Summary of Technical Expert Panel on Updating Practice Expense Allocation in Medicare Physician Fee Schedule

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Preface

On January 10, 2020, the RAND Corporation under contract #HHSM-500-2014-00036I/HHSM-500-T0004 from the Centers for Medicare and Medicaid Services convened a technical expert panel with leading professionals and experts on the topic of updating the allocation of practice expense (PE) in the Medicare Physician Fee Schedule. Panel members were encouraged to share their candid views on the current PE data, the process by which PE data are collected, the process by which data inputs are converted into payment rates, and how each of these components might be improved. This working paper provides a summary of the themes that were addressed. Questions about this summary should be directed to the project leader, Lane Burgette (email: burgette@rand.org).
## Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tr>
<td>AHRQ</td>
<td>Agency for Healthcare Research and Quality</td>
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<td>AMA</td>
<td>American Medical Association</td>
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<td>APC</td>
<td>Ambulatory Payment Classification</td>
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<td>all-payer claims database</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>CPT</td>
<td>Current Procedural Terminology</td>
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<td>electronic medical record</td>
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<td>IT</td>
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<td>MEPS</td>
<td>Medical Expenditure Panel Survey</td>
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<td>MGMA</td>
<td>Medical Group Management Association</td>
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<td>MPFS</td>
<td>Medicare Physician Fee Schedule</td>
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<td>NAMCS</td>
<td>National Ambulatory Medical Care Survey</td>
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<td>OPPS</td>
<td>Outpatient Prospective Payment System</td>
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<td>PE</td>
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<td>PPI</td>
<td>Physician Practice Information</td>
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<td>RUC</td>
<td>Relative Value Scale Update Committee</td>
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<td>RVU</td>
<td>Relative Value Unit</td>
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Introduction

Under a contract from the Centers for Medicare and Medicaid Services (CMS), the RAND Corporation has been researching potential improvements to the data and methodology that underlie practice expense (PE) payments made under the Medicare Physician Fee Schedule (MPFS). To follow up on various issues raised in the first phase, RAND convened a technical expert panel (TEP) on January 10, 2020, with leading professionals and experts on the topic of updating the allocation of PE in the MPFS. The TEP consisted of Dr. Robert Berenson (Urban Institute), David Gans (Medical Group Management Association), Dr. John Goodson (Harvard Medical School), Dr. Mark Holmes (University of North Carolina at Chapel Hill), Dr. Scott Manaker (University of Pennsylvania), Jill Martin (Cedars-Sinai Medical Network), and Sherry Smith (American Medical Association). TEP members were encouraged to share their candid views on the current PE data, the process by which PE data are collected, the process by which data inputs are converted into payment rates, and how each of these components might be improved.

Below is a summary, based on contemporaneous notes and a transcript of the conversation, of the themes that were addressed. In keeping with the TEP charter, themes and comments have been combined so that the identities of the commenters are not disclosed. RAND aimed to provide a thorough account of the day’s conversation. TEP member comments were summarized and grouped into the following topic categories:

- issues with the current system
- changes in medicine affecting PE
- general views on the approach to updating the system
- types of expenses to measure and how to measure them
- the appropriate level of aggregation of PE categories
- PE data collection in large and interconnected organizations
- rethinking direct and indirect expense groupings and relationships
- facility versus nonfacility PE payments
- additional approaches to updating PE inputs beyond a new Physician Practice Information Survey
- using Outpatient Prospective Payment System information to inform PE Relative Value Units
- possibilities to maximize response rates
- other issues.

1 Results of the first phase of this research are available on the RAND website. See Lane F. Burgette, Jodi L. Liu, Benjamin M. Miller, Barbara O. Wynn, Stephanie Dellva, Rosalie Malsberger, Katie Merrell, PhuongGiang Nguyen, Xiaoyu Nie, Joseph D. Pane, Nabeel Shariq Qureshi, Teague Ruder, Lan Zhao, and Peter S. Hussey, Practice Expense Methodology and Data Collection Research and Analysis, Santa Monica, Calif., RR-2166-CMS, 2018, at www.rand.org/pubs/research_reports/RR2166.
At various points in this summary, a qualitative assessment is provided of the level of TEP members’ agreement with particular views expressed. However, during the day’s discussions, members might not always have had an opportunity to voice concern in response to proposals endorsed by others before the conversation moved on. No recommendations or conclusions in this summary should be considered to be unanimously endorsed by the TEP, even if no opposition is noted here.

**Issues with the Current System**

The TEP raised several broad issues with the system used to allocate PE, which relies on a methodology developed by CMS. The system relies on data provided by (1) the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) process and other data resources to measure direct expenses associated with services (e.g., medical supplies, equipment, and labor), and (2) the Physician Practice Information (PPI) Survey to allocate indirect expenses to those services (e.g., office expenses and rent). The broad issues are as follows:

- **Arbitrary distinctions.** Some TEP members mentioned aspects of the system that stem from early decisions on how to build PE payments on a fee-for-service chassis and should be revisited when CMS considers system updates. Specific aspects mentioned were the division of expenses into direct and indirect components, using specialties as a means of operationalizing how measured inputs determine the indirect portion of PE, and how to handle physician payments depending on whether a service is performed in a facility or a nonfacility setting. Some members felt that some of these paradigms were arbitrary, might not be conducive to successfully measuring costs, or could create imbalances or inequities across physicians.

- **Unintended practice and market effects.** Members expressed concern about how some aspects of PE allocation create incentives that influence the way medicine is practiced and organized. For example, some TEP rememberers were concerned that practices servicing populations with access issues were not receiving PE commensurate with their true expenses (and insufficiently adjusted by such mechanisms as the geographic practice cost index).

- **Issues with payment universality.** Some members did not agree with the principle that PE allocation should be fixed for a service across or even within specialties because of the systematic variation that exists in the expenses associated with the same service across different specialties and practice types. Some members said that facility and nonfacility adjustments were not adequate, and it was noted that PE burden both within and across specialties that deliver services in a facility can be very different depending on the needs of the portion of their practice that occurs in a nonfacility physician office. Universal payment under these circumstances could lead to systematic under- or overpayment of some physicians and specialties.

- **Poor transparency.** Some members described the process that converts PE inputs into payment rates as a “black box,” and they said that a lack of clarity on how inputs are used to determine rates complicates any discussion on how to improve inputs.
• **Outdated components.** At various points, the TEP discussed ways that changes in the practice and organization of medicine have made components of the MPFS outdated, such as the PPI Survey that was conducted in 2007–2008. (For more information, see the next section.) Additionally, many members agreed that the scaling factors determined from the PPI Survey cannot change over time and that this is a major flaw, leaving the system unable to adapt to changes likely to happen in practice cost structures. This inability to adapt creates imbalances when PE changes disproportionately among specialties.

### Changes in Medicine Affecting PE

One of the circumstances motivating reform discussions is the rapid pace of change in the practice and organization of medicine, such as market consolidation, practice integration into large health systems, and the declining number of physicians in solo and independent practices. Physician practice cost structures have likely changed over the past decade in ways that are not reflected in current inputs. At various points in the discussion, members referred to additional changes occurring in medicine that should be considered, including the following:

- **Pay-for-performance and quality monitoring.** Members noted that quality reporting has become a task that can involve significant amounts of clinical labor, including from physicians. Any development of a new infrastructure of measuring expenses should account for a growing set of tasks that are required for payment but not associated with a specific patient encounter or billing code. Labor for these tasks is sometimes spread across a variety of occupations.
- **Empanelment.** Members noted that the creation and management of patient panels has created costs—e.g., information technology (IT) costs, task delegation—that are not tied to face-to-face encounters and not captured in the payment system. This was cited as an issue in both primary care and in specialty care.
- **Care management.** Members noted that codes relating to care management are not connected to a specific patient encounter but do relate to the expenses of the specific encounters they support. For this reason, it was argued that the costs associated with care management should be measured in some way. As it is, the system ignores these costs, which were largely not present at the time of the PPI Survey. Some members argued that not accounting for care management exacerbates the distortions between specialties.
- **Retail clinics.** The growing presence of retail clinics in such places as drug stores and shopping centers has introduced a new model for delivering care, likely with different cost structures and accounting than traditional practices.
- **Higher-efficiency independent practices.** Members referred to data that indicate that private (independent) physician practices that remain in the market have become more efficient and more profitable than in the past. This is believed to be because of business failure in an increasingly competitive market landscape or absorption of less profitable practices into larger organizations.
- **Telemedicine.** New technologies, such as telemedicine, could change the cost structures of practices, potentially reducing some aspects of PE (e.g., space costs) while increasing others (e.g., labor, internet, and other IT costs).
Demographic change. The aging population has put pressures on ambulatory settings as hospitals try to contain costs and move more care into community-based settings.

General Views on the Approach to Updating the System

TEP members had a variety of perspectives on how CMS should generally approach updating PE payment determination. They identified several goals and issues that should be considered during the process, including the following:

- **Conducting a new survey.** Members said that conducting a new survey of adequate quality and coverage of specialties would be very difficult. As a reference point, members noted that the design and administration of the PPI Survey relied on multiple survey contractors and had a response rate of 10 to 15 percent despite significant efforts over two years; members also noted that identifying independent private practices would be more difficult now because of the large shift from private practice to employed models for physicians. Members also noted that the PPI Survey was initiated after a previously failed survey effort to replace the Socioeconomic Monitoring Survey.

- **Prioritizing methods over data collection.** Some members said that upcoming decisions regarding how to update data inputs will be dependent on whether the methodology used to determine payments is changed. Members said that decisions regarding updating data inputs should be tied to the method of using those inputs in determining payments. For example, it was suggested that respondent burden in a survey could be minimized by collecting direct and indirect PE in two precisely defined questions, but data in this format would require that CMS change the methodology used to calculate rates. It was suggested that staging reform so that methods were changed before data collection might be a preferred approach, given the cost of new data collection and anticipated political difficulties of updating both at once.

- **Limiting harmful incentives.** Members stated that updates or reforms should not create incentives that lead to fewer medical resources going toward taking care of the sickest and most-vulnerable people. This is a risk if payments are blind to sociodemographic and community characteristics that are associated with vulnerable populations of greater medical complexity.

- **Adjusting PE for patient characteristics.** In reference to harmful incentives and other issues, one member advocated reforms to the system that would make it more patient-based. The same service for different patients across different specialties may incur different amounts of PE. A precedent for this kind of approach was cited in the recent CMS initiative to add Evaluation and Management (E/M) add-on codes for some specialties to account for patient complexity. It was argued that patient-based modifiers for services, based on characteristics of the patient, could help address distributional issues in PE payments across specialties and types of practices.

- **Limiting “upcoding.”** Concern was expressed that any system of determining PE allocation must account for the issue of inappropriate service code billing. Some specialties might be billing higher intensity codes than necessary and therefore receiving higher PE than merited.

- **Targeting respondents.** Members generally agreed that, in many cases, physicians are not the right people to provide PE data because their knowledge of PE is increasingly limited.
It was suggested that data come from qualified professionals, such as certified public accountants, who abide by standards of professional accountability in this area. However, relying on nonclinical respondents to gather PE data, which determine payment rates, might be viewed negatively for a couple of reasons: (1) Smaller practices could view these data as being biased toward large practices with accounting staff, and (2) some physicians might question the fairness or accuracy of inputs provided by people without clinical backgrounds. However, some members said that the number of physicians that do not rely on some degree of professional help to fill out expenses is decreasing and that the importance of accuracy should take precedence. One suggestion for a possible way forward was to allow physicians to fill out the survey in practices below a certain size.

- **Stratifying on specialty.** There was disagreement among the TEP members on whether a new survey or other data collection effort needs to be stratified on as many specialties as the PPI Survey, or if fewer groupings of specialties and/or some other characteristics of the practice might be more effective in gathering representative PE data. One member raised the issue that cost structures can be quite different among subspecialties of the same specialty. Another member noted that accounting for every specialty and subspecialty in a survey would be intractable. As an alternative means of grouping specialties, one member suggested that specialties with similar cost structures might be identified by cross-referencing a specialty with the distribution of service codes it bills, but others cautioned that this method would still need to be sensitive to differences in how different specialties bill the same code. Members suggested several criteria beyond specialty that could be used to identify practices with similar cost structures, such as the following:
  - practice size and type (e.g., large multispecialty, hospital-owned)
  - proceduralist versus nonproceduralist
  - location (rural versus nonrural)
  - characteristics of the patient base.

**Types of Expenses to Measure and How to Measure Them**

RAND presented the TEP with a list of PE types and an illustrative survey prior to the meeting and asked for members’ input on which PE types are important to measure, how to measure them, and whether expense types or categories that should be collected had been excluded. Here is a summary of PE types mentioned by at least one TEP member for inclusion in future data collection:

- **Occupations of growing importance.** Members suggested that any new survey or data collection effort should try to include new occupation types that have become important in recent years (e.g., scribes, care management roles, patient educators).
- **Costs associated with office space.** The TEP discussed issues in achieving accurate measurement of office occupancy costs and possible solutions, such as the following:
  - **Ownership versus leasing.** Whether a practice owns or leases space was cited as an important distinction to PE. For example, occupancy and other expenses vary
depending on whether a space is owned or leased, and these expenses are treated differently in the tax code. These tax considerations can influence a practice’s cost structure. Large practices that own their space can reduce tax expenses by writing off building costs, which encourages a higher level of spending on the building and office.

- **Parent organization relationship.** For leased space, it is necessary to understand whether that space is owned by the practice physicians (directly or indirectly) or a parent organization, in which case the lease might be provided at a cost different from the market rate.

- **Square footage.** To avoid the above issues, members were receptive to using square footage to estimate space-related PE. Square feet would be measured and then multiplied by a standardized rate that is either newly collected or informed by existing data (and can be adapted depending on what is considered to be fair market value). In taking this approach, some members said that different categories of square footage would be important to collect (e.g., waiting rooms, procedure rooms, exam rooms). For this approach, members said that data collectors should be mindful of such potentially revenue-generating spaces as parking lots and space rented out to other practices or businesses. Survey questions should be clear regarding what to include or exclude in square footage measurements depending on use of that space.

- **Subleasing and shared space.** Similar to revenue-generating space, the TEP discussed the notion that some practices might share space with other practices. Hence, it is necessary to measure the extent to which rental costs are offset by subleasing or sharing.

- **Room types.** Counting room types (e.g., the number of exam rooms) was another approach discussed that could ease the burden of reporting. Members did not agree that this would be as reasonable an approach as reporting square footage because of the differences that exist in room size by description and specialty.

- **Additional expenses.** Members discussed the following expenses worthy of consideration for inclusion:

  - **Managed care service.** Members discussed how health plan processing costs related to risk-bearing should be included.

  - **Quality reporting.** The costs of data curation and submission for payment adjustments under such programs as CMS’ Merit-based Incentive Payment System (MIPS) might vary across specialties.

  - **Refrigeration.** The costs and importance of refrigeration differ among specialties. For example, pediatricians often keep vaccines in the office in part because they get direct expense for immunization administration.

  - **Taxes.** One member pointed out that that all types of taxes should be measured, such as building, income, and business license.

  - **Other Insurance.** One TEP member said personal liability insurance expenses beyond malpractice have been increasing. Furthermore, some organizations might incur expenses for actuarial services.

  - **IT.** Members discussed the increased importance of IT expenses and the need to measure differing IT needs to inform rates. Members mentioned that IT needs—
such as internet access, data, data storage, cybersecurity (including consulting fees), software, technical support, and software upgrades—can vary significantly by specialty or by the types of services that are provided by a particular practice. This variation also might be driven by different preferences in terms of electronic medical record (EMR) or billing functionality.

- **Separately billable expenses.** It was noted by a member that PE data collection will need to differentiate supplies, equipment, and staff that are separately billable to Medicare.

### Appropriate Level of Aggregation of PE Categories

PE data inputs could be collected at a wide variety of levels of aggregation, from precise measures of individual items (e.g., office supplies, office furniture) to expansive groupings (e.g., all office expenses). The decision to collect data at higher or lower degrees of aggregation involves trade-offs among sometimes competing goals, such as data detail, accuracy, consistency, and respondent burden. RAND sought TEP members’ views regarding the appropriate level of aggregation for PE data collection and whether groupings of expenses already exist that a typical practice could easily report.

- **Different accounting practices.** Members discussed how practices could be loosely categorized into accounting *lumpers* (i.e., practices that tend to rely on higher aggregations of expenses) and *splitters* (i.e., those that divide expenses into component pieces). This distinction is correlated with practice size; smaller practices tend to be lumpers and larger practices tend to be splitters. However, specific accounting practices within each of these categorizations can vary widely.
  
  - **Lumpers.** Lumped accounting systems, more common among small practices, might have greater difficulties reporting accurate data. Panelists noted that aggregated accounting presents particular challenges within payroll. Nonwage compensation, for example, can be lumped together across all staff types, including physicians. Accurately apportioning these payroll costs for purposes of PE payment might be difficult because the benefit value can vary considerably by staff type.
  
  - **Splitters.** Larger practices are more likely to use a detailed, standardized accounting system, such as the Medical Group Management Association (MGMA) chart of accounts, because they can afford complex accounting systems and can more effectively realize the benefit of collecting detailed expense data to help inform managerial decisions.

- **Different survey instruments.** Panelists discussed the feasibility of using two different surveys or two different survey forms to accommodate lumper and splitter accounting styles, allowing organizations to report at the level of detail at which they feel most comfortable. Some members said that multiple survey instruments might compound issues of response bias. Moreover, members asserted that multiple instruments would not address the major challenge of collecting accurate data from disorganized practices. With these practices, neither a detailed nor aggregated format of a questionnaire will solve data collection issues.
accuracy issues because some of the information on individual expenses necessary to report at either level does not exist. It was suggested that less-organized practices (which might be less likely to respond to a survey) could have different PE cost structures than practices with better-developed accounting systems. Some members argued that, if data collection were to use highly aggregated PE inputs, questions would need to be very specific and well-defined, outlining exactly which items should be included when reporting that aggregated figure.

**Commonalities.** Some members did not view differences in accounting among practices to be so great as to require individualized instruments from practice to practice, but some degree of flexibility in the instrument was seen to be required in order to match with different practice accounting systems.

- Some members agreed that a pilot data collection effort could identify a list of accounting modalities that could be matched to appropriate respondents.
- Members agreed that, in the case of variation by specialty, having a different set of instructions to help clarify how questions should be answered for certain specialties, or delineating some survey sections that would only be filled out by certain classes of practitioners (e.g., proceduralists versus nonproceduralists, time spent in a facility), might be workable instead having separate survey instruments by specialty.

**PE Data Collection in Large and Interconnected Organizations**

The TEP provided input on approaches to collecting updated PE in an environment in which medical practices are increasingly large and interconnected. RAND sought input on two topics in particular; first, whether it would be reasonable to measure PEs for such organizations at a single location (office, building) or for a single medical specialty, and second, whether certain types of financial relationships between practices and other medical organizations are particularly useful for identifying instances in which resources and expenses might be shared. Approaches that were discussed included the following:

**Collecting data at a single location.** Some members did not think that PE could be accurately collected at the office level in some larger practices both because of variability in costs from one location to another within the same practice and because of other issues, such as flow of funds and programmatic support from other parts of the practice or a larger entity that owns the practice. Some members said that, even though many large multispecialty practices tend to be able to break out expenses by specialty or location, internal allocations among parts of the practice or programmatic support given to a practice for hospital services could lead to inaccuracies when reporting on the PE of only a portion of the practice. Instead, some members said that respondents to any data collection effort should be allowed to report expenses at the level that is most convenient. In some cases, for very large organizations, this would mean filling out several surveys at different levels of the organization that have their own accounting systems. A survey instrument should therefore be flexible enough to fit a variety of reporting levels.

**Accounting for shared resources and expenses.** Several members acknowledged the importance of accounting for interorganizational transfers and relationships that involve
expense sharing. RAND facilitators asked members if these relationships could be accurately accounted for by identifying ownership arrangements. The TEP discussed that, in addition to ownership relationships, reporting of financial relationships needs to include incentives and bonuses shared across organizations, such as accountable care organizations and pay-for-performance arrangements.

- **Screening for data quality.** RAND facilitators asked members for their thoughts on potentially ignoring responses from practices whose expenses are extensively distributed across entities or other characteristics that raise questions on data validity. One panelist was concerned that this approach would systematically exclude certain types of practices and create bias in the data. Another panelist said that this might be necessary in some cases, but some practices would not have an issue collecting needed expenses data from a parent organization.

Rethinking Direct and Indirect Expense Groupings and Relationships

Under current policy, indirect PE for most services is determined in part based on CMS’ valuations of direct PE and physician work for that service. This method might not be reasonable for all types of indirect expenses, and alternative bases for scaling could yield more-accurate results. RAND sought TEP members’ views on possible adjustments to the use of direct and indirect expense categorizations in the MPFS.

- **Alternative basis for scaling.** Members were asked if they thought some indirect expenses could be accounted for more accurately by using different indirect allocation bases. Some members saw appeal in alternative scaling bases, such as on a per-encounter or per-unit time basis, for some expense types.

- **Scheduling.** Scheduling was suggested by RAND as an indirect expense that might be allocated directly to CPT codes, perhaps being allowed to vary by characteristics of those codes. One member of the TEP raised the issue that scheduling expenses can vary significantly for different specialties. For example, a surgeon needs a registered nurse to schedule some types of procedures, but other patient visits or specialties might not need clinical expertise for scheduling.

- **Billing.** The TEP suggested billing as an example of an indirect expense that might be more directly allocated based on features of service codes. One TEP member suggested that billing might be predictably complicated or simple depending on the process of documentation for the clinical activities, providing an opening for an alternative basis for assigning billing PE to particular codes.

- **Electronic Health Records (EHRs).** Members suggested EHRs as a PE element for which physician and clinical staff time could be a conceptual basis for expense calculation. Members mentioned that newer IT-related costs have generated debate about whether expenses are direct or indirect; e.g., there are some EHR/EMR or IT functions that directly support certain types of procedures.
Recording Facility Versus Nonfacility

The differences in PE that occur when services are performed in a facility versus a nonfacility is an aspect of PE that might have changed since the PPI Survey was last conducted. This being the case, the TEP discussed issues with this distinction and how fees ought to reflect it.

- **Inadequate differentiation.** Some members said that the ways in which facilities and nonfacilities are distinguished and accounted for in PE Relative Value Units (RVUs) does not necessarily reflect true differences in PE. For example, when a hospital system purchases a private practice, services might then be billable under the facility fee schedule even though the practice and its PE have not changed. A mix of financial incentives and preferences will then affect how a particular system chooses to shift costs from off-campus locations to on-campus ones, with different consequences for PE.

- **Differential impact on specialties.** Members of the TEP raised concerns about applying a universal method to distinguish PE in facility settings versus nonfacility ones because some specialties maintain much larger presences outside the facility than others and therefore have different costs (e.g., need for and use of an office for many surgeons).

- **Fixed cost of nonfacility offices.** The TEP discussed how, although physicians need to make a facility/nonfacility distinction in the split of their time (or patient visit volume) for billing, some physicians need to maintain an office that has at least some fixed costs regardless of how many patients or procedures or how much physician time is associated with that office. This is likely to vary by specialty (e.g., hospitalists versus radiologists). Some TEP members stated that the unit of measurement for nonfacility use should attempt to capture these costs even if the office is idle.

Additional Approaches to Updating PE Inputs Beyond a New PPI Survey

TEP members discussed several alternative or supplementary approaches to a new, large national survey to update PE inputs, including the following:

- **Using a small cohort design.** Some members expressed support in principle for adopting a cohort approach to measuring PE with a relatively small, purposeful sample for which intensive efforts are made to collect valid data. This could either augment or replace a survey sample like the PPI Survey, which sampled more than 40 specialty strata and gathered supplemental data from specific specialties. The group discussed balancing the political tractability of this approach against the high-quality data it would produce.
  - **PE nuances.** Several members agreed that a cohort approach would allow for collecting PE at a level of detail necessary to tease out many of the issues and nuances that had been described as necessary to accurately and fairly measure PE. This level of detail would not be possible on a survey like the PPI without overly burdening respondents.
  - **Sample strata.** Concerns were raised that the wide degree of variation in PE between and within specialties could create large distortions if the small number of practices selected to represent a particular specialty were not typical. Moreover, some members were worried that this approach might be affected by
large variations in expenses that occur from year to year for the practices that happen to be sampled—e.g., a smaller practice that happened to purchase a very expensive item that year. That said, not all on the TEP agreed that stratified sampling was an insoluble problem; some research suggests that alternative practice groupings—such as by practice size—could be created where relatively few strata (eight to ten) could cover a large portion of total Medicare charges. Members disagreed over the extent to which data collection should reflect specialties or practice types that account for a very small portion of overall Medical services/costs but might have highly unusual cost structures.

- **Adjustment for practice demographics.** Members discussed whether adjustment based on a limited set of demographic or practice features would be enough to account for wide variation in practice cost structures, with some arguing that existing data show that these adjustments work reasonably well.

- **Rotating panel.** To collect data that capture changes in PE across specialties, a rotating panel could be implemented, with participating practices cycling in and out of the survey sample over time.

**• Repurposing ongoing surveys to collect PE on an individual encounter basis.**

- **National Ambulatory Medical Care Survey.** One member said that a possible alternative would be to collect PE data within the National Ambulatory Medical Care Survey (NAMCS), which was mentioned as having a very high response rate (more than 60 percent). The NAMCS has recently begun including CPT codes and associated diagnoses. Data could be collected to complement and validate NAMCS’s data collection efforts to be representative of all patient encounters.

- **Medical Expenditure Panel Survey (MEPS).** Another suggestion was to look at the MEPS model as a way to update the PPI Survey method of collecting PE data. MEPS is administered by the Agency for Healthcare Research and Quality (AHRQ), is household based, and uses in-person interviews to collect detailed data on medical expenditures. MEPS employs a rotating panel design, which could be useful for PE data collection, both in reducing the administrative burden of recruiting new practices for periodic updates for PE survey data and in better understanding PE changes within practices over time.

**• Using alternative data sources.**

- **Public data.** RAND sought feedback from the TEP on a variety of publicly available data sources—such as the Service Annual Survey (SAS), the Economic Census, the Occupational Employment Statistics (OES), the Current Population Survey, and the American Community Survey—that could be used in an effort to update PE inputs.
  - Members voiced general agreement that extant data on PE such as the SAS or Economic Census could be used as validation for any new data collected in the survey process.
  - Members discussed whether external salary data, such as from the Bureau of Labor Statistics’ OES, might be used to inform PE calculations for nonphysician clinical and nonclinical staff. Members discussed the possibility of collecting data from practices on full-time equivalent labor for different
occupations and applying a standardized rate based on external data sources. Data drawn from the Bureau of Labor Statistics for direct labor costs were viewed by panelists as being relatively accurate. Some members cautioned that usability would depend on the level of job description detail. In the context of this conversation, a separate issue was raised about applying standardized clinical labor rates in PE given differences in clinical pay for same occupations across specialties.

- **Proprietary Data.** Members discussed the limitations to using proprietary data sources, such as the MGMA, as sources for PE inputs. Members identified legal and/or statutory prohibitions on the use of such data in rate-setting; the reluctance on the part of proprietary data owners of using their data in this way, for confidentiality or other reasons; the lack of representativeness of these surveys, particularly their applicability to small practices; some stakeholders’ inability to access data used in rate-setting; and inadequate coverage of all specialties currently required for calculating rates.

- **Government data.** One panelist proposed that there is a possibility for cross-agency collaboration and data-sharing among the Center for Medicare and Medicaid Innovation, Office of the National Coordinator (ONC) for Health Information Technology, AHRQ (MEPS), the Centers for Disease Control and Prevention (NAMCS), and CMS. The panelist suggested that data collection efforts can be structured so that data gathered can be used by multiple agencies and provide internal methods of assessing the effects of payment policy changes over time.

- **Vendor data.** One panelist suggested that deidentified vendor data might be used to determine the unit cost of some PE items, such as EHR systems.

### Using Outpatient Prospective Payment System Information to Inform PE Relative Value Units

A possible alternative data source for establishing PE RVUs is to use data from the Outpatient Prospective Payment System (OPPS), which could better align the two payment systems and reduce site-of-service payment differentials. The rationale for using OPPS information is that many health care services can be provided in multiple settings, and the relative costs for providing a service might be similar regardless of the setting. However, there also could be differences in underlying costs between office and outpatient settings. OPPS information could be applied in different ways, such as helping to identify misvalued codes, grouping codes at a higher level than procedures (such as using the Ambulatory Payment Classification [APC]), and deriving estimates to value PE RVUs or components of PE RVUs. TEP members discussed several issues with using outpatient data to inform PE RVUs.

- **Understanding differences in the OPPS and MPFS.** Some TEP members pointed out that nonfacility settings and outpatient departments are very different systems with different underlying cost structures. OPPS uses distinct APC payment amounts, unlike MPFS, which has PE RVUs for individual CPT codes. A member reported that the 3,140
CPT codes that are billed in nonfacility settings map to only 162 distinct APC-based payment rates. One TEP member said that the mix of services furnished in physician offices versus outpatient departments are different—and that, after removing exempt office visits, nearly 40 percent of services by allowed charges are never performed in a hospital setting. TEP members also mentioned that sometimes payment and cost are higher in physician offices; sometimes they are higher in outpatient departments. Another member explained that differences can sometimes result from different equipment utilization rates and patient selection (sicker patients going to facilities); in addition, site differences are complicated by incentives when physicians own facilities. As an example of an instance where payment is much higher when furnished in an outpatient setting than in a physician office, a TEP member brought up Healthcare Common Procedure Coding System (HCPCS) code 55700 for prostate biopsy and reported that the service receives a PE payment of $156 in the office but an OPPS payment of $1,807.

- **Similarities and known differentials.** When asked whether there are services furnished in both settings that have similar clinical content, TEP members mentioned ancillary services, such as X-rays, electrocardiograms, and cardiology imaging. However, other TEP members pointed out that even these services can have different costs, and costs can go in either direction; some services have higher costs in offices while others have higher costs in outpatient departments. TEP members mentioned different reasons for cost differences in both directions. For example, hospitals have more purchasing power than physician offices, so some items might be less expensive when performed there. In addition, fixed costs for equipment are lower in hospitals, where utilization rates tend to be higher. On the other hand, wages for nurses and technicians are higher in hospitals.

- **Using outpatient data.** Some TEP members said that it would be overly simplistic to pay the same rates in both settings. Furthermore, it would be difficult to implement payment differentials for cost differences unless many factors could be measured. Even if measurement were possible, it would be difficult to know whether the relative values are valid. However, one TEP member said that the RUC acknowledges value in using OPPS data to screen for procedure codes that are misvalued in the MPFS, particularly for procedures that are paid more in nonfacility settings than outpatient settings. For example, PE RVUs for imaging codes are already capped at OPPS payment levels.

- **Grouping procedure codes for payment.** A TEP member said that, in general, there are pressures against grouping procedure codes for payment. The RUC receives many proposals for distinct codes because physicians want services priced in a granular way, which could reflect nuances between services provided by different specialties, new technology, or other differences. Another TEP member said that some CPT codes are written in different ways for different specialties, vendors, or technology while other CPT codes are written in a neutral way. The RUC has recommended against bundling high-cost disposable supplies with procedures and has said that these things should be priced separately and tracked annually, partly so that indirect costs are allocated more appropriately than under the current system. On the other hand, the RUC has worked with CMS to standardize and define clinical staff time by similar tasks to ensure uniformity and ease of updating.
Possibilities to Maximize Response Rates

The TEP members discussed the challenges of getting responses to physician surveys and possible approaches to improving response rates in future data collection.

- **CMS involvement.** Members discussed the difficulty of getting potential respondents to cooperate in an intensive investigation of their costs. TEP members with experience doing similar work reported that mustering participation is not easy for an independent contractor, but that if CMS were to commit to a major initiative that provides added value to participating practices (both through compensation and helping to understand their own operations), response rates would be better. Additionally, members agreed that mutual goodwill and support between CMS and physicians will be important for data collection and other work of the government.

- **Emphasis on data usefulness.** Some members asked whether practices could be encouraged to participate in data collection if they could be convinced that organizing and providing those data would result in improved practice management decisions. Other members said that it would be hard to motivate people with an undefined benefit at some undefined time in the future.

- **Alleviation of participation fears.** Other members voiced the concern that practices would fear being ostracized from their peers if participation led to reimbursement redistributions. Some said that identities of respondents could be shielded and that responsibility for changes would be diffused by the fact that multiple practices respond to the surveys and that CMS would bear ultimate responsibility for data-collection requirements and rate-setting.

Other Issues Discussed

TEP members also touched on several other themes that do not fall neatly into the preceding categories. These topics included:

- **Increasing transparency and avoiding political barriers.** Some members acknowledged that making substantial changes to the MPFS is, in part, a political process. It was argued that any changes to MPFS should be developed and adopted in a transparent, accountable, and representative fashion. Many members acknowledged that input and buy-in from stakeholders is important, as is the central role of CMS. One suggestion for achieving this buy-in was to involve stakeholders early in the process by holding one or more “town hall” meetings, where proposals and ideas could be introduced and discussed. Members suggested that it might be possible to achieve broad consensus among stakeholders on the process of updating the PE rate-setting methodology and data. Whatever changes come from an agreed-on process would be much more easily accepted (even if some practices experience lower payment rates) than would be the case if the process were less open to stakeholder input in its early stages.

- **Involve of the AMA.** There was spirited debate on the degree to which professional organizations, such as the AMA, should be involved in new data collection. Mentioned among the benefits of involving organized medicine was the convening power of such groups as the AMA (i.e., ability to boost response rates). It was also argued that accurate PE rate-setting requires input from a variety of clinical specialties, and without the
support of an organization with the broad footprint of the AMA, it could be very difficult to secure broad participation. CMS has faced difficulty in successfully convening a replacement survey to the PPI without the involvement of organized medicine. It was also argued that the AMA has felt a need to step in when CMS has not produced necessary data or analyses—e.g., with the PPI Survey. On the other hand, concerns were expressed regarding professional organizations exerting too much control over physician payment policy, fair representation of physician interests among specialties that may be less powerful than others, the financial stake that the AMA has through CPT codebook licensing, and the need for transparency and accountability. One member argued that the AMA has a “special privilege” when it comes to providing input into CMS’ rate-setting decisions and that this should not be the case.

- **Low volume in rural practices.** The TEP discussed that the allocation of PE is problematic for low-volume practices, such as those in rural areas. These practices incur higher equipment and building costs per service because the fixed and labor costs associated with them is distributed over fewer units (i.e., limited economies of scale). Similarly, new reporting requirements could be more onerous in low-volume practices because there might not be staff dedicated to handling these responsibilities who can process them efficiently. It was pointed out that these issues would not be solved by the geographic adjustments that occur in setting fees because those only deal with differences in prices. Future updates, therefore, might take these utilization-based differences in expense into account. These changes also need to be harmonized and not redundant with policy levers already in place intended to improve access in underserved areas.

- **Other rural differences.** Other issues that are unique to rural practices were mentioned, such as differences in expenses associated with greater commute distances for practice staff, as well as time to get between the practice location and a hospital.

- **PE measure denominators.** Members discussed views on tracking PE by various units (i.e., per hour or per work RVU). Another issue was that there are a significant number of smaller practices that do not track their RVUs; they are more likely to track expenses by encounter or visit. Members also mentioned that RVU data from large organizations have been found to be more accurate. More broadly, the TEP discussed the accuracy of currently used time variables and whether RVUs might be more accurate. Although there were concerns about the accuracy of CMS’s time estimates, there was no consensus that work RVU–denominated PE measures would be expected to result in greater accuracy. One member cited literature suggesting that the current system of determining work RVUs is very inaccurate. It was argued that if work RVUs were to be used in CMS’s data collection, there would need to be a parallel effort to improve their accuracy.

- **Using only states with All-Payer Claims Databases (APCDs) for national estimates.** The TEP discussed whether full geographic representation will be necessary for new data collection or whether it would be efficient to focus on states with APCDs. This was discouraged by another member because of known, large variations between states in care delivery and cost (per the Dartmouth Atlas). That said, it was suggested that perhaps responses could be adjusted by procedure volumes to get at national figures, but participants disagreed on whether higher volumes result in lower costs to provide services. Another member proposed that this might work if CMS had 20 states with APCDs (this would be 40–50 percent of total claims nationally) and data from Medicare
and Medicaid for the rest of the states; together that might provide enough data for this approach. Whether this would be representative (i.e., of practice mix) was not resolved.