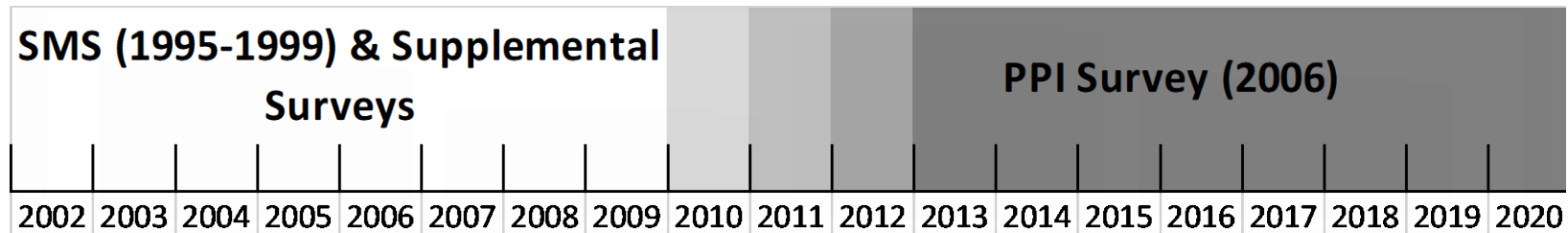
- One-size-fits-all indirect allocator
- Not adaptable to new types of services
- Specialty-based allocation could be improved

CONSEQUENCES OF DEFICIENT DATA AND/OR METHODS

- Service-level
 - Improper allocation of PE across services may limit access to certain services
 - Patients may pay relatively too much or little for particular services
- Practice-level
 - Incorrect relative payments for indirect costs among practices can cause labor market distortions that may affect access to certain specialties

TOPIC I. A SYSTEM OF ONGOING DATA COLLECTION

TIMELINE OF UPDATES TO INDIRECT PE DATA



- Data collection for PE has been irregular and haphazard
 - Early data were not designed for PE
 - Specialty supplements created inconsistencies
 - Infrequent updates can produce large changes in payments
 - Updated data old by the time they are in use

POSSIBLE GUIDANCE FOR DATA COLLECTION

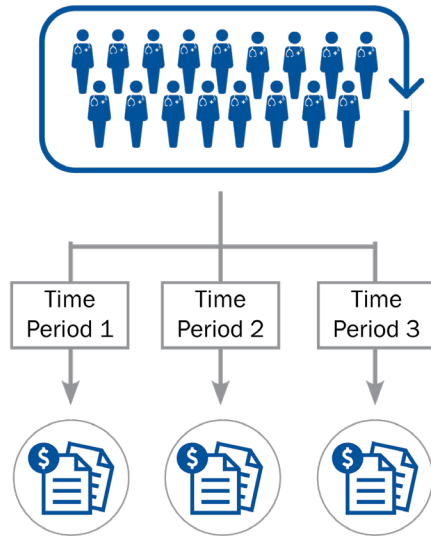
Data should:

- Be timely, accurate, representative, and consistent across specialties
- Be collected efficiently and limit burden on the community
- Avoid large fluctuations in payments from year-to-year
- Enable improvements to the MPFS methodology

APPROACHES TO PERIODIC DATA COLLECTION

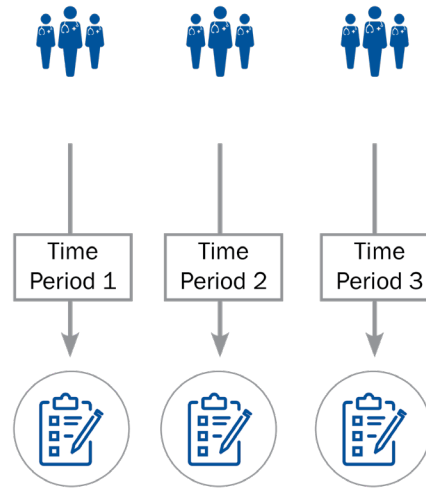
Universal Cost Reports

- Mandatory expense reports for qualifying practices



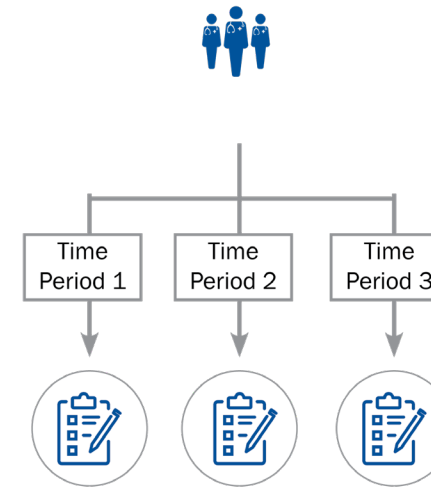
Repeated Cross-sectional Survey

- Survey of randomly selected practices
- New sample of practices for each survey



Longitudinal Survey

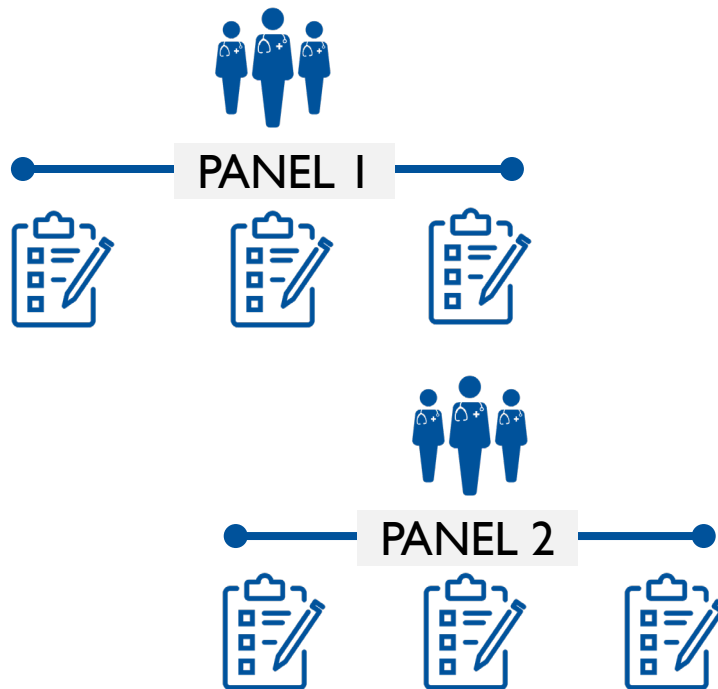
- Survey of randomly selected practices
- Same sample of practices for each survey



A hybrid approach would combine aspects of Cross-sectional and Longitudinal surveys

HYBRID APPROACH: ROTATING SURVEY PANEL OF PRACTICES FOR COLLECTING PE

ROTATING PANEL



- Overlapping longitudinal surveys of fixed length
 - MCBS
 - MEPS

SOME ADVANTAGES OF A ROTATING PRACTICE PANEL

- Combines statistical efficiency, lower burden, and functionality of longitudinal data with ability to track market changes and maintain representativeness
- Produces smooth changes in inputs over time due to overlapping samples
- Is a possible vehicle for collection of practice information related to PE, such as practice patterns
- Provides CMS with a channel of communication with practice managers and physicians that could produce information on a range of issues surrounding PE and the MPFS

HOW FREQUENTLY DO PRACTICE EXPENSES CHANGE?

Direct PE RVU

- Medical supplies and services
- Medical equipment
- Non-physician clinical labor

Indirect PE RVU

- Non-clinical labor
- Lease or Rent
- Office services
- Office Supplies and Equipment
- IT
- Professional services

IMPROVING PARTICIPATION

- Achieving an adequate response rate is a major stumbling block to data collection efforts
 - Specialties want adequate representation
 - Low response threatens precision and representativeness
- Prior efforts at data collection have struggled with low response rates

POTENTIAL APPROACHES TO IMPROVE PARTICIPATION

- Effective communication and involving stakeholders
- Financial compensation for staff time
- Provision of credits towards trainings or assistance in business and accounting methods
- Personalized benchmarking reports
- Other non-monetary incentives

TOPIC II. COLLECTING PE DATA BY SPECIALTY

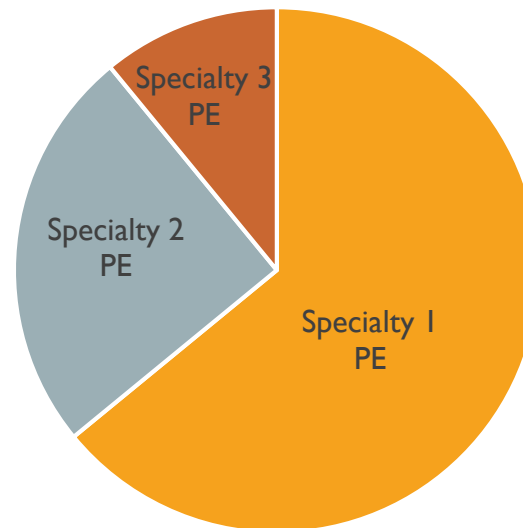
THE ROLE OF SPECIALTY IN THE ALLOCATION OF INDIRECT PE

Indirect PE for a service **depends on the Medicare specialties that bill for that service**

PPI Survey PE data for specialties 1-3



Service Y utilization



Service Y allocation

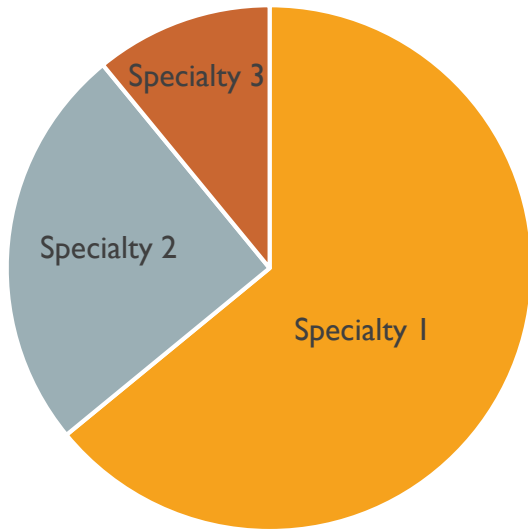
Indirect PE allocation formula

NUMBER OF DISTINCT SPECIALTIES

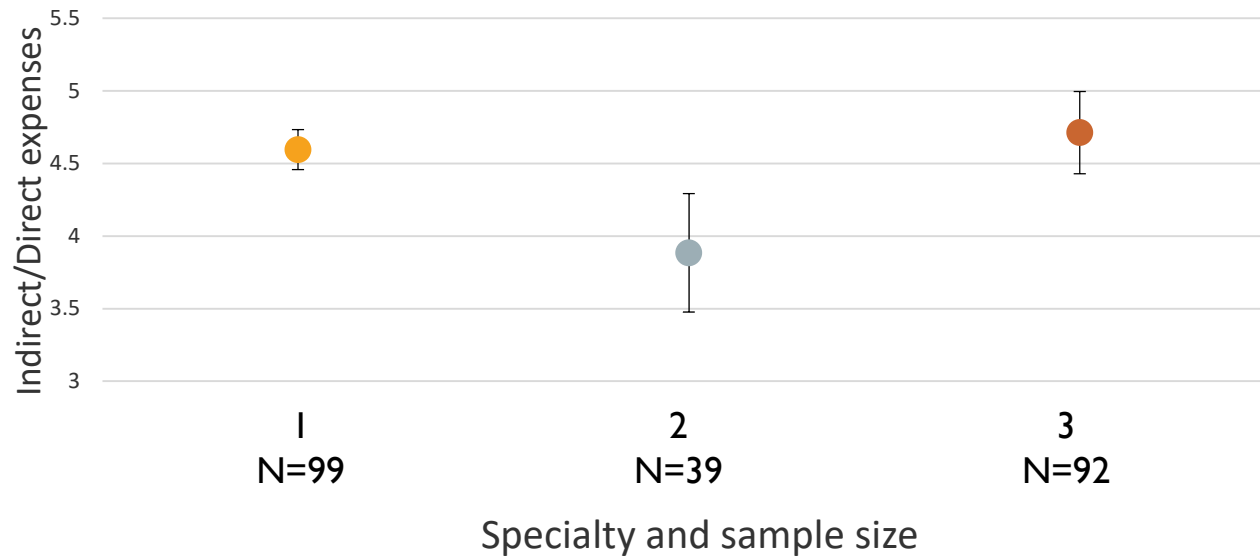
- Current statistics for some specialties are imprecise
- Collecting data from many distinct specialties is burdensome and costly
- Public commenters often encourage CMS to recognize *more* distinct specialties for rate-setting purposes
 - More specialties risks smaller samples
 - Specialties differentially exposed to sampling error in both their own and in *other* specialties

COMBINING ESTIMATES ACROSS SPECIALTIES

Service Y utilization



Indirect/direct expenses for three specialties with 90% Confidence Intervals (PPI Survey)



Note: Illustrative example using data from the PPI Survey applied to a hypothetical service.

90% confidence intervals on transformed statistics approximated based on standard error of PE per hour. 24

HANDLING IMPRECISE SURVEY ESTIMATES

- There are several possible approaches if one or more specialties do not produce enough completed survey responses to provide precise estimates
 - Use only the reported values that meet acceptable precision targets
 - Combine data from that specialty with those of one or more specialties that provides similar services for the sake of PE rate-setting
 - Use a weighted average of the values reported by that specialty and other similar specialties (i.e., each specialty gets its own PE/HR measures, but low precision specialties borrow information from similar specialties)

QUESTIONS FOR STAKEHOLDER FEEDBACK

- 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?

QUESTIONS FOR STAKEHOLDER FEEDBACK (2)

- 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?

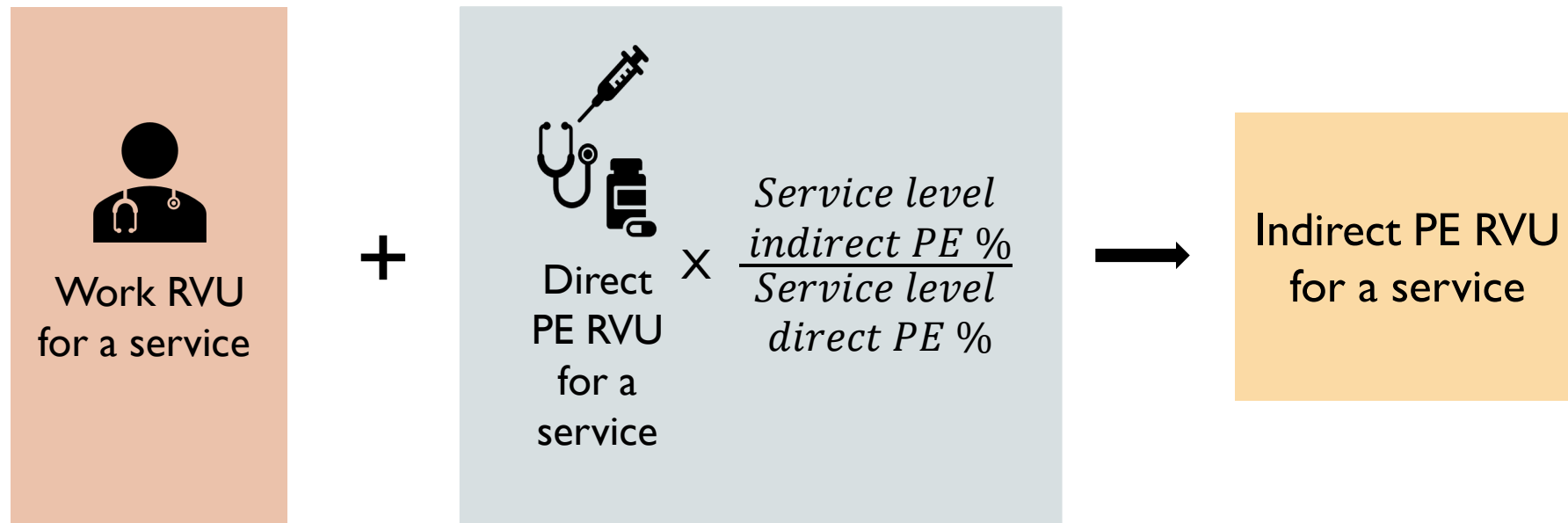
QUESTION FOR STAKEHOLDER FEEDBACK (3)

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

TOPIC III. IMPROVING ALLOCATION

ALLOCATION OF INDIRECT PE (2)

Indirect PE for a service **depends upon physician work and direct PE** for that service



POSSIBLE GUIDANCE FOR ALLOCATION METHODS

Allocation methods should:

- Reflect relative differences in indirect PE among services when possible
- Be standardized across common PE components when possible
- Avoid needless complexity

POTENTIAL FLAWS IN INDIRECT PE ALLOCATION

- 1) Current allocation formula for indirect PE based on physician work and direct costs for a procedure may be flawed for some types of indirect PE
 - Higher direct costs may not always indicate proportionately higher indirect costs (e.g., high equipment costs)
 - Some indirect costs may be better captured if allocated equally across classes of services (e.g., billing, scheduling)
 - Some indirect costs may be more closely related to clinical time than work (e.g., EMR costs)
- 2) New types of services may not be well accounted for in current methodology

WHAT IS DIRECT? WHAT IS INDIRECT?

Direct PE
(Medical Supplies,
Equipment, and
non-Physician
clinical labor)

Indirect PE
(Administrative
overhead—non-
clinical labor, rent,
IT)

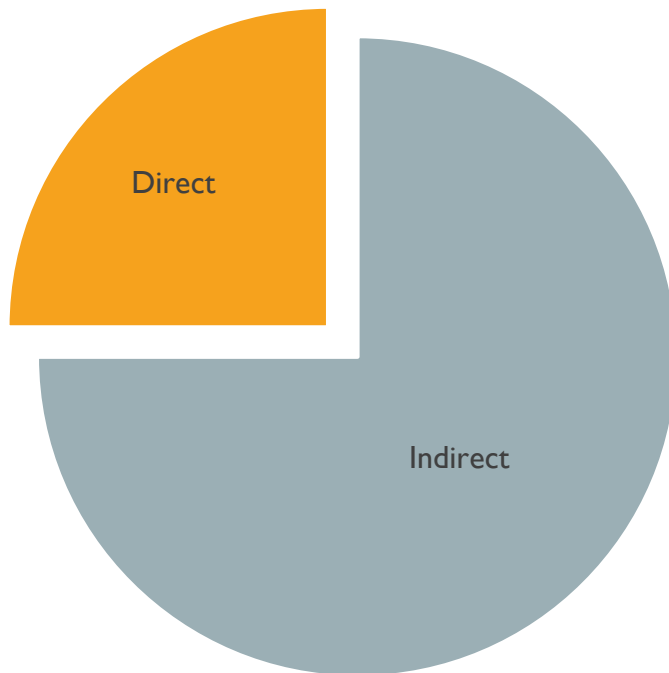
- Concerns are frequently raised about costs inappropriately treated as direct or indirect expenses
- Some expense categories may not neatly fit into either direct or indirect pools
 - Staff time
 - Computers and other electronic devices used in the clinical setting
 - EMR expenses
 - AI screening services

EXAMPLE: “PER CLICK” FEES

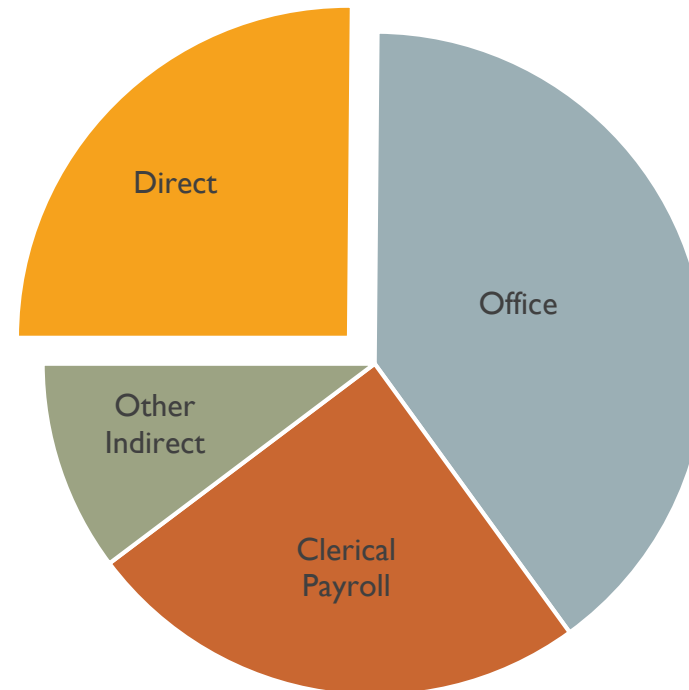
- Artificial Intelligence (AI) tools are starting to be used in clinical settings, e.g., to interpret images from eye exams
- When practices pay for these tools on a per-use basis, there are questions as to whether the payment should be paid as a direct or indirect expense
 - AI tools are not accounted for in current data
 - Practices may incur an expense that is directly tied to a specific patient encounter
 - Little additional indirect PE may be incurred for such services
- Transitioning away from rigid indirect/direct pools could provide flexibility for new expense types such as AI tools

ALTERNATIVE POOLS

Current PE pools



Example alternative PE pools



Note: Proportions reflect differences in mean PE per hour for all physicians using PPI data (2007-2008)

EXAMPLE ALTERNATIVE ALLOCATORS

- Clerical staff
 - Clerical staff cost per patient encounter
- EMR
 - $(\text{EMR cost} / \text{HR}) * (\text{Clinical time})$
- Clinical space
 - $(\text{Sq. ft. required}) * (\text{Utilization rate}) * (\text{Cost} / \text{sq. ft.}) * (\text{Clinical time})$

BEYOND SPECIALTY?

- In PE rate-setting, specialty serves as a proxy for the types of services that a practice provides
- A more direct approach would be to identify classes of services that require specific practice expenses, relative to a broad group of practice types (e.g., office-based primary care)
- If portions of what is currently considered indirect PE were measured across relatively large groups of specialties, smaller sample sizes could produce statistically precise estimates of the portions of PE that vary by specialty or specific types of services

WHAT DATA SHOULD BE COLLECTED?

Direct PE

Indirect PE

- Some stakeholders have advocated collecting the minimum information required to update inputs to current methodology
- However, additional data could be useful to develop and supply methods that allow for more nuance in how PE is allocated
- In public comments we've seen some concerns that – all else being equal – more indirect PE is allocated to services that are “high intensity” (i.e., high work per unit time) or that involve expensive equipment or supplies
 - More detailed data collection could facilitate improved methods of allocation for such services

QUESTIONS FOR STAKEHOLDER FEEDBACK (4)

- 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?