United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

For Release on Delivery
Expected at 12:00 Noon
Tuesday, March 3, 1998

MEDICARE

HCFA Can Improve Methods for Revising Physician Practice Expense Payments

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GAO/T-HEHS-98-105

Medicare: HCFA Can Improve Methods for Revising Physician Practice Expense Payments

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the efforts of the Health Care Financing Administration (HCFA) to revise the practice expense component of Medicare's physician fee schedule. The Medicare program uses a fee schedule, implemented in 1992, that specifies the payments to physicians for each of over 7,000 services and procedures. In 1997, the physician fee schedule payments totaled about $43 billion.[1] The fee schedule system was intended to relate Medicare's payments to three categories of resources used to provide a service—physician work,[2] practice expenses, and malpractice expenses. Currently, only the physician work component, which accounts for about half the payment for each procedure, is resource-based. The practice expense and malpractice expense components, which account for about 41 percent and 5 percent, respectively, of the fee schedule allowances, are still based on historical charges for physician services.

In the Balanced Budget Act of 1997,[3] the Congress asked us to evaluate HCFA's proposed fee schedule revisions published in a June 18, 1997, notice of proposed rulemaking and the impact of those revisions on access to care. Our report, Medicare: HCFA Can Improve Methods for Revising Physician Practice Expense Payments,[4] provides a detailed analysis of the methods HCFA used to develop the June 1997 proposed rule. In my testimony today I will provide an overview of the challenges involved in revising the fee schedule and some problems HCFA will have to resolve as it moves toward implementing the revisions in January 1999.

In summary, HCFA's general approach for collecting information on physicians' practice expenses was reasonable. HCFA convened 15 panels of experts to identify the resources associated with several thousand services and procedures. These resources include physicians' equipment and supplies, and the time of physicians' staff, such as nurses, technicians, and billing clerks. Other approaches for collecting these data, such as mailing out surveys and gathering data on-site, may be useful supplements to

[1]For each service or procedure, Medicare pays 80 percent of the allowed amount set by the fee schedule, and Medicare patients are responsible for the remaining 20 percent. In this testimony, we refer to the Medicare fee schedule allowance as the Medicare payment.

[2]Physician work is based on the time the physician spends, the intensity of effort and level of skill required, and stress as a result of the risk of harm to the patient.

[3]Sec. 4505, P.L. 105-33, 111 Stat. 251, 435, Aug. 5, 1997.

[4]GAO/HEHS-98-79, Feb. 27, 1998.

HCFA's use of expert panels, but they would not be practical approaches for the primary data gathering.

HCFA made various adjustments to the expert panels' data that were intended to (1) convert the panels' estimates to a common scale, (2) eliminate expenses reimbursed to hospitals rather than to physicians, (3) reduce potentially excessive estimates, and (4) ensure consistency with aggregate survey data on practice expenses for equipment, supplies, and nonphysician labor. While we agree with the intent of these adjustments, we believe some have methodological weaknesses, and other adjustments and assumptions lack supporting data.

HCFA has done little in the way of performing sensitivity analyses that would enable it to determine the impact of the various adjustments, methodologies, and assumptions, either individually or collectively. Such sensitivity analyses could help determine whether the effects of the adjustments and assumptions warrant additional, focused data gathering to determine their validity. We believe this additional work should not, however, delay phase-in of the fee schedule revisions.

Since implementation of the physician fee schedule in 1992, Medicare beneficiaries have generally experienced very good access to physician services. The eventual impact of the new practice expense revisions on Medicare payments to physicians is unknown at this time, but they should be considered in the context of other changes in payments to physicians by Medicare and by other payers. Recent successes in health care cost control are partially the result of purchasers and health plans aggressively seeking discounts from providers. How Medicare payments to physicians relate to those of other payers will determine whether the changes in Medicare payments to physicians reduce Medicare beneficiaries' access to physician services. This issue warrants continued monitoring, and possible Medicare fee schedule adjustments, as the revisions are phased-in.

Background

The Social Security Act Amendments of 1994[5] required the Secretary of Health and Human Services to revise the fee schedule by 1998 so the practice expense component would reflect the relative amount of resources physicians use when they provide a service or perform a procedure. The legislation required that the revisions be budget neutral—in other words, Medicare payments for practice expenses could increase for some procedures and decrease for others, but the revisions

[5]Sec. 121, P.L. 103-432, 108 Stat. 4398, 4408, Oct. 31, 1994.

must not increase or decrease total Medicare payments. Physicians could, however, experience increases or decreases in their payments from Medicare, depending on the services and procedures they provide.

HCFA published a notice of proposed rulemaking in the June 18, 1997, Federal Register describing its proposed revisions to physician practice expense payments. HCFA estimated that its revisions, had they been in effect in fiscal year 1997, would have reallocated $2 billion of the $18 billion of the practice expense component of the Medicare fee schedule that year. The revisions would generally increase Medicare payments to physician specialties that provide more office-based services while decreasing payments to physician specialties that provide primarily hospital-based services. The revisions could also affect physicians' non-Medicare income, since many other health insurers use the Medicare fee schedule as the basis for their payments. Some physician groups argued that HCFA based its proposed revisions on invalid data and that the reallocations of Medicare payments would be too severe. Subsequently, the Balanced Budget Act of 1997 delayed implementation of the resource-based practice expense revisions until 1999 and required HCFA to publish a revised proposal by May 1, 1998. The act also required us to evaluate the June 1997 proposed revisions, including their potential impact on beneficiary access to care.

HCFA's Method to Estimate Direct Expenses Was Reasonable

HCFA faced significant challenges in revising the practice expense component of the fee schedule—perhaps more challenging than the task of estimating the physician work associated with each procedure. Practice expenses involve multiple items, such as the wages and salaries of receptionists, nurses, and technicians employed by the physician; the cost of office equipment such as examining tables, instruments, and diagnostic equipment; the cost of supplies such as face masks and wound dressings; and the cost of billing services and office space. Practice expenses are also expected to vary significantly. For example, a general practice physician in a solo practice may have different expenses than a physician in a group practice. For most physician practices, the total of supply, equipment, and nonphysician labor expenses is probably readily available. However, Medicare pays physicians by procedure, such as a skin biopsy; therefore, HCFA had to develop a way to estimate the portion of practice expenses associated with each procedure—information that is not readily available.

Ideally, estimates of the relative resources associated with each medical procedure would be based on resource data obtained from a broad,

representative sample of physician practices. However, the feasibility of completing such an enormous data collection task within reasonable time and cost constraints is doubtful, as evidenced by HCFA's unsuccessful attempt to survey 5,000 practices. After considering this option and the limitations of survey data already gathered by other organizations, HCFA decided to use expert panels to estimate the relative resources associated with medical procedures and convened 15 specialty-specific clinical practice expense panels (CPEP).[6] Each panel included 12 to 15 members; about half the members of each panel were physicians, and the remaining members were practice administrators and nonphysician clinicians such as nurses. HCFA provided national medical specialty societies an opportunity to nominate the panelists, and panel members represented over 60 specialties and subspecialties.

Each panel was asked to estimate the practice expenses[7] associated with selected procedure codes.[8] Some codes, called "redundant codes," were assigned to two or more CPEPs so that HCFA and its contractor could analyze differences in the estimates developed by the various panels. For example, HCFA included the repair of a disk in the lower back among the procedures reviewed by both the orthopedic and neurosurgery panels.[9]

We believe that HCFA's use of expert panels is a reasonable method for estimating the direct labor and other direct practice expenses associated with medical services and procedures. We explored alternative primary data-gathering approaches, such as mailing out surveys, using existing survey data, and gathering data on-site, and we concluded that each of those approaches has practical limitations that preclude their use as reasonable alternatives to HCFA's use of expert panels. Gathering data directly from a limited number of physician practices would, however, be a useful external validity check on HCFA's proposed practice expense revisions and would also help HCFA identify refinements needed during phase-in of the fee schedule revisions.

[6]For example, one panel reviewed general surgery codes, while another reviewed orthopedic codes.

[7]The CPEP members were instructed to base their estimates on the typical patient—the patient who most frequently undergoes a particular procedure—not necessarily a Medicare patient. For example, most women receiving hysterectomies are in their 40s and 50s and are not Medicare patients.

[8]The Current Procedural Terminology (CPT), compiled by the American Medical Association, is used by the Medicare program and most other payers to identify, classify, and bill medical procedures. It consists of procedure codes, descriptions, and modifiers to facilitate billing and payment for medical services and procedures performed by physicians. When the terms "code" and "procedure code" are used in this testimony, they refer to CPT codes.

[9]This was procedure code 63030.

Weaknesses and Limitations of HCFA's Adjustment of Direct Expense Estimates

HCFA staff believed that each of the CPEPs developed reasonable relative rankings of their assigned procedure codes. However, they also believed that the CPEP estimates needed to be adjusted to convert them to a common scale, eliminate certain inappropriate expenses, and align the panels' estimates with data on aggregate practice expenses. While we agree with the intent of these adjustments, we identified methodological weaknesses with some and a lack of supporting data with others.

HCFA staff found that labor estimates varied across CPEPs for the same procedures and therefore used an adjustment process referred to as "linking" to convert the different labor estimates to a common scale. HCFA's linking process used a statistical model to reconcile significant differences between various panels' estimates for the same procedure (for example, hernia repair). HCFA used linking factors derived from its model to adjust CPEP's estimates. HCFA's linking model works best when the estimates from different CPEPs follow certain patterns; however, we found that, in some cases, the CPEP data deviated considerably from these patterns and that there are technical weaknesses in the model that raise questions about the linking factors HCFA used.

HCFA applied two sets of edits to the direct expense data in order to eliminate inappropriate or unreasonable expenses: one based on policy considerations, the other to correct for certain estimates HCFA considered to be unreasonable. The most controversial policy edit concerned HCFA's elimination of nearly all expenses related to physicians' staff, primarily nurses, for work they do in hospitals. HCFA excluded these physician practice expenses from the panels' estimates because, under current Medicare policy, those expenses are covered by payments to hospitals rather than to physicians. We believe that HCFA acted appropriately according to Medicare policy by excluding these expenses. However, shifts in medical practices affecting Medicare's payments may have resulted in physicians absorbing these expenses.

In a notice published in the October 1997 Federal Register, HCFA asked for specific data from physicians, hospitals, and others on this issue. After we completed our field work, HCFA received some limited information, which we have not reviewed. HCFA officials said that they will review that information to determine whether a change in their position is warranted. If additional data indicate that this practice occurs frequently, it would be appropriate for HCFA to determine whether Medicare reimbursements to hospitals and physicians warrant adjustment.

HCFA also limited some administrative and clinical labor estimates that it believes are too high. Specifically, HCFA believes that (1) the administrative labor time estimates developed by the CPEPs for many diagnostic tests and minor procedures seemed excessive compared with the administrative labor time estimates for a midlevel office visit; and (2) the clinical labor time estimates for many procedures appeared to be excessive compared with the time physicians spend in performing the procedures. Therefore, HCFA capped the administrative labor time for several categories of services at the level of a midlevel office visit. Furthermore, with certain exceptions, HCFA capped nonphysician clinical labor at 1-1/2 times the number of minutes it takes a physician to perform a procedure. HCFA has not, however, conducted tests or studies that validate the appropriateness of these caps and thus cannot be assured that they are necessary or reasonable.

Various physician groups have suggested that HCFA reclassify certain administrative labor activities as indirect expenses. Such a move could eliminate the need for limiting some of the expert panels' administrative labor estimates, which some observers believe are less reliable than the other estimates they developed. HCFA officials said that they are considering this possibility.

Finally, HCFA adjusted the CPEP data so that it was consistent in the aggregate with national practice expense data developed from the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) survey—a process that it called "scaling." HCFA found that the aggregate CPEP estimates for labor, supplies, and equipment each accounted for a different portion of total direct expenses than the SMS data did. For example, labor accounted for 73 percent of total direct expenses in the SMS survey data but only 60 percent of the total direct expenses in the CPEP data. To make the CPEP percentages mirror the SMS survey percentages, HCFA inflated the CPEPs' labor expenses for each code by 21 percent and the medical supply expenses by 6 percent and deflated the CPEPs' medical equipment expenses by 61 percent.

The need for scaling was due in part to the equipment utilization rates HCFA used. HCFA officials told us that actual equipment utilization rates were not available from the medical community and therefore they had to make assumptions about the rate at which equipment is used in order to assign equipment costs to each code. For equipment associated with specific procedures, such as a treadmill used as part of a cardiology stress test, HCFA assumed a utilization rate of 50 percent, while, for equipment

that supports all or nearly all services provided by a practice, such as an examination table, HCFA assumed a utilization rate of 100 percent. Scaling provided HCFA with a cap on the total amount of practice expenses devoted to equipment that was not dependent upon the equipment rate assumptions HCFA used.

While HCFA officials acknowledge that their equipment utilization rate assumptions are not based on actual data, they claim that the assumptions are not significant for most procedures since equipment typically represents only a small fraction of a procedure's direct expenses. The AMA and other physician groups that we contacted have said, however, that HCFA's estimates greatly overstate the utilization of most equipment, which results in underestimating equipment expenses used in developing new practice expense fees. HCFA agrees that the equipment utilization rates will affect each medical specialty differently, especially those with high equipment expenses, but HCFA staff have not tested the effects of different utilization rates on the various specialties.

In a notice in the October 1997 Federal Register, HCFA asked for copies of any studies or other data showing actual utilization rates of equipment, by procedure code. This is consistent with the Balanced Budget Act of 1997 requirement that HCFA use actual data in setting equipment utilization rates.

Impact on Access to Care Needs Continued Monitoring

It is not clear whether beneficiary access to care will be adversely affected by Medicare's new fee schedule payments for physician practice expenses. This will depend upon such factors as the magnitude of the Medicare payment reductions experienced by different medical specialties, other health insurers' use of the fee schedule, and fees paid by other purchasers of physician services.

While beneficiary access to care has remained very good since implementation of the fee schedule began in 1992, the cumulative effects of the transition to the fee schedule, recent adjustments to the fee schedule that were mandated by the Balanced Budget Act, and the upcoming practice expense revisions could alter physicians' willingness to accept Medicare's fee schedule payments for some procedures. For example, between 1992 and 1996, cardiologists experienced a 9 percent reduction in their Medicare fee schedule payments; gastroenterologists, an 8-percent reduction, and ophthalmologists, a 12-percent reduction. HCFA's June 1997 proposed rule would result in further reductions of 17 percent,

20 percent, and 11 percent, respectively, for these specialties once the new practice expense component of the fee schedule is fully implemented in 2002. Additionally, Medicare payments for surgical services were reduced by 10.4 percent beginning in 1998 as a result of provisions contained in the Balanced Budget Act. The combined impact of the proposed and prior changes on physicians' incomes will affect some medical specialties more than others. Therefore, there is a continuing need to monitor indicators of beneficiary access to care, focusing on services and procedures with the greatest reductions in Medicare payments.

Observations

Even though HCFA has made considerable progress developing new practice expense fees, much remains to be done before the new fee schedule payments are implemented starting in 1999. For example, HCFA has not collected actual data that would serve as a check on the panels' data and as a test of its assumptions and adjustments. Furthermore, HCFA has done little in the way of conducting sensitivity analyses to determine which of its adjustments and assumptions have the greatest effects on the proposed fee schedule revisions. There is no need, however, for HCFA to abandon the work of the expert panels and start over using a different methodology; doing so would needlessly increase costs and further delay implementation of the fee schedule revisions.

The budget neutrality requirement imposed by the Congress means that some physician groups would benefit from changes in Medicare's payments for physician practice expenses to the detriment of other groups. As a result, considerable controversy has arisen within the medical community regarding HCFA's proposed fee schedule revisions, and such controversy can be expected to continue following issuance of HCFA's next notice of proposed rulemaking, which is due May 1, 1998. Similar controversy occurred when Medicare initially adopted a resource-based payment system for physician work in 1992. Since that time, however, medical community confidence in the physician work component of the fee schedule has increased.

In our recently issued report, we recommended several actions HCFA should take to improve its methods for revising Medicare's payments for physician practice expenses. These recommendations, if adopted, would

give physicians greater assurance that the revisions HCFA proposes are appropriate and sound. HCFA officials said that they would carefully review and consider each of our recommendations as they develop their rule.

Mr. Chairman, this concludes my statement. I will be happy to answer your questions.

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