

Statement of the AANS and CNS to the Physician Payment Review Commission

Contact(s):

Heather L Monroe

I. MEDICARE FEE SCHEDULE

- HCFA should undertake as broad a review as possible so we have an opportunity to improve the relativity of RVWs within families of codes and within the entire spectrum of neurosurgical procedures. The AANS and CNS are particularly concerned with the issues of compression of values, reference set and cross-specialty links.
- The Commission should investigate the extent of Carrier Medical Director involvement and determine the precise influence they have in determining final RVWs.
- More accurate and reliable data for determining the work, practice expense and malpractice Geographic Practice Cost Indices (GPCIs) should be utilized.

II. MANAGED CARE

- Congress should enact legislation making the point-of-service option mandatory for all health plans.
- Congress should extend the OBRA 90 requirements for Medicare and Medicaid risk plans to all private health plans. These provisions place certain restrictions on incentive payments to physicians and will assure that decisions regarding patient care are based on medical judgment and not financial considerations.
- The Commission should evaluate the Medicare risk plan program, with particular focus on the excessive profits of many HMOs. If abuses such as those in California are widespread, Congress should enact legislation aimed at limiting HMO profits.
- The Commission should examine the impact of managed care on academic health centers. It is critical that these institutions are given a meaningful opportunity to participate in managed care plans, as they are crucial to the development of our nation's future physicians. Congressional intervention may be necessary to preserve the viability of these institutions.
- The Commission should evaluate the inadequacy of the DOJ/FTC guidelines, particularly with regard to the permissible market concentrations for specialists and the definition of risk sharing. The definition of risk sharing should include the investment of capital.
- The Commission should conduct a coordinated review of the whole body of laws affecting provider integration, particularly the anti-kickback and self-referral laws.

III. COBRA HOSPITAL ANTI-DUMPING LAW

- The Commission should examine the use of the COBRA law as a federal malpractice statute. Congress should enact legislation prohibiting the use of COBRA as a federal malpractice statute.
- Congress should enact legislation clarifying the following aspects of the law: (1) the definition of facility capability, (2) what constitutes a transfer, (3) the conditions of the medical screening examination, (4) the definition of emergency medical condition, and (5) the liability of the on-call physician.

IV. GRADUATE MEDICAL EDUCATION

- The Commission should explore potential antitrust relief for the accreditation bodies so they may reduce the number of residents trained without fear of antitrust liability.
- Residency training programs should be fully funded for the entire length of training. Incentives to encourage the training of more primary care physicians should not include the weighting of the direct GME payment.

V. PRACTICE GUIDELINES

- A national mechanism for evaluating and disseminating practice guidelines should be established.
- Practice guidelines should be developed based on the AHCPR model rather than on a consensus basis.

Mr. Chairman, Members of the commission, the American Association of Neurological Surgeons (AANS) and the congress of Neurological Surgeons (CNS), which represent over 4,000 neurosurgeons in the United States, would like to comment on several issues that the Commission will address in its next annual report to Congress.

I. MEDICARE FEE SCHEDULE

In our past testimony to the Commission, the AANS and CNS have expressed our ongoing concerns with the current Medicare Fee Schedule (MFS), including the compression of values, the site-of-service payment differential, and development of resource-based practice expenses. We would like to reiterate these concerns and take this opportunity to comment more extensively on these and other issues related to the MFS.

Physician Relative Work Values (RVWs)

1. 5 Year Review of the MFS - The AANS and CNS are looking forward to the 5 year review process as a means to correct the anomalies that exist in the current MFS. We are very worried about HCFA's posture that they are unwilling to do a wholesale review of the fee schedule, but are hopeful that the agency will utilize an adequate reference set of procedures to allow for appropriate extrapolation and cross-specialty linkages. We firmly believe that the agency should be committed to review every procedure code in the MFS if credible and accurate data are presented regarding misvaluation. Organized medicine will lose faith in the system if HCFA arbitrarily limits the number of codes subject to challenge.

It is critical that the entire MFS be a fair representation of the physician resources that comprise the work of each procedure, and that the numerical representation reflect the relationship between allied as well as different procedures throughout the fee schedule. We urge the Commission to closely monitor this process and suggest that HCFA undertake as broad a review as possible so we have an opportunity to

It is critical that the entire MFS be a fair representation of the physician resources that comprise the work of each procedure, and that the numerical representation reflect the relationship between allied as well as different procedures throughout the fee schedule. We urge the Commission to closely monitor this process and suggest that HCFA undertake as broad a review as possible so we have an opportunity to improve the relativity of RVWs within families of codes and within the entire spectrum of neurosurgical procedures.

2. Compression of RVWs - Since the final values were implemented, the AANS and CNS have complained that numerous neurosurgical procedure codes have compressed values. We believe this result is due largely to the approach Hsiao took utilizing the magnitude estimation technique. Subsequent interviews with neurosurgeons have revealed that many provided Hsiao with rough estimations of the time it takes to do a procedure, rather than using actual database information such as time logs, etc. For example, in the Hsiao Phase I survey, the time for neurosurgery's benchmark procedure, 63030, was 85.6 minutes. Information exists to suggest this is grossly undervalued. For example, the California Association of Neurological Surgeons conducted a survey which resulted in a time estimate of 150 minutes. Moreover, the time from an anesthesia billing database, which included 469 cases of 63030, was 169 minutes. Even in Phase II, the time for 63030 was only raised to 97.

Since this time factor was used to develop our benchmark procedure and appears to be inaccurately measured, it sustains our concern about the validity of the entire spectrum of RVWs in neurosurgery's section of the MFS.

3. Cross-Specialty Linkages - The AANS and CNS are also concerned that the cross-specialty links were done without regard to the available data and with results that confirmed our concerns about the compression of higher valued procedures. Three examples will support this issue and demonstrate that there was substantial downward dislocation in the neurosurgical procedure RVW when linked to the other specialty cross-specialty procedure and subsequently adjusted.

| Procedure | CPT-4 Code | Hsiao II Work RVUs | HCFA Work RVUs 1992 | Specialty |
|----------------------------------|------------|-----------------------|------------------------|-----------------|
| Ant. Cervical discectomy | 63075 | 1566 | 14.42 | Neurosurgery |
| Expl/parathyroid adenoma | 60500 | 1230 | 16.23 | General Surgery |
| Craniotomy for meningioma | 62512 | 3122 | 25.56 | Neurosurgery |
| Revision, total hip arthro. | 27134 | 2760 | 25.86 | Orthopedics |
| Post. fossa tumor removal | 61518 | 3829 | 34.01 | Neurosurgery |
| Total cystectomy with ileal loop | 51595 | 2830 | 36.09 | Urology |

This analysis and comparison clearly shows that the work values assigned by HCFA did not reflect the data developed by the Hsiao Phase II teams. In each case, the Hsiao RVWs for the neurosurgical procedure were higher than the other specialty cross-linked procedure. In each case, the final RVWs assigned to the neurosurgical procedures were actually lower than those for the other specialty procedure, and the amount of the reduction reflected by the HCFA compression increased as the original RVWs of the neurosurgical procedure increased.

We are therefore extremely concerned about this and urge the Commission to closely monitor the cross-specialty linkage component of the 5 year review process.

4. Carrier Medical Directors (CMDs) - The AANS and CNS have long questioned the apparent arbitrary reduction in RVWs, and despite multiple inquiries to HCFA, we have never received an adequate explanation. We suspect that this result was due largely to the extensive involvement of the CMDs. This is bolstered by the fact that the same reductions have occurred during the refinement panel process for new and revised codes.

We remain concerned about the influence that the CMDs have on final values, particularly in light of the rigorous valuation process that new and revised codes must go through, i.e., the RUC and multispecialty refinement panels. We fear that if their involvement is extensive during the 5 year review process, the accuracy of the MFS will continue to be questioned by the physician community. We therefore urge the Commission to investigate the extent of CMD involvement and determine the precise influence they have in determining final RVWs.

5. AMA RVS Update Committee (RUC) - The AANS and CNS are extremely pleased with the RUC. It has become a respected forum for the review and refinement of RVWs. We are hopeful that HCFA will continue to view the RUC's role as essential and credible, and that the agency will adopt its recommendations without significant alteration.

Practice Expense RVUs

1. Resource-Based Practice Expenses - The AANS and CNS are generally supportive of the proposal to change the way in which practice expense relative values are calculated to a resource-based methodology. We are pleased that HCFA is undertaking this task without any apparent preconceived notions about the final outcome and potential redistribution of values. We are also encouraged by HCFA's willingness to keep organized medicine informed as it proceeds. Organized neurosurgery continues to feel strongly that any changes should fairly and accurately reflect the costs associated with the practicing neurosurgeon's delivery of quality healthcare.
2. Practice Expense RVUs for 1995 - The current practice expense and malpractice expense RVUs for the 1995 MFS are still based on the AMA Socioeconomic Characteristics of Medical Practice. The AANS and CNS recently did an internal evaluation of neurosurgical practice expenses and found that the respective percentages of practice expense represented by work, practice expense and malpractice expense are at a significant variance from the AMA data.

Socioeconomic Characteristics of Medical Practice. The AANS and CNS recently did an internal evaluation of neurosurgical practice expenses and found that the respective percentages of practice expense represented by work, practice expense and malpractice expense are at a significant variance from the AMA data.

| | Work | Practice Expense | Malpractice Expense |
|---|-------|------------------|---------------------|
| Distribution of Income AMA Data | 54.2% | 41% | 4.8% |
| Distribution of Income AANS/CNS Data | 29% | 63% | 8% |

These figures suggest that if Medicare payments continue to dwindle such that neurosurgeons cannot cover their overhead adequately, they may start to limit the number of Medicare patients that they will treat. We therefore urge the Commission to carefully consider this issue.

3. Geographic Practice Cost Indices (GPCIs)

1.

We believe that this introduces an averaging factor that reduces the differences in physician earnings between geographic areas, thus artificially interfering with the basic intent of the GPCI. Moreover, the county-wide median wages assigned to the Medicare Service Areas (MSA) has a further averaging effect that acts as another involuntary discount mechanism for the physicians serving in the suburbs.

It seems to us that using physician net earnings rather than these proxies would be a more reliable method of measuring relative differences between geographic areas. Simply discarding the available data on physician earnings because these fees are, in large part, the determinants of the earnings does not seem valid. If the object of the Work GPCI is to make some adjustments to acknowledge the real differences in physician work as measured by differences in physician net earnings, we question whether the use of historically old data from a group of non-physician professionals that do not suffer the same market forces and regulation as physicians can be justified. The current rate of change in the healthcare marketplace and in reimbursement requires a currently valid yardstick to measure these adjustment factors. Using out of date and inappropriate proxies as a substitute for use of real physician earnings data indicates that the validity of this GPCI is questionable.

We suspect that HCFA is reluctant to use this data because of the differences in physician earnings from Medicare prior to imposition of the Medicare Fee Schedule in 1992. However, we submit that data about physician earnings that is current for 1992-3 is available in the federal system, perhaps in the records of the Internal Revenue Service. This would include data on physicians in all parts of the United States. Use of factual physician net earnings data in different geographic areas would make this aspect of the GPCI more valid. We urge the Commission to explore this prospect for a more accurate and appropriate basis for the Work GPCIs.

2. Practice Expense GPCIs - We are still concerned about the use of fair market rental data for residential rents as a proxy for physician professional office rents. We believe that efforts to secure better data for this factor are needed, and suggest the development of other sources of valid rental data that have more direct relevance to this item of cost for physicians.

3. Malpractice GPCIs - HCFA's use of current data averaged from 1990 through 1992 and obtained from insurers that represent the majority of the market in each state is commended. Collection of data from 20 specialties rather than