

December 2004

**MEDICARE  
PHYSICIAN FEE  
SCHEDULE**

**CMS Needs a Plan for  
Updating Practice  
Expense Component**





Highlights of [GAO-05-60](#), a report to congressional committees

## Why GAO Did This Study

Medicare's payments for the costs physicians incur in operating their practices are based on two sets of estimates: total practice expenses and resource estimates for individual services. Total practice expense estimates were derived from American Medical Association (AMA) physician surveys, which the Centers for Medicare & Medicaid Services (CMS) refines with supplemental data submitted by medical specialty societies. Resource estimates for individual services were developed by expert panels and refined by CMS with recommendations from another expert panel. In response to a mandate in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, GAO evaluated CMS's processes for updating total practice expense and resource estimates and whether CMS will have the data necessary to update the fee schedule at least every 5 years as mandated by law.

## What GAO Recommends

GAO recommends that CMS modify its review of supplemental data submissions, base changes to the expert panel's recommendations on data analysis and a documented, transparent process, and develop and implement a plan to develop data for the mandated updates. CMS said it had taken or planned to take most actions recommended, but its actions do not obviate the need for the recommendations. AMA agreed with the findings but not with all of GAO's conclusions.

[www.gao.gov/cgi-bin/getrpt?GAO-05-60](http://www.gao.gov/cgi-bin/getrpt?GAO-05-60).

To view the full product, including the scope and methodology, click on the link above. For more information, contact Laura A. Dummit at (202) 512-7119.

# MEDICARE PHYSICIAN FEE SCHEDULE

## CMS Needs a Plan for Updating Practice Expense Component

### What GAO Found

CMS reviews supplemental data from medical specialties on total practice expenses to determine whether it should use the data, but aspects of CMS's review may result in its not utilizing the best data. CMS's review is necessary because it helps protect against perceived or actual bias in the estimates. Risk of bias exists because only specialties that believe their Medicare fees are too low are likely to submit supplemental data, and the data are not audited. CMS, however, may still use certain data submissions that are not representative of physician practices within a specialty. CMS also may reject some data that are more representative of a specialty's total practice expenses than the data currently used for that specialty. In addition, CMS reviewed a 2002 data submission for accuracy, which is an important additional check, yet when the data did not meet the accuracy test, CMS did not reject the data. CMS has not stated whether it will review the accuracy of all supplemental data submissions.

Stakeholders such as specialty societies and AMA said the expert panel improved resource estimates for individual services because of the rigor of its evaluation process. CMS and specialty societies generally accepted the panel's estimates because the panel represented a broad range of specialties and its collaborative evaluation process became increasingly systematic. CMS implemented almost all of the panel's estimates but appropriately changed some estimates that conflicted with Medicare coverage rules and changed others to make them consistent across services. In modifying other estimates, however, CMS did not always rely on adequate data or explain its rationale. Certain physician groups told GAO that this had diminished their confidence in the process for updating Medicare's fees, and physicians' confidence in the process is important to ensure their continued participation in Medicare.

CMS does not have a plan for developing and using appropriate data for the mandated review of the fee schedule. CMS reported that it is in the process of obtaining a contract to collect practice expense data from the major physician and nonphysician specialties but did not provide specifics. A plan for the data collection is important for several reasons. Data sources that had been used no longer exist or are insufficient. The AMA physician survey that provided total practice expense data was last conducted in 1999 and was modified in 2000 such that it no longer collected the necessary data. Data submitted voluntarily by specialties to update these estimates are not an appropriate substitute for a systematic data collection effort. In addition, the expert panel that reviewed resource estimates for individual services completed its work in its final meeting in March 2004. CMS indicated that an ongoing AMA committee would continue to develop estimates for new and revised services. While CMS officials told GAO they believe CMS can complete the review of the fee schedule as required by 2007, without a specific plan CMS cannot ensure that it will be able to collect the data and update the fee schedule in a timely manner.

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## Abbreviations

AMA	American Medical Association
AOA	American Optometric Association
ASCO	American Society of Clinical Oncology
BLS	Bureau of Labor Statistics
CMS	Centers for Medicare & Medicaid Services
CPEP	clinical practice expert panels
HCFA	Health Care Financing Administration
OIG	Office of Inspector General
PEAC	Practice Expense Advisory Committee
RUC	RVS Update Committee
SMS	Socioeconomic Monitoring System

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December 13, 2004

Congressional Committees

Medicare pays for physician services using a fee schedule based on the resources required to deliver each service. Under this fee schedule, a single fee is paid for each of the more than 7,000 services (such as office visits, surgical procedures, and tests) delivered by physicians and certain other health professionals, regardless of the medical specialty performing the service. The fee is made up of three parts that recognize different types of resources required to provide each service. The physician work component provides payment for the physician's time, skill, and training to perform the service. The malpractice component provides payment for the expenses of obtaining professional liability insurance. The practice expense component provides payment for the expenses incurred in operating a practice, such as nurses' salaries, space, and equipment.<sup>1</sup> Almost half of the approximately \$53 billion Medicare paid for services under the physician fee schedule in 2003 compensated physicians for practice expenses. The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers Medicare, is required to review and adjust the fees for all physician services at least every 5 years to account for a number of factors, including changes in medical practice.<sup>2</sup>

Some medical specialty societies have raised concerns that Medicare's practice expense payments do not cover their physicians' practice expenses, in part because of inadequacies in the data used to establish the payments. We previously reported that although the data used were the best available at the time resource-based practice expense payments were developed, they needed refinements to correct potential weaknesses.<sup>3</sup>

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<sup>1</sup>This report refers to the practice expense component of payments as "practice expense payments."

<sup>2</sup>See 42 U.S.C. 1395w-4(c)(2)(B)(i), (ii).

<sup>3</sup>GAO, *Medicare Physician Payments: Need to Refine Practice Expense Values During Transition and Long Term*, [GAO/HEHS-99-30](#) (Washington, D.C.: Feb. 24, 1999) and GAO, *Medicare Physician Fee Schedule: Practice Expense Payments to Oncologists Indicate Need for Overall Refinement*, [GAO/HEHS-02-53](#) (Washington, D.C.: Oct. 31, 2001).

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Practice expense payments are developed with (1) estimates of the total practice expenses that physicians in each specialty incur to operate their practices and (2) estimates of the resources required to perform each of the individual services provided by the physicians in each specialty. Total practice expenses were estimated originally using data from American Medical Association (AMA) surveys of physicians. To refine total practice expense estimates, CMS was required to establish a review process to accept data submitted voluntarily by medical specialty societies that were collected through a survey of physicians practicing in that specialty to supplement the AMA survey data.<sup>4</sup> As of June 2004, six specialties had submitted supplemental data,<sup>5</sup> and CMS had accepted three submissions. The resources required to perform individual services originally were estimated by panels of clinicians convened by the Health Care Financing Administration (HCFA).<sup>6</sup> To refine these estimates, CMS made its own changes but largely relied on recommendations from the AMA-sponsored Practice Expense Advisory Committee (PEAC), which comprised expert panels of physicians and other clinicians that developed service-specific resource estimates based on information from specialty societies.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 directed that we review the processes and data used to refine practice expense payments for all specialties.<sup>7</sup> As agreed with your offices, we (1) evaluated CMS's process for reviewing the supplemental data submitted by specialty societies on total practice expenses, (2) evaluated CMS's process for updating estimates of resources required to perform individual services, and (3) determined whether CMS will have the data necessary to review and adjust the physician fee schedule at least every 5 years, as required by law.

To conduct this work, we invited 50 medical specialty societies to meet with us to discuss their experiences with developing and submitting

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<sup>4</sup>See Section 212 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, App. F, 113 Stat. 1501A-321, 1501A-350.

<sup>5</sup>Since we sent our report to CMS for comment on June 15, 2004, CMS posted information on its Web site about four additional supplemental data submissions.

<sup>6</sup>On July 1, 2001, the agency that administers the Medicare program was renamed from HCFA to the Centers for Medicare & Medicaid Services (CMS). In this report, we will refer to HCFA where our findings apply to operations that took place before July 1, 2001.

<sup>7</sup>Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106-554, Appendix F, Section 411, 114, Stat. 2763A-463, 2763A-508.

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supplemental practice expense data and their views of the PEAC process. We met with representatives of the 32 specialty societies that responded and reviewed written materials they gave us. (App. I lists the 32 medical specialty societies that responded.) We evaluated CMS's review of the supplemental total practice expense data by examining specialty societies' submissions and reports from the contractor CMS hired to provide technical assistance to the specialty societies and CMS on the supplemental data submission process. We also interviewed CMS officials and the contractor about the process CMS uses to review submissions. To evaluate CMS's process for updating resource estimates for individual services, we interviewed the specialties' representatives, attended PEAC meetings, and examined supporting materials that specialties provided to the PEAC. To determine CMS's decisions on PEAC recommendations and CMS's rationale for other changes to resource estimates for individual services, we reviewed relevant documents published in the *Federal Register*<sup>8</sup> and an HHS Office of Inspector General (OIG) report.<sup>9</sup> We also discussed with CMS staff CMS's rationale for decisions regarding the refinement processes and its views about prospects for obtaining data to perform the mandated reviews. We performed our work from November 2001 through December 2004 in accordance with generally accepted government auditing standards. (App. II provides details of our scope and methodology.)

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## Results in Brief

CMS's review of supplemental data provided by medical specialties on total practice expenses is necessary to protect against the risk of bias inherent in a voluntary submission process, since only those specialties that believe their estimates are too low are likely to submit data. However, certain aspects of the review may result in CMS's not utilizing the best available data. First, in assessing whether the respondents to the supplemental data survey are representative of all physician practices within a specialty, CMS may not be examining physician practice characteristics that affect practice expenses. For example, CMS does not consider whether the respondents are in independent or hospital-based practices, which may have a greater bearing on practice expenses than some of the more general characteristics that are used, such as a

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<sup>8</sup>See 64 *Fed. Reg.* 59,380, 59,399 – 59,403, (1999); 65 *Fed. Reg.* 65,376, 65,390 – 65,399 (2000); 66 *Fed. Reg.* 55,246, 55,255 – 55,262 (2001); 67 *Fed. Reg.* 79,966, 79,973 – 79,976 (2002).

<sup>9</sup>HHS, OIG, *Medicare Payment for Nonphysician Clinical Staff in Cardiothoracic Surgery*, OEI-09-01-00130 (Washington, D.C.: HHS, April 2002).

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physician's gender or number of years in practice. Second, CMS's assessment of the precision<sup>10</sup> of the estimates based on the data from the supplemental survey has led the agency to reject submissions that might be more representative of a specialty's total practice expenses than the data CMS currently uses to establish practice expense estimates—particularly for specialties that were not represented in the original AMA survey data, such as optometry. CMS also elected to assess the accuracy, or reasonableness, of a 2002 submission by comparing the data with benchmark data from other sources. Although specific expense items were much higher than comparable benchmark data, CMS ultimately accepted these data without revisions. These data were deemed representative, even though they were influenced by certain high-cost practices, indicating that CMS's test for representativeness is problematic. Assessing submissions for accuracy is important; however, CMS has not indicated whether it will assess the accuracy of all supplemental data submissions.<sup>11</sup>

Stakeholders such as AMA and specialty societies stated that the PEAC recommendations CMS used to update resource estimates for individual services improved these estimates, but certain specialty societies told us that CMS modified estimates at times without adequate justification, and our review of CMS's changes indicated that this had occurred. CMS and specialty society officials expressed confidence in PEAC-recommended estimates because the PEAC comprised representatives from multiple specialties and a cross section of providers, and the PEAC's collaborative process of developing estimates became increasingly systematic from its inception in 1999. CMS implemented almost all of the PEAC-recommended estimates for approximately 6,500 services but modified certain original estimates and PEAC-recommended estimates at times without adequate justification. For example, CMS decided to remove expenses for clinical staff that certain surgeons bring to help them in the operating room and elsewhere in the hospital before it requested and received a study from the HHS OIG on this issue and without evidence that other Medicare payments accounted for these expenses. Because CMS indicated that it would not reverse this policy decision, the PEAC did not have the opportunity to deliberate on this issue. The success of the PEAC process depended on physician participation and acceptance, and physicians told us that CMS's

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<sup>10</sup>Precision measures how far the estimate may be from the true value; for example, there is a 95 percent chance an estimate is +/- 2 percent from the true value.

<sup>11</sup>CMS assessed the accuracy of three of the four recently posted data submissions.



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changes to estimates without adequate data or explanation lowered their confidence in the process and the resulting estimates.

CMS has not developed a plan for systematically acquiring and using data to update total practice expense estimates. CMS reported that it is in the process of obtaining a contract to collect practice expense data from the major physician and nonphysician specialties but did not provide specifics. A plan for the data collection is important for several reasons. Data sources that had been used no longer exist or are insufficient. AMA's Socioeconomic Monitoring System (SMS) survey, which was the source of total practice expense estimates for each specialty, was last conducted in 1999 and had been modified such that it no longer collected data detailed enough for this purpose. Data submissions from specialty societies are voluntary and therefore unlikely to be comprehensive. In addition, the PEAC process concluded in March 2004 because, according to AMA representatives, it had successfully completed its work. CMS indicated that AMA's ongoing resource review committee would update estimates for new or revised services. While CMS officials told us they believe they can complete the review as required by 2007, they have not laid out a plan to ensure that the necessary practice expense data are available.

We are recommending that the CMS Administrator consistently assess the accuracy of all supplemental data submissions, modify the assessment of representativeness to ensure that supplemental data submissions better reflect the variation in practice expenses within a specialty, and adjust the precision requirement so that supplemental data submissions that would improve the information currently used to set fees are accepted; base changes to resource estimates for individual services on sufficient data analysis and a documented and transparent rationale; and develop and implement a plan to acquire representative data on total practice expenses and the resources required for individual services. In commenting on a draft of this report, CMS agreed with the need for a plan but said that it had substantial concerns with our report. CMS stated that the agency already conducted or planned to conduct most actions we recommended. We do not agree that CMS has taken actions that obviate the need for our recommendations; however, we have revised our report to reflect CMS's recent actions. AMA did not comment on our recommendations. It agreed that the PEAC process had improved resource estimates for individual services but objected to our conclusions that CMS had not always provided adequate justification for making changes and that this reduced physician confidence in the process.

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## Background

Practice expense payments under Medicare's physician fee schedule are based on estimates of total practice expenses for each specialty and estimates of the resources required for individual services. The adequacy and appropriateness of fees are important to ensure Medicare beneficiary access to physician services. If fees for a particular service are too low, physicians may choose not to provide this service, which may limit Medicare beneficiary access. If fees are too high, the Medicare program will be wasting scarce resources. Determining the appropriateness of physician fees is particularly difficult with regard to practice expenses. The total expenses of operating a practice vary significantly, depending on the specialty, organization of the practice, and services provided. Further, these total expenses must be allocated to over 7,000 individual services, and the expenses associated with individual services cannot be easily identified because a large share of practice expenses, such as rent and office equipment, are not associated with the delivery of any given service but are incurred across all services provided by the practice. In addition, the resources involved in delivering certain services may be expected to shift over time with technological innovations or as wages change for clinical staff. Every year, approximately 200 to 300 service codes are added to the fee schedule, which could change resource allocations for other services. The uncertainty of these considerations underscores the importance of the method CMS employs to refine and update the estimates underlying practice expense payments.

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### SMS Survey Used to Estimate Specialties' Total Practice Expenses

HCFA derived its original estimates of total practice expenses for each specialty using data from AMA's annual SMS surveys from 1995 through 1997. The SMS survey, which was not specifically designed for this purpose, gathered a broad range of information about economic and other characteristics of physician practices and included questions on the number of patient visits, medical practice revenues, and professional expenses. The survey sample was randomly drawn from the AMA Physician Masterfile, the most comprehensive available listing of physicians practicing in the United States. Other health care professionals (such as physical therapists or optometrists) paid under the physician fee schedule were not included in the survey sample.

We have previously noted several potential problems with using SMS data to estimate total practice expenses across all specialties.<sup>12</sup> First, the

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<sup>12</sup>[GAO/HEHS-99-30](#) and [GAO/HEHS-02-53](#).

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reported practice expenses may not have been representative of all physicians in some specialties because of a limited number of respondents. Even though AMA adjusted the survey results to minimize the effects of responding physicians who may not have been representative of all physicians in a specialty, the number of respondents may have been too small to ensure representative estimates.<sup>13</sup> For instance, the 1995 through 1997 SMS data HCFA used for oncologists were based on 27 respondents, and the data for allergists/immunologists were based on 31 respondents. Second, the SMS survey only distinguished among 26 major physician specialties, while Medicare recognizes over 65 physician and other health care professional specialties. Thus, HCFA had to use the practice expenses of the major physician specialties as proxies to represent the expenses of smaller specialties or other health care professionals, even though their practice expenses might not have been similar.<sup>14</sup> Third, the reported expenses in the SMS survey included items that were not in Medicare's definition of practice expenses. For example, some oncology practice respondents included chemotherapy drugs in their supply expenses. Such expenses need to be excluded from estimates of practice expenses in setting Medicare fees because Medicare pays for them outside of the physician fee schedule; however, there was no way for CMS to do this accurately with available data.

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### Physician Specialty Societies May Submit Supplemental Data on Total Practice Expense Estimates

As the physician fee schedule was implemented, Congress required CMS to establish a process to accept specialty-supplied total practice expense data that could supplement the SMS survey data. Any specialty society may submit data for CMS to consider in refining the physician fee schedule. CMS evaluates the supplemental data collection method and the survey respondents to ensure that they meet the criteria used in its review process for acceptance. If CMS accepts a specialty society's submission, the data are blended with the existing SMS data used to estimate that specialty's practice expense payments, although for some nonphysician specialties that were not represented in the original AMA survey, the

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<sup>13</sup>In making these adjustments, AMA considers characteristics such as AMA membership, physician gender, years since the physician graduated from medical school, physician membership in a medical specialty organization, and board certification status.

<sup>14</sup>Total practice expense estimates for smaller specialties or subspecialties were based on practice expense data from the major specialty that was the "closest fit." For example, data from internal medicine practices were used to estimate the expenses for practices from the subspecialties of internal medicine, such as nephrology (the medical specialty concerned with kidney function and disease) or infectious diseases.

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supplemental data replace the existing SMS data.<sup>15</sup> To be considered for changes to the following year's fee schedule, supplemental data must be submitted by March 1 of the preceding year. The last year that CMS will accept such submissions is 2005.

CMS's criteria for acceptance of supplemental data govern the data collection method and the survey respondents (see table 1). To collect the data, a contractor experienced with the SMS survey (or other national survey of physicians) must use an instrument based on the SMS survey instrument and protocols.<sup>16</sup> The surveyed physicians must be randomly selected from the AMA Masterfile or, for nonphysician specialties, from a nationally representative listing of practitioners.<sup>17</sup> The names of the physicians contacted for the survey must be kept confidential so no interested parties can contact them about the survey.

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<sup>15</sup>The supplemental data have also replaced the original SMS data for two physician specialties—oncology and cardiothoracic surgery.

<sup>16</sup>For example, the instrument must request expense data for the categories that CMS uses in establishing Medicare's practice expense payments and must use SMS definitions of expenses and hours worked.

<sup>17</sup>CMS allows specialties to use a stratified sample (that is, a specialty's practices may be divided into subgroups from which random samples are drawn) to help ensure that the responding practices are representative. Stratification allows more follow-up to encourage participation among subgroups with low response rates.

**Table 1: CMS Criteria for Evaluating Specialty Society Supplemental Data Submissions**

<b>CMS criteria</b>	
<b>Data collection</b>	
Survey instrument	Is based on SMS survey.
Survey administration	Is conducted by experienced contractor. Uses SMS protocols. Keeps sample member identity confidential.
Sample selection	Is randomly drawn from the AMA Masterfile of physicians or from a nationally representative listing of practitioners for nonphysician specialties.  May be a stratified sample with random selection within each stratum.
<b>Survey respondents</b>	
Representativeness of responses	Must have a high response rate, or respondents must have the same characteristics as all physicians in the specialty or responses must be weighted to reflect the overall composition of the specialty.
Precision of responses	Estimates must have an error rate of no more than plus or minus 15 percent of the mean.

Sources: 67 *Fed. Reg.* 43,555 – 43,557 (2002) (interim final rule with comment period) and 67 *Fed. Reg.* 79,971 – 79,972 (2002) (final rule with comment period).

The supplemental data survey respondents must be representative of the entire specialty, as demonstrated by a high response rate or by the respondents' having the same characteristics as all physicians in the specialty.<sup>18</sup> The number of respondents must be sufficient so that the estimated expenses comply with a precision criterion. Specifically, the estimates must have an error rate of no more than plus or minus

<sup>18</sup> A specialty may show that the physicians who did not respond were not different from those who responded with regard to factors affecting practice expenses. Alternatively, the estimates could be adjusted to reflect the differences between the respondents and all practitioners in that specialty. For example, if solo practitioners represent 20 percent of all physicians within a specialty but represent 40 percent of the physicians responding to the survey, responses from the solo practitioners would be weighted according to their representation in the specialty.

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15 percent.<sup>19</sup> The supplemental data from a typical specialty need about 140 usable responses for the estimates to meet the precision criterion.<sup>20</sup>

Six specialties have submitted supplemental data, and CMS accepted three of these submissions (see table 2).<sup>21</sup> The data from vascular surgery met the criteria and were accepted for use in establishing the practice expense payments. The data from physical therapy were initially rejected because they did not meet the precision criterion. That criterion was relaxed, however, in June 2002, and the physical therapy submission was accepted because the data met the new requirements. CMS deferred acceptance of data submitted by oncology in 2002. After the agency resolved its concerns about the accuracy of the data, it accepted the submission.

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<sup>19</sup>The estimated average practice expenses from the supplemental surveys must have a margin of error not greater than 15 percent of the estimated average, at a 90 percent confidence level. A 90 percent confidence level means that there is a 90 percent probability that the actual average falls within plus or minus 15 percent of the estimated average. The precision criterion had originally required a margin of error of no more than plus or minus 10 percent of the estimated average, but this was relaxed in June 2002. As a result, the number of responses needed to meet this criterion was reduced by about half.

<sup>20</sup>This estimate is based on the amount of total practice expense variation exhibited across all the practices included in the SMS survey. Small, homogeneous specialties with less variation across their practices will require fewer survey responses, whereas specialties with wide variation in their practice expenses will require more.

<sup>21</sup>Since we sent this report to CMS for comment on June 15, 2004, CMS has posted information on its Web site about four additional supplemental data submissions. Three specialties' data met the criteria: CMS indicated that it would accept the data from pathology for use in the 2005 practice expense methodology and stated that it would wait to accept the data from cardiology and radiology, at the specialties' request, until technical issues about the practice expense methodology have been resolved. CMS rejected data from the fourth specialty, radiation oncology, because they did not meet the precision criterion.

**Table 2: Supplemental Data Submissions by Specialty, CMS Decision, and Reasons for Rejection, 2000 through 2002**

Specialty	CMS decision	Reason for rejection
<b>2000 submissions</b>		
Physical therapy	Rejected	Precision criterion not met.
Vascular surgery	Accepted	
<b>2001 submissions</b>		
Physical therapy	Rejected	Precision criterion not met.
Optometry	Rejected	Precision criterion not met.
Pediatrics	Rejected	SMS protocols and survey not used; sample was not representative.
<b>2002 submissions<sup>a</sup></b>		
Physical therapy <sup>b</sup>	Accepted	
Oncology	Accepted	
Cardiology	Rejected	SMS protocols and survey not used.
Pediatrics <sup>c</sup>	Rejected	SMS protocols and survey not used; sample was not representative.

Sources: GAO analysis of the annual reports prepared by CMS's contractor: The Lewin Group, *Recommendations Regarding Supplemental Practice Expense Data Submitted for 2001* (Falls Church, Va.: 2000); The Lewin Group, *Recommendations Regarding Supplemental Practice Expense Data Submitted for 2002* (Falls Church, Va.: 2001); and The Lewin Group, *Recommendations Regarding Supplemental Practice Expense Data Submitted for 2003* (Falls Church, Va.: 2002).

<sup>a</sup>The precision criterion was relaxed in June 2002.

<sup>b</sup>The American Physical Therapy Association resubmitted the data it had submitted in 2001. These data met the relaxed precision criterion.

<sup>c</sup>Pediatrics resubmitted the data it had submitted in 2001.

## Expert Panels Establish and Refine Resource Estimates for Individual Services

To develop the original estimates of the resources required for individual services, HCFA convened 15 specialty panels composed of physicians, nurses, and practice administrators. These clinical practice expert panels (CPEP) estimated the amount of direct expenses, such as clinical labor, medical equipment, and medical supplies, associated with providing each service to the typical patient.<sup>22</sup> In general, the panel for a particular specialty included clinicians from that specialty who reviewed the services that its physicians typically provided. AMA, some specialty societies, and some researchers who specialize in physician reimbursement issues

<sup>22</sup>Indirect expenses, or overhead—administrative labor, office expenses, and other expenses—are allocated to specific services in proportion to the direct expenses and physician work involved in providing that service.

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supported using the panels' estimates of service-specific resources to establish the practice expense payments, but other specialty societies noted some concerns.<sup>23</sup> They stated that panel members did not represent a cross section of physician practices (by size or urban and rural location) or all types of physicians who provided a particular service. They also stated that the panels used differing assumptions about and definitions of the resources required for providing similar services, resulting in inconsistent estimates across panels.

In 1999, AMA convened the PEAC as an expert panel to refine the resource estimates for individual services. The PEAC had representation from all major medical specialties and rotating membership for smaller subspecialties. CMS representatives also participated, as observers, in the PEAC meetings. The PEAC reviewed the resource estimates for approximately 6,500 services from 1999 through March 2004, which account for close to 90 percent of total Medicare physician payments. It initially focused on high-volume services for each specialty, "families" of similar services (for example, an endoscopy procedure without biopsy, with biopsy, with removal of a single tumor, or with removal of multiple tumors are considered a family of endoscopy services), and services that specialty societies believed had inaccurate estimates. After completing its review, the PEAC made recommendations to CMS, through AMA's ongoing physician payment review committee, about modifications to service resource estimates.<sup>24</sup>

The PEAC review relied on data from specialties on the resources required to provide the specialties' services. Once a service or family of related services was identified for refinement by the PEAC, specialties that normally provide these services gathered data on the resources needed to furnish each service to a typical patient, such as the time a nurse spends with a patient and the supplies and equipment used.<sup>25</sup> AMA provided the specialty societies with background materials, such as the current

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<sup>23</sup>GAO, *Medicare: HCFA Can Improve Methods for Revising Physician Practice Expense Payments*, [GAO/HEHS-98-79](#) (Washington, D.C.: Feb. 27, 1998).

<sup>24</sup>This committee is known as the RVS Update Committee (RUC).

<sup>25</sup>A specialty society can gather these data using a panel of experts or a survey of the specialty's practitioners. If data are collected through a survey, the survey sample size, response rate, and distribution of respondents by geographic setting and type of practice (single-specialty, multispecialty, independent, or hospital-based) have to be submitted with the proposed resource estimates.



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resource estimates for the service and any estimates the PEAC had previously approved for individual tasks or supplies involved in performing the service.<sup>26</sup> The specialty society then presented the PEAC with its proposed resource estimate for a service, a description of how the estimate was developed, and a list of the tasks included in the estimate.<sup>27</sup>

The PEAC reviewed the resource estimate in a two-step process. First, a subgroup of the PEAC examined the data gathered by the specialty, assessed whether the resource estimate for a service was reasonable and comparable to those for similar services, and voted on whether to endorse the resource estimate. The subgroup recommended that the full PEAC approve the estimate, consider modifying it, or request additional data. Second, the full PEAC made its decision, either approving the specialty's estimate or a modified version of it or delaying its decision until it received additional data. Official recommendations to CMS required the approval of two-thirds of the PEAC members.

CMS made all final decisions about changes to the resource estimates that were used in calculating physician fees, including its own changes to original or existing resource estimates and those recommended by the PEAC. Its approach to reviewing PEAC recommendations varied: CMS staff made site visits to observe services being performed or consulted the medical directors of insurance companies to learn how other payers established payments for a service. CMS modified estimates for different reasons, including to make them consistent with estimates for other services and to remove expenses that were accounted for in other Medicare payments. For example, CMS changed the PEAC-recommended time spent by a nurse providing patient education and counseling for one service to be consistent with the time for this task already assigned to a comparable service. In the earlier years of the process, HCFA rejected or modified certain recommendations. In 2003, CMS accepted all of the PEAC's recommendations. AMA stated that the PEAC process was concluded in March 2004 because the PEAC had completed its work of reviewing most services. In May 2004, a representative from AMA told us

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<sup>26</sup>For example, the PEAC established 3 minutes as the standard time for clinical staff to obtain between one and three patient vital signs before the physician sees the patient for an office visit.

<sup>27</sup>The tasks included might be completing paperwork, explaining the procedure to the patient, obtaining the patient's consent, calling in prescriptions to a pharmacy, and arranging follow-up visits.

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that although the PEAC had been officially discontinued, a committee would be appointed to refine the resource estimates for the approximately 200 services that had not been reviewed by the PEAC.

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## Certain Aspects of CMS's Review Are Problematic

Although a review of specialty-provided supplemental data from surveys on total practice expenses is necessary to protect against the risk of bias inherent in a voluntary submission process, because of certain aspects of its review, CMS may not be accepting the best available supplemental practice expense data. In assessing whether the respondents to the survey for supplemental data are representative of all physician practices within a specialty, CMS may not be examining practice characteristics that adequately reflect the range of practice expenses within a specialty, such as whether a practice is single- or multispecialty or hospital-based. In addition, CMS's precision requirement for estimates based on the submitted data has led the agency to reject some supplemental submissions that could improve upon the information it currently uses to establish estimates. CMS also elected to assess the accuracy, or reasonableness, of a recent submission by comparing it with data from other sources but has not indicated whether it will consistently assess the accuracy of all supplemental data submissions. Moreover, CMS ultimately accepted practice expense data in this submission that were much higher than comparable benchmark data, which is problematic. The data were deemed representative, yet were influenced by high-cost practices, raising concerns about CMS's test for representativeness.

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## Review of Supplemental Data Is Necessary

A review of supplemental data submissions is necessary because medical specialty societies voluntarily gather and submit these data, and the data are not audited or verified before being used to establish fees. In addition, because the specialty societies have an incentive to engage in this endeavor only if they believe the practice expense estimates used to establish their Medicare fees are too low, the supplemental submission could be biased if a disproportionate share of those who complete the survey represent high-cost practices. CMS has established review criteria regarding the data collection method and the respondents to help guard against any perceived or actual bias in the estimates based on these data.

CMS's review of the data collection method—the survey instrument, survey administration, and sample selection—helps ensure that supplemental data can be used to update practice expense estimates. For example, by requiring that the survey instrument be based on the SMS survey instrument, CMS ensures that the definitions of the various

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categories of expenses between supplemental and previously used data are consistent.<sup>28</sup> CMS's requirement that the supplemental data submissions be based on the same survey administration protocols as the SMS survey increases the comparability of the supplemental data to the SMS data.

CMS's review of respondent characteristics is necessary to ensure that the data are representative of the average practice expenses within a specialty and are not distorted by a disproportionate share of respondents of one type or another. If the response rate is high, and the sample is randomly drawn from a nationwide listing of the physician specialty, the submissions are assumed to be representative of the entire specialty. If the response rate is low, CMS evaluates whether the respondents are representative of the specialty by comparing respondent characteristics with characteristics of the entire specialty.<sup>29</sup> In 2002, CMS also reviewed a data submission to determine whether the reported values were reasonable, as a test for accuracy. Assessing the accuracy of the data, by comparing them with other benchmarks or norms, is important because establishing the representativeness of the respondents and the precision of the data do not guarantee that the responses themselves are accurate.

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## Certain Aspects of Review Process Are Problematic

In evaluating whether supplemental data submissions are representative of the entire specialty, CMS examines practice characteristics of the respondents that do not necessarily reflect the variation in the specialty's practice expenses. CMS compares its survey respondents with all physician practices within a specialty using characteristics that AMA used, such as physician gender, years in practice, and membership in a medical specialty organization, to adjust responses to produce published reports on the nation's physicians. CMS uses these characteristics to ensure that supplemental data submissions are consistent with SMS data already collected, but other characteristics may better reflect the potential range and distribution of practice expenses for the specialty. For example,

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<sup>28</sup>Supplemental data surveys may include questions not included in the SMS that are designed to provide previously unavailable information needed for the practice expense estimates. For example, the supplemental data survey might ask for information on the cost of separately reimbursed supplies, such as drugs for oncology and optical materials and supplies for optometry, which should be excluded from the practice expense estimates. CMS must approve these additions.

<sup>29</sup>Most of the specialty societies' supplemental data submissions have been based on surveys with response rates below 20 percent.

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hospital-based practices may have lower practice expenses than independent practices because hospitals may pay for clinical staff, supplies, and equipment needed to provide a service, while in an independent practice the physician bears these expenses.<sup>30</sup> For some specialties, expenses for practices that are independent can be as much as 50 percent higher than those for practices that are hospital-based. If a supplemental data submission includes a disproportionate share of hospital-based practices compared to the specialty as a whole, then the total practice expense estimates for the specialty may be too low; if the submission includes a disproportionate share of independent practices, the total practice expense estimates for the specialty may be too high. Thus, practice expense payments, which are based in part on these total practice expense estimates, may also be correspondingly either too low or too high.<sup>31</sup>

In addition, CMS may be rejecting data that could improve estimates. In rejecting data that do not meet the agency's precision criterion, even though they are deemed representative, CMS ignores data that could provide a better estimate of the specialty's practice expense data than the data it currently uses, particularly the proxy data used for nonphysician specialties. For example, in 2001, the American Optometric Association (AOA) collected supplemental practice expense information from optometrists. CMS rejected the data because they did not meet the precision criterion, although its contractor recommended that the data be accepted because they were valid and the best available information on practice expenses of optometry practices.<sup>32</sup> Optometrists' practice expenses were originally established with the practice expenses of the average physician because optometrists were not included in the SMS survey. Supplemental data submitted by the specialty would be likely to

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<sup>30</sup>In a 2000 report, CMS's contractor acknowledged that the characteristics used to make the data representative of all physicians in a specialty did not necessarily relate to practice expenses because the SMS survey was not designed to calculate practice expense payments. The contractor suggested that characteristics such as the size of a practice and whether it is a single- or multispecialty practice would be more relevant to consider. The Lewin Group, *An Evaluation of the Health Care Financing Administration's Resource Based Practice Expense Methodology* (Falls Church, Va.: 2000).

<sup>31</sup>CMS examined whether practices were independent or hospital-based to determine representativeness in one of the four recent submissions, and used other characteristics, such as the type of services provided, for another two of the four submissions.

<sup>32</sup>The Lewin Group, *Recommendations Regarding Supplemental Practice Expense Data Submitted for 2002* (Falls Church, Va.: 2002).

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improve the estimates because they are specific to the specialty, whereas the practice expenses of the average physician would be less likely to closely match optometrists' practice expenses. Supplemental data also could improve the estimates for those specialties with few respondents in the SMS survey, as long as the data were from a representative sample of practices.

In addition to assessing representativeness and precision, CMS assessed the accuracy of a 2002 submission, although it has not indicated whether it will consistently assess the accuracy of all submissions.<sup>33</sup> CMS delayed accepting the 2002 submission from the American Society of Clinical Oncology (ASCO) because ASCO's estimates appeared to be too high. CMS assessed the accuracy of this submission by comparing the supplemental data with data for similar specialties and from other sources to see whether the submitted data appeared reasonable. The comparison with benchmark data enabled CMS to evaluate aberrant data that had passed the representativeness and precision tests. Salaries in the supplemental data were more than four times higher for clerical staff than salaries reported in Bureau of Labor Statistics data; and salaries for clerical staff in the oncology submission were even higher than some of the salaries for clinical staff that ASCO reported. These comparisons indicated that the supplemental data might not accurately represent oncologists' practice expenses. CMS later accepted the submission for use in setting 2004 payments without revisions after ASCO explained that the differences were due to certain high-cost practices among the respondents in the sample.

CMS's acceptance of the ASCO data raises concerns about the review process. First, the respondents in the ASCO survey were deemed representative, yet the reported costs were much higher than benchmark data, underscoring the concern that CMS's assessment of representativeness is problematic. Second, the basis on which CMS accepted the ASCO data after assessing its accuracy is problematic because the explanation that the estimates were influenced by high-cost practices should have increased, not alleviated, CMS's concerns about the representativeness of the data. Our replication of the hourly practice expense calculations and discussions with CMS's contractor led us to conclude that the average hourly practice expense estimates were higher when the few practices with high costs were included.

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<sup>33</sup>CMS also assessed the accuracy of three of the four recent submissions.

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## Updating Process Improved Resource Estimates for Individual Services, Although Certain CMS Changes Were Made without Adequate Justification

Stakeholders agree that the PEAC improved resource estimates for individual services, and although CMS used almost all of the PEAC-recommended estimates, it at times used estimates that differed from PEAC recommendations and made other changes to estimates without adequate justification. CMS relied on the PEAC's recommendations to update the estimates. The PEAC's process for developing estimates became increasingly systematic from its inception in 1999, and its recommendations were widely accepted by specialty societies and AMA as leading to improved resource estimates for individual services. This acceptance stemmed in part from the broad representation on the PEAC of multiple specialties and a cross section of physicians and from the PEAC's standardization of estimates for tasks that are common to many services. CMS implemented almost all of the PEAC-recommended estimates, but it has modified certain original estimates and PEAC-recommended estimates. However, CMS did not always use adequate supporting data or explain the rationale for its changes, which has reduced some physician specialties' confidence in the PEAC process and the resulting estimates.

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## Stakeholders Agree that PEAC Improved Estimates

AMA and CMS officials, as well as representatives from specialties told us that they believe the PEAC improved the estimates of the resources required to furnish individual services. These stakeholders said the PEAC process for developing estimates became more systematic from its inception in 1999. The PEAC established standard estimates for the clinical staff time, equipment, and supplies needed to perform certain activities or tasks common to many services, such as taking vital signs, whereas previously estimates for the same task may have varied by type of service or specialty. The PEAC's multispecialty representation further standardized estimates because many of the tasks, such as administration of an injection, are performed by multiple specialties. A specialty could receive PEAC approval to deviate from an estimate for a service only if the specialty satisfied the PEAC that the existing estimate was not appropriate for that service because the service the specialty provided was different from other services that appeared comparable. In addition, the PEAC adopted rules about how estimates were to be established. For example, the PEAC provided guidance to specialty societies on how to gather data, such as through expert panels or a survey, and on the information that had to accompany any recommendation to change a resource estimate, such as a detailed listing of tasks performed by nurses in providing a service. As a result of these changes in the PEAC process, CMS accepted most of the PEAC's recommended estimates without modification in recent years.

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## CMS Changed Certain Estimates without Adequate Justification

Although CMS implemented almost all of the PEAC's recommended resource estimates for individual services, it at times made changes to PEAC-recommended estimates and to the original physician panel estimates. Some of these changes were to estimates that conflicted with Medicare coverage rules or to make estimates consistent across services. For other changes, however, CMS did not always use adequate supporting evidence. For example, CMS removed from the original resource estimates the cost of clinical staff time associated with certain procedures performed by specific surgical specialties, basing its decision to do so on inadequate data. Certain surgical specialties, primarily thoracic surgeons, provided CMS data showing that they routinely bring their own clinical staff to the hospital to help in the operating room and provide other assistance on patient floors and stated that these expenses should be reflected in their resource estimates for individual services.<sup>34</sup> CMS rejected these claims and removed the expense of clinical staff time from these surgical specialties' resource estimates for all services provided in the hospital. CMS officials claimed that Medicare paid for these expenses through other payment mechanisms. CMS also stated that it removed this expense on the basis of evidence that most physicians across all specialties combined did not bring staff with them to the hospital. Although CMS later asked the HHS OIG to assess whether specific specialties typically brought clinical staff to the hospital, it did not reverse its decision in the meantime. The OIG subsequently issued a report indicating that it was a typical practice for certain surgical specialties to bring clinical staff to the hospital.<sup>35</sup> However, the OIG did not analyze whether other Medicare payments account for the expenses associated with clinical staff accompanying physicians in the hospital setting.

In addition, CMS did not always make public its reasons for making changes to PEAC recommendations. In our meetings with specialty representatives, some noted that CMS did not provide adequate explanations for some of its changes to PEAC recommendations. For example, in reducing the time established by the PEAC for radiation therapists to deliver a specific radiation therapy, CMS stated that the

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<sup>34</sup>PEAC representatives told us that the thoracic surgeons did not formally present to the PEAC their resource estimates for services that include the costs of clinical staff they bring to the hospital because CMS officials said the agency would not accept resource estimates that included these expenses.

<sup>35</sup>*Medicare Payment for Nonphysician Clinical Staff in Cardiothoracic Surgery*, April 2002.

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service commonly takes less than the recommended time and requires fewer therapists to perform. CMS officials told us that they based their conclusion on interviews with practicing physicians and a site visit to witness the procedure being performed, neither of which was mentioned in the public notice.<sup>36</sup> Physicians told us that they did not understand why CMS did not explain these decisions, since CMS representatives participated in all of the PEAC meetings and had the opportunity to raise concerns there. Moreover, they said that CMS's inadequate explanation for certain decisions lessened their confidence in the process used to develop the estimates.

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## CMS Has Not Specified a Plan for Developing Appropriate Data to Update the Fee Schedule

CMS has not outlined a plan for obtaining and using the necessary data to update practice expense resource estimates for all specialties. Such a plan would include data collection, evaluation, and incorporation. CMS officials told us they are in the process of obtaining a contract to collect total practice expense data from the major physician and nonphysician specialties, although it has not provided specifics. CMS has indicated that the ongoing AMA committee—the RUC—will develop resource estimates for new and revised services. Although CMS officials told us that they believe they can complete data collection and review by 2007 as required, they did not identify nor outline a plan to implement the actions needed to ensure that CMS will be able to comply with the mandate to update the fee schedule at least every 5 years.

CMS cannot rely on its previous approaches to complete this review. Data sources CMS used to refine the fee schedule no longer exist or are insufficient. The SMS survey, which was the source of total practice expense data for all major specialties, was last conducted in 1999, and a modified version of that survey fielded in 2001, called the Patient Care Physician Survey, did not collect data detailed enough for this purpose. Data submissions from specialty societies are voluntary and therefore unlikely to be comprehensive. In March 2004, AMA discontinued its sponsorship of PEAC after it had concluded its review of over 6,500 physician services. AMA told us that the RUC would review resource estimates for new and revised services and that there would be no need for a detailed review of the services that had been reviewed by the PEAC.

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<sup>36</sup>See 66 *Fed. Reg.* 55,310 (2001).



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Updating estimates of total practice expenses and resource estimates for individual services is increasingly important given the ongoing introduction of new medical services and technologies, and changes in wages. The attendant resource requirements for individual services can change significantly when, for example, a new procedure augments or replaces a traditional procedure, resulting in changes to the staff or equipment needed to provide the service. Similarly, a new pharmaceutical can change the treatment for a condition, resulting in different resource requirements for caring for the typical patient.

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## Conclusions

CMS's collaboration with physician specialty societies to update total practice expense estimates and resource estimates for individual services has helped ensure the appropriateness of fees and physician acceptance of Medicare's payment approach. However, CMS's updates to estimates of total practice expenses using supplemental survey data that do not always represent the range of practices within a specialty may result in Medicare payments that either overcompensate practices for their costs or undercompensate practices, which could discourage physician participation. In addition, CMS's deviation from its own process in evaluating resource estimates for individual services has caused some physician and specialty societies to question the soundness of the process and CMS's decision making.

Congress recognized the importance of continually updating the fee schedule by mandating that CMS review the fee schedule at least every 5 years. The processes CMS had in place to update total practice expense estimates and estimates of the resources required for individual services were not suitable for the comprehensive update required for this review. While CMS has taken a first step at collecting data for this review, without a detailed plan, CMS may not be able to gather and refine representative data necessary to update the fee schedule in a timely manner and ensure its integrity over time.

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## Recommendations for Executive Action

To improve and update the physician fee schedule, we recommend that the CMS Administrator take the following three actions:

- Consistently assess the accuracy of all supplemental data submissions on total practice expenses, modify the assessment of representativeness such that the data submitted by specialties better reflect the variation in practice expenses within a specialty, and adjust the precision requirement

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so that supplemental data submissions that would improve the information currently used to set fees are accepted.

- Base any revisions to the resource estimates for individual services on sufficient data analysis and a documented and transparent rationale.
- Develop and implement a plan to update the fee schedule in a timely manner with representative data on total practice expenses and the resources for individual services so that the fees appropriately reflect changes in medical services and the costs of their delivery.

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## Agency and Industry Comments and Our Evaluation

We received comments on a draft of our report from CMS and AMA. CMS indicated that it routinely conducted, or was in the process of conducting, most of the actions we recommended. However, it stated that it had substantial concerns with our report. AMA agreed in general with our findings but took issue with some of our conclusions. AMA also conveyed comments from ASCO, which disagreed with our conclusion regarding CMS's acceptance of ASCO's supplemental survey data. CMS and AMA also provided technical comments, which we incorporated as appropriate. (We have reprinted CMS's comments in app. III but have not included the attachment pages reprinting statements from specialty societies and detailing technical comments, nor have we reprinted the technical comments submitted by AMA.)

To address our first recommendation, that CMS make revisions to its assessment of supplemental data submissions, CMS responded that its contractor consistently assessed the representativeness of supplemental data submissions. CMS noted that its contractor's assessments of surveys submitted in 2004 from three specialties included as "a fundamental feature" a review of whether a physician practice was hospital- or office-based. The contractor's report was made available on CMS's Web site after our report went to CMS for comment. While we applaud CMS's use of the practice location characteristic in its assessment of recent surveys, we believe that CMS should conduct an analysis to determine whether there are other characteristics that could be used to better describe the potential variation in practice expenses within a specialty.

CMS said it rejected AOA's data on the basis of the precision requirement, noting that (1) the data's representativeness was questionable because the data did not include responses from non-AOA members and (2) the inclusion of the data would have made little difference to the final practice expenses because the AOA per hour data were very similar to the data currently used. We note that CMS's contractor had recommended that CMS accept the AOA data because they were "valid and the best available

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information on practice expenses for optometry practices,” and we have added this information to the report. We believe that including the data from the specialty, rather than relying on the use of proxy data, would improve the estimates. Our concern with the precision requirement is that in applying it CMS may reject data that are more representative than data it currently uses. If data were deemed representative on the basis of characteristics that describe the variation in practice expenses across practices, a precision requirement might not be needed.

In assessing ASCO’s 2002 submission for accuracy, CMS stated that its acceptance of the data complied with requirements in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that CMS use supplemental survey data meeting certain requirements, which CMS says these data met. CMS added that it was satisfied with ASCO’s explanation that the anomalous results were caused by a few extreme survey responses and that elimination of these extreme responses had little effect on the hourly practice expense estimates. We were able to obtain the ASCO survey data only after our draft report went to CMS and AMA for comment. Our own analysis of the ASCO data and discussions with CMS’s contractor led us to conclude that elimination of the extreme values would have had a significant effect on the hourly practice expense calculations, and we have revised the report to reflect this. Although CMS considered the data “anomalous,” CMS accepted them because they met the representativeness criterion as required by law. CMS’s acceptance of these data raises issues about the review process. We are concerned that the practice characteristics CMS uses to assess representativeness may not describe the range and distribution of practice expenses. CMS was silent regarding our recommendation that it consistently assess supplemental data submissions for accuracy.

In response to our second recommendation, that CMS base revisions to resource estimates for individual services on sufficient data analysis and a documented and transparent rationale, CMS stated that the vast majority of these revisions had been based on PEAC recommendations and that on the rare occasions when it disagreed with the PEAC, CMS documented its rationale in the proposed or final rules. As we noted in the draft report, CMS implemented almost all of the PEAC-recommended estimates without change and it generally documented its rationale in instances in which it did make changes to PEAC-recommended or original estimates. Also as noted in the draft report, however, CMS did not always use adequate justification when it made changes. For example, CMS based its decision to remove from the original estimates the cost of clinical staff for all services provided in the hospital on data from the American Hospital

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Association survey pertaining to all specialties, rather than on evidence pertaining to certain surgical specialties that claim that they routinely bring their own staff to the hospital. CMS took issue with our statement that its lack of supporting data or rationale in these cases has reduced physician confidence in the PEAC process and in the resulting estimates, and provided comments from six specialty organizations as evidence of support for CMS's decision making regarding PEAC data revisions. As we noted in the draft report, specialty societies and AMA told us they supported the PEAC process. Nevertheless, other specialties conveyed their concerns to us regarding the PEAC process.

CMS agreed with our recommendation that it needs to develop and implement a plan to acquire representative data on an ongoing basis to update the fee schedule. CMS indicated that it was in the process of obtaining a contract to collect data for future updates to the practice expense portion of the physician fee schedule and that the RUC would continue to be involved in developing practice expense resource estimates for new or revised individual services. We are encouraged by this new information from CMS and have revised our finding and recommendation accordingly. However, contracting for data collection, collecting and reviewing the data, using the data in developing the fees, and addressing public comments take time, making it imperative that CMS expedite these actions. CMS needs to develop a plan to ensure that it can comply with the congressional mandate to update the physician fee schedule at least every 5 years.

In its other comments, CMS took issue with our draft report's reference to updating estimates of total practice expenses with data that are not representative of the range of practices within a specialty, which, as we stated in the draft report, either "overcompensate practices for their costs and waste taxpayer dollars or undercompensate practices and discourage physician participation." CMS stated that because the system is budget neutral, any alternative would reduce payments to the overcompensated specialty and raise payments to all other specialties. Even within a budget neutral system it is wasteful to overcompensate for some services. However, it was not our intention to imply that the system was not budget neutral, and we have revised the report to avoid misinterpretation.

AMA's comments covered the method for establishing total practice expense estimates and resource estimates for individual services and included specific comments it had received from ASCO. AMA commented that it had advised CMS in the past that CMS's criteria for supplemental practice expense data appeared to be appropriate. AMA also stated that it

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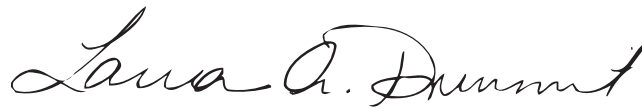
would be inappropriate to use supplemental data that were significantly less reliable and valid than the original SMS data. We concur with this statement. AMA agreed with our conclusion that the PEAC process has improved resource estimates for individual services. It objected to the draft report's statement that AMA had discontinued sponsoring the PEAC as a result of resource constraints and stated rather that the PEAC process had concluded in March 2004 because it had successfully completed its work. It also reported that it would continue to review, through the RUC, the resource estimates for new or revised codes. Although AMA representatives of the PEAC had told us that resource constraints had contributed to their decision to discontinue the PEAC, we have modified the report to indicate that the PEAC concluded its initial review of the codes as of March 2004 and that the RUC will continue this review for new or revised codes. AMA also objected to our conclusion that certain CMS revisions to the PEAC recommendations were made without adequate information, stating that this was unfair criticism of the process. As we noted in the draft report, CMS accepted the majority of PEAC recommendations, although there were instances in which it modified earlier resource recommendations without using adequate information or providing adequate explanation. Finally, AMA noted that CMS's collaboration with physician specialty societies to update the practice expense estimates does not help ensure the appropriateness of the fees because the level of Medicare payments largely depends on other components of the payment methodology. While it is true that other parts of the payment method affect the final payment amounts, the practice expense estimates remain an important determinant.

ASCO disagreed with our concerns about its supplemental survey data. It reiterated that it had discussions with CMS regarding the few practices with high costs for certain items that had no significant effect on the average hourly practice expense estimates used in CMS's methodology. As noted earlier, our replication of the hourly practice expense calculations and discussions with CMS's contractor led us to conclude that including the few practices with high costs did in fact raise the average hourly practice expense estimates. We have revised the report to include this information.

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We are sending copies of this report to the Administrator of CMS and other interested parties. We will make copies available to others upon request. This report also is available at no charge on GAO's Web site at <http://www.gao.gov>.

Please call me at (202) 512-7119 if you or your staffs have any questions. Major contributors to this report are listed in appendix IV.

A handwritten signature in cursive script that reads "Laura A. Dummit".

Laura A. Dummit  
Director, Health Care—Medicare Payment Issues

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*List of Committees*

The Honorable Charles E. Grassley  
Chairman  
The Honorable Max Baucus  
Ranking Minority Member  
Committee on Finance  
United States Senate

The Honorable Joe Barton  
Chairman  
The Honorable John D. Dingell  
Ranking Minority Member  
Committee on Energy and Commerce  
House of Representatives

The Honorable Bill Thomas  
Chairman  
The Honorable Charles B. Rangel  
Ranking Minority Member  
Committee on Ways and Means  
House of Representatives

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# Appendix I: Medical Specialty Societies Interviewed for This Report

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We interviewed representatives from the following 32 medical specialty societies:

American Academy of Dermatology  
American Academy of Family Physicians  
American Academy of Neurology  
American Academy of Ophthalmology  
American Academy of Otolaryngology – Head and Neck Surgery  
American Association of Neurological Surgeons & The Congress of  
Neurological Surgeons  
American Association of Vascular Surgery  
American College of Cardiology  
American College of Emergency Physicians  
American College of Obstetricians and Gynecologists  
American College of Physicians-American Society of Internal Medicine  
American College of Radiation Oncology  
American College of Radiology  
American College of Rheumatology  
American College of Surgeons  
American Optometric Association  
American Osteopathic Association  
American Physical Therapy Association  
American Podiatric Medical Association  
American Psychiatric Association  
American Society for Gastroenterology  
American Society for General Surgery  
American Society of Anesthesiologists  
American Society of Clinical Oncology  
American Society of Plastic Surgeons  
American Thyroid Association  
American Urology Association  
College of American Pathologists  
Joint College of Asthma, Allergy and Immunology  
Renal Physicians Association  
Society of Thoracic Surgeons  
The Endocrine Society



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# Appendix II: Scope and Methodology

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To evaluate the process that CMS uses to review specialty-submitted supplemental practice expense data, we interviewed representatives from medical specialty societies. We identified 50 medical specialty societies by searching the Internet using AMA's categories of major specialties. We contacted each group and met with representatives from the 32 specialty societies that responded (listed in app. I). Using structured interviews, we asked the specialty society representatives whether they were satisfied that AMA Socioeconomic Monitoring System (SMS) survey data used to estimate their specialty's total practice expenses were representative. We obtained their views about whether the supplemental data submissions improved the practice expense estimates and about CMS's process for evaluating the data. We reviewed written materials provided by specialty societies and followed up by telephone when necessary. We reviewed relevant *Federal Register* documents to determine how CMS evaluated the supplemental data submissions and reviewed CMS's decisions about whether to accept the data. We interviewed CMS staff about the supplemental data submission process and interviewed the contractor that CMS hired to provide technical assistance to the specialty societies. We also reviewed the contractor's report on the oncology data submitted by the American Society of Clinical Oncology.<sup>1</sup>

To evaluate the process that CMS uses to update resource estimates for individual services, we asked the specialty society representatives about the resource estimates developed by the clinical practice expert panels (CPEP) and the refinement process used by the Practice Expense Advisory Committee (PEAC). We asked for their views about the role CMS played in the PEAC and any changes CMS made to the estimates. We also met with representatives of AMA to determine AMA's views on the PEAC process. We attended PEAC meetings and reviewed supporting materials provided by specialties. To better understand the issue of physicians' use of clinical staff in the inpatient hospital setting, we reviewed survey data and other materials provided by the Society of Thoracic Surgeons. To determine whether clinical staff time was included in the physician work component, we analyzed detailed estimates from AMA's RVS Update Committee (RUC). We reviewed the Department of Health and Human Services Office of Inspector General (OIG) report, *Medicare Payment for Nonphysician Clinical Staff in Cardiothoracic Surgery*, including

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<sup>1</sup>The Lewin Group, *Recommendations Regarding Supplemental Practice Expense Data Submitted for 2002* (Falls Church, Va.: 2001), and The Lewin Group, *Recommendations Regarding Supplemental Practice Expense Data Submitted for 2003* (Falls Church, Va.: 2002).

analyzing the raw survey data upon which the report was based, and discussed it with OIG staff. OIG indicated that its data reliability checks were performed in accordance with generally accepted government auditing standards. We interviewed CMS staff about the bases for their decisions relating to changes to PEAC resource estimates. We attended CMS's "Open Door Forum Meetings," during which physicians and other clinicians discussed their concerns about fees and other issues related to services provided to Medicare beneficiaries. We conducted a review of relevant *Federal Register* documents to identify any decisions CMS had made with regard to resource estimates.

To determine whether CMS will have the data needed for the mandated review of the physician fee schedule at least every 5 years, we held discussions with CMS staff.

We performed our work from November 2001 through December 2004 in accordance with generally accepted government auditing standards.

# Appendix III: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** SEP 15 2004

**TO:** Laura A. Dummit  
Director, Health Care—Medicare Payment Issues  
General Accountability Office

**FROM:** Mark B. McClellan, M.D., Ph.D. *MM*  
Administrator

**SUBJECT:** General Accountability Office's Draft Report: *MEDICARE PHYSICIAN FEE SCHEDULE: CMS Needs to Plan to Refine and Update Practice Expense Component (GAO-04-289)*

Thank you for the opportunity to review the General Accountability Office's (GAO) draft report entitled, *MEDICARE PHYSICIAN FEE SCHEDULE: CMS Needs to Refine and Update Practice Expense Component, (GAO-04-289)*.

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103-432) enacted on October 31, 1994, required us to develop a methodology for a resource-based system for determining practice expense relative value units (RVUs) for each physician's service beginning in 1998. In developing the methodology, we were to consider the staff, equipment, and supplies used in providing medical and surgical services in various settings.

In response to a mandate in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, GAO evaluated the Centers for Medicare & Medicaid Services' (CMS) processes for updating total practice expense and resource estimates and whether CMS will have the data necessary to update the fee schedule at least every 5 years, as mandated by law.

We have substantial concerns with the GAO report. Our specific comments to the report are attached. We ask that our comments be included in their entirety in the GAO report.

Attachment

**Centers for Medicare & Medicaid Services' Comments to the GAO  
Draft Report: *MEDICARE PHYSICIAN FEE SCHEDULE: CMS Needs to  
Refine and Update Practice Expense Component (GAO-04-289)***

**GAO Recommendation**

*CMS needs to consistently assess the accuracy of all supplemental data submissions on total practice expense data, modify the assessment of representativeness such that the data submitted by specialties better reflect the variations in practice expense within a specialty, and adjust the precision requirement so that supplemental data submissions that would improve the information currently used to set fees are accepted.*

**CMS Response**

Our contractor, the Lewin Group, has consistently assessed the survey methodology and representativeness of the supplemental data submissions. They have provided us with detailed reports that we have made public on the CMS Web site. For example, the GAO report discusses the hospital or office-based nature of the survey respondents as a potential issue. We note that this was a fundamental feature of Lewin's review of three surveys that were submitted to us in 2004 by radiology, radiation oncology, and cardiology. With respect to the precision requirement, we request that the GAO indicate any flaws it perceives in the current methodology. This would assist us in evaluating the recommendation.

**GAO Recommendation**

*CMS should base any revisions to the resource estimates for individual services on sufficient data analysis and a documented and transparent rationale.*

**CMS Response**

The vast majority of revisions to the resource estimates have been based on the recommendations of the multi-specialty Practice Expense Advisory Committee (PEAC) process. As described in greater detail below, the rare occasions where we have differed with the PEAC have been well-documented each year in the physician fee schedule proposed and final rules. We have included as an attachment comments from some of the major specialty organizations supporting CMS' work as it relates to PEAC data revisions.

**GAO Recommendation**

*CMS needs to develop and implement a plan to acquire representative data on total practice expenses and the resources for individual services on an ongoing basis to update the fee schedule so that it appropriately reflects changes in the nature of medical services and the costs of their delivery.*

Page 2 - Attachment

**CMS Response**

We agree with this recommendation and are taking the appropriate steps to acquire practice expense data for potential future revisions.

**Additional Comments:**

**Page 6:**

The report states that although we implemented the vast majority of PEAC recommendations, we also “modified certain original estimates and PEAC-recommended estimates at times without using adequate supporting data or explaining its rationale.” The report also states that “physicians told us that CMS’ changes to estimates without adequate data or explanation lowered their confidence in the process and the resulting estimates.” However, the majority of feedback CMS has received through the regulatory process has been overwhelmingly supportive of both our participation in the PEAC and our decision-making capability with regard to the PEAC recommended values (See p. 7 of attachment).

Below we review the Physician Fee Schedule rules in which we discussed our acceptance or modification of the PEAC recommendations.

- In the November 2, 1999, Physician Fee Schedule final rule, we discussed our review of the recommendations on 65 codes from the first PEAC meeting (we note that CMS is not a voting member of the PEAC). This meeting was a learning experience for all involved, standards had not yet been developed, and there was confusion among the presenters regarding the technical and policy requirements of our methodology. Therefore, although we accepted most of the recommendations, it was necessary to make several, mostly minor, revisions. For example: we deleted supplies that were difficult to allocate to a single procedure, as well as separately billable drugs and casting supplies; we matched the quantities of patient gowns, table paper, and pillow cases to the number of visits; we deleted items that were office supplies or equipment because these were considered indirect costs and deleted equipment costing less than \$500; and we eliminated duplicated supplies. We explained this in the rule.
- In the November 1, 2000, Physician Fee Schedule final rule, we stated, “We have reviewed the submitted... recommendations and have accepted **all** of them with only two minor revisions... we have deleted the marking pen when it appears in a recommended supply list because it is not practical to allocate its use to individual procedures. In addition, for the ophthalmology codes that were refined before the supply packages were adopted, we have substituted the ophthalmology visit supply package as appropriate.” In addition, in this same rule we positively responded to the majority of comments we received on our previous actions on the 1999 PEAC recommendations.

Now on p. 4.

Page 3 - Attachment

- In the November 1, 2001, final rule, we again stated that we have accepted most of the PEAC recommendations with only minor technical revisions. The only significant changes from the PEAC recommendations were for the therapy codes where we deleted assistant time for obtaining vital signs and measurements, patient education, and phone calls because, we explained, we believed that these tasks are done by the therapist and are captured in the work RVUs. We did, however, add in extra time for the therapy aide to ensure that the total times appeared accurate. In this rule, we also responded to comments from specialty societies representing osteopaths, rheumatologists, neurologists, ophthalmologists, obstetricians, and gynecologists commending us for implementing the refinements submitted by the PEAC and relative value update committee (RUC) as part of the on-going refinement process. Other commenters had also praised CMS staff for being helpful in responding to the PEAC members' questions...as well as for our willingness to work with physician specialty societies toward establishing fair and appropriate reimbursement values.
- In the December 31, 2002, final rule, we stated that we had received recommendations from the PEAC on the refinement to the clinical practice expense panel (CPEP) direct practice expense inputs for over 1,200 codes and that we were able to accept **all** of the recommendations without any revision. We also responded to the argument presented in a comment from the specialty societies representing therapists by reinstating the time we had previously deleted. In addition, we responded to comments from societies representing radiology, orthopedic surgery, general surgery, family practice, and dermatology thanking us for our implementation of PEAC recommendations.
- In the August 15, 2003, proposed rule, we discussed the PEAC recommendations we had received on over 4,000 codes. We reviewed these recommendations and proposed acceptance of **all** of them without change. In the November 7, 2003, final rule, we responded positively to the majority of specialty comments we received on the CPEP changes. Once again, we received comments from many diverse specialty societies expressing appreciation for our acceptance of the PEAC recommendations and our commitment to the PEAC process.

With respect to the time that had been assigned by the CPEP panels for physicians' clinical staff brought into the hospital and our removal of that time, we note the following points.

- In our Notice of Intent to Regulate published on October 31, 1997, we solicited detailed information regarding the issue of clinical staff used in the facility setting, along with the name of any facility where the practice occurs. We received only 16 responses, most of them anecdotal. Two specialties submitted the results of the surveys. The society representing ophthalmologists submitted results that indicated that while the practice does occur, it is not typical. The society representing cardiothoracic surgery submitted a survey done by a physician assistants (PAs) association that indicated that PAs frequently assist in the operating room. However, because PAs are physician extenders and we pay

Page 4 - Attachment

for assistants at surgery, we believe that the costs for these services are not practice expense, but would be captured in the work RVUs.

- After the issue of clinical staff time in the hospital setting was raised by the primary care specialties at the first PEAC meeting, no code that included such time was passed by the PEAC.
- In the July 22, 1999, proposed rule, where we proposed eliminating the clinical staff intra time in the facility setting, we laid out a lengthy and detailed statutory, regulatory, and policy rationale for this proposal and also requested data “regarding situations where the recognition of costs associated with the use of a physician’s clinical staff in a facility would be appropriate.” In that year’s final rule, we discussed the data that we had received. Although many specialties asserted that it was a common practice to bring staff to the hospital, the American Hospital Association submitted data from a national survey of 1,459 hospitals that refuted these assertions. We also examined the 1996 Socioeconomic Monitoring System (SMS) survey and did not find support for the specialties’ assertions. Only two specialties provided any extensive information on the issue. The society representing anesthesia submitted a survey that actually indicated that it was not a typical practice for the specialty, and the society representing thoracic surgeons resubmitted the PA survey discussed above.

Page 17:

- GAO raises concerns about CMS’ decision on the American Optometric Association (AOA) survey. The AOA survey was not used because of its failure to meet the precision requirements and the questionable representativeness of the data. We note that the data did not include responses from non-AOA members. We also note that the use of the AOA data would make little difference to the final practice expense RVUs since the survey practice expense per hour is very similar to the crosswalk we are using.

Page 18:

- GAO expresses concern that CMS accepted oncology data that was much higher than benchmark data from other sources. The CMS and the Lewin Group met with the American Society of Clinical Oncology (ASCO) and its contractor to discuss what appeared to be anomalous results in the data. ASCO explained to both CMS’ and Lewin’s satisfaction, that the anomalous results were explained by a few extreme survey responses and that CMS’ policy was not to eliminate any data from either the SMS or supplemental surveys. Further, while elimination of these extreme responses made the salary per employee data comparable to what GAO refers to as “benchmark” data, it actually had little effect on the practice expense per hour.

Now on p. 16.

Now on p. 17.

Page 5 - Attachment

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the use of supplemental survey data meeting certain requirements. The ASCO survey data meet these requirements.

Now on p. 19.

**Pages 20-21:**

- The GAO Report states that, “The OIG subsequently issued a report indicating that it was a typical practice for certain surgical specialties to bring clinical staff to the hospital.” The conclusion of the OIG report was, “Medicare pays for nonphysician clinical staff even though surgeons do not receive additional payments for some of the staff they bring to the hospital. Instead, services of these staff are paid either to physicians through the work relative value units, to the mid-level practitioners directly, or to the hospital through Part A or the Ambulatory Payment Classification system for outpatient services...”

Now on pp. 20-21.

**Page 21:**

- The report indicates that CMS has no plan in place for future updates to the practice expense portion of a fee schedule payment. However, CMS is currently in the process of obtaining a contract that would collect practice expense data from the major specialties, both physician and nonphysician. This survey instrument would include additional questions that would improve the current precision associated with the practice expense inputs. Also, we are proposing updated costs for all the equipment in our CPEP database in the upcoming proposed rule.
- Although the PEAC will no longer exist for future updates, the RUC will continue to be involved with the development of practice expense RVU recommendations. The RUC is more than capable of providing CMS with recommendations on practice expense inputs as the majority of the RUC members have already been involved in recommending the practice expense inputs for new and revised codes. The RUC has also indicated willingness to take part in the 5-year review of practice expense.

Now on p. 21 and p. 5.

**Page 23 & last paragraph of page 6:**

- The report makes reference to overcompensating practices and wasting taxpayer dollars. However, the system is budget neutral and any alternative would reduce payments to the overcompensated specialty and raise payments to all other specialties.
- The GAO makes a general recommendation that adjustments be made to the precision requirements. In order to assist us in evaluating this recommendation, we request that the GAO indicate what the flaws are in the current precision requirement.



Page 6 - Attachment

- The GAO recommends that CMS consistently assess the accuracy of all supplemental data and modify the assessment of representativeness to better reflect the variation in practice expenses within a specialty. Our contractor, the Lewin Group, has consistently assessed whether a survey's respondents are representative of the population and has provided us with detailed reports that we have made public on the CMS Web site. With respect to modifying the assessment of representativeness to consider whether a specialty is hospital or office-based, we note that this was a fundamental feature of their review of three surveys that were submitted to us in 2004 by radiology, radiation oncology, and cardiology.

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# Appendix IV: GAO Contact and Staff Acknowledgments

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## GAO Contact

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## Acknowledgments

Major contributors were Iola D'Souza, Elizabeth T. Morrison, and Gerardine Brennan.

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