CHCPP NEWS

COMMISSION ON
HEALTH CARE POLICY AND PRACTICE

UPDATE ON HCFA/Abt ASSOCIATES PRACTICE EXPENSE PROJECT

Under the 1994 Social Security Amendments, Congress directed the Secretary of Health and Human Services to implement Medicare Fee Schedule resource-based relative values for practice expenses for physician services. The legislation specifically states that the methodology must take into account the nonphysician labor, equipment and supplies that are used in the provision of services in various settings. Congress mandated that the new practice expense relative values are to be implemented in January 1998. Practice expenses make up 41% of the resource-based system. The other two components are physician work (54.2%) and liability premiums (4.8%).

Development of the new practice expense relative value units will be based on data collection in a two-pronged approach. To collect data on direct costs (nonphysician labor, equipment and supplies), HCFA convened Clinical Practice Expert Panels (CPEPS). To determine indirect costs (practice costs and case-mix data), HCFA intended to conduct a survey of physician practices.

On October 9, 1996, officials at the Health Care Financing Administration (HCFA) held a briefing for specialty societies on the status of the national study of physician's practice expenses.

Update on the Abt Associates Study

Both the first and second phase of the Clinical Practice Expert Panel (CPEP) meetings have been completed. The Society of Nuclear Medicine had two members (Kenneth McKusick, MD and Patricia Miale) on the Radiology CPEP. During the first phase, the panel members assigned direct costs for a group of reference services. The second phase was used to extend the cost estimates to the rest of the CPT codes in the family (extrapolation phase). HCFA is in the process of receiving the CPEP data from Abt Associates (a HCFA contractor). They are compiling CPEP data on: clinical labor inputs; administrative labor inputs; supplies; and equipment. In addition, Abt is supplying data on labor wages by category, supply prices and capital equipment prices. Once all the raw data are delivered, HCFA must clean the data and link the CPEPs through redundant codes. The dataset will then be available to specialty societies (on or about December 1996). Given the increasingly compressed time schedule HCFA is under, they do not intend to reassemble the CPEPs to review the results of their findings.

The national mail survey component of the study, to determine indirect costs, was divided into first and second replicates by the Office of Management and Budget. The survey was designed to determine patient case mix, and identify labor costs and capital equipment. The first replicate, a 1700-member subsample of the original 5000 physician sample, was fielded in the spring. The response rate to the survey was low (27%) and the process was very time-consuming. In light of the poor response rate and slow return, HCFA decided that the results of the survey would not be reliable and would not arrive in time to affect the outcome. As such, the decision was made to cancel the survey and not to use any data gathered from it thus far.

Despite the demise of the national mail survey, HCFA still intends to meet its legislative mandate for a January 1, 1998 implementation of practice cost relative values. They intend to use a formula methodology using extant data. Questions remain whether HCFA has developed alternatives to the mail survey that would allow it to establish direct/indirect cost ratios, verify data gathered in the Clinical Practice Expert Panel process, and verify the allocation techniques developed by the Cambridge Health Economics Group and Health Economics Research. HCFA officials have stated that they will maximize the direct costs and CPEP data, look to proxies and formulas for indirect costs that would have less of an impact, and is exploring all other possible sources of data to address these issues.

Update on Alternative Approaches Using Extant Data

Two HCFA-funded studies rely on existing data. Since HCFA plans to use the results of the CPEP process for direct costs, these studies would primarily be used by HCFA to allocate indirect costs across procedures (see related article below on Physician Payment Review Commission).

The Cambridge Health Economics Group study (Daniel Dunn, PhD) allocates indirect costs based on the physician time required to perform a service. The Health Economics Research study (Russel Burge, PhD and Gregory Pope, MS) ties indirect costs to a service's work value. Significant concerns have been expressed about both studies. One physician commented that the Cambridge Health Economics Group approach used direct/indirect proportions that are based on the old practice cost breakdown. Others commented that the Health Economics Research method is based on untested and potentially flawed assumptions about work and practice costs. In particular, concern was expressed that the approach is not based on the resources involved in procedures, but is founded on specialty revenue/expense ratios. Also, since this study is at the specialty level, it treats specialties as monolithic and does not consider subspecialties. Many parties have expressed concern that this could adversely affect subspecialties.

HCFA officials reiterated at this meeting that indirect costs may be based on a combination of allocation formulas and from the CPEP direct cost data.

Physician Payment Review Commission

On September 20 ,1996, Katie Merrell provided an update on the resource-based practice expense relative values to the Physician Payment Review Commission (PPRC). Merrell began by stating the PPRC approach: (a) collect direct costs data from physician practices, (b) allocate indirect costs in an incentive-neutral manner, (c) establish service-specific site-of-service payment differences based on direct costs

and (d) implement a 2- 3-year transition and establish a refinement process.

Merrell then explained two alternative methodologies being examined by HCFA for allocating indirect costs:

1. CAMBRIDGE HEALTH ECONOMICS GROUP (Daniel Dunn, PhD)

Direct and indirect costs are based on volume-weighted averages of specialty revenue share. They use resulting direct costs as services direct cost relative value. They sum indirect costs across services and reallocate with regard to physician time. This approach has an option to establish service-specific site-of-service payments.

2. HEALTH ECONOMICS RESEARCH (Russel Burge, PhD and Gregory Pope, MS)

The Health Economics Research (HER) approach uses service-level revenue share to determine practice expense value from physician work value. This plan has an option to establish service-specific site-of-service payment differences based on direct costs.

In assessing the PPRC, Cambridge and HER approach, PPRC staff suggested a number of caveats for comparing results. The PPRC analysis is based on a limited group of services. PPRC uses 1991 volume estimates and 1992 service codes and RVUs. Both the Cambridge and HER studies use 1994 volumes and 1996 service codes and RVUs. She added that payment effects differ from the reported RVU effects by specialty because of the continued use of three conversion factors (PPRC and HCFA are proposing a single conversion factor). PPRC looked at the three methodologies for several specialties and found them essentially consistent, with the exception of ophthalmology.

One of the PPRC commissioners, Earl Steinberg, MD, was adamant that Cambridge and HER studies have a flawed process for calculating indirect costs but he also was not particularly supportive of PPRC's approach either. He suggested and PPRC ultimately concurred, that PPRC should support a correctional approach that would be phased in over several years beginning in 1998 with refinements being made as better data becomes available. The phase-in is not new policy but a reiteration of existing policy. This approach was favored over telling Congress that it couldn't be done for 3 to 4 years and then having the specialties absorb the change in one year. Gail Wilensky, PhD, PPRC chair, agreed and stated that PPRC will wait until the CPEP data from HCFA is available for analysis (December 1996), but added that the PPRC position emphasizes the critical need for a transition.

PPRC staff also reported that HCFA's PPAC recommended that the Department of Health and Human Services delay implementation until reliable, valid data are available. They recommended a 2- to 3-year transition period.

HCFA's December Meeting with Specialty Societies

At the next specialty society meeting with HCFA, tentatively scheduled for December 1996, HCFA is expected to: release the CPEP data on direct costs; distribute impact analyses by specialty on the Cambridge Health Economics Group and Health Economics Research studies for allocating indirect costs; propose a methodology for allocating indirect costs; and propose the proportion of direct versus indirect costs for practice expenses.

HCFA still must resolve several issues that arose during the CPEP process. Among these are:

- Should the time of clinical staff brought into out-of-office settings to assist the physician in performing a procedure, and capital equipment that is purchased by a practice, but used in the hospital, be included in the practice expense component? Medicare prohibits payment for office personnel in a hospital setting (including professional staff). HCFA is considering whether this work may be a substitute for physician work.
- How should the CPEPs be linked? While panels were internally consistent, they varied among panels and redundant codes were costed out differently.
- Do billing and other administrative costs generally vary on a procedure code-specific basis, and should they be counted as direct or indirect costs?
- How should the cost of capital equipment be proportioned over the life of an item and what is a typically useful duration?

Several key issues for nuclear medicine are still under consideration by HCFA and require clarification at the December meeting. How will HCFA handle capital equipment costs? Will there be site-of-service differentials? Will there be specialty society differentials for allocating direct versus indirect costs? How to deal with technical codes which do not have physician work attached?

The Society of Nuclear Medicine will continue to monitor and respond to issues of concern dealing with practice expense. We are working closely with the Practice Expense Coalition to ensure that all specialty societies are fairly reimbursed under the new fee schedule.

—Wendy J.M. Smith, MPH, is the associate director of health care policy

Medicare Alert

Effective for claims processed on or after July 1, 1996, Medicare will no longer pay claims for diagnoses not coded to the highest level of specificity (or truncated diagnoses). This means, for example, if the ICD-9-CM coding book indicates that a fourth or fifth digit is applicable, it must be used to prevent denial. For example: 786.5 (chest pain) is NOT coded to the highest level and will be denied if billed. According to the 1996 ICD-9 book, this should be coded to the fifth digit (786.50 -786.59).

Medicare carriers will "deny as unprocessable, with no appeal rights, assigned claims for physician services submitted with truncated diagnosis codes." If the claim is "non-assigned" the carrier will delay processing until additional information is received.

The good news is that Medicare has developed an office tool which includes all of the ICD-9 code groups and to what digit it must be reported. If you would like a copy, please contact Wendy Smith at (703) 708-9000. Otherwise check the current ICD-9 book to make sure the code in questions is codable to a fourth or fifth digit.

Growth of Medicaid Slows

The growth rate of federal Medicaid costs slowed to 3% in the fiscal year that ended September 30, 1996. That was much lower than in recent years, federal figures show. Increased use of cheaper, managed care insurance systems and a lower medical inflation rate were cited as probable reasons for the slowdown. Experts predict there will be no more huge increases like the 29% growth rate in 1992, even if the current low rate is only temporary.

—Richard C. Reba, MD, University of Chicago