REPORTS REGARDING MEDICARE PAYMENT POLICIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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REPORTS REGARDING MEDICARE PAYMENT POLICIES

TUESDAY, MARCH 3, 1998

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at noon in room 1100, Longworth House Office Building, Hon. William M. Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 24, 1998
No. HL–19

CONTACT: (202) 225–3943

Thomas Announces Hearing on Reports Regarding Medicare Payment Policies

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on reports regarding Medicare payment poplicies. The hearing will take place on Tuesday, March 3, 1998, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 12:00 noon.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include Dr. Gail Wilensky, Chairman of the Medicare Payment Advisory Committee (MEDPAC) and Dr. William Scanlon, Director, Health Financing and Systems, U.S. General Accounting Office (GAO). However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On March 1, 1998, MEDPAC will issue its first report on Medicare payment policies since the merger of the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC). For more than a decade, ProPAC and PPRC provided analysis for the Congress on hospital, physician, post-acute care, and managed care issues. The Balanced Budget Act of 1997 (BBA) (P.L. 105–34) contains several provisions that reflect earlier recommendations of ProPAC and PPRC.

This legislation requires the Secretary of Health and Human Services to develop rules to expand private health plan options under the Medicare+Choice program, expand preventive benefits, and implement prospective payment systems for skilled nursing facilities, hospital outpatient departments, home health agencies, and rehabilitation services. The Subcommittee will be seeking extensive guidance from MEDPAC on many of the important details of the BBA reforms.

The BBA included a one-year delay in the implementation of the Administration's proposed rule for physician practice expense values and requested that GAO conduct a thorough review of the Health Care Financing Administration's (HCFA's) proposed methodology. The GAO report will address several issues including: (1) the appropriateness of resource-based methodology for practice expenses, (2) the adequacy of HCFA's data, (3) the categories of allowable costs, and (4) the methods for allocating direct and indirect expenses.

In announcing the hearing, Chairman Thomas stated: "Congress passed important reforms to make the Federal Government a more prudent purchaser of health care by offering our seniors more private plan choices, expanding preventive benefits, getting tough on fraud and abuse, and modernizing the fee-for-service part of the program. The Administration's implementation of this transformation—from a 1960s-style program to one that is market-based—will need constant monitoring.

Over the next few years, we will continue to look to the Medicare Payment Advisory Commission for up-to-date analysis and recommendations and to the watchful eye of the General Accounting Office for evaluation of the program. I look forward to receiving their initial reports.''

FOCUS OF THE HEARING:

The hearing will focus on the MEDPAC's 1998 recommendation on Medicare payment policies and the GAO's report on physician practice expenses.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) single-space legal-size copies of their statement, along with an IBM compatible 3.5-inch diskette in ASCII DOS Text or WordPerfect 5.1 format only, with their name, address, and hearing date noted on a label, by the close of business, Tuesday, March 17, 1998 , to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on an IBM compatible 3.5-inch diskette in ASCII DOS Text or WordPerfect 5.1 format. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS__MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. The hour of noon having arrived, the Subcommittee on Health will come to order.

The Balanced Budget Act, BBA, made fundamental changes to virtually every part of the Medicare Program. Most significant, I guess from most people's perspective, is the new Medicare+Choice program that will bring our seniors a menu of private plan options.

The Congressional Budget Office, CBO, estimates that within 4 years, a quarter of all Medicare beneficiaries will choose to enroll in a private plan instead of traditional fee-for-service Medicare. To show how late Medicare arrived on the scene, current estimates are that the private sector who get health care through their employer are currently at 85 percent in terms of a Medicare+Choice type option.

The reforms contained in the Balanced Budget Act obviously didn't stop there. This Subcommittee held several hearings last spring in which we heard from experts that pretty obviously the fee-for-service portion of Medicare, the predominant portion of Medicare needed, is in need of an overhaul, or at least a tuneup. The Balanced Budget Act modernizes this part of the program from its sixties style cost-based reimbursement to deal with the fastest growing cost setter such as home health care and other areas with the prospective payment system and simple fee schedules that, for far too long, have been common practice in the private sector and overdue for adoption.

In making these historic changes, we looked to the recommendations of, as we have done historically, two commissions that were established to advise Congress on these technical issues. The Prospective Payment Assessment Commission, ProPAC, and the Physician Payment Review Commission, PhysPRC.

The Balanced Budget Act merged these commissions, just as we've talked about change in HCFA. Congress felt we needed a change in the structure that advised us into the Medicare Payment Advisory Commission, MedPAC. So ProPAC and PhysPRC are gone, but MedPAC is now with us.

Our first witness will be Dr. Gail Wilensky, who is the Chairperson of MedPAC. As the administration grapples with the technical details regarding implementation of the Balanced Budget Act over the next few years, we will look to Dr. Wilensky and the MedPAC commissioners and the staff for their advice and counsel and this is an annual occurrence, it is just a slightly different structure that is providing us with our annual occurrence.

At the same time at this hearing, our second witness, Dr. Bill Scanlon, will report the results of the General Accounting Office's examination of the physician practice expense issue. As we continue to implement the second major cost area, the work profile or the RBUS portion which we had implemented and the practice expense being the second one, we heard from physicians back home that they were concerned about the administration's methodology, if you will, in revamping of the physician payment portion on exercise.

Many of the physicians that I and others spoke with felt that the administration was making these changes partially devoid of real-world experience inside a kind of a black box, that we weren't completely aware of the number of adjustments that had been made or, more importantly, why the adjustments were made.

So to shed light on this issue, Congress chose to delay the implementation of the new practice expense payment method for a year to ask the General Accounting Office to give us their opinion after a thorough examination and, after that examination notwithstanding, to phase in the new system over several years.

I look forward to hearing Dr. Scanlon's report and then, obviously, the followup panel to give us a comfort level in terms of what has been discovered, the timetable, and the steps that need to be made to implement this very important adjustment in the payment structure.

And with that, I would indicate that any Member who wants to put a written statement into the record can and when the gentleman from California comes, he will have obviously missed an opportunity to make some cogent comments as he always does.

Mr. MCDERMOTT. Mr. Chairman, could I put a statement in for Mr. Stark?

Chairman THOMAS. Without objection, the written statement from my colleague of California will be made a part of the record.

[The opening statement of Mr. Stark follows:]

Opening Statement of Hon. Pete Stark

Mr. Chairman,

Thank you for holding this hearing.

On the Practice Expense issue, I can't tell whether the GAO and MedPAC have given HCFA a C+ or a B−, but their statements remind me of my parents talking to me about my report cards, "Fortney, we know you can do better." It is too bad we don't have HCFA here to respond to the recommendations, and I urge you, Mr. Chairman, to send a letter—I'd be happy to join it—asking HCFA to respond, ASAP, to the recommendations of MedPAC and the suggestions of the GAO.

MedPAC's first report to Congress is an excellent starting point for launching the debate over Medicare's long-term future. Prior to passage of the Balanced Budget Act last year, it was fashionable to argue that Medicare was in dire straits—too rigid to survive into the 21st century. But the budget that we enacted in 1997 showed that Congress can and always will respond to keep the program both solvent and intact. The BBA cut the 75 year tax shortfall in the Part A Trust Fund in half, and that assumes we return to the old rates of provider inflation after 2002. Yet MedPAC finds that hospital prospective payments under last year's bill will remain "reasonable"—a term of art that translates into PPS margins of about 15% per year. Read that as: "the highest in history." MedPAC also notes more than once that a lower update this fiscal year could easily be justified. Clearly, a long term policy of restraints on provider inflation, coupled with modest, reasonable and progressive changes in beneficiaries' contributions can preserve the Medicare program without radical shifting of costs to the 73% of seniors living on less than $25,000 a year.

That's not to say that the cost containment battle was been won. In one key area, MedPAC notes that the hospital industry has moved to diversify during the last 10 years into other lucrative areas, including moving ever-more procedures to outpatient services departments, where charges are far higher.

Perhaps the gloomiest news is that MedPAC calculates the BBA will take about 40 YEARS before hospital outpatient department beneficiary copayments drop to 20% of the fee schedule. What happened? The budget package of last year supposedly reached the 20% goal in about 25 years. Mr. Chairman, this is an area we should revisit—and we should be more aggressive in paying for outpatient services in the lowest cost, quality setting.

Mr. Rangel, myself and other subcommittee Democrats favor carving out DSH payments from Medicare HMO payments, since it is dubious that for-profit Medicare managed care plans—which are in the business of providing care only to their enrollees—can easily be persuaded to spend money in the hospitals that bear the

extra costs of serving the uninsured poor. I am pleased that MedPAC supports this proposal, and I hope we can act on it soon.

Chairman THOMAS. And with that, I would ask Dr. Wilensky to come forward and initiate the era of MedPAC, which, I might hastily add, is not in any way affiliated with any political group raising funds for any purpose. It is, in fact, an advisory group.

STATEMENT OF GAIL R. WILENSKY, PH.D, CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION; ACCOMPANIED BY MURRAY ROSS, EXECUTIVE DIRECTOR, MEDPAC

Ms. WILENSKY. Thank you, Mr. Chairman. It is a pleasure to be here today to testify before you and the other Members of the Subcommittee. I have with me the new Executive Director of MedPAC, Murray Ross. You may have known him from his previous incarnation at the Congressional Budget Office, but we are very pleased that he has joined the MedPAC staff.

We are also very pleased to be here today with our first of what will be a series of mandated reports to the Congress, this being our first, March 1 report on payments under Medicare.

We have now completed this first phase of our new existence, having gotten out our first report and over the weekend having actually moved the staffs of the predecessor commissions into a single location. We feel that we are now fully on our way to being a new, unified commission.

In our report to Congress, one volume of which is a set of recommendations and the second volume of which is a more technical series of discussions about these recommendations, we have covered a lot of area, reflecting the many changes that occurred in the Balanced Budget Act.

This has been an enormous amount of change to the Medicare Program, more than has occurred at any other time in history and, therefore, there were many areas for comment.

What we have focused on in this first report was whether or not the payments that were prescribed under the Balanced Budget Act appear to be adequate as best we can tell, as opposed to looking at payment rates de novo as we have done in the past. We will continue this type of assessment over the next several years because of the inclusion of specific payment changes in the Balanced Budget Act for many parts of Medicare.

But there are a number of other areas that we have brought to the Congress' attention where either the work was complete or where recommendations may need to be reconsidered.

Let me just indicate a couple of these areas.

The payments that are made to the capitation plans, because of the floors and the minimum payments and the requirements for budget neutrality, are not entirely internally consistent and we need to get further direction from you as to how you would like these various factors to interact with each other.

In addition, in what will be a common theme when it comes to risk adjustment, we think that phase-ins are important. Risk adjustment is only one of a number of changes that will affect the

capitation plans, in addition to putting in remaining payments for graduate medical education, having floors, and blended rates. A result of all these changes, we think that the notion of phasing-in change an important concept.

When it comes to the hospital payments, as best we can tell, the amounts that are included in the Balanced Budget Act, for inpatient spending appear to be reasonable. We believe a consistent payment increase for capital would be something between 0 and 0.7 percent. This is within a range that is consistent with the payments that exist for current operating expenses and would therefore be appropriate.

We have a couple of recommendations, regarding the physician payment. One is that the volume and intensity change, which was included in the HCFA-proposed rule and which I remember well because of the experience on that issue which I encountered in 1991, not be included for practice expense. Times have changed, and the change in the sustainable growth rate makes it not necessary. If there is any error in projections, a difference in expected versus actual payments, there is an appropriate mechanism for recouping the overpayment.

We have raised a number of important issues with regard to outpatient hospital payments. We strongly support strengthening the protection for seniors so that they pay only a 20-percent copayment and shortening the timeframe when this occurs.

There are a number of other areas which I would be glad to discuss in the question-and-answer period, including some of the specific recommendations for postacute care and other parts of the Medicare system.

Let me try to summarize several themes that are in the report.

One, as I have indicated, is the need for a phase-in. With all of the change that has been included in the Balanced Budget Act having phase-ins is a constant theme and an important one.

A second theme is the need for monitoring. A lot of change has been included in the Balanced Budget Act. We think it is important for the Congress to monitor the effects of the change, for HCFA to monitor the effect of the change, and for MedPAC to assist the Congress in monitoring the effect of all of this change and make sure the change is what you have intended.

In addition, we think it is important to look for the effects of interactions. Because there has been so much change in some parts of Medicare, it won't be enough to look at the effect of any one of these changes, but rather to look at how they interact with each other and to make sure that these are the changes that you intended.

Finally, it will be important to monitor missed regulatory deadlines that may occur. You have put an enormous amount of work on HCFA's plate. It is important to assess whether these changes are occurring on time. If not, it will be critical to specify penalties and acknowledge needed adjustments.

There is a last issue, one that is not specifically in this report, one that we will touch on in our June report and then come back to over the next several years. This is to begin to look at the rationale and consistency of payment rates for similar services which occur across different sites.

We need to start looking at the implicit signals we are sending in terms of payments for services that occur both in the outpatient hospital setting and in the physician's office. We need to look at the implicit signals for similar services that occur in a rehabilitation facility, in home care, and in skilled nursing facilities. This will be very difficult. It will be hard to come up with specific recommendations as to exactly what these differences should be, but we think the differences in payment have been occurring far too long without this kind of explicit recognition. We are sending signals to the providers of care, whether or not we recognize them. It is time for us to take more of an in-depth look at what we have been doing and make sure that the signals we have been sending are the ones that we intend.

Let me stop here and answer any questions that you may have.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of Gail R. Wilensky, Ph.D, Chair, Medicare Payment Advisory Commission; accompanied by Murray Ross, Executive Director, MedPAC

Mr. Chairman and members of the Subcommittee, I am pleased to be here today to present the Medicare Payment Advisory Commission's (MedPAC's) first report to the Congress. This report focuses on Medicare payment policies. In our June report, we will examine broader issues affecting the Medicare program and its relationship to the American health care system as a whole.

The Congress laid out a broad agenda for reforming Medicare payment policies in the Balanced Budget Act of 1997 (BBA), enacted last August. The creation of the Medicare+Choice program opens opportunities for beneficiaries to enroll in a broader range of managed-care options. Changes to the methods for determining per capita payments to these plans will reduce volatility and raise rates in low-cost areas, setting the stage for a greater number of plans to participate. Successful implementation of the risk adjustment of payments to Medicare+Choice plans called for in the act will make for a more level playing field for these plans and may also improve the quality of care for Medicare beneficiaries with high-cost conditions.

The legislation also included significant changes intended to improve Medicare's traditional fee-for-service program. Both to slow spending growth and to improve the distribution of payments, the Congress set timetables for implementing prospective payment systems (PPS) for a range of providers. Interim payment provisions were outlined for most providers until those systems are developed. The legislation also included a provision to reduce beneficiaries' effective coinsurance for outpatient hospital services.

The BBA provides the context for most of MedPAC's recommendations this year. The Commission's deliberations in its first five months have focused on key issues that will arise as the legislation is implemented by the Health Care Financing Administration (HCFA).

In developing our recommendations, we evaluated the impact of the BBA in light of the evolution of the health care delivery system. Because its mission combines those of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, MedPAC can look across the entire Medicare program. We were able, therefore, to consider the implications of these policy changes across the many components of Medicare. In our discussions, inconsistency in incentives across payment policies was a major area of concern. In addition, we considered the interaction between policies and their effects across health care providers. The Commission will continue to explore these issues in our June report and beyond. An issue that will need continued attention is how payment policies for Medicare+Choice and traditional fee-for-service affect each part of the program.

Let me begin by discussing the information and recommendations the Commission provided regarding the Medicare+Choice program. Then I will present the Commission's views and recommendations on the traditional Medicare fee-for-service program.

MEDICARE+CHOICE

Two major components of the Medicare reforms that became law in the BBA were the expansion of options for private health plan participation under the new Medicare+Choice program and the restructuring of the method for paying those health plans. The new law changes the way capitation payments are calculated at the county level, requires HCFA to implement a new system of risk adjustment in 2000, and makes other changes that will significantly change the adjusted community rate (ACR) process used to establish minimum benefit levels in private plans.

County-Level Payment Rates

Under prior law, each county's payment rate was determined by its per capita fee-for-service spending. Under the new system, the 1997 payment rate is the starting point for calculating each county's rates for 1998 and beyond, but payment rates will no longer be strictly tied to the local pattern of fee-for-service spending. Instead, the rate will be the highest of a blended local and national rate, a floor amount, or the prior year's rate increased by 2 percent. These changes were designed to lessen the volatility of payment rates over time and their variation across areas. They were also intended to expand the availability of Medicare+Choice plans in some markets where rates were low and constrain rates in other areas where they were higher than necessary to compensate plans fairly.

The changes made by the BBA will effectively eliminate year-to-year volatility in county payment rates. As the changes are phased in over the next five years, rates will generally grow by a minimum of 2 percent each year and by a maximum of about 2 percentage points above the nationwide increase in program spending. The new system will reduce the amount of variation among counties. Although central urban counties will generally remain well above the national average and all other counties will remain below, the differential between them is projected to shrink over the first five years of new rates.

The impact of these changes will be substantial. Therefore, the Commission recommends careful monitoring of plan and beneficiary participation, risk selection, plan premiums, supplemental benefits, beneficiary cost sharing, and access to care. All of these could be affected by the new payment rules, risk adjustment methods, and the expanded range of plans that can participate. Continued monitoring will allow policy makers to consider additional changes that may be needed to address adverse effects on beneficiaries. The Commission plans to continue analyzing these characteristics of the Medicare+Choice program, as should HCFA, and adequate resources should be made available to fulfill this important function.

The Commission also has three specific recommendations regarding payments to Medicare+Choice plans. First, the Commission recommends that disability status be taken into account as a risk-adjustment category at the national level to avoid overpayment on behalf of disabled beneficiaries. Although spending for the disabled was about 86 percent of that for aged beneficiaries in 1997, the BBA did not set a separate lower floor for them. As a result, the rates could be overstated by as much as $60 per month for each enrolled disabled beneficiary in counties that are paid at the floor. Treating disability status as a risk-adjustment category would render this issue moot. Alternatively, the overpayments could be corrected by establishing a separate floor 14 percent below the floor for aged beneficiaries.

Second, the Commission recommends providing an alternative to the mechanism created by the BBA to adjust county-level payment rates without affecting total spending. Depending on factors such as actual growth rates in Medicare spending, budget neutrality cannot always be achieved using that mechanism. This is happening in 1998 and 1999, and may happen again in 2000. Whenever spending growth is low enough that budget neutrality fails, it may be preferable to reduce payment rates below the floor, lower the minimum increase, or both.

Third, the Commission recommends making additional modifications to the base capitation rates to make them more reliable estimates of expected patient care costs. Specifically, the Commission recommends that Medicare payments to disproportionate share hospitals be excluded from the base rates and that spending by Department of Veterans Affairs and Department of Defense facilities on behalf of Medicare beneficiaries for covered benefits be included. Consideration should also be given to rebasing the county rates when all of the transitions called for in the BBA have occurred. Finally, HCFA should develop a more appropriate input price index that reflects the prices faced by plans in delivering health care services in different areas.

Risk Adjustment

In addition to revising the base capitation rates, the BBA mandates risk adjustment of Medicare capitation rates starting in the year 2000. Currently, plans are paid the same whether the beneficiaries they attract are healthy or sick. As a result, plans face a significant competitive disadvantage if they attract the chronically ill. Risk adjustment would change that, paying plans more to care for the sick and less to care for the healthy. This would place plans on a more level competitive basis, an increasingly important consideration as Medicare+Choice options expand and enrollment grows.

Risk selection occurs not only when some plans attract predominantly healthy beneficiaries while others attract those in poorer health, but also when the health status of beneficiaries who enroll in private managed-care plans differs from those who remain in fee-for-service Medicare. Studies have repeatedly found significant risk selection in the Medicare risk-contracting program, with the typical managed-care enrollee being much healthier—and therefore less costly—than the typical fee-for-service beneficiary.

Appropriate risk adjustment of these payments is essential for three reasons. First, because Medicare's capitation payments remain keyed to the cost of the average beneficiary, risk adjustment is needed to ensure that Medicare is not overpaying plans in its capitation program. Second, risk adjustment allows plans that attract more costly beneficiaries to compete adequately with other plans and to provide appropriate care. Finally, risk adjustment helps to ensure adequate access to and quality of care for beneficiaries who have high-cost conditions.

Several factors argue in favor of moderating payment changes caused by risk adjustment. The impact of risk adjustment is uncertain due to the lack of data. Plans do not currently report the data necessary to simulate what any plan's risk adjusted payment will be. Moreover, other major changes in the risk contracting program will affect how risk adjusted payments play out. The expansion of choices, introduction of an annual enrollment period, removal of teaching-related payments from the base, and geographic redistribution of payments will make the market more volatile.

While the Commission recognizes the importance of appropriate risk adjustment, it also recognizes the difficulties in designing and implementing the right approach. Consequently, our report includes five recommendations on this topic, which I will summarize. We will continue to study this issue and offer information and advice as appropriate.

First, the Commission recommends that HCFA phase in the risk-adjustment system—including implementation of the adjusted payment rates—in an orderly fashion and announce the operational details as soon as feasible. The appropriate phase-in period should be long enough to allow plans to adjust to the payment changes and to allow HCFA to refine its payment models without unduly delaying the intended beneficial effects of risk adjustment. These steps will help to reduce the possibility of disruption for plans and beneficiaries.

Second, the Commission recommends that, as soon as possible, Medicare develop the capability to use diagnosis data from all sites of care for purposes of risk adjustment. Appropriate risk adjustment would require data about beneficiaries' health status to distinguish among them in terms of their likely relative costliness, but plans currently do not report these data. In the short run, therefore, Medicare will probably have to rely on diagnosis data only for patients who have been hospitalized. Full encounter data—from both hospital inpatient and ambulatory care sites—would better describe the relative costliness of enrollees and would provide more moderate variations in payment across patient categories than would inpatient data alone. Interim approaches to full encounter data should also be explored, for example, by identifying a sample of beneficiaries with costly conditions, but no inpatient treatment.

The Commission also recommends that, as a further refinement, HCFA adopt a risk-adjustment system that recognizes changes in the costs of health conditions over time. Under risk-adjustment models that use one year of diagnosis data and one year of cost data to adjust rates, payment for an individual may swing significantly from year to year even though the expected costs of care for that enrollee do not. A more appropriate approach would recognize the pattern of future costs that beneficiaries are likely to incur based on their diagnoses. Relatively higher payments could be made for permanent conditions whose costs carried over several years; relatively lower payments could be made for diagnoses that did not entail permanent costs. This will provide more appropriate incentives for plans to care for the chronically ill and to meet the needs of people with multiple health problems.

Developing a sound risk-adjustment methodology will be difficult. Moreover, risk adjustment will not by itself create neutral financial incentives for plans to provide

specific services. The Commission therefore recommends that other approaches be explored to supplement the basic risk-adjustment system. Medicare should undertake a large-scale demonstration of partial capitation or other methods that would pay plans partly on the basis of a capitated rate and partly on the basis of payments for services used. Such a risk-sharing arrangement may be more economically neutral than either fee-for-service payment or capitation alone. It would also reduce a plan's overall financial risks, and might be particularly useful for small, new, or rural plans.

Finally, given the relatively untested state of knowledge regarding the practical details of risk adjustment, the Commission recommends that HCFA closely monitor plans' responses to the rates. It is likely that risk-adjustment policies will need to be refined based on these responses. Special attention should be devoted to the reliability and stability of the method for small plans.

Adjusted Community Rate Process

Medicare's financial relationship with plans does not stop with its capitation payments. Medicare also requires plans to demonstrate that the payments result in good value for beneficiaries. In particular, if Medicare's payment to a plan exceeds the plan's costs (including normal profits), the plan must pass the difference on to enrollees in the form of reduced cost sharing or additional benefits.

The Medicare program requires each risk-contracting plan to estimate the costs of providing services to its Medicare enrollees. This estimate is called the adjusted community rate. By comparing the ACR to Medicare's payment, Medicare defines the minimum benefits a plan must offer. Changes to this process are likely, however, because of both recommendations to overcome shortcomings of the current system and provisions in the BBA.

The existing ACR process has been criticized for several reasons. The ACR amount may not accurately reflect actual costs because of the incentives plans have to overstate costs and the lack of standard methods to measure costs and account for differences between the Medicare population and the commercial population in the volume and intensity of services used. There is no mechanism to review the calculation of the ACR rate adequately or to reconcile this estimate with actual costs. The process relies on an allowance for administrative costs and profit derived from commercial business, which may not reflect costs for Medicare contracts. Plans have flexibility in designing alternative benefit packages across market areas, so the minimum benefits defined through the ACR may not reflect the actual benefits offered. Finally, variation in accounting methods can distort comparisons of costs across plans.

Changes enacted in the BBA will affect the ACR process in a variety of ways. Some aspects of the law may reduce the accuracy or comparability of ACRs among plans. The BBA eliminates the requirement that all plans have significant commercial enrollment. That very directly affects the ACR, because the current ACR calculation depend heavily on plans' commercial premiums and profits. In addition, while most plans must file complete ACR information, high-deductible medical savings account plans and private fee-for-service plans will not be held to the same requirements as other plans. Other changes in the BBA may improve the situation, however, such as regular auditing of financial records relating to Medicare utilization, costs, and the calculation of the ACR. In addition, plans will not be allowed to vary basic and supplemental premiums and they cannot change the benefit package from what was submitted through the ACR process.

Because the information provided through the ACR process is essential to determine whether Medicare capitation payment amounts are appropriate and to monitor how managed care plans provide services to Medicare beneficiaries, the Commission includes several recommendations in our report on improving the ACR process.

First, plans should be required to report their actual accounting costs and revenues from Medicare and commercial enrollees to ensure that plans' projections of costs can be compared with actual costs. These costs should be the basis for the plans' ACR projections. Second, because routine audits of plan financial information are crucial for ensuring their accuracy, the Commission recommends that adequate funds and personnel be made available within HCFA to conduct them.

ACRs based on plans' accounting costs would provide a much stronger administrative tool for ensuring that plans delivered good value to beneficiaries. That is desirable, but is not without some risk of pushing plans too hard. Some monitoring and modification of enforcement may be needed as a revised ACR is implemented to avoid disrupting the current Medicare managed care market. In particular, plans in highly competitive markets may already be driven to offer generous benefits to maintain their market share. The Commission recommends that HCFA monitor the

effects of any new ACR in such markets and consider ways to smooth the transition to a new and more effective ACR policy.

A revised ACR would also give HCFA expanded and more accurate information on the value that plans deliver. The Commission recommends that HCFA use these data to construct standardized reports on the payment, costs, and benefits of Medicare+Choice plans. Such reports would be particularly important in areas where the BBA increases Medicare's capitation rates in demonstrating what Medicare's additional spending is buying. They would also be important for tracking the value offered by provider-sponsored organizations and other plans located in markets with little or no direct competition among plans.

FEE-FOR-SERVICE PAYMENT POLICIES

As I observed earlier, the BBA also made significant changes to the way providers are paid under the fee-for-service program. The Commission examined these policies and ways to improve them, focusing particularly on issues in developing and implementing prospective payment systems for a range of providers. As a result of that study, the Commission has made a series of recommendations concerning fee-for-service payment methods, beginning with those regarding hospitals and updating the prospective payment rates for acute-care inpatient services.

Hospitals

Medicare pays for inpatient services at general acute care hospitals using predetermined per discharge payment rates developed under a prospective payment system. The BBA made major changes to the PPS policies, including reductions in the annual updates for PPS operating and capital payment rates over the next several years and lower payments for indirect medical education costs to teaching hospitals. The BBA also constrained special payments to hospitals with a disproportionate share (DSH) of low-income patients and required the Secretary of Health and Human Services to report on potential changes to the DSH payment formula.

- Updates to PPS Hospital Payments

The Commission's analysis indicates that hospitals continue to fare well financially under PPS. Since 1991, even though payment increases have been moderate, cost increases have been even lower, resulting in rising PPS margins. Hospitals have sharply reduced cost growth across the board in response to pressure from private insurers, resulting in higher total margins. This indicates that the hospital industry has successfully adapted to a more competitive environment by changing its practice patterns, holding its resource costs down, and in general operating more efficiently.

Although the PPS provisions of the BBA will have a substantial effect on hospital payments, the Commission's analysis indicates that using conservative assumptions of cost growth, the hospital industry will achieve the highest PPS margins in history by 2002. Although other changes may exert increasing pressure on hospitals' continued viability, Medicare's payments will still more than cover the costs of providing inpatient hospital services to its beneficiaries even with the update reductions in the BBA.

Even though the PPS operating payment rate updates are set in law, the Commission will continue to develop update recommendations to provide Congress with an assessment of whether the updates are appropriate. Establishing this recommendation involves an examination of the appropriateness of the current payment rates by analyzing the latest information on hospital financial performance. The Commission finds that the update set in current law for fiscal year 1999—market basket minus 1.9 percentage points—is appropriate. In fact, this amount is closer to the high end of the range considered by the Commission than to the low end.

The update to capital payments under PPS was not established in the law. Based on analysmission recommends an update for PPS capital payments of between zero and 0.7 percent. This would be consistent with the increase in operating payments.

- Disproportionate Share Payments

For more than a decade, Medicare has made a special payment adjustment for hospitals that treat a disproportionate share of low-income patients under the prospective payment system. Concerns have been raised for some time, however, about the accuracy of the underlying measure of care to the poor and the policies for targeting payments to specific hospitals. The BBA requires the Secretary to report on a revised methodology for Medicare DSH payments by August 1998.

The Commission has three recommendations designed to improve the way that DSH payments are distributed among hospitals. This would be done through a better measure of providing care to the poor than is currently available and a distribu-

tion formula that more consistently links each hospital's per case DSH payment to its low-income patient share.

First, the Commission recommends distributing DSH payments according to each hospital's share of low-income patient costs and volume of Medicare cases. This would help to target payments toward the hospitals most in need while protecting Medicare patients' access to care at facilities they use. The measure of low-income patient share should include Medicaid and poor Medicare patients, patients covered by state and local indigent care programs, and those who receive uncompensated care. These should include those in both inpatient and outpatient settings.

Second, DSH payments should be concentrated among hospitals with the highest shares of poor patients by establishing a minimum threshold for low-income patient cost share. Based on the Commission's analysis, a reasonable range for the threshold would be levels that make between 50 percent and 60 percent of PPS hospitals eligible for a DSH payment. This would focus payments on facilities that provide the most care to the poor, while minimizing the disruption in the current distribution of payments. The adjustment should increase gradually from zero at the threshold. Further, the same formula should apply to all hospitals, regardless of location or other characteristics.

Finally, the Commission recommends that the Secretary be given the authority to collect the data necessary to improve the DSH formula based on the approach discussed above. The only data needed would be charges for Medicare, Medicaid and other programs for the poor, and uncompensated care and total patient care charges. Initially, these data would be needed from all PPS hospitals to evaluate and perhaps recalibrate the formula. At some point, however, only those hospitals requesting DSH payments would need to submit the necessary data.

Providers Excluded From the Acute Care Hospital PPS

The Commission also considered the appropriate update to payments for providers that were excluded from the acute care hospital PPS. Rehabilitation, psychiatric, long-term care, children's and cancer specialty hospitals and rehabilitation and psychiatric distinct-part units in acute care hospitals are a diverse group that share a common payment method that was established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

Prior to enactment of the BBA, excluded facilities were paid the lower of their Medicare-allowable costs or a facility-specific target amount. The target amount was based on a facility's actual costs in one of its early years of operation (the specific year depends on the type of facility), so new facilities had strong incentives to inflate their costs to establish a high target. Providers that kept their costs below their target received additional incentive payments and those with costs above it received some additional payments to offset their losses up to a specified amount. This system resulted in strong financial performance for new facilities. Because older facilities tended to have lower targets, they may have faced more difficulty in keeping their costs below their target.

The BBA specified several changes to the TEFRA payment method that will help to treat old and new facilities more equitably. The changes include reduced annual increases to the target amounts, further constraints on payments to high-cost facilities, limits on payments for new providers, and opportunities for older providers to raise their cost limits. The BBA also requires that a prospective payment system be implemented for rehabilitation facilities and that a study of PPS for long-term care hospitals be completed by fiscal year 2000. The Commission strongly supports these modifications.

The Commission evaluated the update formula established in the BBA and recommends that it be based on the forecasted market basket increase minus 0.4 percentage points in fiscal year 1999, rather than the full market basket. This reduction reflects forecast errors in the market basket that was used to set the fiscal year 1997 update. In addition, the formula should be modified so that all facilities that have costs above their target amount receive a positive update to their target. In addition, the newly instituted cap on target amounts should be adjusted to account for geographic differences in wages. This change in method may require legislation.

The BBA includes provisions to implement prospective payment systems for many providers. Because the TEFRA system—even with the recent legislation—is not a payment mechanism for the long term, the Commission views the movement toward prospective systems as desirable. HCFA is required to begin a transition to a prospective payment system for rehabilitation facilities beginning in October 2000. The Commission is concerned, however, that HCFA is considering using the RUG-III classification system, which was designed to explain variation in nursing home patients, in the PPS for rehabilitation facilities. Research indicates that this may not

be appropriate. The Commission will continue to examine appropriate payment approaches for these providers.

Of the three major categories of excluded providers, there was no provision in the BBA to move forward with a prospective payment system for psychiatric facilities. The Commission urges the Secretary to continue trying to improve Medicare's payment policies for these providers. Although research about case-mix classification systems for these facilities has indicated some major difficulties due to differences in treatment goals across hospitals, the limitations of TEFRA mean that these providers should not be overlooked in future payment reforms.

Hospital Outpatient Services

Payments for hospital outpatient services have been one of the fastest-growing sectors of the Medicare program. The variety of largely cost-based methods used by the program to pay hospitals has become tremendously complex over time, making it a difficult system to administer and under which to operate. There are few incentives for hospitals to constrain either the growth of costs per service or the growth in the volume of services. Further, an anomaly in the way Medicare calculates hospital payments for these services led to beneficiaries paying a much larger share of the total payment than the 20 percent coinsurance they pay for most other services.

These problems led the Congress to enact in the BBA a prospective payment system for hospital outpatient services. Under this system, nearly all hospital outpatient services will be brought under a single payment system, in which a hospital will receive a predetermined payment amount for a given service.

In severing the direct link between hospital costs and Medicare payments, the BBA's outpatient provisions arguably represent the most significant changes to the way Medicare pays for these services since the inception of the benefit. Given the potential magnitude of the impacts of these changes, the Commission is concerned how these provisions are implemented could result in significant disruptions in access to hospital outpatient services. We have therefore developed a set of recommendations related to the hospital outpatient PPS—one that addresses the somewhat independent issue of beneficiary coinsurance liability and several that concern technical aspects of the new system.

Medicare calculates a beneficiary's coinsurance liability for a hospital outpatient service at the time the bill is submitted, based on a hospital's charges. The program payment, however, is calculated retrospectively on the basis of the hospital's costs, net of the beneficiary copayment. Since hospitals' charges have increased more rapidly than their costs over time, beneficiary copayments have come to constitute an ever larger proportion of the total payment to hospitals. Currently, Medicare beneficiaries pay about half of the total payment to hospitals for outpatient services, compared with 20 percent for most other Medicare services.

The BBA includes a mechanism whereby this disproportionate liability would be reduced over time under the outpatient PPS. However, the length of time required to reach the goal of a 20 percent beneficiary copayment for hospital outpatient services is considerable, possibly as long as 40 years. It is the Commission's position that this phase-in does not adequately protect the interests of Medicare beneficiaries. We believe that the Congress should revisit this issue and specify a reduction in beneficiary coinsurance that takes place over a defined period of time, significantly shorter than that implicit in the BBA.

The Commission has also taken an active interest in technical aspects of the implementation of the outpatient PPS. We are especially concerned that changes in payment policy resulting from the implementation of the BBA provisions may result in reduced access to hospital outpatient services for some beneficiaries or, since many of these services may be provided in other ambulatory settings, shifting of services to less clinically appropriate settings. To help minimize adverse impacts on Medicare beneficiaries, the Commission has made several recommendations that would help ensure that Medicare payments for hospital outpatient services accurately reflect the appropriate costs that hospitals incur in providing them. We recommend that the individual service be the initial unit of payment, that relative weights be based on the costs of individual services, rather than groups of similar services, that certain medical education costs be excluded from the calculation of relative weights and budget targets, and finally, that adjustments be made as necessary to preserve access on behalf of vulnerable populations or for specialized services.

Finally, the Commission addresses the BBA's requirement that a volume control mechanism be implemented to control the growth in expenditures for hospital outpatient services under the PPS. While we acknowledge that the historical rate of growth for these services is unsustainable, we are concerned that the factors that contribute to growth in outpatient service volume are not well enough understood

to allow informed decisions about volume growth. Therefore, the Commission recommends instead that these expenditures be controlled at least initially through an expenditure cah to controlling outpatient service volume should be developed once the outpatient PPS is implemented.

Post-Acute Care Providers

The BBA incorporated significant payment policy changes for post-acute providers—skilled nursing facilities, home health agencies, long-term care hospitals, and rehabilitation facilities. Medicare spending for services provided in these facilities has been rising rapidly. It appears that hospitals have shortened their stays and controlled their costs in part through shifts in service delivery to these other sites. There is also evidence that beneficiaries are changing the types of providers they use following an acute event. The Commission will continue to analyze how these changing treatment patterns affect the use of and spending for these services.

- Home Health

Development of a prospective payment system for home health services by fiscal year 2000 may be one of HCFA's most difficult undertakings. There are currently few limits on who can receive these services and how many visits they may receive. As a result, home health visits more than doubled between 1992 and 1996. The reasons beneficiaries use home health and the patterns of care should contribute to the design of the payment system, yet not enough is known. The Commission will continue to explore variations in episodes of care as well as differences between the typical home health user, who receives these services for a short time, and those who receive visits over extended periods and account for the largest share of visits and spending.

Home health care is the only major Medicare benefit with no beneficiary copayment requirements. Further, it lacks serious restrictions on coverage and has exhibited substantial billing fraud. Accordingly, the Commission recommends imposing modest copayments, but with an annual limit to protect vulnerable beneficiaries who would be subject to these payments.

The Commission also recommends standardized coding for home health visits. HCFA needs more information about visits both to develop an appropriate case-mix adjustment system and to monitor service provision after the payment method is changed. This would involve, in addition to coding the length of the visit on the bill, recording the services provided.

Finally, the Commission recognizes that in developing a prospective payment system for home health services, the Secretary may need to make special provisions for long-term users. Based on analysis by the Commission, there are at least two distinct populations who receive home health services. One group includes people who receive a limited number of visits following an acute event. The other group consists of long-term users who are likelier to be older or disabled. Further, the Commission recommends that an independent case manager should review the plans of care for Medicare beneficiaries receiving home health services for extended periods. The case manager would ensure that the services provided met the patient's needs and would recommend to the certifying physician appropriate changes to the plan of care.

- Skilled Nursing Facilities

HCFA will implement a prospective payment method for skilled nursing facilities in July of this year. This will be a great improvement to the current payment method. When the proposed rule is released, the Commission may provide more detailed comments on that system. The Commission will be particularly interested in whether the proposed system could be improved by having a single payment for a stay instead of a day of care. Further, the Commission is concerned with the need for consistent policies across the providers that treat similar patients, and will be considering the policies adopted for skilled nursing facilities in light of payment methods for rehabilitation facilities and long-term care hospitals, and possibly home health agencies. The Commission will continue work in this area to move toward payments for services rather than sites of care.

Physician Payment

With the Medicare Fee Schedule now in its seventh year of implementation, a number of payment policy issues have already been addressed. The fee schedule's relative value units for physician work have been updated annually for new services, and all work values were reviewed in 1996. A process is in place for monitoring beneficiary access to care, and no changes in access have been detected since the fee schedule was introduced. Finally, the new sustainable growth rate system will overcome limitations of the former volume performance standards policy.

During the coming year, the most important physician payment issue is likely to be implementation of resource-based practice expense relative values. Much work remains to be done before the values will be ready for implementation in 1999, however. The Commission has focused on two issues in particular that need to be resolved before the new values are implemented.

The first issue concerns a proposal to reduce practice expense payments for nonsurgical services provided in conjunction with an office visit. In a June 1997 proposed rule on practice expense, HCFA proposed a 50 percent reduction in practice expense payments for such services. The Commission agrees that payment reductions may be appropriate but has concerns about the magnitude and uniformity of the proposed 50 percent reduction. It recommends that HCFA delay the proposed policy change until data are collected allowing development of service-specific reductions that reflect the economies of providing nonsurgical services with an office visit. Plans for development of service-specific reductions should be included in the practice expense proposed rule due from HCFA by May 1, 1998.

The second issue considered by the Commission involves HCFA's plans to use a volume aned practice expense values are implemented. This adjustment would reduce the fee schedule conversion factor to account for expected increases in the volume and intensity of services that experience a reduction in payment rates. In the June 1997 proposed rule, HCFA proposed a volume and intensity adjustment of −2.4 percent. The Commission recommends use of the sustainable growth rate system to adjust the conversion factor for any increases in volume. HCFA should not use a volume and intensity adjustment in anticipation of those increases.

Dialysis Services

MedPAC is required to recommend to the Congress an annual update to the payment for dialysis services. Our deliberations on this topic followed the framework developed by the former Prospective Payment Assessment Commission. We considered the factors that were likely to affect the costs of providing dialysis, the base payment received by dialysis providers, and Medicare's special obligation to its beneficiaries with end-stage renal disease. Medicare is the dominant payer for these services and these are particularly vulnerable beneficiaries, so it is critical that quality of care and patient outcomes be considered in evaluating the payment rates and methods.

Based on the Commission's analysis, payments for dialysis services should be updated by 2.7 percent to reflect the market basket increase in the cost of inputs to a treatment session. It is important, however, that this increase be used to improve the quality of care provided to beneficiaries with ESRD. Therefore, we urge HCFA to monitor closely the relationships among treatment patterns, patient outcomes, and facility costs. In addition, the Medicare program should have more accurate cost information to use in evaluating its payment rates. Therefore, consistent with the BBA, we recommend annual audits of dialysis facility cost reports. Rather than auditing every facility every three years, however, more useful information might be obtained through focused audits on facilities chosen based on past audit results or other indicators of potential problems.

Chairman THOMAS. Thank you very much. And I guess the first question I would ask is not a substantive one based on what you are reporting, because it looks familiar to what has been done in the past but rather how is the change over going? All of us are concerned about the new responsibilities at HCFA and we have talked about not just reorganization but reculturalization of folks who have a new role to play. Not that they weren't beginning to move in that direction, but in fact a far greater one of a fact-gathering, information-disseminating, consumer-customer-support structure is going to be required.

How is the reculturalization of the former PPRC and ProPAC coming in creating a MedPAC? From the appearance of the work product coming out, it looks much the same, that is, it looks like quality work but I am just curious and I assume others are as well.

Ms. WILENSKY. Reorganizations always produce some struggles. I would be less than honest if I were to say that it hasn't occurred here, but we are fortunate to have an excellent group of professionals. They have come out of somewhat different operating styles as independent commissions, but the bottom line is they have come together to produce what I believe is a very high-quality report. For each and every commission meeting that we have held since October 1, we have been very pleased with the quality and timeliness of material that has been produced.

We are physically together now in our new headquarters on 17th and K Streets. We will, I think, be moving forward now truly as a single commission because of this move to a single location. I think, all things considered, we have gotten through the first 6 months with, in the final analysis the only thing that counts, a high-quality product on time.

Chairman THOMAS. And in the long run, it's pretty obvious that this restructuring will focus our support groups in a way that will give us meaningful data because the restructuring is going on on the outside to meet the restructuring on the inside.

Thank you, also, for your usual good product in terms of the updates, support numbers. Clearly as we move forward to graduate medical education question and the associated historic payment structure is going to be a major concern that we will look at.

The other thing that has bothered a lot of us is our failure, notwithstanding HCFA's efforts over the years, to deal with risk adjustment. I used to say there were two things I wanted under the Christmas tree which would make our job a whole lot easier. One of them was a good measuring device to deal with the risk-based capital standards, as we were trying to figure out who really shared risk as we moved toward these new models of delivery provider, sponsor organizations, and others, and actually the NAIC came through in a relatively short period of time with that wish list, and a gift that we could utilize in a way that we had not before.

No one has been forthcoming with the risk adjustment mechanism that really works. We've got some surrogates and I agree with early reports that we've got to move these surrogates into place, but clearly to create a really useful model is going to require the collection of data that requires costs and there are folk who are in the forefront of gathering this kind of data almost totally for proprietary purposes in terms of reducing their internal costs of delivering, but we need to externalize that and get HCFA to collect it.

I know there are some concerns about some of the plans who are now active because of Medicare+Choice and they are concerned about the administrative cost associated with this collection of data. Do you have any words of wisdom to us? My goal is to get it and I want to make sure that we are not being unfair in the collection of this data.

One, I don't want to over collect, but, two, I want to get enough to be able to move a product relatively quickly. I don't want to create unnecessary costs but if there are necessary costs associated with it, I am willing to make sure that they be paid. So, where are we in this business of moving toward a risk-adjustment mechanism, how do we gather the data, who should pay, what's a fair

payment, how much data is appropriate, are we on target in that area?

Ms. WILENSKY. It is probably the most serious technical issue that we face. If you keep in mind the notion of phasing in, not just in terms of going forward with the adjustment but in terms of starting with what we have available and making it better as we go along, it will be a good guiding principle.

Let me give you a couple of examples about what I mean. Right now we have most readily available inpatient data on patient diagnoses. We know that that is not the best data to use for risk adjustment. It would be far better to have full encounter data, data from the outpatient setting, but we are going to have to, in all likelihood, begin the risk adjustment process using only inpatient data and then move forward with full encounter data.

One of the reasons that PPRC, as the predecessor commission, and MedPAC now, as the current commission, has recommended a phase-in for risk adjustment, and also not attempting to recoup all possible money that selection bias might have suggested.

Progress on risk adjustment is going slowly but it is moving. One of the first milestones that will alert you as to progress in this area is whether or not HCFA can meet its 1999 reporting date. And if it can't meet that, it will certainly suggest some serious problems with meeting the year 2000 implementation.

I have had a couple of conversations about this with Nancy-Ann Min DeParle, the new HCFA Administrator. She is very interested in having HCFA and MedPAC work as well together as possible and to have more interactions between our staffs than have sometimes occurred in the past. This interaction has had a somewhat checkered history, sometimes better, sometimes not so good. We have already had MedPAC staff over to share the recommendations that were part of this report and to further that exchange.

But you are correct in your concerns. It is a difficult area and it has seemed that we haven't been making as much progress over the last decade as we should have, and now the time is very short for change to be implemented.

Chairman THOMAS. I will tell you that my operating structure is something is better than nothing and we cannot wait around until we've got a perfect model. We will try to be as flexible as possible to update when better models are given to us, but everybody needs to know we are going to go with something, because something is better than nothing.

Ms. WILENSKY. I agree wholeheartedly and, furthermore, something will drive a better future product. It is, in my opinion, the best way to move risk adjustment forward, to go with the best you have, to recognize that it will have to be modified, and to try to include some cushioning, and some phase in. It's also important to monitoring the affect of those changes on the plans and on the seniors who are in these plans, so that you can protect both the seniors and the plans from inappropriate change. But it is important to recognize that if we wait for the perfect risk adjuster, we will be waiting a lot longer than this millennium.

Chairman THOMAS. Correct. And the sooner we start, the better we will understand the faults in the one that we will be working with which will allow us to fine tune it to move it. But I think real-

ly in this instance, the going is the goal, because we are going to constantly adjust this as we collect data, hopefully under a structure that provides maximum confidentiality and maximum usability of language, not just for risk adjusters but also for outcomes, so that we can begin to get some kind of a measure of quality which all of us are concerned about and that all of them are focused around the collection of data in a reasonable way with new understanding of patient confidentiality.

Thank you very much.

Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman. Mr. Ross, I have a few questions about Louisiana's Medicaid Program—just joking.

I trust your new job will be a more dynamic one than your previous job.

Dr. Wilensky, with respect to your recommendation that the coinsurance for outpatient services go down to 20 percent at a faster rate than was outlined in the BBA, is it still the estimate that the faster rate of progress toward the 20-percent coinsurance would cost about $19 billion and, if so, have you suggested some way to pay for that additional cost to the system?

And I'd also like for you to comment on the wisdom of such a proposal. Is it true that by reducing the coinsurance amount we are merely shifting costs from insurance plans, which the vast majority of seniors have, the so-called Medigap policies, to taxpayers?

Ms. WILENSKY. Well, how much it will cost depends on how much quicker you try to bring the 20-percent coinsurance to actuality. It was our belief that the current plan is projected to require 40 years until there will actually be a 20-percent coinsurance for seniors and that this is not appropriate. How much faster, in part, will depend on how much money is available for additional spending and while we have all heard many interests in spending the anticipated surplus, before we actually have a surplus, I guess maybe this affected our view as well. We did not, however, specifically indicate where the additional dollars ought to come from, but because the Congress had recognized the problem of the current arrangement, where seniors may be paying as much as 50 percent of the cost rather than the nominal 20 percent that they are supposedly paying, that the Congress needs to make the adjustment faster.

With regard to the comment as to whether or not we're shifting to taxpayers what would otherwise be coming out of the insurance companies, there are really two responses. For the most part, of course, it is the seniors collectively, not the insurance companies, that are paying the extra commission because the seniors are paying for them in the premiums that seniors pay to the insurance companies which, in turn, pick up this element of coinsurance. And, of course, we do have a small number of individuals who do not have Medigap or Medicaid and who are not part of the risk-based plans, although they represent a relatively small number of seniors.

It is unfortunate that we let this problem go as long as we have. It is not a new issue. I was aware of it when I was HCFA Administrator in the early nineties and the cost of fixing it stopped us then. Unfortunately, what has happened is that as it has gone on longer, it has become an even more expensive problem because the gap be-

tween charges and the Medicare-recognized cost has grown, and since the senior is billed 20 percent of charges as opposed as to 20 percent of the Medicare allowed cost, as this gap has gotten bigger so has the burden and that is why we now have a problem fixing it.

My recommendation is if there is serious interest in resolving the problem sooner, we will be glad to work with you in making some estimates as to how not to wait 40 years for resolution but to do it in a way which won't cost too much additional moneys. CBO traditionally has provided you with such estimates. We would also be glad to help you with some suggestions.

This was a discussion that represented strong agreement on the part of commissioners who frequently took differing views on other issues. All of us felt very strongly that the current 40-year estimate for resolution was an unreasonable burden to place on seniors.

Mr. MCCRERY. Well, thank you for that answer. Isn't it true, though, that as we see more and more seniors in capitated plan, this is less and less of an issue.

Ms. WILENSKY. That I do agree with. To the extent that we see some substantial increases in people going into capitation plans although we're still at only 13 percent. Current expectations are that in a decade, it will be only about 40 percent. If that, in fact, is not a correct estimate, if there is substantially greater growth in capitation plans, it will make this a smaller issue. It may make it easier to change it then.

Mr. MCCRERY. Yes. That estimate is based on the current model. We're hopeful the Medicare Commission meeting this year will come up with something different from the current model so we may have to revise our estimates in that.

Thank you.

Chairman THOMAS. If the gentleman from New York doesn't mind, I want to work in, if possible, although he's not now a Subcommittee Member he once was and therefore carries a responsibility by showing up, which I'm very much appreciative of, depending on the question asked. [Laughter.]

The gentleman from Washington.

Mr. MCDERMOTT. Thank you, Mr. Chairman, for the disclaimer. Dr. Wilensky, I have a specific question. I looked at the report and read that there are some recommendations for your changing of the AAPCC, adjusted average per capita cost, rates. My understanding is that number is arrived at by taking the total amount spent by Medicare beneficiaries as the numerator and divided by the number of people who receive their Medicare benefits in that county. Is that a correct statement?

Ms. WILENSKY. Well, what you start with is Medicare per capita spending. It used to determine the capitation rates. Now you use it as a starting point, but you take in a number of other factors as well including the blended rate, the minimum floor, and so forth.

Mr. MCDERMOTT. Well, let me tell you what the specific problem is. The veterans.

Ms. WILENSKY. Yes, that——

Mr. MCDERMOTT. Some areas of the country have more veterans, maybe geography, maybe it's a nice place to retire, maybe it's more

military bases, whatever. And my understanding is that number, the numerator, does not include costs Medicare beneficiaries received in veterans or DOD health facilities. The average cost, as I think your report says, is understated 3 percent nationwide, but in King County, Washington, my county, it is understated 4.3 percent, and if you go to the county immediately south, which is Congressman Dicks' and Congressman Adam Smith's Districts, you are looking at a 22.6-percent participation by veterans that are not counted, so that the number is low.

And I see that you recommended——

Ms. WILENSKY. Yes.

Mr. MCDERMOTT [continuing]. That there is a change in this, but I'd like to hear how quickly you think that can be done. I get an awful lot of letters from veterans, because they get complaints from the HMOs about what they are being paid because of the fact that veterans aren't counted.

Ms. WILENSKY. We agree that the problem that they are raising is a legitimate one. In fact, there are two modifications, one that we've suggested in terms of taking out some expenditures, exclusions of special payments that hospitals receive for disproportionate share payments, that ought not to be in there and also including some that we ought to have in there, particularly the cost of care that is currently provided, either by VA or DOD facilities.

There is a problem regarding the availability of needed data we need to have data at the county level. This is the one difficulty that we've recognized is, because the Medicare payment rates are set at the county level. This is what the C part of the AAPCC measure stands for. We need this data in order to make the adjustment, which we think, in fact, is appropriate. We are not including VA and DOD costs here, but we need to be sure that we have the information available at the county level.

As I recall, there is some difficulty in gathering the data immediately, but my impression is that this is a problem that could be resolved in a year or two. This is not an insurmountable problem. It was only a problem in fixing it immediately, but we strongly recommend HCFA begin to include VA and DOD spending and make whatever adjustments in the data collection they need to make.

Mr. MCDERMOTT. I want to thank you for looking at this whole issue because it is a problem, and particularly a problem for the Northwest generally, in that the AAPCC rate is about 8 percent below the national average. The feeling in the Northwest is that we are being punished. It's sort of the old adage that no good deed goes unpunished. The fact that our system has been more efficient, we are now paying for that by lower AAPCC rates, and it is unclear to me when that is going to be rectified, if ever.

Ms. WILENSKY. There are a number of things that will help. The Puget Sound area, and the whole State of Washington, as well as Oregon, have had traditionally relatively low rates of health care spending in and in Medicare, the capitation rates were also low.

During the first few years following the Balanced Budget Act, it is mostly the floor payments, the $367 floor, that will impact your area. Over time, the blending of the national and the local rates will begin to kick in, so that places that have had low payments,

but not the lowest payment counties, will also begin to have some effect.

Differentials will continue, but they will be far less than what we have seen in the past and if, as we've recommended, we make the adjustments for the VA, DOD expenditures, that will also help.

It's not a gift. It is a better reflection of the expenditures that are going on in the community and they ought to be reflected in the measure of Medicare spending in an area.

Mr. MCDERMOTT. Could I, with the indulgence of the Chairman, one last question, and that is, I noticed in the commission's report——

Chairman THOMAS. Will the gentleman yield on the point? I will let you go on with your other question, but I want to respond to that point, because you have brought up an issue that actually cuts several different ways.

Obviously, as Dr. Wilensky pointed out, one of our major concerns both from a Medicare+Choice point of view and frankly from a political point of view as well, is to make sure that we create a reasonable floor. Not a floor that would simply overcompensate the old structure, but actually be an attractant to the Medicare+Choice. I do believe that you will shine, but not immediately, because you were not overweight. You have a very aggressive managed care structure. You shouldn't see it as a good deed going unpunished. It isn't denied; it's just delayed.

When other people begin having to take the 6-day forced marches, you will already be in shape and you will benefit immensely by it—if not in this life, in another life.

But, we're going to have to monitor this because we have got to make sure that those areas that have done a good job do get rewarded and the structure right now is minimal penal end on the areas who have the high AAPCCs who haven't done a good job and the low areas in an attempt to create a more uniform structure and you're kind of in the middle and I'm very sympathetic to that and we are going to review that constantly.

The other point you brought up has to deal with veterans and the fact that they are not currently figured in. And, in fact, it's even a worse profile than that. Because they aren't figured in to get the benefits where they are, so that you can have a realistic view of population and the VA, frankly, has not been as aggressive in offering programs to the low-income veterans, where the low-income veterans are.

And I've run into this for years in a suburban rural area with a high veteran population where they get shipped all over the place. We cannot continue to build outpatient clinics and one of the more exciting things we are working on is in working with the Veterans Administration, Dr. Kizer there, and others, to make sure that the Veterans Administration is in fact performing for veterans, especially low-income veterans, through its vision program.

And we're trying to create legislation which would coordinate the VA's outreach program under vision with the Medicare eligible aspect of every World War II veteran who is now Medicare eligible and blend the two, separate from adjusting the AAPCC.

Hopefully this year we will move that legislation, not as a demo, but as a permanent change. And you need to talk to your friends

in this administration, not to try to push a demo but to try to put a program in place for the low-income veteran.

Mr. MCDERMOTT. I raised it partly, Mr. Chairman, because the subvention program—Seattle is one of the demos—so they are acutely aware of the numbers, and that is part of the reason why that is an issue and it will soon be an issue everywhere.

Chairman THOMAS. And we need to look at it carefully and blend the two as we go forward.

The numbers on the DOD and the TriCare and the subvention demonstration there are of a concern, but they are nowhere near the magnitude that we need to deal with in the veterans program. One is thousands and the other is millions, and frankly, they've been underserved for far too long and it's because we haven't been as imaginative as we need to be to create a positive blend, a change both inside the culture of the VA and the positive blend using Medicare moneys.

Ironically, when we try to score it, since they have been underserved, if we try to give them adequate service, this is a new consumption of services and therefore the costs go through the ceiling which is an outrage because they should have been given this level of service all along.

And I look forward to working with the gentleman as one of the demo areas to make sure we move it in rapidly. That's your first question. Your second question.

Mr. MCDERMOTT. Well, my second question was the commission report notes a tremendous difference in payments between hospital outpatient departments and the so-called ASCs, ambulatory surgical centers. But the language seems to warn that there are quality problems in doing some of the procedures in the ASCs or doctor's offices. Yet we have a tremendous disparity in pay. We actually pay more for it to be done in a place where we raise questions of quality. I would appreciate a comment or two from you about this. It would seem to me from a quality standpoint, you'd want to say let's stop paying in the outpatient or the doctor's office and get it done in the hospital because the quality would be better and we would actually pay less. So——

Ms. WILENSKY. My closing comments were intended to address the generic issue that you have just raised. That is, we pay for the same service or similar service in different settings and how we pay in different places for roughly the same service hasn't received very much scrutiny. It's because our traditional way of assessing payment in Medicare has typically been by service type. As a result we spend a lot of time thinking about outpatient spending, or physician payments, or PPS, prospective payment system, excluded hospitals, usually by type of excluded facility.

This is one of the areas that MedPAC has raised for its own future work plan, starting in June and for our retreat after the June report, but this is a hard problem. We anticipate we'll be working on this issue for several years. Do the kinds of payment differentials that occur for a similar service across different sites make any sense. What are we implicitly signaling to these sites? Is that justified?

Now, it is far easier to say this is the problem then to fix it. We understand it will be very difficult for us to come up with a ration-

ale for fixing the problem but we think it has gone on far too long. If a similar service is provided in a rehabilitation hospital, long-term care facility, skilled-nursing facility, or home care you're liable to have enormously different payments.

If you provide a similar service, it may or may not be for a patient of similar severity in the outpatient facility, in a freestanding facility or in a doctor's office. However, we now have very different payment levels by rate and it is not clear that these make sense and are sending people in the right directions.

So, MedPAC will be looking at this. I don't want to promise an immediate solution, because I think we are cognizant of how hard this problem is, but we're especially concerned that 15 years after PPS has started, and almost a decade after you passed legislation for the resource-based relative value system, RBRVS, this issue has not yet been studied to the best of our knowledge.

Mr. MCDERMOTT. I think the Chairman's nodding indicates that everybody understands this is a big problem, but it seems to me that there are quality questions. If I read your language, it appears you are looking at quality as well. It's clear that it is a more important issue than perhaps some other things that might be on the list, so I would hope that that would get these quality issues to the top of the list.

Thank you, Mr. Chairman.

Ms. WILENSKY. We'll keep that in mind. Thank you, Mr. McDermott.

Chairman THOMAS. Well, thank you. Obviously, there were a number of difficult decisions to make. Some of them, frankly, arbitrary, because we had to start but it was more important to start, and fine tuning as we go along is absolutely essential.

I thank you the gentleman for his questions.

Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes, Mr. Chairman. I have three questions and they don't require elaborate answers. The first question, I understand that the MedPAC feels that if a PSO, provider-sponsored organization, is the only Medicare choice plan in an area it requires some monitoring and the American Medical Association, AMA, doesn't. So maybe you can explain that.

The second question is home health care. You suggest there be a modest copayment. Why?

And third, I'd just like to know how the merger is going between the ProPAC and the PPRC.

Ms. WILENSKY. OK, I'll be glad to answer all three.

Let me explain our sense of what is likely to happen in highly competitive markets, versus markets in which there is little competition. I think that is what I see is the best answer for the questions raised with regard to the PSOs. Up until now, the adjusted community rate was a measure that forced any savings from the payment covering the Medicare benefit to be provided as additional benefits for seniors. What we have seen is that in highly competitive areas, we really didn't have to worry about the ACRs, adjusted community rates, serving as the device that made sure seniors got the benefits they should have got out of savings from HMOs, health maintenance organizations.

It's really within this sense of having the ACR as the measure that would allow us to assess what could be offered above the Medicare package. There has been a problem about how good a measure the ACR is. Will the ACR be relevant for groups that don't have commercial products which may include PSOs.

But more importantly, if you're in an area where there isn't much competition, then the kinds of pressures that make sure additional benefits are offered won't be present. It's the concerns about what happens with the extra moneys, particularly for areas where Medicare payment is being impacted by the floor, so the Medicare payment which might have been $280, or $300, or $325 per person if you looked at traditional Medicare becomes a capitation rate of $367.

If there are areas where there is very little competition, it will be especially important to monitor how the extra money is spent, to make sure that seniors are getting value for the additional money being spent.

What you are seeing reflected in the MedPAC report is a distinction between areas where there is a competitive environment and a number of different plans, PSOs or traditional HMOs or whatever, and areas in which there isn't a competitive environment. That was the source of the comments about noncompetitive markets.

Mr. HOUGHTON. I'd like to make a comment after that.

Ms. WILENSKY. OK. The second one, with regard to the copay for home care is a reiteration of a recommendation that was made last year by ProPAC and it was, to be honest, a controversial issue for MedPAC. We are struggling with two conflicting desires. We don't want to keep needed services from frail seniors who need home care, but we are mindful that home care is an area that has seen explosive growth. The number of people who receive services has doubled in the last decade and the number of services that are provided has also grown rapidly.

What we have done is try to craft a balancing of these concerns. We therefore recommended a modest copayment, we did not give a specific amount but we are thinking something in the $3 to $5 range, subject to an annual limit. We did not specify the limit but we are not thinking of hundreds of visits before you hit the annual limit.

Furthermore, we are recommending the introduction of an independent case manager for long-term users of home care, both to relieve some of the pressure that physicians have told us about, that they receive from the families of people who want to have someone checking in on a senior, whether they really need home care per se, and also to be sure that the seniors are getting the right services. We sent somebody who is an independent observer, who doesn't have an economic stake in continuing home care. We want to make sure that the seniors get the services that they need. So we have attempted, with this modest copayment, subject to an annual limit, and an independent assessment by a case manager for long-term users, to balance off these different needs.

If you don't ever want to risk having some impediments receiving home care, then of course you wouldn't have any sort of copayment

or any other kind of constraint. On the other hand, we normally have copayments of some sort in most other parts of Medicare.

We were struggling with this balancing of concerns for seniors and the concerns about what has been reported to us regarding overuse and what we observed going on in the program.

Finally in regards to your question about how the merger is going. We've gotten through the first phase, not too much the worse for wear, I think. A high-quality report, on time and or we're physically together in a single location. Personally, if I don't have to do this again for a while it's OK.

Mr. HOUGHTON. Let me just follow up, if I could. You know, getting back to the PSO issue, intellectually if you have two people, you have competition. If you have one person, you don't.

But I wonder whether that's true here. If I'm a service organization, as I envision it, and again I come from a rural area, it's really a community organization and everybody's involved, everybody's looking at it all the time. From the true economic standpoint, you wouldn't have competition but there are so many people involved looking at it, pouring over it all the time, I would think it would be a good idea maybe to try to hold back rather than having the government breathe down the necks of those people who are trying to make something that I think is terrific work.

Ms. WILENSKY. Well, I have been a longstanding proponent of a PSO option. I think it is important that the physicians and the hospitals that have been providing care to seniors be allowed to come together and provide that care within a risk-based system so that substantially increased moneys can go to that same group that has been providing services to seniors.

However, I want to be pretty sure that there will be more services provided to seniors, and not just higher reimbursements to the people who are providing care. I know if there is some competitive force between PSOs or a PSO and an HMO, this is likely to happen, but if there is just a single group in town, particularly if they are not under the pressure of showing the government what they've done with the additional money they've received the extra payment could go as extra reimbursement. We just want to make sure it is the seniors who get the benefit from the additional money.

Chairman THOMAS. Just briefly because the gentleman's questions were extremely important ones. Would that we could get to the level of discussion that was just undertaken on PSOs. My problem is notwithstanding, that we are trying to empower this new arrangement principally in rural and suburban areas in savings doctors and hospitals, some of the latest information we're getting is that there are two types of provisions in terms of dollars and cents that are causing us problems in moving in that direction. One of the things we are going to have to do is either get GAO or somebody else to take a look at things we didn't do which have now produced impediments to allowing provider sponsored organizations to move forward in a timely and reasonable way.

These are unintended consequences, of earlier legislation that was enacted for good and noble purposes but which has continued to cause us problems in a number of areas that lovingly bears the

name of my colleague from California either in its first version or, more importantly, in its second version.

The other problem, I tell the gentleman from New York, in terms of the home health care copayment question is just the tip of an enormous iceberg which was the movement of the home health care from part A to part B. Or moving it from a payroll tax structure to a 75 cents on the dollar general fund payment. If he wants just a little flavor of this ongoing battle, take a look at the venipuncture question in terms of how folks are currently able to receive the home health care benefits and our attempt to try to channel it to necessary and appropriate home health care support. This is a little bit of flavor of the ongoing concerns about the way in which people are utilizing the home health care question.

It's to the point that you wonder to what extent is home the major focus versus health care. And that is going to be an ongoing area of examination and illumination. I think the emphasis out of the Medicare fund, whether A or B as an anachronism or combined, has got to be only on health and not on the home support assisted living aspect where it doesn't merely touch on health. That's going to be an ongoing problem that we are going to have to rely on you folks providing us with the kind of timely and appropriate understanding of what is going on out there.

Again, focus on venipuncture only as the first of a number of battles we are going to have to face before we get this anywhere near right.

I thank the gentleman for his questions. They are right on.

The gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. Thank you.

Nice to see you again. I have a few questions that I want to get through that I'd like to ask. First of all, you do comment that studies have repeatedly found significant risk selection in the Medicare risk contracting program. Now that we really have pretty good data, that there is little disenrollment, it would seem to me that over time, and over not a very long time, the experience in those plans would be the same as fee-for-service. That even if you select risk, over time that selection has little effect. Would you expect that to be the case and if so, what impact would the risk adjuster have?

Ms. WILENSKY. Well, I do think the issue that few people leave risk plans is an important issue. Because of the fast growth plans have experienced, and anticipate for at least the next decade, many plans will still mostly have new enrollees for the first several years. This means the potential for new plans to experience very favorable selection for at least the first couple of years of their existence is still an issue that we ought not to ignore. The plans will be getting average payments, but unusually healthy individuals.

Mrs. JOHNSON of Connecticut. Recently, the department did receive a report on the Medicare Select plan. It was required by legislation we passed a number of years ago, making that potentially a permanent alternative and now because this report is favorable, it will be a permanent alternative.

But my contention in that at the time we wrote that legislation was that HMOs tend to attract people with high costs. When I go from senior citizen center to senior citizen center, the people who

are most considering the HMOs are the people who have no drug coverage and need the $500 or the whatever drug coverage that's provided and who often have to go to the doctor far more often than their colleagues, so the higher cost people are attracted to the HMOs, in my estimation, or at least that certainly is anecdotally a significant factor.

Ms. WILENSKY. Well, in fact one of the reasons you want to have risk adjustments is because you want to make sure sick people can go to HMOs and that the HMOs will be well paid by them. We also need to recognize that in some areas you may get people who are moving to new areas where they don't have ties to the physicians, who, by virtue of their moving, will tend to be healthier than the average senior, and will be attracted to HMOs. As a result, in some areas of the country, some HMOs can expect, anecdotally and intuitively, to attract healthier individuals.

Some HMOs, because of where they are located, may not attract healthier seniors. So it is not just a selection between fee-for-service and managed care or HMOs that we need to be concerned about. Risk adjustment will also allow for adjustments between those HMOs or PSOs that get a lot of sick people and those that get healthier seniors.

The evidence has been pretty consistent that at least seniors joing an HMO are healthier than average and have been using less services. Now, the fact that they tend to stay in the HMOs may mean that over time that some of the selection problem goes away.

As you know, even with a number as small as 4 percent disenrollment, can be a problem. What we know about the 4 percent who go back to traditional Medicare is that, they tend to be very heavy users of services.

Now it may be their choice, it may not be that these seniors are pushed out by the HMO. It may be that they anticipated requiring some services like home care that they think they can get in more unlimited quantities outside of an HMO and so seek to go to traditional Medicare for that reason. We want to get the adjustment right. We're not trying to penalize HMOs, we're just trying to make whatever adjustments appear to be supported by empirical facts.

Again, we need to do this as much so we can make sure that sick people can go to HMOs, receive the kind of services that they want and need, and not put the HMO out of business as to make sure that traditional Medicare doesn't bear the burden of a lot of old and frail individuals.

Mrs. JOHNSON of Connecticut. I certainly agree that we want to look at acuity and seriousness of illness, but I am very concerned about making the assumption that in the first 2 or 3 years a managed care plan can help healthier people because in this recent study I don't think that is supported and, when we look at disenrollment, I'm not familiar with your 4-percent figure. My understanding is that of the disenrollees, most of them choose another managed care plan and don't go back to fee-for-service. So, I don't know what that breakout is.

Ms. WILENSKY. It's about 7 or 8 percent disenroll over the course of the year; about half of them, or a little more, go to another HMO and about 3.5 to 4 percent go back to traditional fee-for-service Medicare.

That group that goes back to traditional fee-for-service Medicare tends to be very high users of services. Again, I am not trying to say this as a way to sound punitive to HMOs. It is really to try to recognize that you can get different groups of healthy and sick people going into health care plans and to recognize that can be as true among different HMOs as between HMOs and traditional fee-for-service.

Mrs. JOHNSON of Connecticut. And I think that is a very valid point and I think geography has something to do with that and a number of things, but that is a very valid point.

Just briefly, under the Balanced Budget Act, we do have an IPS, an interim payment system, for home care providers and we pegged the payment system for new providers at the national average. I can't quite remember if there is some accommodation or not.

But in my district we've run into a new problem and I wonder if you have any new data that could help us with it. It's a facility that is new so it wasn't in existence in 1994, the base year. But it serves almost entirely, I guess entirely, mentally retarded patients. So, its cost structure isn't the same as the national average. I wonder if you have any data that could help us look at the cost structure of this kind of facility nationwide so we would have a better, fairer base for it to start from.

Ms. WILENSKY. I would be glad to have whoever in your office is working on this issue, work with Murray Ross on MedPAC staff to see if there is some way we can provide information that will at least clarify what these costs might be.

Mrs. JOHNSON of Connecticut. Thank you very much. And then you say that the commission is concerned that HCFA is considering using RUG III classification system which was designed to explain variations in nursing home patients and a PBS or rehabilitation facility.

Ms. WILENSKY. Correct.

Mrs. JOHNSON of Connecticut. Because research indicates that it is not appropriate. I'm pleased to see your recommendation. Do you have any reason to believe that HCFA is going to use that RUG III system for long-term hospitals?

Ms. WILENSKY. Well we have struggled with this issue of trying to come up with a classification system, a common classification system, which would cover facilities that sometimes or frequently are providing common sets of services. We are more now in the position of saying we have not as yet been able to come up with this common system. Furthermore, some of the data with regard to the rehabilitation hospitals is proprietary and therefore brings additional difficulties as a basis of information.

I don't know whether there was reason to believe HCFA was about to go ahead with the RUG III option, other than the fact that they are under Congressional instructions to proceed with prospective payment, first for the nursing facilities and then for rehabilitation facilities and for other excluded hospitals.

But we are concerned that it appears empirically that the RUG system which has been under development for the last 10–15 years is, unfortunately, not a very good predictor for rehabilitation facilities. We want it clear for the record that as desirable as having a single system is, if it doesn't work, it doesn't work.

Mrs. JOHNSON of Connecticut. I appreciate that. I also was very interested in your recommendations in regard to DSH payment. But I'm a little concerned about your second recommendation that recommends that there should be a minimum threshold of low income patient cost share. Last year when we were working on all this stuff, we found that while Medicare margins are healthy across the board, there is a small group of hospitals at which they are not very healthy. Now those are not DSH hospitals, so I'm not making a direct line here, but it does seem to me that for certain hospitals, even if they have a relatively small number of DSH payments, for them they could be very significant costs. I'm a little worried about minimum thresholds.

Ms. WILENSKY. As in the home care copayment issue, we have attempted to weigh a number of factors and to balance them. Our concern about minimum thresholds is easier to explain. Previously the threshold differed depending on whether the hospital was urban or rural. The threshold had a cliff effect, and low income didn't include all the components of income the commission thought represented the relevant measures of low income.

What we have tried to do is continue to concentrate DSH payments, to not spread these payments over all hospitals, but rather to have them go to the 50 or 60 percent of the hospitals that were funding most of the low-income care. The DSH payments depend on how much Medicare services the hospital is providing, so that it not become a general support for hospitals that provide care to low-income people and to phase-in payments so as to prevent a cliff effect.

Whether there will be some hospitals that only provide a small amount of Medicare services or have a relatively small low-income population, and therefore could use a small amount of support, is something that can clearly happen. Again it's a tradeoff—do you want to have no concentration and just have all hospitals get a little bit of help. Will that provide enough help to the 30 or 40 percent of the institutions that do a lot of uncompensated care. Our real concern is to reraise this issue. We're sure you can make DSH payments better than they are now.

Mrs. JOHNSON of Connecticut. It may be that your broader definition which is your first recommendation. I think it is very, very important. It may sort of satisfy this problem but I do want to be alert to it because the proportion of care, even though it may be small in the institution, could be a factor.

And just last, let me comment that, you mention that HCFA is proposing a volume in intensity of services, a reduction in payment rate. This is the section that talks about the practice expense adjustments. And I'm very concerned about this because what I'm finding from this particular group of specialists is that the costs in these areas, of equipment, of paperwork, of administrative costs, have gone up in many instances doubling really in recent years and that often the time it takes to do the test is considerable. And so the idea that they would be able to just increase the volume in some of these specialty areas does not, with those examples I've been given, hold water the way it did in just an office visit practice concern.

Ms. WILENSKY. Well, as you know this is an issue I discussed with many of you in 1991 during the work value phase of the relative value scale. It is, with some pleasure on my part, that I can say I am supportive of the position of not including a behavioral effect in the proposed rule. I think that the empirical experience that occurred after the first phase of the relative value scale indicated there was far less change than HCFA had anticipated, but equally important, the constraints on collecting whatever unanticipated change existed with the volume performance standard are no longer present because Congress has put into place the sustainable growth measure.

And so, it seems to us the expectation for change is far less, given the changing environment facing the physician and the constraints on getting any excess payments back are far less because of your adoption of the sustainable growth rate. As a result, we recommend that there not be an adjustment for anticipated volume and intensity.

Mrs. JOHNSON of Connecticut. Thank you, Dr. Wilensky. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you gentlewoman.

Does the gentleman from California wish to inquire?

Mr. STARK. Yes, Mr. Chairman, and I apologize to you and our star witness today for being late and missing her prepared testimony.

Chairman THOMAS. We have a galaxy of witnesses.

Mr. STARK. I actually had these questions prepared before her testimony was available and wanted to ask Dr. Wilensky a couple of things.

As she knows, I have been somewhere between reminding and pestering her, about doctors' opposing the President's proposal for paying for drugs on the basis of acquisition cost rather than on this so-called average wholesale price which is sort of the equivalent of the sticker price on an automobile. If you know anybody who paid that for their car, you found somebody to sell a bridge to.

These drugs are reimbursed by Medicare at 10 times the amount the doctor pays for them. Doctors are saying they can't afford to administer these drugs because of the cost of syringes, refrigeration, and so on. Aren't those costs supposed to be covered by the practice expense component of the Medicare reimbursement system?

Ms. WILENSKY. Yes, it should be and to the extent there are problems, they should be dealt with directly. The work value part of the relative value scale was just reviewed as part of its first 5-year review and the practice expense rule will be coming out soon.

If the argument is that the physician needs to cross-subsidize, I think the response is we ought to fix the initial payment if there is indeed a problem with regard to the fee schedule; that's the place that needs to be fixed and you need to make a different argument to justify a higher reimbursement for the drug.

Mr. STARK. My second question, or comment, is that your report, indicates that it is going to take us 40 years for the beneficiary's share of the outpatient payments to get down to the 20-percent level. That doesn't seem correct. Particularly when, in many of these cases, the same procedure could be done in an ambulatory surgical center, where Medicare doesn't pay anywhere near what

we pay them for the outpatient department. We need to save the trust fund and, more importantly, we need to answer our beneficiaries who come in screaming because their copays are often huge relative to the cost of the procedure. Is there any way we can make this change more quickly? The hospitals say they go broke, but it is my understanding that it is only a reduction in prospective earnings, not a reduction in current cash flow. Can you offer us any suggestions as to how we could get our patients, or our constituents, off the hook for more than a 20-percent copay.

Ms. WILENSKY. I think the commissioners who initially raised the issue on the commission were surprised that the commission came forward with the recommendation that we did. We understand our recommendation is a "coster" in the traditional sense that under the current rules it would cost the Government money, but we think that allowing 40 years to pass before seniors would pay no more than a 20-percent copayment for outpatient services is inappropriate. It appears that there are instances now when seniors are paying up to 50 percent rather than the 20 percent they should.

Mr. STARK. How much in my lifetime?

Dr. Wilensky. There are two ways to attack this problem. Before you came in, I had discussed that one of the areas that the commission wants to take on during the next couple of years, is looking at payments that are made for essentially the same service that are provided in different settings. This is a very difficult issue, but we think it is high time that we looked at this.

Mr. STARK. And if they are equally safe, shouldn't we just pay for the lowest one?

Ms. WILENSKY. Well, we need to take into account such factors as the severity of illness of the patient to the extent that there tend to be different patients in different settings. We also need to be careful that we don't shut down too many outpatient departments or emergency rooms and that may justify some margin of difference in payment.

Mr. STARK. My only concern is where the——

Ms. WILENSKY. We are sympathetic with the differences that exist but even more so that they have not occurred because of rational pricing policies. With regard to the other matter, there are a lot of ways to try to get the 40-year period shorter, some of which would cost either the government or the hospitals money. If you are indeed serious in trying to shorten the time from 40 years, which we felt was unreasonable, we would be glad to work with you to come up with different options.

Chairman THOMAS. Will the gentleman yield briefly on that point?

Mr. STARK. Surely.

Chairman THOMAS. Obviously we're trying to undo something that developed over time, but didn't we also empower hospitals to negotiate that, so that there could be some market force pressure in terms of hospitals and patients in terms of what that amount is going to be.

Ms. WILENSKY. I don't know. I will be glad to look into how much it would affect the number of years. To be honest, the 40 years was not our estimate, it was an estimate we picked up from CBO. But

we were concerned with the amount of time that would need to pass before seniors paid no more than 20-percent copayment for outpatient services.

Chairman THOMAS. My only point is that there are potentially three players and not two and that although clearly revenue to replace it is the desired goal of hospitals, and patients, market forces to negotiate down that amount can also play a factor at least at particular hospitals with particular patients.

I thank the gentleman for yielding.

Mr. STARK. My final question deals with TEFRA cost limits, and more particularly the Vencor story in the Wall Street Journal. That story indicates that Vencor jacked their costs up in the nineties to $68,000 a patient. Then they quit taking severe cases and their costs dropped, but they are operating on the old high-cost base that they established.

Now, that's not available in the future, but it's still an issue. One, they probably are getting overpaid. Second, they prohibit entry of new competitors into the field. I wonder if you might be able to suggest some legislative fixes, if it can't be done administratively, to level the playingfield. So we would pay people what they ought to get paid and not based on some system that was gamed. Why not fix it to make it as fair a system as we could? Your advice in that would be useful. Do you think it is a good idea to make those adjustments?

Ms. WILENSKY. We would be glad to work with you to come up with such payment rate changes. We have been concerned that what you get paid depends on when you joined Medicare and how clever you were in fixing that initial rate. This is something we should look at.

Mr. STARK. Thank you very much.

Chairman THOMAS. I am sure there are individual horror stories, there always are, but as a collective group, as I recall in the balanced budget agreement changes we got about $4 billion over 5 years as a corrector as we move forward in this area and we'll continue to look at it.

If there are no further questions, then, as a segue into Dr. Scanlon's presentation, would you briefly give us MedPAC's comments on the GAO study dealing with the physician practice expense payments. Or did you have any.

Ms. WILENSKY. We do not have it. We will be glad to make such comments available as soon as we're had time to assess the report.

Chairman THOMAS. Alright. Do you want to make any general statement? No, I'm just kidding you. Thank you very much. I look forward to seeing you again.

Ms. WILENSKY. Thank you, Mr. Thomas.

Chairman THOMAS. Thank you, Dr. Scanlon. As usual, obviously, the GAO report and any testimony that you may have will be made a part of the record as a written statement. And you can address us in any way you see fit about your findings in this important legislative area.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. SCANLON. Thank you very much, Mr. Chairman. Members of the Subcommittee I am very pleased to be here today to discuss the report that we did on the efforts of the Health Care Financing Administration, HCFA, to revise the practice expense component of the Medicare physicians' fee schedule.

As you noted, in the Balanced Budget Act the Congress asked us to evaluate HCFA's proposed fee schedule revisions that were published last June and the impact of those revisions on the access to care.

On Friday we issued our report that provides a detailed analysis of the methods that HCFA used. In my testimony today, what I'd like to do is provide an overview of the challenges involved in revising the fee schedule and some of the problems that HCFA should address as it moves toward implementing the revisions in January of 1999.

Before commenting on the methods that HCFA employed, I'd like to first note the magnitude of the task of creating resource-based practice expense relative values.

Medicare's fee schedule pays physicians for almost 7,000 services and procedures, each of which may involve different amounts and types of practice expenses, including different types of staffs such as nurses, lab technicians, receptionists, billing clerks, as well as a myriad of supplies, equipment, and office space.

Creating resource-based practice expense relative values means estimating how much each of these resources is used in the delivery in each of those 7,000-plus procedures. We believe that HCFA has made substantial progress in addressing this formidable task. Its general approach for collecting information on physicians' practice expenses by convening 15 panels of experts to identify the resources associated with services and procedures is reasonable.

Other approaches for collecting this data such as conducting surveys or gathering data onsite may be useful supplements to HCFA's use of expert panels, but these alternatives would not be practical approaches for the primary data gathering. A survey to collect the detailed information needed to build the full fee schedule would be very time consuming to complete and runs the risk of poor response rate as HCFA experienced in its attempts to collect detailed information on indirect expenses.

Similarly, onsite direct measurement of the resources involved for a sufficient number of procedures and practices is impractical as the primary means of data collection due to the likely enormous costs. In using the expert panel data, HCFA made various adjustments that were intended to convert the panel's estimates to a common scale, to eliminate expenses that are reimbursed to hospitals rather than to physicians, to reduce potentially excessive estimates, and to ensure consistency with aggregate survey date on practice expenses.

While we agree with the intent of those adjustments, we believe that some of them have methodological weaknesses and other adjustments and assumptions lack supporting data.

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

With regard to the potential impact of the revisions on access, I would echo the sentiments expressed in the Medicare Payment Advisory Commission's report, and our own report. There have been very significant reductions in fees for selected services since the Medicare fee schedule was implemented in 1992. Changes associated with the Balanced Budget Act for 1998 add to those reductions. The likely practice expense revisions will compound those cuts.

It is impossible now to predict the impact of the total reductions on Medicare beneficiaries' access. It is important to remember, however, though, that access will depend not just on the change in Medicare fees, but how those fees relate to those paid by other purchasers.

Recent successes in controlling health care cost growth are partially the result of purchasers and health plans aggressively seeking discounts from providers. On a relative basis, Medicare fees may remain sufficient to preserve beneficiary access. Nevertheless, this is an issue that warrants continued monitoring and possible Medicare fee schedule adjustments as the revisions are phased in.

In conclusion, I would note that switching from charge-based to resource-base relative values for practice expense, while maintaining budget neutrality, inevitably creates winners and losers, as well as controversy. Controversy arose last June with the issuance of the proposed revision and may be expected this May with the next version.

It should also be noted that similar controversy surrounded the introduction of the resourced-based work relative values in 1992 but since then the medical community's confidence in those values has increased. In our report we recommend several actions HCFA can take to improve its methods and data. We believe if adopted these would give the physicians greater assurance that revisions HCFA proposes are appropriate and sound. HCFA officials have said that they would carefully review and consider each of our recommendations.

Mr. Chairman, that concludes my statement. I'd be happy to answer any questions you or Members of the Subcommittee have.

[The prepared statement follows:]

Statement of William J. Scanlon Director, Health Financing and Systems Issues, Health, Education, and Human Services Division, U.S. General Accounting Office

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the efforts of the Health Care Financing Administration (HCFA) to revise the practice expense component of Medicare's physician fee schedule. The Medicare program uses a fee schedule, implemented in 1992, that specifies the payments to physicians for each of over 7,000 services and

procedures. In 1997, the physician fee schedule payments totaled about $43 billion.[1] The fee schedule system was intended to relate Medicare's payments to three categories of resources used to provide a service—physician work,[2] practice expenses, and malpractice expenses. Currently, only the physician work component, which accounts for about half the payment for each procedure, is resource-based. The practice expense and malpractice expense components, which account for about 41 percent and 5 percent, respectively, of the fee schedule allowances, are still based on historical charges for physician services.

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

In summary, HCFA's general approach for collecting information on physicians' practice expenses was reasonable. HCFA convened 15 panels of experts to identify the resources associated with several thousand services and procedures. These resources include physicians' equipment and supplies, and the time of physicians' staff, such as nurses, technicians, and billing clerks. Other approaches for collecting these data, such as mailing out surveys and gathering data on-site, may be useful supplements to HCFA's use of expert panels, but they would not be practical approaches for the primary data gathering.

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

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

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

BACKGROUND

The Social Security Act Amendments of 1994[5] required the Secretary of Health and Human Services to revise the fee schedule by 1998 so the practice expense component would reflect the relative amount of resources physicians use when they provide a service or perform a procedure. The legislation required that the revisions be budget neutral—in other words, Medicare payments for practice expenses could increase for some procedures and decrease for others, but the revisions must not increase or decrease total Medicare payments. Physicians could, however, experience

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

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

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

[4] GAO/HEHS–98–79, Feb. 27, 1998.

[5] Section 121, P.L. 103–42, 108 Stat. 4398, 4408, Oct. 31, 1994.

increases or decreases in their payments from Medicare, depending on the services and procedures they provide.

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

HCFA'S METHOD TO ESTIMATE DIRECT EXPENSES WAS REASONABLE

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

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

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

We believe that HCFA's use of expert panels is a reasonable method for estimating the direct labor and other direct practice expenses associated with medical serv-

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

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

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

[9] This was procedure code 63030.

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

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

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

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

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

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

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

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

Finally, HCFA adjusted the CPEP data so that it was consistent in the aggregate with national practice expense data developed from the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) survey—a process that it called "scaling." HCFA found that the aggregate CPEP estimates for labor, supplies,

and equipment each accounted for a different portion of total direct expenses than the SMS data did. For example, labor accounted for 73 percent of total direct expenses in the SMS survey data but only 60 percent of the total direct expenses in the CPEP data. To make the CPEP percentages mirror the SMS survey percentages, HCFA inflated the CPEPs' labor expenses for each code by 21 percent and the medical supply expenses by 6 percent and deflated the CPEPs' medical equipment expenses by 61 percent.

The need for scaling was due in part to the equipment utilization rates HCFA used. HCFA officials told us that actual equipment utilization rates were not available from the medical community and therefore they had to make assumptions about the rate at which equipment is used in order to assign equipment costs to each code. For equipment associated with specific procedures, such as a treadmill used as part of a cardiology stress test, HCFA assumed a utilization rate of 50 percent, while, for equipment that supports all or nearly all services provided by a practice, such as an examination table, HCFA assumed a utilization rate of 100 percent. Scaling provided HCFA with a cap on the total amount of practice expenses devoted to equipment that was not dependent upon the equipment rate assumption HCFA used.

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

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

Impact on Access to Care Needs Continued Monitoring

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

While beneficiary access to care has remained very good since implementation of the fee schedule began in 1992, the cumulative effects of the transition to the fee schedule, recent adjustments to the fee schedule that were mandated by the Balanced Budget Act, and the upcoming practice expense revisions could alter physicians' willingness to accept Medicare's fee schedule payments for some procedures. For example, between 1992 and 1996, cardiologists experienced a 9 percent reduction in their Medicare fee schedule payments; gastroenterologists, an 8-percent reduction, and ophthalmologists, a 12-percent reduction. HCFA's June 1997 proposed rule would result in further reductions of 17 percent, 20 percent, and 11 percent, respectively, for these specialties once the new practice expense component of the fee schedule is fully implemented in 2002. Additionally, Medicare payments for surgical services were reduced by 10.4 percent beginning in 1998 as a result of provisions contained in the Balanced Budget Act. The combined impact of the proposed and prior changes on physicians' incomes will affect some medical specialties more than others. Therefore, there is a continuing need to monitor indicators of beneficiary access to care, focusing on services and procedures with the greatest reductions in Medicare payments.

Observations

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

methodology; doing so would needlessly increase costs and further delay implementation of the fee schedule revisions.

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

In our recently issued report, we recommended several actions HCFA should take to improve its methods for revising Medicare's payments for physician practice expenses. These recommendations, if adopted, would give physicians greater assurance that the revisions HCFA proposes are appropriate and sound. HCFA officials said that they would carefully review and consider each of our recommendations as they develop their rule.

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

[The GAO Report is being retained in the Committee's files.]

Chairman THOMAS. Thank you very much, Dr. Scanlon.

This is an important issue, and we're hoping that your report will turn a page in the ongoing attempts to get it right. It is important because it does involve a zero-sum redistribution, which has caused some concern about getting it right, and I want to make sure we get it right.

We will hear, after you, a panel of physicians, and their opinion of what you've done. So Dr. Pearlman will be able to more fully elaborate on his own testimony. But in reading his testimony I was taken apart by a statement he makes on the bottom of the last page. Although I understand that in certain of these words there's plenty of wiggle room, I want you to react to this statement to see if you agree with it fully, disagree in part, or basically disagree with it, because it is important for us to understand what we have in the GAO report.

And he says on the bottom of the last page, "The first step is to recognize, as has the General Accounting Office, that the unresolved questions over data and methodology are too great to support confidence in any proposal made this year that purports to be the final word on the issue." I guess the argument would be, is it the final word or not? I think none of us are looking to the final word; we're looking to some reasonably conclusive word that will allow us to move forward.

So in that sense, do you agree with his assessment that the General Accounting Office believes that the unresolved questions over data and methodology are too great to support confidence in any proposal made this year?

Mr. SCANLON. I think that you've touched the point where we would differ, which is the issue of the final word versus, as you said, whether we have a reasonably conclusive basis for moving forward. In our report we discuss the critical importance of a refinement process that's going to improve these relative values over time. We recognize, and HCFA recognizes, that not only in the process of estimating these originally are difficulties in gathering sufficient information to feel totally comfortable—but that the

world changes, and the resources that may be involved in different procedures and new procedures may require that one readdress the question. So we don't agree that you can't move forward at this point, but we would agree that, in moving forward, we're not going to have the final relative values units.

Chairman THOMAS. The other question I would ask you is, again, on methodology, because, frankly, we're all trying to get it right. My understanding is that the Practice Expense Coalition has Coopers and Lybrand to try to develop a practice expense methodology based on cost accounting. Although the idea of allocating costs at the practice level is relatively straightforward, what I would appreciate, if you have the ability to make some comment on, is that if the costs are going to be allocated according to the Current Procedural Terminology code book, which I've acquired and looked at there, about 7,000 individual procedures that would have to be part of that coding aspect, is that a practicable, a reasonable, and appropriate approach, in your opinion?

Mr. SCANLON. I've had a chance to look at Dr. Pearlman's statement, and in particular, the description of the Coopers and Lybrand approach, and there are remarkable similarities between it and other approaches, as well as the approach that HCFA has employed. The heart of what's involved here is the ability to assign expenses to each of those 7,000 procedures. In Dr. Pearlman's statement, I think that his language or his words are that we either know or we can learn how to assign different expenses to those procedures. That's the challenge.

In looking at other methods, as well as what HCFA has done, there's a combination of assumptions and actual data. HCFA gathers its data through the expert panels. Other people have proposed going into offices with stopwatches or going into offices with staff logs and asking people to record what they do every 15 minutes.

The alternatives will produce data of different precision at very, very different costs. The issue is to balance the amount of precision you get with the cost, gathering that kind of information. We think HCFA made a reasonable compromise in bringing together the panels to try to get that information.

Chairman THOMAS. And the old saw, time is money, so although the gathering of that data does have differing costs, it also deals with different timetables.

Mr. SCANLON. That's correct.

Chairman THOMAS. And the concern is, do we have enough to go forward—not, is what we have—perfect. That's our biggest concern in dealing with this.

Mr. SCANLON. We think we have enough——

Chairman THOMAS. It's degrees of comfort level——

Mr. SCANLON. Right.

Chairman THOMAS [continuing]. Not absoluteness.

Mr. SCANLON. And I would underscore the recommendation we made that, to increase our comfort level, the importance is to understand what are the most important assumptions and data elements that contribute to changes in fees that we're going to be introducing, and then to work to verify that those assumptions and the data elements that we had were reasonable. Across the board

we can't afford to go back and try and develop perfect data, but in a targeted way we can improve the data that we have for this task.

Chairman THOMAS. And then, just finally, I have had my share of criticisms with HCFA, but what I got out of your study—and if it's incorrect, let me know—is that in this instance HCFA has been open and cooperative in trying to resolve concerns about the content and level of accuracy of their data; is that correct?

Mr. SCANLON. They've certainly been open and cooperative with us, and we believe they've had continued contact with the medical societies. They've requested information from the medical societies. We think that they need to add an additional effort which is a more proactive stance in terms of gathering information themselves.

Chairman THOMAS. My goal is to focus on the difficulty of the job, not on trying to line up folks who are villains in terms of not trying to get to the bottom of it. I think this is an extremely difficult process, and that if there is a degree of cooperation on all sides, that's very positive. Is that a fair statement?

Mr. SCANLON. That's very fair.

Chairman THOMAS. Thank you.

The gentleman from California.

Mr. STARK. Well, thank you, Mr. Chairman.

Mr. Chairman—I'm puzzled that we don't have HCFA here to respond to some of Dr. Scanlon's review. I can't tell whether you gave them a C+ or a B−. But, perhaps you would like to write a letter to HCFA? I'd love to join in asking them to respond to the various suggestions we've heard today.

Chairman THOMAS. I'd just tell the gentleman that it may seem to be appropriate if they were sitting at the table. The problem is I believe that their response to every question we asked them would be that they're in the process of developing regulations that are going to be issued on May 1, and they'd be free to comment when the regulations have been issued, and I thought I could do that adequately——

Mr. STARK. Let's do it on May 2. [Laughter.]

Chairman THOMAS [continuing]. As a kind of a cover for them. So sometime after May 1 will be appropriate. Until then, they're in the process of developing regulations; they're going to be out on May 1, and it would be inappropriate to comment until those regulations are issued. [Laughter.]

Mr. STARK. It sounds like a stone wall.

Dr. Scanlon, let me just review the issue because I may be more objective about this. As I recall, when the physician reimbursement plan was devised, it was meant to be "relative," am I correct? You've used the word relative several times in the last 15 minutes.

Mr. SCANLON. That's correct.

Mr. STARK. So that we could, under the law, just decide that practice expense for heart transplant is a dollar, but then we might say that a pediatric visit is one cent, and it's all relative. There is no suggestion that the practice expense was ever going to be an accurate determination of the dollar cost of the expenses of each procedure and reimbursed on that basis; is that correct?

Mr. SCANLON. There was no intent to fully reimburse the practice expenses. The idea was just to get the relative values correct. The level that you're——

Mr. STARK. I think you've hit on what is causing some angst amongst ourselves in the physician community. Many of them are saying, "This doesn't begin to cover my cost." It's a very hard thing to say, "But, Doc, it was never intended to cover your cost. It was intended to pay some portion of those costs relative to what your colleagues in other specialties may be getting." And, that's often overlooked, these many years later, I believe. I just think it's important that we remind people that what doctors now want really was never on the table.

Mr. SCANLON. There's also a question being raised—and this is something that we did not try to verify, both because of the timeframe for our study, as well as the fact that HCFA is in the process of revising its rule for the May 1 issuance—but the issue raised by the physicians' community is that it's a different proportion of practice expenses that may end up being reimbursed for different types of services.

Mr. STARK. You're also hearing mostly, I suspect, from those physicians who have the highest fees and the lowest volume in number of procedures. In other words, the $6,000 surgery rather than the $50 office visit. Therefore, the practice expense for each time they receive that fee is more significant.

When we were doing the professional side of it, we didn't hear any complaints from the high-cost-per-procedure community because they were getting a hundred times what the primary care people were getting for these high, expensive procedures. But the interesting thing is they all agreed with the Shiao study.

If we got all the doctors to agree and the accountants to agree, and everybody else to agree, on the relative value basis that the Shiao study put forward, which defines the relative difference between transplanting a liver and a heart? Talk about a complex and very subjective decision.

Now, they were able to agree on the relative value between these very subjective procedures. I can't imagine that you can't figure out what the office costs are on a relative basis. This leads me to believe that this is merely a course of complaints among those who will have some reduction. Even the people who are getting increases aren't getting very much. Is that not the question? When we make these adjustments that have been proposed in the past, the primary care guys and the GPs and the interns are going to get a few bucks' increase. But, the people who take the decrease, while there are fewer of those procedures, will take a much higher dollar cost. In other words, the decreases might average $500, and the increases might average $5. Is that a fair assessment of what we're faced with?

Mr. SCANLON. I'm more familiar with it in percentage terms, and again, we didn't focus on this a lot because we knew they were temporary numbers that were going to be replaced, but, as I recall, the increases would average by specialty somewhere in the order of 10 percent for the biggest gainers and some of the specialties that would lose could lose on the order of 20 percent or more. So we're talking about whatever that number is times the base——

Mr. STARK. Times the base. And if all of the gainers were pretty low-cost procedures, because they were the volume people. And, the losers were those whose $600,000 incomes were made up of fewer procedures. Then it would stand to reason that you're going to get bigger dollar cuts per procedure, would it not?

Mr. SCANLON. That's correct.

Mr. STARK. As I say, I would hope that you will continue to give us your excellent advice——

Mr. SCANLON. I think that at the time the work values were computed, I agree with you that the task was enormously complex. This task in some ways is as complex or more complex, given the fact that what we're talking about is trying to deal with an office operation and assign it to all the different procedures that are going on with that office——

Mr. STARK. It's complex, but much more objective, is it not? Much more empirical as it were?

Mr. SCANLON. Well, it could be empirical in the sense that if we could afford to have someone in there with a stopwatch and have someone monitor every supply and the equipment used, then we could be very, very precise, but we really can't afford that. So, instead, what we need to do is rely on very skilled observers to tell us their best estimate of what——

Mr. STARK. Let me try this a minute. In the dim, dark past, I used to fuss with this professionally. You don't need a stopwatch per procedure; you can deal with the averages. You are not going to pay for the semiretired surgeon who does one procedure a week. You're not going to load the full practice expense into that one procedure. You have to deal with a surgical office where the full-time surgeon has to do five procedures a day, or let's assume, three a day. You take that average and say, "I'm sorry, if you don't work up to the average, Pal, you don't get a higher cost per procedure just because your productivity is low." That would be un-American.

Mr. SCANLON. No, these were all calculated for what would be the typical patient, we assume, within an average practice, but the reality is that the estimates of expenses for different procedures vary considerably because of the time that's involved and in some instances because of the equipment and supplies that are involved in those procedures.

Mr. STARK. Thank you. Thank you, Madam Chairman.

Mrs. JOHNSON of Connecticut. Mr. McCrery.

Mr. MCCRERY. Dr. Scanlon, I just want to try, if I can, clear up the gist of what you said and what your report says. First of all, you mentioned that the data that HCFA has accumulated is OK. I mean, that's probably as good as the data that you could expect to get. But you've also said that HCFA must be careful to interpret the data and use methodologies designed to interpret the data in a way that will give us a fair result. Is that basically what you said?

Mr. SCANLON. I don't think I'd use the word "fair." I think it would be a result that we'd have more confidence in, and we did recognize that in collecting the primary data, which are the estimates of these panels as to the time and equipment and supplies involved in procedures, that there are differences across panels in

estimates, as there would be differences in physicians and offices, if they were to fill out surveys.

HCFA's task was to try to bring that information, combine it in a way that they could come up with one value for each procedure. They also had a number of other adjustments that they felt necessary to make, for some, they didn't have data to support the assumptions underlying those adjustments. People would feel more comfortable about the end result if they had a comfort level with the adjustment to combine the panel data, as well as those other adjustments to the data that HCFA has imposed.

Do you think HCFA has time between now and when they are supposed to submit their recommendations to follow through on your suggestions?

Mr. SCANLON. We feel that they have time to follow through on some of our suggestions, but they also, we believe, should be instituting an ongoing process that's going to allow them to refine the relative values and to collect the additional information as well as to adjust the methods, so that during the phase-in, as called for by the Balanced Budget Act, that we see the relative values modified in a way that again increases people's confidence in them.

Mr. MCCRERY. Are you suggesting that GAO participate in that oversight or——

Mr. SCANLON. We would be happy to examine what HCFA is doing at any point, including the May rule that will be published, and then to follow the activities of HCFA for this Subcommittee as well as for the Congress.

Mr. MCCRERY. Madam Chair, I just want to point out that while we can somewhat dispassionately discuss changes like this, we are talking about substantial changes in how the government reimburses specialties and physicians in general that will affect their income in a substantial way in some cases, and we ought not take what we're doing lightly. We ought to demand that HCFA follow through on the recommendations of the GAO and we ought to provide that oversight that Dr. Scanlon is suggesting, perhaps in concert with GAO and this Subcommittee, because I am concerned that we are going to impose on some specialties decreases and reimbursement levels that would be greater than warranted by a true reflection of what their costs are. So I'm hopeful that we will follow through with the recommendations of GAO and look very closely at this transition period, and make sure that HCFA follows the recommendations closely of GAO, and perhaps we can work with GAO to develop a rigorous oversight regime during the transition period.

Mrs. JOHNSON of Connecticut. Dr. Scanlon, I find your report really very concerning. You say, overall, their data is good; overall, their methods are OK. Then you go on to say, "While we agree with the intent of the adjustments they made, we believe that some methodological weaknesses and other adjustments and assumptions lack supporting data." Now, frankly, I think that matters a lot. It's not just that some people are going to get paid a lot less, but you say, yourself, that the cumulative effects—now, it's true, you're pointing to more things than the adjustment and practice expense reimbursements, but the cumulative effects of the transition to the fee schedule—"recent adjustments to the fee schedule

that were mandated by the Balanced Budget Act and the upcoming practice expense revisions could alter physicians' willingness to accept Medicare's fee schedule payments for some procedures.''

Now I think that's very serious, and frankly, that does reflect a lot of things I've been hearing out there. Earlier on—I imagine you were here—I mentioned to Dr. Wilensky that the volume assumptions were not sound, and when I talk to physicians, I'm keenly aware of the additional equipment they're now required to buy, some of it OSHA-mandated, some of it other mandated; the longer time it takes for some of the sterilization procedures. Some of the procedures that we're going to cut by 50 percent now take 1 hour instead of 45 minutes, and the paperwork and the overhead is much greater. When I hear that this is OK and we should go ahead, in spite of the weaknesses, I do find it disturbing.

You mentioned the equipment utilization section; that HCFA officials ''told us actual equipment utilization rates were not available, and therefore, they had to make assumptions about the rate at which equipment is used in order to assign equipment cost to each code,'' and then you go on to go through some of the concerns that people have had about the equipment utilization rates. This is very fundamental. If you make the wrong assumptions about equipment utilization rates, you're going to come out with wrong numbers. It does seem to me that while their overall approach seems to have been rational, that we would be ill advised to move ahead with this until we get a better handle, for example, on equipment utilization rates.

Mr. SCANLON. In terms of the equipment utilization rates, the effect of equipment on the practice expense relative values is not just the result of their assumption, but they also use data from the American Medical Association, actual practice expenses, to scale the relative values, and in the process they are able to adjust for an error in their equipment rates. This is still an area, though, that's of concern to us because in doing that they did an adjustment for all procedures, and one of the things that we've talked with them about is the issue of whether one needs to vary that adjustment for different types of procedures or for different specialties.

Our concerns about their methods are significant, but in weighing what the possible impact would be on fees, we felt that it was still justified to move forward at this time. We would be much more comfortable if HCFA implements the sensitivity analysis that we asked for in terms of identifying what each of these assumptions and each of the types of data that we think of as a bit weaker, what impact they have on the fees being paid. If then we discover that there's a significant problem for particular procedures, we think that we'd have the opportunity to get information to adjust the fee for that procedure or——

Mrs. JOHNSON of Connecticut. All right. I would remind you that, generally, by the time we discover that we've made a mistake, at least 2 years have elapsed, for us to collect the data and figure it out.

Let me give you one specific example because my colleague from California, Mr. Stark, mentioned drug reimbursement rates. We can figure out how to reimburse right about drugs if we also are

sure that in the RBRVS we have taken into account the work required to deliver the drug, but what's happening is that techniques of delivering are changing, and we are not doing that. So that when you look at the recent report on oncology drugs, those reimbursement rates, and you look at the codes for reimbursing the oncologist, neither take into account it uses an infusion therapy operation; you have to give a predrug, then you have the person there; often they're there 6 hours in your office. You have to have certain OSHA-qualified hoods to do this and that and the other thing. If you open the bottle, you have to get rid of it. So it's not one dose; you can use half the bottle, and you have to waste the other half. You have to pay the insurance and the inventory upkeep, and so on, of a whole variety of drugs, so you can deliver them.

I am concerned about what we're doing in practice expenses because we're getting at that sort of soft, odd area that we have not been able to take into account very well in, for instance, drug reimbursement rates, and we have not taken into account very well in RBRVSs in some of the more recently—in some of the areas where the practice has changed and the instruments, sometimes surgical, but sometimes pharmaceutical, have changed dramatically. I think there are key things that we don't know here about the machinery equipment, that it has to be standard now in offices, even if it's only used rather seldom, and the cost of delivering pharmaceuticals and things like that. How would you deal with? Have you focused any attention, for instance, on the oncology area and delivery of drug therapies? And who's paying for what? How accurate are we?

Mr. SCANLON. The oncologists were members of certain panels, but there was not a special oncology panel, but we didn't focus on individual procedures. We focused on HCFA's overall method.

I agree with you that there is changing technology in terms of the delivery of services, and that needs to be reflected in these relative values. One of the things that HCFA has done, since the publication of the June rule, is solicited information from the medical community to help them make better assumptions in terms of limiting excessive cost, help them understand what types of personnel may assist physicians in different settings. We think those are the kinds of things that are important to have information on. At this point in time HCFA made some assumptions that affected the relative values that were published in the June rule. With information, they'll be able to assess whether or not those assumptions should be retained.

The example that you give of oncology drugs is a perfect example where the easiest way would be if the medical community would come forward with information that HCFA could then use to adjust fees. But if that doesn't happen, we would encourage HCFA, recognizing that this may be an important area, to pursue information on its own.

Mrs. JOHNSON of Connecticut. Thank you. I would just say, making mistakes in this area is going to be very costly because if we get it wrong, it's not hard to not have the equipment and send them down to the hospital for the equipment, where the costs are higher. If we get it wrong, it's better not to deliver the drug and let them go to the hospital and have the drugs delivered, and that

will be more expensive, and less convenient. So access and quality for actually the senior out there in the small town is a very big issue if we get the practice expenses matter wrong. So I'm interested that your focus was really on the overall, and I appreciate your responses very much. I guess I find the weaknesses in HCFA's work that you point to very substantial, and so I would see your comments about their being overall right and their data being overall OK as being a rather big umbrella statement and not the basis on which to set specific reimbursement rates.

Mr. SCANLON. If I could add, our concerns with what HCFA did all involve the adjustments that occurred after they collected the original panel data. It is possible, with the data that they have, to pose a different set of adjustments before their May rule. That's quite feasible for them to do.

Mrs. JOHNSON of Connecticut. OK.

Mr. SCANLON. And we think that the basis for doing that can be either the information that's coming in from the medical communities or in further consideration on their part as to what's an appropriate adjustment.

Mrs. JOHNSON of Connecticut. Yes, thank you. I join Mr. McCrery in believing that there ought to be a lot of oversight of those adjustments that clearly need to be made.

And, just last—and you could yes/no to this because we do have our guests that we would like to have a chance to ask you questions also—should this have been done without the constraint of budget neutrality, so we could see what we were doing, and then come back to, what can we afford?

In other words, is the constraint of budget neutrality creating a certain dishonesty in this process?

Mr. SCANLON. We have considered that issue, and I don't think the answer is yes, but I'm not positive about that.

Mrs. JOHNSON of Connecticut. OK. Dr. Cooksey, it's a pleasure to have you with us.

Dr. COOKSEY. Thank you.

Dr. Scanlon, you're with the General Accounting Office. I'd assume your Ph.D. is in accounting?

Mr. SCANLON. No, my Ph.D. is in economics.

Dr. COOKSEY. Do you sometimes get the feeling that there are not enough people in Washington that have taken accounting courses?

Mr. SCANLON. Well, being in the General Accounting Office, I don't necessarily get that feeling. We have an ample supply of accountants. [Laughter.]

Dr. COOKSEY. Good, good. I'm sure you do. I hope you do.

Mr. SCANLON. Right, but maybe more generally.

Dr. COOKSEY. How long have you been in your position in dealing with health care issues?

Mr. SCANLON. I've been in my position at GAO for 4 years, and I've been dealing with health care issues since 1975.

Dr. COOKSEY. I've seen your name around for many years. Do you get the feeling that we're dealing with a highly regulated, highly politicized, very complex health care system?

Mr. SCANLON. No question about that.

Dr. COOKSEY. Do you get the feeling that all of these hearings, all the votes, all the sound and fury is merely tinkering with a complex system without really addressing some of the basic problems?

Mr. SCANLON. I think we probably often feel that the only thing that we can do is touch the edges, that we really are not equipped to deal with the core issues.

Dr. COOKSEY. Is there any concern on your part that the balanced budget bill—now act—the way it came out, the final version, will skew the RBRVS system?

Mr. SCANLON. No, I don't think I have that concern. I mean, I think that what the instructions from the Balanced Budget Act are is to calculate for resource-based relative values based on actual cost, and that the issue there is the ability to undertake that activity within reasonable resource constraints in terms of budget and time, and to achieve the most precise and most accurate result that you can.

Dr. COOKSEY. I've taken a few accounting courses. It's been several years ago, but it's my understanding that the accounting profession and a lot of the more progressive businesses that have good accounting procedures are moving to more cost accounting. Would you agree with that or disagree with that?

Mr. SCANLON. I think cost accounting is essential in terms of operating a business, in the sense that if one isn't aware of the cost of producing either your product or your service, it's very difficult to understand how to price it or understand how to promote or whether you should promote it. So I think that a good and a successful business is going to be very aware of its cost for producing different services.

Dr. COOKSEY. Do you feel like the U.S. Government, from your perspective in the General Accounting Office, is moving to take advantage of these new cost accounting trends? Are the government agencies on the leading edge or the trailing edge of this trend toward cost accounting?

Mr. SCANLON. Well, I think that the Federal Government, and particularly through the Government Performance Results Act, GPRA, that the Congress has indicated very clearly that there is a concern that we understand what the product of government is. The challenge is that the product of government is often very intangible; a business has a service or a product to sell, whereas in government we have many potential effects that come from governmental activities. And the difficulty is in terms of identifying what those effects are and then measuring the quantity of the effect that we have, and then finally being able to relate that to the resources going into that activity.

In reality, we are only now moving through the first stages of the GPRA effort, and so in some respects we are at the opposite of this activity in terms of trying to do cost accounting for government, but someday we maybe will be pleased with the progress, but we certainly shouldn't be pleased today.

Dr. COOKSEY. Do you envision a time that the government, as a major stakeholder, as a payor of health care for many different segments of the American population, could reach a point that the government could trust market forces, market patient's choice, and

trust competition for those people that it's providing health care for, as an alternative to what we agreed upon earlier in this discussion, that we have a highly regulated, highly politicized situation where you have all the stakeholders there orchestrating the political system? Is this alternative feasible? Is it feasible within this millennium or the next millennium or even within Pete Stark's lifetime?

Mr. SCANLON. Let's hope it's at least feasible within the next millennium. I'm not sure about this one. I think we have the fundamental problem we are trying to address now, which is that identifying the outcomes of health care is a difficult task. We don't want to hold providers more accountable for positive outcomes than they should be, and we don't know what is the appropriate prognosis for any individual patient.

We're moving in the direction of trying to measure outcomes with respect to health plans, and someday we may be able to do the same thing with respect to providers. Then I think we would have a lot more confidence in market forces because we would be able to decide who is producing the appropriate amount of services for what we're paying.

Up until then, what our traditional approach has been is that we do do regulation. We do regulation of the inputs that we have. We ask that providers be qualified before we allow them to offer services, and then we often look at the process in which they're delivering services to see that it's safe and sound and according to accepted practices. The dilemma we have, it's the only thing to deal with until we get a better fix on outcomes.

Dr. COOKSEY. In this millennium that we're about to finish, in the early part of this century, the health care profession was more of a cottage industry, and in the examining room you had a patient and a physician. With the advent of World War II, you had a patient and a physician and employer, and then a labor union leader, and then with 1965 you had the government paying for Medicare and Medicaid, and then in the eighties we had corporate medicine and managed care. So I feel like the examination and treatment room is getting very full in this millennium with all of these people I just outlined.

Do you think you could ever trust your patients that the government pays for, that the taxpayers pay for, to go back into that waiting room where it's just the patient and the physician without the companies, without the labor union leaders, without the bureaucrats, without the regulators, without corporate entities? Is that feasible?

Mr. SCANLON. Again, I think it may be feasible if we understand what should be the outcome of that encounter with a physician or with any other health care provider; then we will be able to know whether the appropriate outcome occurs.

Dr. COOKSEY. Final question: When you go see a physician, how many of those players do you want in the examination and treatment room with you?

Mr. SCANLON. I prefer to go alone.

Dr. COOKSEY. Thank you. Thank you, Mr. Chairman.

Mrs. JOHNSON of Connecticut. Thank you very much, Dr. Scanlon, for your testimony and your work in this area.

I'd like to call now the next panel: Dr. Flaherty, the American Medical Association; Alan Nelson, the American Society of Internal Medicine; Deborah Haynes, the American Academy of Family Physicians; Dr. Alan Pearlman, on behalf of the Practice Expense Coalition.

I appreciate you all being here. You do know the rules. Your testimony will be entered in the record in its entirety, and we invite you to make an opening statement of 5 minutes. Because of the schedules of Members, we will go right through the whole panel, so we get to hear all of you and then take questions thereafter.

Dr. Flaherty.

STATEMENT OF TIMOTHY T. FLAHERTY, M.D., MEMBER, EXECUTIVE COMMITTEE, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. FLAHERTY. My name is Dr. Tim Flaherty. I'm a practicing radiologist from Neenah, Wisconsin, and a member of the AMA, American Medical Association's, executive committee of the board of trustees. I want to thank you for the opportunity to testify on this critical physician payment issue.

With the Balanced Budget Act, Congress brought Medicare beneficiaries a new benefit and new choices. For physicians, however, the BBA also brought extensive new payment restraints and redistribution that could eventually affect the care of beneficiaries received. Provisions calling for a single conversion factor and changes in practice expense values will lower payments for some physicians and raise them for others. However, the new spending targets established by the BBA may reduce Medicare payments to all physicians below current levels.

The combined payment cuts for a number of physical specialties could be severe. Both the GAO and MedPAC point to the need to carefully monitor how these changes will affect the access and quality of care available to elderly and disabled Americans. The AMA agrees, but is concerned that the current monitoring tools may not identify potential access or quality problems until they become significant or widespread.

One important tool for identifying potential access problems was eliminated in the BBA, and we are asking Congress to reinstate that tool which requires HCFA and MedPAC to report each spring on the projection of physician payment updates for the following year. Under the sustainable growth payment updates, we will be reduced when the utilization of service grows by more than the gross domestic product, GDP. The CBO predicts utilization will, in fact, exceed the target. As a result, CBO predicts that Medicare payments rates in the year 2002 will be 11 percent lower than payments today—11 percent lower than payments today—and 19 percent lower when adjusted for inflation. Ironically, this severe target was imposed despite the fact that since 1991 growth in spending for physician services has been well below Medicare overall rate of growth. No other provider group can match this record. Yet, physicians face projected payment cuts, while other providers can expect payment increases. In fact, Medicare+Choice care plans are even guaranteed a 2-percent increase each year.

As originally proposed and debated, the sustainable growth rate target was to be set at GDP plus 1 or 2 percent, but it was tightened to GDP plus 0 in the Balanced Budget Act. This is not realistic, and the result in payment cuts could stifle development and availability of new medical innovations. The spending target must be raised to GDP plus 2. Even then, projected growth in physician spending over the next 10 years will be lower than the BBA set for Medicare as a whole.

BBA also addressed the development of resource-based practice expense values for Medicare fee schedule. The AMA supports resource-based values so long as they reflect actual practice expenses. It is imperative that HCFA get this right because practice expense represents 41 percent of physician payments.

We supported the BBA provisions extending the implementation dates for requiring HCFA to revise its proposal, and we thank the Subcommittee and its Members for your support in these provisions. Congress also called upon the GAO to comply with HCFA's methods and data. We believe the GAO has developed an excellent report, and it is consistent with AMA policy. The AMA agrees that the use of expert panels to identify direct costs is appropriate, but we share the GAO's criticism of the way HCFA edited and linked the panel data, and do not believe it should be as is. Instead, adjustments should be made to improve the data's consistency.

We also agree that HCFA should explore including billing and other administrative costs in the indirect costs, just as office and other overhead expenses are now included. HCFA also should use specialty-specific data from the AMA's annual SMS, socioeconomic monitoring survey. Specialties vary in the dollars spent and practice resources per hour worked. The SMS was not designed to support development of relative values, but it has become clear that the survey is presently the most valid means of measuring practice costs. If the new values are to be truly reflective of the physician's actual cost, HCFA must make more extensive use of these data.

In addition, the AMA believes HCFA needs to collect some additional data from medical practices and other sources. However, we think this data can be collected without delaying implementation. We concur with the GAO that starting data collection over again would needlessly increase costs and further delay implementation.

We also strongly support MedPAC's recommendation that HCFA should not apply—should not apply, not apply—a behavioral offset to practice expense charges. Physicians have repeatedly challenged this offset, which would have reduced payments by $1 billion across the board in HCFA's June rule. In fact, we don't think these offsets are warranted for other payment charges either.

I appreciate the opportunity to appear, and I'd be happy to answer questions.

[The prepared statement follows:]

Statement of Timothy T. Flaherty, M.D., Member, Executive Committee, Board of Trustees, American Medical Association

Mr. Chairman and members of the Subcommittee, my name is Timothy T. Flaherty, MD. I am a practicing radiologist from Neenah, Wisconsin, and a member of the Executive Committee of the American Medical Association's Board of Trustees. I thank you for the opportunity to testify today on a number of critical issues raised in two recently-released reports from the General Accounting Office and the Medicare Payment Advisory Commission.

With the enactment of the Balanced Budget Act of 1997 (BBA), Congress opened a broad array of new private plans to Medicare beneficiaries and began the work that will be necessary to preserve the program for future generations. As with any new endeavor, careful monitoring will be required to ensure that nothing goes awry and patients are protected as the new Medicare+Choice program is implemented over the next few years. At the same time, we must all remember that many, if not most, beneficiaries will remain in Medicare's fee-for-service program for years to come. It is therefore appropriate that the subcommittee has chosen to focus on both sides of the program at this important hearing.

While the BBA brought Medicare's 37 million beneficiaries new benefits and new choices, it also brought extensive payment restraints and redistributions for their caregivers. For example, we note that modifications in the calculation of practice expenses and movement to a single conversion factor are expected to lower payments for some physician services and raise them for others. In addition, it is possible that the Sustainable Growth Rate target established in the BBA will bring about an across-the-board reduction in Medicare payments for physician services.

Monitoring Access and Quality

Both GAO and MedPAC have pointed to the need to carefully monitor the impact of these changes on elderly and disabled Americans. The AMA fully agrees with this conclusion. However, we are concerned that current monitoring tools may not identify potential access or quality problems until they become egregious and widespread.

To date, studies based on claims data and beneficiary surveys have found little evidence of any widespread deterioration in the availability of services to Medicare patients. However, anecdotal evidence suggests that some physicians are responding to growing cost pressures by foregoing investment in new technologies, reducing office staff, eliminating costly educational materials, curtailing the number of Medicare patients they see, and reducing the time they spend with them.

Should these trends become more prevalent, the availability and standard of care Medicare patients enjoy today may decline. The AMA is now conducting more comprehensive research on how payment cuts affect medical practice. We would be happy to share our results with MedPAC and this committee. In addition, however, we would urge MedPAC and others with a responsibility to protect Medicare beneficiaries to devise more refined methods of detecting and addressing access problems before they become widespread.

Physician Update Reports

We would further submit that the BBA eliminated one very important safety feature that has helped ensure that large numbers of physicians continue to participate in Medicare. We ask that Congress take immediate action to reinstate a requirement that the Health Care Financing Administration and MedPAC report each spring on projected physician payment updates for the following year.

When Congress first created a Medicare spending target (or volume performance standard) with an automatic formula for determining future payment updates, lawmakers acknowledged the potential for the formula to trigger updates that were either excessive or inadequate. They therefore asked HCFA and the Physician Payment Review Commission to advise Congress each spring on whether the default updates should be modified or allowed to stand.

These spring reports turned out to be a crucial ingredient in the new physician payment system. Lawmakers repeatedly turned to the reports for advice on refining the new payment system or altering the updates. Moreover, since HCFA officials repeatedly ignored a directive requiring them to produce quarterly reports on physician expenditures, the spring reports became the only information any of the interested parties had for evaluating and modifying upcoming changes in the payment rates before it was too late.

Sustainable Growth Rate

Despite its important role, the required update preview was dropped this year when the previous spending target was replaced with a new "Sustainable Growth Rate" target tied to increases in the gross domestic product. We note that MedPAC does conduct an annual review of the updates for hospitals and other health care facilities. And we believe that as PPRC's successor, the new commission can play an important role in ensuring that payment rates are set at levels that are fair to the government and adequate to maintain continued access to high quality care for Medicare patients.

This is especially important in view of the fact that physicians face a potential downward payment spiral that could lead to negative updates and payment rates that are well below those in place today. Shortly after the BBA was enacted, for example, the Congressional Budget Office predicted that the conversion factor used to determine Medicare payments will drop to $32.63 in 2002—or 11% (unadjusted for inflation) below this year's conversion factor of $36.63.

Whether the CBO is right or not will depend on how much Medicare patients' utilization of physician services grows over the next few years. If growth per beneficiary can be held to only 3% a year, for example, a recent AMA study suggests that physicians could see annual updates of about 0.5%. If the volume of services rises by 6% instead, however, payments would fall by 2% a year. Moreover, once adjustments are made for inflation, physicians face real per-service payment cuts of −1.5% or −4% under either scenario.

These declines are of particular concern because, since 1991, physician spending growth has been well below the rate for any other major sector of Medicare, and well below overall Medicare growth. Moreover, the projected Medicare payment level for physicians is a steep actual decline, while hospital and other provider payment rates go up. In fact, the Medicare+Choice plans are even guaranteed a 2% positive increase each year.

Such reductions, especially if they are accompanied by the new provider taxes or user fees proposed in the President's latest budget, may make it impossible for some physicians to cover their costs of treating Medicare patients. Some physicians may have no choice but to scale back the number of Medicare patients they see or the level of services they provide. For this reason, the AMA is convinced that, in addition to reinstating MedPAC's spring payment reports, Congress needs to modify the SGR.

With the SGR system, expenditure targets are determined through a formula that includes changes in Medicare payments, the number of fee-for-service beneficiaries, projected growth in the gross domestic product per capita, and recently-enacted laws and regulations. As originally proposed by PPRC, the formula would have included an allowance of one or two percentage points to make room for utilization increases stemming from technological innovation, emerging diseases, or potential favorable selection into the new Medicare+Choice plans. While Congress had endorsed this concept in prior budget bills, the allowance was dropped last year and the formula became GDP +0% rather than GDP +1% or +2%.

This year, the system will permit Medicare expenditures for fee-for-service patients to rise by just 1.5% in total, or about 4% per beneficiary. Such tight constraints will hold increases in physician spending well below historical levels and overall Medicare program growth, and could hamper efforts to encourage care in more cost-effective settings outside the hospital.

Such severe limits also could inhibit the creation and diffusion of new medical technologies and innovations. As the SGR is currently constructed, if adoption of new technologies generates even modest increases in the use of physician services, Medicare spending could exceed the target and trigger across the board reductions in physician payments. Facing such financial disincentives, physicians might be reluctant to invest in new devices and provide new technologies to Medicare patients, who then would be denied the advantages of recent increases in funding for biomedical research and changes in the FDA device approval process.

It is hard for physicians to understand why they alone among provider groups should be expected to absorb continued across-the board payment cuts. If Congress is serious about expanding the opportunities for medical innovation and if the SGR is to have any credibility with physicians, then the SGR allowance for utilization growth must be raised to at least GDP + 2%. We note that, even at that level, physician spending over the next 10 years would be held to lower growth rates than the BBA set for Medicare as a whole.

Practice Expense Payments

The BBA also included important provisions affecting another aspect of Medicare's physician payment system: the development of resource-based practice expense values. Due to major problems with HCFA's initial proposal for resource-based practice expense values, we strongly supported the BBA provisions extending the implementation date for the new payments and requiring that HCFA revise its proposal to incorporate accurate cost data. We wish to thank the Chairman and Members of this Subcommittee, as well as the full Congress, for your support in enacting these provisions. We were also pleased that Congress directed the General Accounting Office to evaluate HCFA's methods and data and the potential impact of the payment

changes on beneficiary access. The AMA continues to support the change to resource-based values, so long as they reflect the actual costs of clinical practice.

Since enactment of the BBA, we have been impressed with the dedication of both GAO and HCFA staff to meeting the Act's requirements. Project teams from both agencies have consulted frequently with AMA staff, particularly with regard to potential use of data from the AMA's annual survey of physicians in the new values. The GAO recommendations are generally consistent with AMA policy, and we believe the agency has developed an excellent report. We also believe that HCFA is likely to adopt many of the modifications recommended by the GAO.

In comments on its June 1997 proposal, we identified many flaws in HCFA's methods and data. The AMA agrees with the GAO that use of expert panels is an appropriate way to gather information about procedure-specific, or direct, practice costs. However, the way that HCFA used the panel data in its June proposal indicated that even the agency itself had little confidence in the results. A variety of methods were utilized, including a statistical approach called "cross-specialty linking" and a series of across-the-board data "edits," that substantially reduced the cost estimates provided by the expert panels. HCFA did not describe the criteria that it used to judge the relative accuracy of the panel estimates. Nor did it explain its apparent conclusion that only one of the panels produced accurate results. Moreover, in contrast to the process used to construct the physician work values, the cross-specialty linking process for practice expense relied exclusively on statistical methods, with no opportunity for clinical judgment.

Despite our criticism of the way HCFA altered the direct cost data in its June proposal, however, the AMA believes that the expert panel data require some adjustment and should not be used "as is." AMA observers attended all of the expert panel meetings and concluded that the panel estimates of billing costs, and possibly other administrative costs, were of questionable validity. Over the last six months, HCFA has made several well-intentioned but unproductive efforts to evaluate and correct these data. In our estimation, it is now time to move on and try other approaches to obtain accurate billing and administrative cost estimates. We support the GAO recommendation, therefore, that HCFA make targeted adjustments to improve the expert panel data's consistency and eliminate the need for linking. We also agree with the GAO that the agency should explore the option of including billing and other administrative costs in indirect costs, such as office rent and other overhead costs. This approach would eliminate the need to rely on panel estimates to measure billing and administrative costs for each procedure, thereby also eliminating the need to adjust or link the panel estimates for these resource costs.

In another recommendation favored by the AMA, the GAO also suggests that HCFA utilize the specialty-specific AMA Socioeconomic Monitoring System (SMS) data. With a response rate greater than 60%, the SMS is of high quality and is the only existing practice expense database derived from a randomly selected national sample. The SMS core survey has been conducted since 1982 by respected survey research firms and its validity is well-recognized. Although the SMS was not designed to support the development of relative values and the sample sizes for some specialties are not large enough to produce statistically valid responses, it has become clear that no other valid and reliable cost data are currently available.

HCFA's June proposal used the SMS data only to establish the total proportion of direct and indirect practice costs. The SMS reveals significant practice cost differences among specialties, however, including wide variations in the total dollars expended on practice resources per hour worked, as well as on individual cost components, such as medical equipment, staff labor, and materials and supplies. We concur, therefore, with the GAO's conclusion that HCFA should make more extensive use of the SMS data in its revised practice expense proposal.

With the expert panel and SMS data, we believe HCFA could develop reasonably accurate values. Consequently, we also agree with the GAO that starting data collection over again would needlessly increase costs and further delay implementation. At the same time, we appreciate the GAO's recognition of the need for HCFA to engage in some limited additional data collection. We are eager to see a detailed new proposal from HCFA explaining how it plans to use expert panel data, SMS data, and data provided by specialty societies. Even without knowing the details, however, it seems likely to us that these data will prove sufficient for initial implementation of the new values to proceed as scheduled in January 1999.

Nonetheless, it is important for data collection efforts to be initiated before a final rule is issued and continued during the four-year transition period to validate information provided by the expert panels and supplement information available from the SMS. As a first step, we believe HCFA could collect data on administrative and equipment costs from a representative sample of medical practices, firms that provide billing, coding, transcription, and procurement services to practices, and indus-

try groups such as the Medical Group Management Association and the Health Industry Manufacturers Association.

One of the most serious flaws in HCFA's June practice expense proposal was the application of a "behavioral offset" that would have removed more than $1 billion from Medicare's budget for physician services. HCFA actuaries' assumption that physicians would manipulate patient demand to recoup 50% of any payment reductions in their services led to a proposed 2.4% payment cut for all services. An earlier analysis by PPRC staff suggested that the actuaries' assumption was incorrect and MedPAC has now recommended that no behavioral offset be applied when the new practice expense values are implemented.

In the commission's view, the offset is unnecessary since the SGR would recover any additional spending that might be generated by changes in practice expense values. We wholeheartedly endorse this recommendation. In fact, we would submit that the same rationale should apply to all legislative or regulatory changes in physician payment rates. There is no need to apply a behavioral offset in calculating savings from federal budget proposals or determining budget neutrality when other modifications are made in physician payments.

The AMA also agrees with the MedPAC recommendation that HCFA delay its proposed payment reductions for procedures done at the same encounter as an office visit. HCFA has neither collected nor presented data or rationale to justify the proposed reductions.

Hospital Outpatient Department Payments

Along with its specific physician provisions, the BBA also includes a number of other changes in fee-for-service provider payments that will affect physicians and their patients less directly. Chief among these is a requirement that Medicare move to a new prospective method of paying for hospital outpatient services.

In its discussions of the new system, MedPAC's goal was to ensure that the site where care is delivered is dictated by medical decisions rather than financial incentives. The AMA wholeheartedly endorses that goal along with the commission's conclusion that the goal can best be achieved if hospital outpatient payments are consistent with payment in other ambulatory settings such as physicians' offices. As noted by MedPAC, at least initially, this would require a system based on disaggregated payments, rather than the bundled payment system that HCFA is developing.

We believe both physicians and outpatient departments would prefer to continue using the CPT coding system that is already familiar to them. Consequently, the AMA has grave reservations about the commission's recommendation that HCFA "continue to investigate service classification systems that would allow a broader definition of the unit of payment and could be applied consistently in all ambulatory settings."

The difficulties that have arisen in setting disproportionate share payments on the inpatient side lead us to wonder whether it is possible to create accurate adjustments for the cost of "providing socially valued services." Should this commission recommendation prove feasible, however, we believe Congress should also consider whether certain physician clinics might also be eligible for a "socially-valued service" bonus. A less complicated solution might be to reverse the BBA provisions that reduce state and federal governments' financial liability for patients dually eligible for both Medicare and Medicaid. As you know, the AMA vigorously opposed this BBA provision and continues to advocate for a legislative correction.

The AMA also cannot endorse MedPAC's recommended cap on outpatient expenditures. The commission proposes to monitor the cap's impact on access and quality. However, as noted earlier, the AMA is worried that many beneficiaries might experience serious problems before monitoring detected any deterioration in access and quality.

Should Congress adopt a cap on outpatient payments despite its potential disadvantages, however, any savings should be used to bring about a more rapid reduction in hospital outpatient copayments. These copayments are scheduled to decline under the BBA. However, MedPAC estimates that they won't reach the 20% level applied to other services for another 40 years. Like the commission, the AMA thinks 40 years is far too long. Even if lawmakers wisely reject the outpatient expenditure cap and are forced to look for alternative funding, we believe a faster phase-down is in order.

Home Health Care

At the same time, the AMA, like the commission, is in favor of imposing a new copayment for home health services. Some thought is required in determining ex-

actly how these copayments should be applied, however, and we would like to work with MedPAC and Congress in determining the most appropriate approach. With regard to the commission's call for a case manager to review the plan of care for beneficiaries receiving home health services for extended periods, we submit that any legislation to carry out this recommendation should clarify that the case manager could be the patient's physician.

MEDICARE+CHOICE

On another issue of great importance to Medicare beneficiaries, the AMA appreciates MedPAC's efforts to ensure a smooth implementation of the new Medicare+Choice program. With its detailed work on risk adjusting payments to the private plans, the commission and its staff have made a significant contribution to the challenge ahead.

Since we have not yet had an opportunity to review the report in full, the AMA is not ready to support each and every recommendation the commission has made in this area. However, we agree that it is time to move ahead with new risk adjusters and that, ideally, these adjusters should reflect more than a single year of data for diagnoses and costs if some existing data issues can be resolved. Like MedPAC, we also believe that Medicare should undertake demonstrations of partial capitation or other methods that pay plans based partly on a capitated rate and partly on fee-for-service rates.

We also concur with MedPAC's conclusion that improvements are needed in the adjusted community rate used to determine how much of the Medicare payment must be used to supplement benefits or defray premiums. However, we do not share the commission's view that PSOs in non-competitive markets should be subjected to some sort of special reporting and monitoring.

The AMA has previously endorsed proposals to exclude hospitals' disproportionate share payments from the fee-for-service costs used to calculate payments for capitated plans. We would therefore favor MedPAC's recommendation to exclude the DSH payments from the local component of the new blended rates created in the BBA.

To ensure equal treatment across all Medicare providers, the AMA also backs the commission's proposal to take additional steps, if necessary, to ensure that payments to Medicare + Choice plans are budget neutral. If physician payment changes must be budget neutral, then private plans should be held to the same standards.

Mrs. JOHNSON of Connecticut. Thank you very much, Dr. Flaherty.

Dr. Nelson.

STATEMENT OF ALAN R. NELSON, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE

Dr. NELSON. I'm Dr. Alan Nelson, the executive vice president of the American Society of Internal Medicine. My testimony will focus on two questions: First, are the basic methodology and data being used by HCFA to develop resource-based practice expenses fundamentally sound——

Mrs. JOHNSON of Connecticut. Excuse me, Dr. Nelson. Could you come a little closer to the microphone?

Dr. NELSON. Of course.

Mrs. JOHNSON of Connecticut. Thank you.

Dr. NELSON. Are the basic methodology and data being used by HCFA fundamentally sound? And, second, are the requirements of the Balanced Budget Act of 1997 being met by HCFA?

Some critics of HCFA's current rulemaking process have argued that the agency's approach is so fundamentally flawed that it needs to start over with some other approach. The report of the GAO rejects this conclusion. It specifically concluded that HCFA's ap-

proach of using expert panels is a reasonable method for estimating direct labor and other direct practice expenses. The report refutes the criticisms that the expert panels were composed in unrepresentative fashion, that their members were not prepared in advance to provide accurate estimates of practice expenses, and that their estimates were based on speculation, not data.

We also concur with the GAO that it would not be practicable to conduct onsite analyses or mail survey of physician practices for the purposes of developing a proposed rule. As the GAO notes, such approaches have their own limitations, including the potential for low or biased responses that preclude their use in a proposed rule.

The GAO also agrees that HCFA's approach to allocating indirect costs on the basis of physician work, direct practice expenses, and malpractice cost is reasonable. Most importantly, the GAO concludes that, "There is no need for HCFA to abandon the work of the expert panels and start over using a different methodology. Doing so would needlessly increase costs and further delay implementation of the fee schedule revisions." This should put to rest the argument that HCFA's data and methodology are so fundamentally flawed that it needs to adopt a cost accounting analysis, activity-based accounting, or some other unproved alternative to develop an acceptable proposed rule.

The improvements recommended by the GAO address the adjustments HCFA made to the expert panel data. For example, HCFA used a statistical formula to link the labor cost of physician services on a common scale. The intent of this adjustment, which the GAO supports is to eliminate variations in labor costs that otherwise would have resulted in some categories of services having much higher labor costs than other services that in fact have comparable costs. HCFA found that the labor costs of surgical and other procedural services, as estimated by the expert panels, are too high compared to those for office visits and other evaluation and management services.

ASIM agrees that it is appropriate for HCFA to consider changes in how it links labor costs on a common scale, but it's important to emphasize that the GAO does not call for HCFA to eliminate linking or other adjustments. On the contrary, the GAO says that, "We consider linking to be desirable. It's clear from the GAO report that, without some method to link labor costs on a common scale, some categories of services will continue to be significantly overvalued compared to other categories of services.

ASIM agrees with the GAO that the impact on access should be monitored. Improvements as well as decreases in access should be monitored. However, resource-based practice expenses, by improving payments for primary care services, may help improve overall access for some Medicare beneficiaries.

The GAO report demonstrates that HCFA has met the requirements of the Balanced Budget Act. BBA mandates that HCFA consult with physicians and consider using actual cost data to the maximum extent practicable. The GAO report details the extensive consultation with physicians that has occurred and details why it's not practicable for HCFA to survey physicians on their actual costs in order to develop an acceptable proposed rule. We agree with the

GAO that additional data might be considered in the annual refinement process that is mandated by the Balanced Budget Act.

In conclusion, ASIM is committed to working with HCFA to refine and improve its data and methodology. The GAO report provides a balanced blueprint for achieving the necessary improvements, but without incurring the needless costs of further delay that would have been required had HCFA been forced to use an entirely different approach.

Finally, although we agree with the GAO's view that HCFA should consider changes in the methods it uses to adjust the expert panel data, we are pleased that the GAO endorses the desirability of linking the practice expenses of physician services on a common scale.

I'll be pleased to answer questions.

[The prepared statement follows:]

Statement of Alan R. Nelson, M.D., Executive Vice President, American Society of Internal Medicine

INTRODUCTION

I am Alan R. Nelson, MD, Executive Vice President of the American Society of Internal Medicine (ASIM). ASIM represents physicians who specialize in internal medicine, the nation's largest medical specialty and the one that provides care to more Medicare patients than any other specialty. I am pleased to provide the Ways and Means health subcommittee with internists' perspectives on the current state of HCFA's efforts to develop resource-based practice expenses (RBPEs). Our testimony will address the following questions:

1. Is HCFA meeting the spirit and intent of the provisions in the Balanced Budget Act of 1997 (BBA) relating to practice expenses?
2. Are the basic process and methodology being used by HCFA for developing RBPEs fundamentally sound, and if so, are there improvements that still should be considered by HCFA as it develops the proposed rule?

My testimony will refer to the findings and recommendations of a draft report by the General Accounting Office (GAO), which ASIM had the opportunity to review on February 11. ASIM's testimony also refers to recommendations that the Medicare Payment Advisory Commission (MEDPAC) is expected to include in the Commission's March 1 report to Congress. The MEDPAC report, and the final versions of the GAO recommendations, were not available to ASIM when this testimony was prepared, so there may be some revisions in each of those reports' findings and recommendations from those that served as the basis for our testimony. Quotes attributable to the GAO report are based on our notes and recollections of the exact words used in the draft report.

ASIM's testimony today will explain why we believe that:

1. HCFA is meeting the spirit and intent of the BBA relating to practice expenses, particularly the requirements that it consult with physicians and consider data on actual costs to the maximum extent practicable.
2. HCFA's basic methodology and data are valid, although some improvements are appropriate.
3. It is not necessary for HCFA to start over and use an entirely different approach to develop resource-based practice expenses, which would needlessly increase costs and lead to further delay.

The GAO's draft report concurs with ASIM on each of these conclusions.

REQUIREMENTS OF THE BALANCED BUDGET ACT OF 1997

ASIM supports the practice expense provisions of the BBA. We believe that they represent an eminently fair and balanced approach to addressing the concerns that many physicians expressed last year. The BBA provided another year for physicians to consult with HCFA prior to implementation of RBPEs, and gave direction to HCFA on how its proposal might be improved. At the same time, though, it recognized the concerns of physicians whose services have historically been undervalued by the existing charge-based practice expenses, by beginning the process of redistributing payments in 1998. We appreciate the leadership shown by this subcommittee on this issue.

More specifically, the Balanced Budget Act of 1997 directs the Secretary of the Department of Health and Human Services to:

1. phase-in implementation of resource-based practice expense (PE) payments over four years, beginning on 1/1/99;
2. use generally accepted accounting principles and "actual cost" data to the "maximum extent practicable";
3. consult with physicians and other experts.
4. publish a new proposed rule and new practice expense relative value units (PE–RVUs) by May 1, 1998, with a 90 day public comment period;
5. begin moving payments to resource-based practice expenses, effective on January 1, 1998, by implementing a "down payment" that increased practice expense RVUs for undervalued office visits and reduced them for procedures whose current PE–RVUs are overvalued (based on a comparison of PE–RVUs to work RVUs).

In addition, the law directed the General Accounting Office to submit a report to Congress, within six months of enactment of the BBA, on the data and methodology being used by HCFA to develop the new proposed rule.

CONSULTATION WITH PHYSICIANS

The record shows that HCFA has fully met the law's requirements that it consult with physicians and other experts on the development of the proposed rule. The actions that HCFA has taken since enactment of the BBA include the following:

- A 60 day comment period was provided on a HCFA notice of intent to issue a proposed rule on practice expenses, published in October, 1997. The notice invited comments on how to use generally accepted accounting principles, utilization rates of equipment, and actual cost data in the development of the proposed rule.
- The RVS Update Committee (RUC), which consists of specialty society representatives and the American Medical Association (AMA), was asked by HCFA in September of last year to participate in a "mock" validation panel. This provided specialty societies with an opportunity to advise HCFA on how to structure the validation process, and helped them prepare for the subsequent validation panel meetings. The RUC had another opportunity to question HCFA staff on methodological issues relating to the development of the proposed rule at its February, 1998 meeting.
- Specialty societies nominated physicians, practice administrators, and other experts to participate in panels that met this past Fall to validate the data on direct practice expenses.
- Specialty societies, accountants, health services researchers, and other experts participated in a conference held on November 21 that discussed how to apply generally accepted accounting principles to the development of indirect PE–RVUs. (Indirect costs are the general costs of running a physician practice that cannot be specifically allocated to a particular procedure).
- Specialty societies nominated physicians to serve on a cross-specialty panel that met in December to advise HCFA on how to develop direct practice expense RVUs for a list of high volume, high cost physician services.
- HCFA staff have regularly solicited advice from specialty societies, the AMA, and others on methodological issues relating to development of the proposed rule.

It should be noted that the above actions to solicit the views of physicians are in addition to the extensive consultation that occurred prior to enactment of the BBA. The physicians, practice administrators, nurses and other experts who were selected to serve on the Clinical Practice Expert Panels (CPEPs) that developed the initial direct PE–RVUs were selected from nominations made by specialty societies. Specialty societies and the AMA were given an opportunity to review preliminary data from HCFA as early as January, 1997. They were also given an opportunity to submit comments during a 90 day comment period on the proposed rule on RBPEs that was published in June, 1997.

Physicians were also consulted by the General Accounting Office as it prepared its report to Congress on HCFA's data and methodology. ASIM was invited on three separate occasions to meet with the GAO to discuss internists' views on the process, data and methodology being used by HCFA. The AMA and other specialty societies were given similar opportunities. Since HCFA will likely give great weight to the GAO's recommendations, the GAO report provided another vehicle for physicians to have input into HCFA's decision-making.

It should also be noted that physicians will have another opportunity to comment on the new proposed rule and PE–RVUs that will be published by May 1, 1998. It is likely that the 1998 PE–RVUs will also be published as interim PE–RVUs that will be subject to yet another comment period. The BBA also requires that HCFA make further refinements in each of the transition years, which will provide physi-

cians with additional opportunities to advise HCFA on any improvements that are needed. The RUC will soon be developing a proposal to HCFA to participate in the refinement process, which if accepted by HCFA, will provide an ongoing means for HCFA to consult with the medical profession on refinements of the PE–RVUs.

By the time that the PE–RVUs begin to be implemented on January 1, 1999 physicians will have had far more opportunity to advise HCFA on data and methodology than was the case when resource-based work RVUs began to be implemented on January 1, 1992. As a result, the medical profession should have a higher degree of confidence that their views were considered in developing the PE–RVUs than may have been the case when the resource-based relative value scale (RBRVS) for physician work was first implemented. (It should be noted that many in the medical profession expressed the same kinds of concerns about implementation of the RBRVS that Congress is now hearing about practice expenses, but that over time the RBRVS has become almost universally accepted by physicians). The subsequent refinements that will occur during the four year transition should give the profession an even higher degree of confidence in the final PE–RVUs that will be implemented on January 1, 2002.

USE OF ACTUAL COST DATA AND GENERALLY ACCEPTED ACCOUNTING PRINCIPLES

ASIM also believes that HCFA is in the process of fully meeting Congress' intent that it consider use of actual cost data and generally accepted accounting principles to the maximum extent practicable. As noted previously, HCFA solicited comments on actual cost data, equipment utilization rates, and generally accepted accounting principles in its October notice of intent to issue a proposed rule. The November 21 conference on indirect costs invited further discussion of this issue. Witnesses who provided comments at the conference offered a wide range of opinion on the extent by which the data being used by HCFA was consistent with generally accepted accounting principles, with several of the witnesses concluding that HCFA's approach is consistent with generally accepted accounting principles.

HCFA is also using actual cost data from the CPEPs and validation panels. Data from the AMA's Socioeconomic Monitoring Survey (SMS) can also be used to determine specialty-specific proportions of direct and indirect practice expenses. Independent sources of data on the pricing of labor and equipment costs are also being used by HCFA to develop the direct PE–RVUs.

Despite HCFA's efforts to consider data on actual costs, some physician groups have repeatedly argued that HCFA's data are so fundamentally flawed that the agency needs to start over and conduct a new cost accounting analysis of physician practices, either through on-site studies or through a survey process. They claim that the CPEP and validation panel process was based on speculation, not actual cost data, and that the requirements of the BBA will not be satisfied unless HCFA undergoes a new study of the actual costs of physician practices.

ASIM firmly believes, however, that with some improvements, HCFA's data and methodology will prove to be valid, and that it is not necessary or desirable to conduct on-site studies or surveys of physician practice costs, except possibly on a limited basis as part of a refinement process.

ACCEPTABILITY OF HCFA'S BASIC DATA, METHODOLOGY

It is not only ASIM, however, that reached the conclusion that HCFA's basic methodology is fundamentally sound.

The draft GAO report specifically concluded that the use of expert panels is an acceptable method for estimating direct labor and other direct PEs. It also concluded that alternative methods (including new surveys of physician practice costs or an activity-based accounting methodology) have their own practical limitations that preclude their use in developing the proposed rule.

The GAO's draft report dismissed the argument that the CPEPs were not representative of the physicians that provided the services whose direct costs were being estimated, or that the panel members engaged in "best guesses" that had no factual validity. The GAO found instead that many CPEP participants reviewed practice cost data on their own practices prior to the CPEPs and came to the meetings prepared to discuss the issues, using actual cost data, rather than basing their estimates on pure speculation.

The GAO also concluded that mail out surveys, use of existing data, and on-site gathering each has "practical limitations that preclude their use as reasonable alternatives" to the expert panel approach. The limitations it saw in the other methods include low or biased response rates and high cost (the GAO noted that it cost the PPRC $135,000 to survey one single multi-specialty practice). The draft report also specifically says that activity-based accounting, one of the alternatives favored by

critics of HCFA's current methodology, "does not provide the specificity needed to adjust the MFS" because it allocates costs to broad categories of codes, not specific procedures.

Most importantly, in reference to cost accounting surveys and other approaches that have been recommended by the Practice Expense Coalition, the draft GAO report stated that "starting over and using one these approaches as the primary means for developing direct PE estimates would needlessly increase costs and further delay implementation."

ASIM fully concurs with the GAO's draft conclusion that the CPEP process is an acceptable method of developing labor and other direct practice expenses, although some additional work still must be done to validate the CPEP (and validation panel) estimates and to link and standardize the labor cost estimates across families of services. We strongly agree with the GAO that starting over and using mail surveys of physician practices, on-site cost accounting analyses, or activity-based accounting would needlessly increase costs and further delay implementation.

USE OF SURVEY DATA IN FUTURE REFINEMENTS

The GAO draft report suggested that gathering data from a limited number of practices could be useful in pinpointing problems that should be addressed during the refinement process, and in validating some of the CPEP results for key procedures. It also suggested that gathering such data might be useful in the subsequent refinement processes.

ASIM does not disagree that it may be appropriate to gather data from a limited number of physician practices as one source of information to be used in future refinements. We believe, however, that HCFA would first need to decide, in consultation with physician groups, on how such data should be collected and used. A poorly designed survey could be prone to the same limitations, such as poor response rates and under-representation of small primary care practices, that led the GAO to preclude using such data in the development of the proposed rule. The CPEP data should not be thrown out based on data from a survey of a limited number of practices on the costs of a few procedures.

The AMA has suggested that HCFA attempt to validate and refine the CPEP data by comparing it with other data from other independent sources, such as data from billing companies and transcription services. ASIM concurs that such data should also be considered by HCFA as it validates and refines the CPEP data.

The GAO's draft findings on the acceptability of the CPEP process, and on the practical limitations of alternative approaches, should put to rest the argument that HCFA has failed to meet the BBA's mandate that it consider actual cost data and generally accepted accounting principles to the "maximum extent practicable." The discussion should no longer be over whether an entirely new approach, requiring further delay, is needed. Rather, the discussion now should be directed to what improvements in HCFA's methodology are appropriate, as well as on how the refinement process should be conducted.

SUGGESTED IMPROVEMENTS IN HCFA'S METHODOLOGY, DATA

Linkages

One of the most important—and potentially controversial—recommendations in the draft GAO report concerns the formula used by HCFA to link the labor costs of physician services. The GAO suggests that HCFA consider other approaches to the statistical regression formula proposed in the June 18 notice of proposed rule making.

HCFA's rationale for applying the regression formula was that the relative relationships with the CPEPs are generally correct, but the absolute time estimates need normalization. HCFA noted that absolute numbers within some of the CPEPs may have reflected duplicate counting of tasks that can be performed simultaneously, and that different CPEPs may not have calculated absolute labor costs in the same manner. As a result, HCFA observed that there was considerable variation in the CPEP absolute estimates for the clinical and administrative staff times, including variation in the estimates for services that were evaluated by more than one CPEP.

It is essential that such variation be corrected. To illustrate, if one CPEP came up with absolute estimates of clinical and administrative staff times that are 20% higher than those derived by another CPEP for services that in fact involve comparable labor costs, the result of using the "raw" CPEP estimates—without statistical linking—would be that the services rated by the former CPEP would be overvalued compared to those rated by the other panel. In other words, since the pur-

pose of a relative value scale is to place all the relative value units on a common relative scale, use of the "raw" CPEP estimates would not produce a common scale of the costs of providing one service compared to another as the law requires.

Therefore, ASIM believes that it is absolutely necessary that HCFA standardize the data to create a relative value scale that appropriately values the relationships between all services and that not doing so would fail to meet Congressional intent.

More specifically, ASIM is concerned that with the exception of the panel that evaluated evaluation and management services, the CPEPs generally came up with absolute labor costs estimates that were too high, especially compared to those for E/M services. HCFA implicitly recognized this, since the regression formula had the effect of lowering the labor cost estimates of non-E/M services.

The GAO draft report accurately quotes ASIM as believing that linking is appropriate because some of the CPEPs uniformly assigned higher labor time than the E/M CPEP. The draft report suggests, however, that HCFA's regression formula may have created anomalies that are not supported by the CPEP data. As an alternative to the regression formula, the GAO states that HCFA is looking at "assigning uniform administrative staff times across broad categories of codes," such as the time required to schedule an appointment. It also suggests that shifting billing costs into the indirect cost formula may reduce the need for statistical linking.

ASIM is not opposed to considering whether, as an alternative to the regression formula, there are other approaches to establishing appropriate linkages between the labor costs of E/M services and non-E/M services. However, we strongly believe that any alternative linking method must correct the continued problem of non-E/M codes having excessively high administrative cost estimates compared to E/M services. The validation panels, and the cross specialty panel meeting that HCFA held in December, did not correct the misalignment of the labor costs of non-E/M services compared to E/M services. Therefore, it is essential that HCFA establish an appropriate linkage in the new proposed rule.

In our discussions with the GAO staff, the GAO staff assured ASIM that by asking that HCFA consider alternative approaches to the regression formula, it was not suggesting that it was unnecessary to establish an appropriate relationship between the labor costs of E/M and non-E/M services. Rather, the GAO only intended to suggest that HCFA consider other approaches that would appropriately link the labor costs of E/M and non-E/M services, such as by standardizing certain costs and shifting administrative costs into the indirect cost category. The GAO also did not rule out making such adjustments through a statistical formula. The draft report also states that the GAO cannot yet evaluate other approaches that may be considered by HCFA.

Although it is unlikely that Congress would want to get involved in the technical deliberations on linkage, Congress needs to be aware of the impact this issue will have on whether or not the new proposed rule satisfies the law's intent that practice expenses be based on the resources involved in providing each physician service. If an alternative to the statistical linking formula perpetuates the over-valuation of the clinical and administrative labor costs of in-hospital surgical procedures compared to office visits and other E/M services, the new practice expense payments will still not accurately reflect the resource costs of providing one physician service compared to another.

ASIM is committed to working with HCFA on developing an approach that will assure that the labor costs of non-E/M services are appropriately aligned with non-E/M services. If there is a better way to achieve this than the statistical formula proposed in June, then we have no objection to considering such an alternative. But without knowing what alternative may be offered by HCFA, it is premature to conclude that statistical linking is not necessary.

Scaling

The GAO draft report recommends that HCFA eliminate scaling of the CPEP data to the national survey data (AMA SMS data).

Scaling means adjusting the proportion of direct costs from the CPEP data so that they are consistent with the AMA SMS data. The SMS data suggests that the direct costs can be divided as follows: labor cost, 73 percent; medical supplies, 18 percent; and medical equipment, 9 percent. The CPEP estimates, in aggregate, came up with different shares of direct costs: labor, 60 percent; medical supplies, 17 percent; and medical equipment, 23 percent. Thus, HCFA adjusted the CPEP expenses for labor, medical supplies and equipment by scaling factors of 1.21, 1.06, and .39 respectively.

Eliminating scaling would tend to help specialties with a higher proportion of equipment costs, and disadvantage those with a higher proportion of labor costs. Since the direct expenses of primary care physicians typically have high proportions of labor costs, and lower proportions of equipment costs, than surgical and medical

specialists, the GAO's recommended change likely would disadvantage primary care physicians. ASIM has not, however, made a decision yet on whether or not elimination of scaling is appropriate. We will be examining this further and providing our recommendations directly to HCFA.

Indirect Costs

The draft GAO report recommends that HCFA consider using specialty-specific adjustment factors to determine the ratio of direct and indirect costs; and consider moving administrative costs into the indirect cost category. It also concludes that the basic approach of allocating indirect costs based on physician work RVUs, direct PE RVUs and malpractice RVUs, asble. Some physician groups had argued that the indirect costs should not be allocated using such a "proxy" formula. ASIM agrees with the draft GAO report's conclusion that HCFA's method for allocating indirect costs based on the proposed formula is acceptable.

ASIM does not have any conceptual problems with moving billing and other administrative costs into the indirect cost category, but we believe that this would necessitate treating those costs differently than would be the case if they were allocated based on the physician work+direct cost+malpractice RVU formula. Use of the formula used to determine other indirect practice expense would inappropriately allow surgical procedures with higher work RVUs to get substantially higher billing costs than E/M services, even though the costs of billing for a surgical procedure are not much different than for an office visit.

We support using specialty-specific ratios of direct to indirect costs, provided that there are adequate and valid data for each specialty to accurately calculate specialty-specific ratios.

Use of Physician Nurses

The draft GAO report concluded that "HCFA appropriately disallowed nearly all expenses related to staff that accompany physicians to the hospital since there is no available evidence that these expenses are not already being reimbursed or are a common practice."

Some surgical groups have argued that surgeons often bring their nurses into the hospital and that these costs should be reimbursed by HCFA. The draft GAO report disagreed. In ASIM's meeting with the GAO staff to review the draft report, we were advised that they had been told by surgical groups that there was some new evidence given to HCFA in response to the October rule-making notice that supports the claim that this is a widespread practice. GAO staff said it planned to examine the evidence and determine if it should modify its conclusion. ASIM recommends that the GAO ask HCFA to independently validate any such evidence, to determine if it is the usual practice for a typical Medicare patient, before agreeing that such expenses should be allowed.

DRAFT GAO RECOMMENDATIONS

Based on its overall analysis and findings, as discussed previously in this testimony, the draft GAO report concludes with several recommendations. ASIM's specific reaction to each recommendation is as follows:

1. *HCFA should document how it intends to adjust the CPEP data, the basis for the adjustment, and the effects on physician practices. HCFA should also describe the process for future refinements and updating.*

We concur with this recommendation. ASIM believes that HCFA should describe the elements that are needed in a future refinement process, but should leave the door open for the RUC to submit a proposal on how it might participate in such refinements.

2. *On a limited basis, HCFA should collect actual PE data to identify significant problems that should be addressed in the refinement process.*

ASIM concurs with this recommendation, provided that HCFA also look at o companies and transcription services. Any survey of physician practices or on-site gathering needs to be carefully designed to minimize response bias and other problems inherent in a survey process.

3. *HCFA should revise the linking methods and eliminate scaling to the national survey data.*

We concur with looking at alternatives to the regression formula used in the proposed rule, as long as the revised linking method properly aligns all services on a common scale, and specifically addresses the problem of inflated labor costs for non-E/M services compared to E/M services. We support using specialty-specific ratios of direct and indirect costs. ASIM has not adopted a position yet on the proposal to eliminate scaling to the national survey data.

4. *HCFA should collect data from a limited number of practices to test assumptions that underlie the other adjustments or the limitations on direct costs.*

ASIM concurs, but with the same caveats on the use of survey data that were discussed earlier.

5. *HCFA should evaluate assigning indirect PEs based on specialty-specific data.*

ASIM concurs.

6. *HCFA should monitor the impact of RBPEs on access, focusing on procedures with the largest cumulative reduction.*

ASIM concurs that the impact on access should be monitored. Congress should understand, however, that there are inherent limitations in any study that attempts to link changes in access (which may be due to a myriad of factors) to specific payment changes. Improvements in access to primary care services should also be monitored.

Application of the "Down Payment" to the Transition Years

The BBA began the process of moving payments in the direct of resource-based payments, by mandating a "down payment" in 1998 that improved the practice expense RVUs for office visits, while lowering them for some procedures. The legislative history of this provision, which originated in the Senate Finance Committee but was also accepted by the House conferees, shows that the intent was to increase the PE–RVUs of office visits in 1998 as a first step toward the expected increases that will occur when RBPEs are implemented on 1/1/99. Congress clearly intended for the PE–RVUs, as adjusted by the down payment, to be used in the subsequent years of the transition that begins in 1999 (i.e. the down-payment adjusted PE–RVUs would be blended with the resource-based PE–RVUs). Since other provisions in the BBA postponed implementation of RBPEs for one year (followed by an additional four year transition) the down payment was viewed by Congress as being an essential first step to helping physicians whose practice expense payments for office visits are undervalued.

In its notice of intent to issue a rule, HCFA indicated that the 1998 PE–RVUs, as adjusted by the down payment, would be the basis for the subsequent blended transition. Some physician groups are now trying to influence HCFA to reinterpret the law in such a way as to apply the down payment only to the 1998 PE–RVUs. They argue that the charge-based RVUs, which would be blended with the resource-based PEs beginning in 1999, should revert back to the 1997 PE–RVUs that were in effect prior to the down payment mandated by the BBA.

ASIM strongly opposes any such reinterpretation of the law and congressional intent. If HCFA agreed to apply the down payment only in 1998, but not the subsequent transition years, this would not only violate congressional intent, but would break faith with the members of ASIM and other primary care groups that supported the compromise on practice expense that was adopted last year. (We accepted a delay in implementation and a four year transition, conditioned on the requirement that HCFA begin making improvements in 1998 in PE payments for office visits, with the understanding that such improvements would carry into the transition years). It will also reopen the divisive debate in Congress and within the medical profession on an issue that Congress intended to settle last year. Finally, it could have the effect of raising PE payments for office visits in 1998, then lowering them in 1999—a "ping pong" effect that makes no rational sense.

It must be remembered why Congress mandated resource-based practice expenses in the first place, and why it decided to begin the process of making improvements—through the down payment—in 1998. Congress concluded—correctly—that the historical charge basis for determining practice expense payments undervalued office-based services. Even with the "down payment," the practice expense RVUs of a coronary bypass procedure that is performed in the hospital are more than 81 times that of a mid-level established patient office visit—even though the hospital picks up most of the costs of the bypass procedure. For many office-based services, Medicare payments now barely cover the costs of providing those services. Improved payments for the practice expenses of office visits and other undervalued services will therefore help improve access for those services. The down payment was a good first step to correcting the existing inequities, and Congress should not go along with any attempt to reverse the progress that is being made.

ASIM does not believe that it will be necessary for Congress to enact legislation to clarify the intent of the down payment provisions, since we believe that the intent of the BBA provisions are clear. But if this issue is reopened by HCFA, then we will urge Congress to step in and enact a technical correction that makes it clear that the 1998 PE–RVUs, as adjusted by the down payment, will apply in the transition years.

MEDPAC RECOMMENDATIONS ON PRACTICE EXPENSES

It is our understanding that MEDPAC will recommend that HCFA not adopt its proposal to reduce payments for procedures provided in conjunction with an office visit or other E/M service. ASIM strongly concurs with the MEDPAC's recommendation. HCFA's proposal to reduce PE–RVUs for such procedures by 50% would result in payments that do not reflect the resource costs of providing each procedure. There is no basis for HCFA to arbitrarily assume that the costs of providing procedures in conjunction with an E/M service are reduced by 50% from the costs of the original procedure.

We also understand that MEDPAC will oppose HCFA's proposal to include a volume and intensity adjustment—otherwise known as a behavioral offset—in its calculations of the PE–RVUs. In its June 18, 1997 propose rule, HCFA stated that it intended to assume that 50% of the reductions in payments for specific procedures will be offset by an increase in volume and intensity. The effect of this assumption is to increase the amount of reductions for some procedures, and reduce the expected gain from others. ASIM agrees with MEDPAC's view that HCFA's experience with implementation of the RBRVS does not support the need for such a volume and intensity adjustment. Further, MEDPAC argues—correctly—that the sustainable growth rate for physician services, also mandated by the BBA, already corrects for any increase in the volume and intensity of physician services. ASIM strongly urges Congress to advise HCFA that application of a volume and intensity offset to the PE–RVUs is inconsistent with requirement that resource-based practice expenses be implemented in a budget neutral manner.

CONCLUSION

ASIM is pleased that the draft GAO report fundamentally supports our assessment that HCFA is satisfying the intent of the BBA and that it is not necessary or desirable for HCFA to start over with an entirely different approach. We are pleased that the GAO recognizes the validity of the CPEP process and HCFA's formula for allocating indirect costs. We agree with the report's assessment of the practical limitations of the cost accounting surveys and other alternatives that have been advocated by others. We concur with the GAO that HCFA was correct in disallowing the costs associated with nurses who accompany a surgeon into the hospital, barring independently verifiable data that this is a typical practice.

None of the GAO draft report's recommendations for improvement are fundamentally inconsistent with the way HCFA is going about developing RBPEs. ASIM believes that the GAO's suggestions for improvement are for the most part appropriate, although we have some concern about supporting alternatives to statistical linking until we are certain that there is a better approach that would correct the misalignment of labor costs for non-E/M services compared to E/M services. None of the suggested improvements would result in what the draft report rightly calls the "needless" increase in costs and further delay that would be required if HCFA was forced to use cost accounting studies or some other alternative methodology to develop RBPEs, as the critics of HCFA's current process and methodology have long advocated.

Mrs. JOHNSON of Connecticut. Thank you, Dr. Nelson.
Dr. Haynes.

STATEMENT OF DEBORAH G. HAYNES, M.D., MEMBER, BOARD OF DIRECTORS, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. HAYNES. Good afternoon, Madam Chair and Members of the Subcommittee. I'm Dr. Deborah Haynes, a practicing family physician from Wichita, Kansas, and a member of the board of directors of the American Academy of Family Physicians. Thank you for inviting the Academy to comment on the General Accounting Office's report on the method that HCFA is developing to pay doctors' overhead expenses on the basis of resource cost, starting in 1999.

I have been selected to represent the Academy today because of my participation at various stages of the HCFA rulemaking effort

and my daily work as a family physician who participates in the Medicare Program.

The issue of switching to a resource-based method for making Medicare practice expense payments is a compelling and urgent one for family physicians. Practice expenses are more than 52 percent of a family physician's total Medicare revenue. A number of studies have shown that the services of family physicians and other primary care physicians are still undervalued by the current Medicare payment system.

One of the requirements of the balanced budget law is the GAO report that we have before us today. The Academy is overall pleased with the report. The GAO finds that HCFA has met the three main requirements of the balanced budget law. Physicians and other experts have been consulted extensively in the development of the HCFA proposal. Generally accepted accounting principles have been followed, and actual cost data has been gathered to the maximum extent practicable.

The report also includes five key findings in support of the HCFA method. First, the report specifically expresses the GAO's support for the HCFA method and the soundness of the data flowing from it. As you know, direct practice expense data was obtained by 15 groups, known as the Clinical Practice Expert Panels, CPEPs. These panels were comprised of physicians and practice administrators. The data was reexamined in October 1997 by validation panels. Then the highest volume and highest cost services were further examined by a cross-specialty panel in December 1997.

I served on the validation panel for the E&M codes and on the cross-specialty panel. These panels were representative of the physicians whose direct practice costs were being examined, and the data amounts to more than just estimates. GAO found that HCFA's methods and data were acceptable as a starting point, and we agree.

Second, GAO dismisses alternative data gathering such as activity-based accounting. These alternatives would increase the cost of the HCFA effort while needlessly delaying implementation of the new method.

We could support the use of additional data gathered from a limited number of practices if the data is used specifically during the refinement period to verify CPEP results for some procedures.

Third, the GAO supports the use of a statistical linking method for normalizing the data from the expert panels, but it suggests that HCFA consider evaluating a different linking method than the one it has proposed. We believe that HCFA's current proposed linking formula is statistically valid. It is preferable to simply averaging values across the CPEPs. We believe that a linkage based on the E&M codes, which is what HCFA proposes, is advisable, since virtually every medical specialty provides E&M codes, and virtually all of the CPEPs reviewed the E&M codes, making them a common denominator that can link all of the findings. We could support a new linkage formula, if it is developed in consultation with physicians and eliminates the inflated estimates that exist for some codes.

Fourth, GAO believes HCFA acted appropriately in disallowing practice expense payments for the work done in hospitals by a phy-

sician's staff. We agree with the HCFA decision not to cover practice expenses in this situation.

Fifth, the GAO recommends that HCFA monitor the impact of its practice expense proposal and access to services, focusing attention, in particular, on those procedures with the largest reductions in payments. We also believe that HCFA should monitor improvements in access to primary care services that may result in the new method. We hope that having the Government's principal accounting agency validate HCFA's approach will lay to rest criticisms of the acceptability of HCFA's data and methods. The practice expense issue does not need to be reopened legislatively. HCFA is on the right track, according to GAO, and we could not agree more.

The last issue I'd like to touch on is the $330 million downpayment for office-based procedures. Some medical groups are urging HCFA to use the 1997 practice expense relative value units instead of the new 1998 downpayment-adjusted practice expense RVUs as the base amount for the blend during the 4-year transition. This interpretation defies congressional intent and logic, and would lower payments for office services different than what they should be under the law. We strongly oppose reinterpretation of the law this way.

Thank you for the opportunity to offer the family practice viewpoint on practice expense payments. I'll be glad to answer questions.

[The prepared statement and attachment follow:]

Statement of Deborah G. Haynes, M.D., Member, Board of Directors, American Academy of Family Physicians

INTRODUCTION

My name is Deborah G. Haynes, M.D. I am a member of the Board of Directors of the 85,000-member American Academy of Family Physicians, and I serve as Chairperson of the Academy's Commission on Quality and Scope of Practice. It is my privilege to appear before this subcommittee today to discuss our views on the method being developed by the Health Care Financing Administration (HCFA) for implementing resource-based practice expense relative value units as part of the Medicare physician fee schedule.

As you may know, the HCFA proposal appeared in a June 18, 1997 Federal Register proposal addressing revisions in the Medicare physician fee schedule. On October 31, 1997, HCFA published a Notice of Intent to Regulate in the Federal Register that requested information from the physician community and other experts on specific elements of the proposal. The HCFA practice expense proposal is also examined in reports that Congress is expected to receive from the Medicare Payment Advisory Commission (MedPAC) and the General Accounting Office (GAO). These reports were in a draft form when this statement was prepared, so my comments are based on the draft versions of the MedPAC and GAO reports.

I was asked to represent the Academy today because of my involvement in the HCFA endeavor to develop resource-based relative value units for practice expense payments. I served on the validation panel for evaluation and management (E/M) codes in October 1997, and participated in a cross-specialty meeting in December 1997. Both events were convened by HCFA as part of their effort to gather actual data on physician practice costs to the maximum extent practicable as part of the rulemaking on practice expenses, as required by the Balanced Budget Act of 1997 (P.L. 105–33). I also spoke for the Academy as part of a group of primary care physicians that met at length in October 1997 with the GAO team during the predrafting phase of the report the subcommittee is examining today. Accordingly, my knowledge of the practice expense issue stems from personal experience as a participant in the HCFA rulemaking effort—and from my daily work as a family physician who participates in the Medicare program.

THE NEED FOR RESOURCE-BASED PRACTICE EXPENSE PAYMENTS

Prior to 1992, Medicare compensated physicians on the basis of historical charges that substantially overvalued procedures performed in hospital settings while deeply undervaluing E/M services and other non-surgical services provided in office settings. In 1992, HCFA began to implement a new Resource-Based Relative Value Scale (RBRVS) designed to pay physicians on the basis of relative value units (RVUs) for each procedure. These RVUs are based on the time, skill and effort required of a physician to perform a particular procedure. Payments for physician work, however, are only a part of the whole reimbursement. Physicians also have to be compensated for the Medicare share of their practice expenses and malpractice costs as a part of each payment under the RBRVS system. The RBRVS is intended to eventually encompass all three components of the fee: physician work, practice expenses and malpractice costs. Congress expected the RBRVS to be an accurate and equitable system for paying physicians for their Medicare services.

What is at issue today is resource-based practice expenses. HCFA has not yet proposed a method for determining resource-based RVUs for malpractice costs, but has substantially completed the process of establishing resource-based RVUs for practice expenses. These expenses include the costs of office staff, and the equipment and supplies necessary to run an office. We believe that the HCFA proposal on practice expenses meets the requirements established in the Balanced Budget Act of 1997, because it is the result of extensive collaboration with the physician community, and the methodology is valid as it is based on reliable data on actual physician practice costs. In these conclusions we agree with the General Accounting Office, whose draft report we have reviewed.

Establishing resource-based RVUs for the practice expense and malpractice components of the Medicare physician fee schedule is lagging behind schedule. All physician work RVUs are now resource-based and were even reviewed and modified as part of a five-year review conducted by HCFA and the American Medical Association RVU Update Committee (RUC) in 1995 and 1996. However, the practice expense and malpractice components of the fee schedule have not yet been converted into resource-based RVUs. This is a serious problem given the proportion of the overall fee that is represented by each component. The need to rectify this tardiness is especially compelling when one considers that practice expenses account for 41 percent of the total RVUs in the Medicare Fee Schedule and 52.2 percent of a family physician's total revenue, according to the 1988–1990 AMA Socioeconomic Monitoring Survey.

Congress in 1994 extended the deadline for implementation of resource-based practice expense RVUs to 1998. Reputable, independent studies conducted by the Physician Payment Review Commission, the Harvard School of Public Health and Health Economics Research, Inc. in the mid-1990s confirmed the problems of the current payment system and bolstered the need to correct the practice expenses issue as soon as possible. Thus, HCFA began the process of gathering direct practice expense data for developing the new practice expense RVUs with the assistance of Abt Associates, Inc. in 1996.

PRACTICE EXPENSES AND THE BALANCED BUDGET LAW OF 1997

Preliminary results of the HCFA effort to establish resource-based practice expense RVUs were released in the early part of 1997. The data justified a substantial decrease in practice expense payments for certain facility-based, procedural services and an increase for primary care and other office-based services. Reaction to the data and a subsequent HCFA proposal for implementing a new practice expense method based on it led to a new timetable for implementation of resource-based practice expenses in the balanced budget law enacted last year.

The law spelled out in detail how HCFA is to proceed with the task of completing the implementation of resource-based practice expenses. A transition period totaling five years (1998–2002) was established. HCFA has begun phasing in the new practice expense method this year by shifting $330 million from the most overvalued procedures to the office-based services represented by CPT codes 99201–99215. Further, HCFA is required to consult with physicians and other experts, and use generally accepted accounting principles and actual cost data to the "maximum extent practicable" in drafting a new proposed rule on practice expenses which must be published by May 1. Finally, the law requires GAO to report to Congress on the HCFA proposal.

Although the balanced budget law establishes a five-year transition process that began this January, during which family physicians will continue to be underpaid for their Medicare practice costs, it is encouraging that the long-standing problem with practice expenses will at last be resolved by 2002.

THE GENERAL ACCOUNTING OFFICE REPORT

The Academy is very pleased with the draft report. We believe the GAO displayed commendable objectivity in its thorough examination of the issues surrounding the HCFA proposal as well as balance in its subsequent recommendations to Congress. This draft reflects an impressive amount of research into the complicated topic of Medicare practice expense payments, familiarity with the HCFA proposal and comprehensive knowledge of the various arguments advanced in support of or in opposition to the HCFA proposal.

The GAO report contains a number of significant findings and recommendations that I will address in the order presented in the draft.

The GAO found that using expert panels such as the Clinical Practice Expert Panels (CPEPs) for estimating direct labor and other direct practice expenses is an acceptable method. The GAO rebuts specific criticisms of the CPEP process by noting that these panels were representative of the medical specialties and that members were contributing information based largely on facts, not merely "best guesses." The Academy concurs with this assessment of the HCFA method.

The report is very clear in stating that alternative data gathering proposals that have been advanced are unreasonable and, if followed, would increase costs while needlessly delaying the implementation of a new method for determining practice expense payments. The GAO resoundingly dismisses the activity-based accounting alternative, for example, because it reallocates practice costs to broad categories of codes and not to specific procedures, as required by the law. The Academy agrees with the GAO position on alternative data gathering proposals.

The GAO suggests that data gathered through a limited survey should be used as part of a refinement process and that the refinement process itself should be clearly described to the public. Collecting additional data specifically as part of a refinement process is supportable and could be of assistance to HCFA. Such an activity, however, should not be used as justification to discard the data already amassed from the expert and validation panels. The Academy believes that if additional data is to be collected as part of the refinement process, HCFA must then offer a detailed proposal for conducting a targeted data gathering effort to the public so that physicians may collaborate with the agency on how such data should be gathered and used.

Some specialty groups would like to involve the Relative Value Unit Update Committee (RUC) in the practice expense refinement activities. Although we are supportive in concept of utilizing the RUC in this fashion, the Academy also has concerns with involving the RUC in refinement of the resource-based practice expense RVUs. Before utilizing the RUC, sufficient staffing and resources must be obtained to ensure that the committee is capable of handling an increased workload. Just as importantly, we believe that non-physician clinicians, such as physician assistants, nurses and practice administrators should be invited to participate in RUC practice expense refinement activities. These providers and administrators would bring valuable perspectives on the clinical and administrative labor upon which the allocation of direct and indirect practice expense RVUs is based.

The report supports the use of a statistical linking method for normalizing the data generated by the CPEPs while suggesting that HCFA consider other possible means of linking the labor and administrative costs for E/M and non-E/M services. The Academy reviewed HCFA's proposed regression formula for linking the CPEP data and found it to be a statistically valid one. We also found it more preferable than simply averaging values across all expert panels since this approach can disturb the relative rankings of codes within panels. Further, we believe that a linkage based on the E/M codes is preferable because virtually every specialty provides E/M services and virtually all of the CPEPs reviewed E/M services, making these codes a "common denominator" that can connect all of the findings to one another. In addition, the composition of the E/M validation panel was more balanced between primary care and subspecialties than were other panels, and there was greater consensus among its members, leading us to believe that the data reported by the E/M panel were inherently more accurate and less inflated than those recorded by the other panels.

While the Academy is supportive of HCFA's proposed linking formula, we are not opposed to considering other methods for normalizing the direct practice expense data. However, our flexibility is subject to the following caveats: if the linkage formula is to be modified, a detailed proposal for accomplishing this change should be developed with guidance from physicians, offered for public comment, and it should correct the problem with inflated administrative and labor cost estimates for some non-E/M codes. Otherwise, an alternative formula probably would be unacceptable to family physicians.

The report also recommends that HCFA consider certain improvements in its methodology, including the elimination of "scaling," the use of specialty-specific adjustment factors to determine the ratio of direct and indirect costs, and moving administrative costs into the indirect practice expense category. I will address these individually below.

"Scaling" refers to a statistical adjustment made in the CPEP data so that the proportion of direct expenses attributable to labor, equipment and supplies is consistent with the AMA Socioeconomic Monitoring Survey (SMS). In its June 18, 1997 proposed rule, HCFA noted that in the aggregate, for all CPEPs, labor comprised 60 percent of total direct expenses, medical supplies comprised 17 percent, and medical equipment comprised 23 percent. Further, HCFA noted that the corresponding percentages from the AMA SMS data were 73, 18, and 19, respectively. To equate the aggregate CPEP percentages with those of the AMA SMS, HCFA proposed an adjustment in CPEP expenses for labor, medical supplies and medical equipment using scaling factors of 1.21, 1.06 and .39, respectively. In essence, this involved multiplying the CPEP expenses for labor, equipment and supplies for each code by the given scaling factors so that the overall distribution would be equivalent to the distribution in the AMA SMS.

The impact of scaling on the direct expenses of any given code depends on the distribution of direct expense for that code as compared to the aggregate distribution. This means that codes with a greater-than-average share of labor costs would experience an increase in direct expenses as a result of scaling, while the opposite would occur for codes with a greater-than-average share of equipment costs.

The GAO recommends elimination of scaling in the HCFA practice expense proposal. This is because HCFA never explained why it felt compelled to scale the CPEP data to fit the AMA SMS and, as the Academy commented last year, we failed to understand the value added by scaling, especially given the credibility of the CPEP data. Thus, to the extent that there is no value added by this mathematical manipulation, we concur with the GAO's recommendation to eliminate scaling.

The GAO recommends using specialty-specific ratios to allocate indirect practice expenses among codes. In its proposed rule, HCFA wants to use the aggregate ratio (55/45) for this purpose so the adjustment would be the same across the board for all codes. The Academy has not taken issue with the method HCFA originally suggested for allocating indirect practice expenses among codes. However, scaling indirect practice expense RVUs to the available pool of RVUs on the basis of the percentage of direct and indirect practice expense RVUs billed by each specialty, as recommended by the American Society of Internal Medicine, rather than on a fixed factor of 0.219 as in the HCFA proposal, has merits. We believe that the use of specialty-specific ratios in the formula would represent a further refinement of that formula. Although the ASIM method is more complex, this approach might, in fact, allocate indirect practice expenses more accurately. We would support HCFA's consideration of this refinement, with an understanding of the trade-off between simplicity and precision in this decision.

In reference to the GAO proposal to shift administrative expenses to the indirect side of the equation, the Academy conceptually has no problem with doing this, a position similar to that held by ASIM. The CPEP and subsequent validation panels have highlighted the difficulty with trying to attach administrative costs to individual procedure codes. For example, how does one account for multiple service codes submitted on the same claim form? Or all of the other administrative expenses incurred for a patient presenting with multiple medical problems—a common situation in family practices? Like rent and utilities, administrative costs will probably vary less by procedure code and more by the size and type of practice. The only problem with shifting administrative costs to the indirect category is that the formula for allocating indirect expenses would allow higher payments for the indirect practice costs of surgical services even though associated billing costs, for example, are most likely the same as those costs associated with billing for an E/M service. However, the question of whether these billing and administrative costs should be standardized, or if this data should be obtained from independent data sources such as billing agencies, has not yet been addressed by the Academy.

The GAO challenges the claims of some subspecialists that it is a common practice for them to bring their office staff into the hospital to assist on rounds and in surgery. Specifically, GAO said there is no evidence that utilizing staff in this fashion is a common practice. The Academy agrees. These claims should be subjected to external review and validation, however, and even if validated, we contend that payment for the expenses of staff brought into the hospital should come from Medicare Part A, not Part B.

It should also be noted that the GAO report specifically certifies that the HCFA proposal meets the balanced budget law's requirements for consulting physicians

and other experts and gathering actual cost data to the "maximum extent practicable," as required by the balanced budget law. We hope that having the government's principal accounting agency validate HCFA's approach will finally lay to rest the unfounded criticisms about data gathering efforts, accounting principles, the thoroughness of efforts to consult with physicians and other experts and so forth that have been lodged against the HCFA proposal.

Finally, the GAO recommends that HCFA monitor the impact of its proposal on access to services, focusing its attention in particular on those procedures with the largest reductions in practice expense payments. The Academy believes that HCFA should also monitor improvements with access to primary care services that may result from the new practice expense payment method.

THE MEDICARE PAYMENT ADVISORY COMMISSION REPORT

Two important issues relating to the HCFA practice expense proposal were not included in the GAO report, but are expected to be mentioned in the forthcoming annual report of the MedPAC. We are referring to the HCFA proposals to include in the new practice expense method a behavioral offset and a reduction in practice expense RVUs for multiple procedures performed during an E/M office visit.

The Academy strongly opposes the inclusion in the practice expense proposal of a 2.4 percentage point reduction, or behavioral offset, in the conversion factor to account for increases in the volume and intensity of services that HCFA claims will result from changes in net income caused by implementation of resource-based practice expenses. We have always opposed HCFA's use of a behavioral offset, and oppose it again in this instance. Given that we do not believe that HCFA has ever been able to adequately support the need for a behavioral offset, the Academy opposes this provision of the resource-based practice expense proposal and is pleased by the commission's agreement with us on this matter.

We strongly disagree with HCFA's proposal to reduce by 50 percent the practice expense RVUs for additional procedures furnished during the same encounter as an E/M service. None of the direct cost data gathered for the development of the new practice expense RVUs justifies the proposed 50 percent reduction.

In the short term, HCFA would simply reduce the practice expense RVUs for the additional procedures by 50 percent; the reduction would not apply to the E/M service. This is similar to the way in which HCFA lowers payment for multiple surgical procedures furnished to the same patient on the same day by the same surgeon. In the long term, HCFA would like to apply a procedure code-specific reduction when a given procedure is performed during the same encounter as an E/M service.

Under this proposal, if a patient came into the office for a visit and subsequently received a blood draw and an electrocardiogram, HCFA would reduce the practice expense RVUs for the blood draw and electrocardiogram by 50 percent, even though they probably involve different equipment and supplies and, potentially, different clinical staff. We concede that there may be some savings in administrative staff time associated with multiple procedures performed during the same encounter as an E/M service. However, arbitrarily reducing practice expense RVUs by 50 percent is an inappropriate means of addressing this issue.

Medicare's physician payment system is supposed to be based on resource costs. However, until resource cost data are provided showing that practice expenses for office procedures are reduced by half when an office visit is also provided, there is no rationale for applying a multiple procedure reduction to office procedures.

For these reasons, we encourage HCFA to proceed with the data development necessary to identify procedure code-specific reductions that can be implemented in the long run while not making any arbitrary reductions in the short-run. We are pleased that the commission has adopted a similar stance on this matter. Alternatively, in the short run, HCFA should only reduce the administrative labor component of the direct practice expense RVUs by 50 percent and recognize that the clinical labor, equipment and supply components of direct practice expenses as well as indirect practice expenses are the same whether the procedure is done as a stand alone or with an E/M service.

DOWN PAYMENT IS APPLICABLE IN THE TRANSITION YEARS

As noted earlier, the movement to resource-based practice expense RVUs began this year with a $330 million "down payment" for office-based procedures. It is clear from the legislative history of this provision that the increase in 1998 practice expense RVUs for office visits is supposed to be blended with the new, resource-based practice expense RVUs starting in 1999. HCFA stated precisely this particular understanding in its notice of intent to issue a rule; that is, that the 1998 down-

payment-adjusted practice expense RVUs for office visits would be blended with resource-based practice expense RVUs for office visits beginning in 1999.

It has come to our attention that some medical specialties are urging HCFA to reinterpret the law with respect to the base year for the transition period. That is, using the 1997 practice expense RVUs instead of the 1998 down payment-adjusted practice expense RVUs as the base amount for the blend during the four-year transition period is being advanced at this time. This interpretation defies logic and congressional intent, and would lower overall payments for office visit services from what they would be otherwise under the balanced budget law, and for these reasons this effort is strongly opposed by the Academy.

Also, increasing practice expense payments for office visits in 1998 just to turn around and calculate them in part based on the lower, historical charge-based RVUs of 1997 would, in effect, negate the compromise on practice expenses adopted last year. The Academy and other primary care groups accepted the implementation delay and four-year transition period contingent on HCFA starting to improve practice expense payments for office visits in 1998. If a revision such as the one proposed were accepted by HCFA, it would reopen a very controversial debate that for all intents and purposes was settled with enactment of the balanced budget law. For these reasons we urge Congress and HCFA to leave the balanced budget law untouched.

CONCLUSION

Once again, thank you for this opportunity to present the family practice viewpoint on the resource-based practice expense issue. After so many years of waiting for this component of the Medicare physician fee schedule to be fixed, we are gratified that Congress at last has set a deadline certain of January 1, 2002 for full implementation of the new payment method. It is overdue, but "better late than never" as the old saying goes.

If you take away any one message from my comments, let it be this: the practice expense issue is not an issue anymore; it does not need to be reopened. The GAO report firmly states that the work by HCFA complies with the balanced budget law's requirements for gathering actual data to the maximum extent practicable, using generally accepted accounting principles, and obtaining the guidance of as many physicians and other experts as possible. The GAO confirms that the HCFA proposal is a reasonable and workable one, and that the rulemaking process should proceed uninterrupted so that implementation of resource-based practice expense RVUs can be achieved by the deadline established in the law. We could not agree more.

I invite the subcommittee and its members to continue to look to the Academy as a resource on matters pertaining to the Medicare physician fee schedule and resource-based practice expenses. We would like to continue to be a part of this discussion, and we will try to be as helpful as possible. At this time, I would pleased to answer questions from the subcommittee members.

American Academy of Family Physicians
Federal Grants and Contracts

Funder:	National Institute on Drug Abuse
Project:	American Family Physicians (AFP) Monograph on Diagnosis and Treatment of Drug Abuse
Type of Funding:	Contract
Identification #:	NO1DA-3-2400
Funding Period:	9/30/93 to 3/30/95
Award:	$155,265.00

Funder:	Health Resources and Services Administration
Project:	Interdisciplinary Generalist Curriculum Project
Type of Funding:	Subcontract
Identification #:	240-93-0010
Funding Period:	3/11/93 to 3/10/99
Award:	$122,373.00 (to date)

Funder:	Agency for Health Care Policy and Research
Project:	Development of Practice Guide for Otitis Media
Type of Funding:	Contract
Identification #:	282-91-0086
Funding Period:	10/1/91 to 5/30/95
Award:	$79,333.00

Funder:	Office of Disease Prevention and Health Promotion
Project:	Put Prevention into Family Practice
Type of Funding:	Contract
Identification #:	HP 930002-01-0
Funding Period:	10/1/93 to 5/31/97
Award:	$279,933.00

Funder:	Health Care Financing Administration
Project:	Literature Review and Evidence Tables for Type 2 Diabetes
Type of Funding:	Contract
Identification #:	95-0821
Funding Period:	9/28/95 to 11/30/95
Award:	$23,250.00

Mrs. JOHNSON of Connecticut. Thank you, Dr. Haynes. Dr. Pearlman.

STATEMENT OF ALAN S. PEARLMAN, M.D., PROFESSOR OF MEDICINE AND ANESTHESIOLOGY, DIVISION OF CARDIOLOGY, UNIVERSITY OF WASHINGTON, SEATTLE, WASHINGTON; ON BEHALF OF THE PRACTICE EXPENSE COALITION

Dr. PEARLMAN. Madam Chair and Members of the Subcommittee, I'm Alan Pearlman, a cardiologist practicing in Seattle, Washington. I'm honored today to have the opportunity to represent the 43 member organizations of the Practice Expense Coalition and to offer our reactions to GAO's report.

We agree with GAO that HCFA can improve the methods used to develop practice expense relative value units, and we urge this Subcommittee to tell HCFA that it should improve its work. We renew our offer to work in partnership with HCFA and the entire physician community, offering funds and assistance to get this task completed correctly and on time.

Today I'd like to summarize our submitted statement, which was based on the draft GAO report, react to some changes in the final GAO report, and seek this Subcommittee's willingness to continue its oversight of this critically important issue.

The bottom line is that Congress was right in deciding last year to delay implementation of new practice expense relative value units. The Practice Expense Coalition greatly appreciates the thoughtful leadership exercised by this Subcommittee and the Congress in recommending this reexamination and look forward to continuing to work with you.

The BBA establishes two key criteria for HCFA in preparing new practice expense relative values. HCFA must look at total practice costs, and it must use an accounting methodology. GAO has correctly identified the key troublespots in HCFA's work that caused last year's congressional reaction. If HCFA abides by the statute and takes the steps recommended by GAO, the coalition believes that by the end of the transition period, new practice expense relative values can be developed that will be fair to all physicians.

Let me highlight several key points in the GAO's study. First, although GAO found the use of CPEP panels to be an acceptable estimating tool, the CPEP data were never validated. GAO recommends they should be, and we agree.

Second, GAO's conclusion on HCFA's linking methodology and data edits supports our contention that it is not appropriate to redistribute support for physician services based on methods that are subjective and flawed.

Third, GAO reinforces our concerns about the indirect cost issues in HCFA's revisions and makes it clear that we still have no satisfactory approach to this thorny problem.

Fourth, we agree with GAO that the consequences for beneficiaries must be regularly reviewed, especially in light of all of the changes that have occurred to the physician fee schedule. We know that most Medicare beneficiaries are now able to get timely access to appropriate medical services, whether they be primary care or specialized interventions. What we do not know is whether the same access and quality can be maintained with payment reductions of the magnitude proposed last June. Clear information from beneficiaries studies is needed to make sure that Congress can react on a timely basis if problems arise.

Let me address two changes to our submitted statement made necessary by revisions in GAO's report. First, the GAO changed its initial recommendation on the scaling techniques that HCFA used and now supports their use. Our concerns with scaling remain, and we hope that HCFA will continue to improve this technique and clarify its use to the physician community.

Second, GAO has acknowledged that the use of physician-employed staff in other settings, such as the hospital, is a more complex issue than it first thought. Whereas the draft report supported HCFA's decision to disallow these costs, the final report suggests that further examination of the issues may be in order. We welcome this change. We've made progress in discussing this point with HCFA and believe that a satisfactory resolution can be found.

Our greatest concern at this point is the future. I also participated in both the validation panels and the cross-specialty panel, which were not the focus of the GAO report, and I have significant concerns about where the process is going now. As GAO notes, HCFA has not yet reached a conclusion on how to address a number of key issues. We urge this Subcommittee to require HCFA to make a timely report on these issues in advance of the May rulemaking. Only then can Congress exercise the most effective oversight.

In conclusion, we believe that the two key elements of the Balanced Budget Act—the use of total practice expenses and an accounting methodology—can be achieved. We have presented to HCFA a plan developed by Coopers and Lybrand for how this can be done. I'd be happy to have the Coopers and Lybrand accountants brief you or your staff on the details of this plan.

This completes my testimony. I'd be pleased to respond to questions.

[The prepared statement follows:]

Statement of Alan S. Pearlman, M.D., Professor of Medicine and Anesthesiology, Division of Cardiology, University of Washington, Seattle, Washington; on Behalf of the Practice Expense Coalition

Mr. Chairman, and Members of the Subcommittee: My name is Alan Pearlman, M.D., and I practice cardiology in Seattle, Washington. I am here today on behalf of the Practice Expense Coalition which represents 43 national medical specialty societies, medical organizations and major medical clinics (list attached). My own professional society, the American College of Cardiology, is an active member of the Coalition. We are united by our common desire to ensure that the transition to new practice expense relative value units for the Medicare physician fee schedule is successful and does not disrupt beneficiary access to important, lifesaving medical services and technology.

The members of the Coalition appreciate the opportunity to present testimony today on the General Accounting Office's review of the Health Care Financing Administration's efforts to revise Medicare's practice expense calculations. The continuing oversight of this Subcommittee is critical to a successful outcome. We also appreciate the actions of this Subcommittee and Congress to give HCFA more time to complete this important task and for your efforts to clarify the statutory instructions to the agency. HCFA's assignment is large and complex, and we believe the decisions incorporated in the Balanced Budget Act of 1997 will help to ensure that HCFA will do its work properly.

Coalition representatives recently had the opportunity to review the General Accounting Office's draft report entitled "HCFA Can Improve its Methods for Revising Physician Practice Expense Fees," and this statement is based on our review of that draft. We understand that there may be changes in the tone and even in the content of the final report, and we will reflect those in oral testimony. Based on our review of the draft, we have concluded that it is a generally unbiased view of the challenges and problems that have beset this effort. This report validates the decision of this

Subcommittee and Congress to clarify the instructionr the agency to complete the revisions of practice expense relative value units. While the Practice Expense Coalition has some specific concerns about particular issues in the draft report, we believe that as written it should be helpful to Congress in its continuing oversight of this important physician payment issue. If HCFA responds effectively to each of the points that GAO has made, and follows the mandates of the Balanced Budget Act of 1997 on practice expenses, especially the use of total practice costs and cost accounting methodology, it is our belief that the agency can design new practice expense relative values by the end of the transition period that will generally be fair to the entire physician community.

The Practice Expense Coalition commends GAO for the thoroughness of its analysis and work to date on this complex issue. We appreciate the extent to which the GAO staff consulted with us and the other interested parties. Their work identified the key problem areas and, we believe, raised appropriate criticism of HCFA's work up through the June 18, 1997, Notice of Proposed Rulemaking (NPRM). The GAO draft report identified fundamental problems with the database and the methodology used. We agree with that assessment. However, the Coalition would urge this Subcommittee to go beyond the GAO conclusion of "HCFA can improve its methods" to a requirement that HCFA *should* do so.

It is important to note that GAO did not review and evaluate all the actions of the agency subsequent to that June rulemaking. For example, GAO does not comment on the physician panels convened by HCFA last Fall, nor does it review the public responses to HCFA's October 31 notice of intent to issue a rulemaking. The practice expense issue continues to be a work in progress. Therefore, we urge this Subcommittee to request that GAO continue its evaluation of HCFA's work. Specifically, this evaluation should focus on HCFA's response to the mandates of the Balanced Budget Act of 1is time how, or even whether, HCFA intends to respond to those mandates, and we believe that continued oversight by an independent entity such as GAO is essential.

I would like to comment briefly on the draft conclusions of GAO and its recommendations which confirm the wisdom of the Balanced Budget Act's provisions on practice expenses. GAO's conclusions in many respects parallel the Coalition's comments on the June 18 rulemaking. I will conclude my comments with a proposal for how HCFA can respond to GAO and the directives in the Balanced Budget Act in both the short and long term.

Use of Expert Panels to Estimate Direct Costs

HCFA convened a number of expert panels in 1996 to collect information on direct costs. These panels, known as Clinical Practice Expert Panels (CPEPs), included physicians, practice managers and other health professionals and represented virtually every specialty. The panels met twice to estimate direct costs and labor times for all physician services under Medicare. GAO concluded that the CPEP method of collecting or estimating direct cost information is acceptable, but that the data should be validated based on surveys of actual physician practices. We believe that expert panels can provide useful information about direct costs; however, GAO did not evaluate the accuracy of the particular estimates that were made, nor has HCFA made any such independent evaluation. In the absence of this review, external validation as suggested in the report is critical to building confidence in the specific information derived from these panels. As I will discuss later, there may be other, even more effective ways to identify the costs physicians incur when they provide medical services.

A fundamental problem with the CPEPs was the lack of common ground rules for their operation. As a consequence, there was little consistency across panels. HCFA tried to correct for these differences through its statistical manipulations of the CPEP data, includinging "data reasonableness" edits. These efforts failed, however, because they were neither based on input from clinicians nor on any objective data. The GAO criticism of the manipulations is appropriate.

The key element of GAO's recommendation is the external validation of the original CPEP data. We believe that Congress should insist on such validation if the CPEP data are to be an ongoing part of the practice expense database and should require HCFA to make any needed corrections based on these surveys. This effort does not need to be time consuming or resource intensive, but can be based on a limited number of surveys of physician practices.

Statistical Techniques Used By HCFA

Because of the lack of common ground rules in the CPEPs, the results understandably varied. HCFA tried to correct for this problem after the fact by making

statistical adjustments to the data, referred to as linking and scaling, and applying "data reasonableness" edits. Each technique was intended to adjust the data to establish more consistency in the values that came from each CPEP panel. The use of these statistical adjustments has been a key point of controversy, because most of the redistribution in physician payment is derived from these actions. The large cuts in payments for many procedures that HCFA predicted in its estimates of the impact of the rule proposed last June were in large measure driven by HCFA's decisions at this point in the process.

GAO raises serious questions about linking, scaling and the other data reasonableness rules that HCFA used in the June proposed rule. The Coalition agrees with this assessment and had raised similar concerns in its comments on the June proposal. Basically these steps turned the work of the CPEPs on its head and were undoubtedly the greatest contributing factor to the concerns that we expressed and Congress acknowledged in its 1997 legislation on practice expenses. HCFA needs to completely revise or discard linking, scaling and the other data reasonableness rules. Everyone acknowledges that some means must be found to relate the diverse expenses of physicians into a coherent payment system. It is clear that HCFA has not developed that means, and we are today still unclear how the agency intends to do this.

Indirect Cost Issues

HCFA proposed to divide physician practice expenses into direct and indirect costs. Separate data collection strategies were developed. The CPEP process focused on direct costs, and HCFA planned a mail survey of 5,000 physician practices to collect data on indirect expenses. That survey was never completed, so HCFA was forced to look to other sources for information on indirect expenses. The quality of indirect cost information has been an issue ever since. While GAO did not measure the validity of the data used, it did look at allocation and definition issues. GAO recognized that HCFA's method for allocating indirect costs to the individual procedure codes was an acceptable option, given that there is no one accepted way of doing this. However, GAO properly points out that the use of specialty specific indirect expense data would be more consistent with the requirements of the 1994 and 1997 statutes that HCFA use *actual* data.

We agree that there is more than one way to allocate indirect costs, but we also concur with GAO's comments about specialty specific data. HCFA made assumptions about indirect costs that simply did not reflect the realities of medical practices, and as a result the indirect costs of many specialties were improperly estimated. The key issue with indirect costs is that HCFA never figured out how to substitute for its failed survey of physicians. HCFA and its contractor sent out a survey that was so complicated it could not succeed. We had urged HCFA to work closely with the different medical organizations to assure a reasonable response rate and the accuracy of the responses. These offers were rebuffed by the agency, and the result was predictable. The survey response was inadequate in light of the 70% percent response rate demanded by OMB. HCFA has had to substitute estimates of indirect expenses for actual data. This, in combination with HCFA's allocation decisions, has significantly affected the specialty practice expense totals. Physicians with high levels of indirect costs have had them systematically undercounted in this process.

GAO advocates that administrative and billing costs be moved from the direct pool to the indirect pool. This comment mirrors a discussion held in December 1997 at a HCFA meeting with all medical specialties. This change could have a significant effect on physician payments, and requires further analysis. Both HCFA and the Practice Expense Coalition are currently modeling this change to determine its payment impact and its consistency with the BBA requirements to use generally accepted cost accounting standards. Since the outcome of this recommendation depends on the intersection of many working parts, we are awaiting the results of these studies before judging its merits. We note, however, that the accuracy of the indirect expense pool, however defined, depends heavily on the quality of the total practice cost information that HCFA uses. GAO doetion of whether HCFA has met the BBA requirement that it recognize all costs, so we are unable to evaluate this recommendation more completely at this time.

Disallowance of Certain Costs

As HCFA has defined practice expenses, certain categories of costs have not been included. The Coalition has addressed this with HCFA, and discussions continue on the policy issues that underlie HCFA's decisions to date. We are disappointed that GAO's draft report agreed with HCFA's original decision to disallow any consider-

ation of the costs physicians incur when they bring their own staff to facilities outside their own office to assist in the care of patients. We agree that not every specialty uses its own staff in this way; however, data from the Lewin Group, surveys conducted by the Society of Thoracic Surgeons, and studies by the national physician assistant organizations demonstrate that certain specialties, such as thoracic surgery and neurosurgery, do utilize their own staff outside of the office to a significant extent. These are very real expenses to these physician practices, and a way must be found to incorporate them in Medicare payments. These studies have been provided to both HCFA and GAO, and can be made available to the Subcommittee as well.

We believe that this trend will increase as the revolution in the organization of health care financing and delivery continues. This is true not only for staff, but also for equipment as well. Medicare needs to recognize this changing reality of current medical practice and incorporate it into the payment system. There are several ways this could be done once agreement is reached on the rate of occurrence and the level of cost directly borne by the physician practice. One is to allow for a billing modifier that would be used when such staff or equipment were involved. Another would be to build reimbursement for the cost into payments for all services performed outside the office setting and average the amount across all such payments. The simplest solution is for HCFA to follow the dictates of the BBA and develop practice expense relative value units that start with the actual, total costs of physician practices. The use of staff in this way would thus be captured.

Standby costs and uncompensated care can be significant expense items for some specialties, such as emergency medicine. There is a need to address this issue as well so that physicians not be asked to carry expenses for which there is no compensation.

Impact On Beneficiary Access

GAO suggests that there be ongoing review of beneficiary access to care once these changes are in place, with special focus on access to those services that see the biggest payment reductions. GAO noted that the magnitude of the changes proposed last June were "significant and could affect physician decisions regarding care of Medicare beneficiaries." Of course, the best approach is to assure that the final product does not lead to disruptions in the delivery of medical and surgical services; however, ongoing monitoring of changing physician reimbursement patterns is a critical step, and one that Congress should insist upon. The purpose of Medicare is to assure that beneficiaries have access to the medical care they need when they need it. Payment policies that significantly alter the status quo must be carefully evaluated on an ongoing basis so that any needed corrections can be instituted. Studies by PPRC and others to date indicate that currently beneficiaries do not experience significant access problems to either primary care physicians or specialists. The payment changes that could result from a new practice expense system may upset this balance and should be carefully monitored.

The GAO study still does not answer the question of whether HCFA is on track for the May rulemaking. As I noted earlier, we hope Congress will ask for a subsequent review based on the requirements of the Balanced Budget Act. We believe that the requirements of that act, and the standards laid out in this GAO report, provide the framework for a successful transition to a new set of practice expense relative values.

Additional Recommendations of the Practice Expense Coalition

So that the remaining tasks can be accomplished in a timely manner, we have offered to enter into a public-private partnership with HCFA that would jointly fund the various activities that must be accomplished if this change in practice expense relative value units is to be successful and completed on time. Every physician interest should be included in that joint effort. Although we have received no response from HCFA to this offer, we reiterate it today in the hope that all sides will see the wisdom of such collaboration, and we can proceed to implement it immediately.

Were HCFA to agree with us on this cooperative arrangement, we believe that the work could proceed in the following way.

The first step is to recognize, as has the General Accounting Office, that the unresolved questions over data and methodology are too great to support confidence in any proposal made this year that purports to be the final word on the issue.

Second, we should agree that the practice expense relative values effective in 1999, the first transition year, will probably change quite a bit as the refinement proceeds. Not every question has to be answered in the May rulemaking, but HCFA should clearly define the process that will be in place to get to the final answers.

The next step is to figure out the interim values for 1999 that will make up 25% of the transition values. In consideration of the time and resources HCFA has available, and the lack of general acceptance of significant portions of the work so far, we suggest the agency minimize the reallocation of dollars. We realize that the transition is intended to "soften the blow" to any affected specialty, but we urge that even modest reallocations of payment not occur until HCFA has fully complied with the mandates of the BBA to use total costs and an accounting methodology. We believe that there is enough data available from several sources, and that an acceptable short term methodology can be worked out, to allow a first step toward practice expense relative values that are based on the resources actually used by physicians. However, we must bet data refinements and methodological work remain to be done, and must be done, before the completion of the transition period. There is still much uncertainty, so that is why we recommend that HCFA be sure that the interim system's redistribution impacts are very modest, so that the many remaining issues can be worked out without causing significant disruption to patient care.

We believe that in 1999, HCFA should refine the system around the key requirements of the BBA—actual data on total physician costs and generally accepted cost accounting standards. We recently presented to HCFA the method I will now outline.

The Coalition recommends that the total practice cost requirement be met by using the American Medical Association's statistical monitoring system data as the starting point. It is unlikely that we will find a more robust data base than this one, even if millions more federal dollars are spent and much more time is devoted to the effort. AMA has been collecting this information for more than 25 years, and the survey is conducted by the RAND Corporation, a highly reputable firm. There are some issues with the data base that need to be addressed, such as underrepresented specialties, but these are fairly straightforward and can be accomplished within the time frames of the BBA and with reasonable expenditures. This proposal could also incorporate the direct cost data that HCFA has already collected.

The other key element is a methodology based on cost accounting, and the Coalition has asked Coopers & Lybrand to develop that for us. The outline has been given to HCFA for its review, and I will summarize it here. We realize that more work is required to have a finished product for the fee schedule, and we have asked Coopers & Lybrand to continue its design efforts. This further work will be given to HCFA and to Congress as a demonstration that the mandate of the Balanced Budget Act can be reasonably achieved within the time allotted by the transition period and at a reayers.

The system is relatively straightforward. The fundamental theory behind cost accounting is the identification of resources consumed in the production/provision of goods or services and the corresponding costs (e.g., direct and indirect expenses) of those resources. In healthcare, the final "product" is the treatment provided to a patient; thus the cost accounting system must be able to identify and allocate the actual costs of resources used at the procedural level in treating patients.

In this case, we can identify the total costs through the AMA data. From other sources, we know the proportion of Medicare patients by specialty, and the specialty specific use of various medical and surgical services. We know, or can learn, about the importance of different types of costs/expenses for each type of specialty and each type of service. Using this and other information that now is available, we can allocate to the procedure code level, which is the level of payment. Once this is done, we can use a number of commonly used codes to equate costs for different specialties.

Obviously, at this time, I can only present the skeleton of the process, but I would be happy to arrange for representatives of Coopers & Lybrand to brief you and your staff in greater detail. This is a process that can work. It can be completed in the time allowed for the transition without further legislative action. It needs only the support of Congress and HCFA to be put into place.

Mr. Chairman, this concludes my testimony. I would be pleased to respond to any questions.

MEMBERS OF THE PRACTICE EXPENSE COALITION

American Academy of Facial Plastic and Reconstructive Surgeons
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology -- Head and Neck Surgery, Inc.
American Association for the Study of Liver Disease
American Association of Ambulatory Surgery Centers
American Association of Clinical Urologists, Inc.
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Nuclear Physicians
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American Gastroenterological Association
American Medical Group Association
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of General Surgeons
American Society of Nuclear Cardiology
American Society of Plastic and Reconstructive Surgeons
American Thoracic Society
American Urogynecologic Society
American Urological Association
Arthroscopy Association of North America
Congress of Neurological Surgeons
Macula Society
National Association of Portable X-Ray Providers
North American Society of Pacing and Electrophysiology
Outpatient Ophthalmic Surgery Society
Retina Society
Society for Cardiac Angiography and Interventions
Society of Cardiovascular & Interventional Radiology
Society of Gynecologic Oncologists
Society of Nuclear Medicine
Society of Thoracic Surgeons
Society for Excellence in Eyecare
The Cleveland Clinic Foundation
Vitreous Society

February 10, 1998

Mrs. JOHNSON of Connecticut. Thank you very much, Dr. Pearlman, and my thanks to the panel.

I, unfortunately, am going to have to leave, but I appreciate your comments very much, and it's especially useful to have two of you who have participated in these panels with different points of view. I think it was, to me, at least, as a Member listening often to issues in which I don't have a great depth of knowledge, it's clear from the GAO's report that we do need to do more work, and HCFA seems to acknowledge they need to do more work, and we need to have very good oversight of that work. So, at least I, for one, look forward to your continued input as we move through this process. I do not believe that we can afford to move forward and implement the law we passed unless we also do move forward on the issues raised by GAO.

So I thank you very much, and I'm sure we would be interested in the Coopers and Lybrand study, if the staff doesn't already have it. Thank you very much.

I am going to turn the hearing over to my colleague, Mr. McCrery.

Mr. MCCRERY [presiding]. Thank you, Ms. Johnson.

I want, too, to thank this panel for your excellent testimony. I don't have any questions. I think your testimony was excellent and speaks for itself.

But I do want to point out, before I turn it over to Dr. Cooksey for some comments, that as far as I know, anyway, nobody on this panel and nobody in Congress is out to gore anybody, and we're not out to do something that slights a specialty or overly enhances somebody else. We're just trying, as best we can, within the constraints that we have, the budgetary constraints that we have, to work out a system that is as fair to the greatest number of people possible.

It's unfortunate, in my view, that we even have to go through this exercise, and I've expressed this viewpoint many times here in this room—that I don't want to be, as a policymaker, responsible for telling physicians or anybody else how much they can make or how much they can get reimbursed for doing something that ought to be determined by the private marketplace.

So I'm anxious for the Medicare Commission to do its work this year and to present us policymakers with something that's a little more radical in its thinking than the current system is, and perhaps a proposal that will put us—or give us the chance to put Medicare into more of a free market context, so that it will take us away from this kind of responsibility.

With that, I'll turn it over to Dr. Cooksey.

Dr. COOKSEY. Thank you.

Dr. Nelson, I'm glad to hear a physician that talks as if you have knowledge, or at least a confidence in your knowledge of accounting, because I think that too often physicians are just as guilty as the bureaucrats and politicians of not having an adequate accounting background. So it's good to have you here.

What accounting system do you understand HCFA to be using now, if they're not using activity-based or a cost accounting system?

Dr. NELSON. Well, I certainly can't—I certainly won't pretend that I am an accountant. I have practiced internal medicine for 27 years in Salt Lake City.

The crux of our testimony had to do with GAO's assessment of the methodology, and the fact that GAO concluded that using the expert panels provided adequate information that, with some additional adjustments, could be utilized, so that we didn't have to go back to square one and delay this whole process. So I don't claim any individual expertise in this. I'm just interpreting what we've heard from GAO.

Dr. COOKSEY. Would you prefer to see an accrual accounting system? Or there seems to be some question about cost accounting.

Dr. NELSON. No, as I understand, the expert panel processes—you've heard people who have participated in that—used physicians and their staff to determine what proportion of their practice expenses could be allocated to the various procedures. Some have suggested going with stopwatches and going into physicians' offices and directly measuring that. ASIM believes that that would unduly prolong the process, and not address some serious problems with fairness that are based on historic charges.

We have to remember that we're dealing with a current reimbursement formula that is patently unfair in many instances because of the historic bias. I'm not an accountant, but I understand principles of fairness.

Dr. COOKSEY. Good. OK, I'm misinterpreted your comments about accounting.

Let me ask you another question. Would you trust the system that my colleague, Congressman McCrery, alluded to, a market-driven system in which the patient has choice, in which there is competition, in which the physicians, primary care specialists—and, incidentally, I did general practice before I was in the Air Force and before I did specialize—but would you trust a market-driven system or do you trust the system with government regulators, with the labor union leaders, with the White House, with corporate medicine in the examining room with us? Would you trust market forces? Do you trust the patient to make the choice about providers, about quality of care, about cost of care?

Dr. NELSON. Generally, of course. Of course I do. Obviously, in a public program there needs to be some assurance that the market is working properly, but the American Society of Internal Medicine, for example, supports a Medicare reform that would call for defined contribution, to move it closer toward the market force, market-based system.

Dr. COOKSEY. I, too, think that's a move in the right direction.

Dr. Haynes, it's good to have you here. Your testimony was very good as well. My associate is a woman, and she is wonderful. She was one of my residents that I helped train 20 years ago, and she's now the best surgeon in town. She was long before I left.

What is your basis for stating what the intent of Congress was in using 1997 as a base year or 1998? You know, I'm a member of this body, and I'm not sure what the intent of Congress was, but I'm glad to know that you know. What is your basis for saying what is—what was the base?

Dr. HAYNES. This is based on last year a compromise that, instead of everything being implemented in 1998, it would be a transition period, and the Academy agreed to that transition period, if there would be a downpayment toward starting to offset the inequities that exist in payments to primary care physicians.

So that now in 1998 we have the downpayment being applied to the relative value units, RVUs, already, and there are some groups who are recommending that, as you start to transition in 1999, we go back to the 1997 dollars and not use the downpayment dollars. In essence, some doctors would get more money this year. Then it would go back down next year, and then it might go up the year after that.

Dr. COOKSEY. But my question is, how did you find out what the intent of Congress is? Did I miss a meeting? Was there a meeting in which someone said this is the intent of Congress?

Dr. HAYNES. I just assumed that, because the law was passed that way, that that was the intent; that Congress wanted there to start being some changeover of the undervalued services. And so if we go back to the way it was in 1997, that would not be what the Balanced Budget Act calls for.

Dr. COOKSEY. OK, a very interesting interpretation.

Well, I personally feel that we need to go to a system in which the patient truly has a choice. A system that's driven by the patient getting the highest quality of care at the lowest cost, and government and physicians should have information systems that will let us know who's got the best outcomes. We will have an open window, so that the public can know who the good providers are, who gets the good results, whose patients get well the quickest. In that system, there are going to be winners and losers among physicians, among specialists, and among primary care, and there are going to be some physicians that will go out and take advantage of the information systems while they're providing high-quality care at a low cost, and they will do well. And there will be physicians who will be providing high-quality care at a low cost, but do not take advantage of information systems, and they're going to suffer.

But I trust those market forces more than I trust my colleagues in this, quote, "august" body. I trust patients to make those decisions better than I trust regulators and labor union leaders and the White House and the politicians to make those decisions. So that's what we all need to be driving for—going back to that room where there's a patient and a physician in the examining room, in the treatment room, and trust the market forces, trust the patient, and we'll all be better off. And, most importantly, the patients will be better off, and what's good for the patient will be good for the physicians.

Thank you, Mr. Chairman.

Mr. MCCRERY. Thank you, Dr. Cooksey. Your wisdom is just about to catch up with your years. Any time you want to come and join us here, we appreciate having you.

I thank the panel again for your testimony.

[Whereupon, at 2:45 p.m., the hearing adjourned subject to the call of the Chair.]

[Submissions for the record follow:]

AMERICAN ACADEMY OF
DERMATOLOGY
February 25, 1998

The Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing in reference to the Subcommittee's hearing on Tuesday, March 3, to examine Medicare payment policies. On behalf of the American Academy of Dermatology, I would like to offer the following comments for consideration by the subcommittee and for inclusion in the printed record of the hearing.

The Academy knows that the Subcommittee will hear from a number of groups regarding the implementation of the resource-based practice expense system effective January 1, 1999. We are confident that you will receive recommendations from both the "losing" specialties, particularly surgical groups, and from the primary care organizations. The former, of course, is interested in minimizing any reductions in payment, while primary care groups are generally concerned about increasing payments for office visits.

There are, however, other interests to be considered in this debate. Dermatologists, for example, provide both surgical and medical services primarily in office settings. As such, dermatologists are the most cost-effective providers of care for skin diseases.

Under the June 18, 1997, proposed rule, we would have received substantial increases in payment for practice expenses. These increases are long-overdue. For many years, we have been requesting that the Health Care Financing Administration (HCFA) fully recognize the practice costs associated with office-based surgery, particularly the unreimbursed costs including surgical trays, suture materials, dressings, and other related supplies. In meetings with HCFA staff, we have been told repeatedly that the development of resource-based practice costs would result in more accurate reimbursement for the cost associated with office-based surgery.

The Academy was, therefore, pleased to see in the proposed rule that those costs for surgical trays were finally going to be recognized. However, when implementation of the practice expense system was delayed and the "down payment" for primary care services was enacted by the Congress, the impact of this provision on dermatologists and other office-based procedural specialists was totally ignored. We are similarly concerned that our views might be ignored or inadequately considered by HCFA as it proceeds with plans to implement the new system.

The purpose of this letter is to advise you of our position. First, the Academy understands that HCFA is being asked to initiate additional data collection activities to refine the relative values during the transition period. Obviously, we cannot quarrel with any effort to improve the reliability of the data upon which the system is based. However, it is critical that any data collection be objective and not used to achieve some "political" outcome for particular groups of providers, whether a reduction in the decreases for "losing" specialties or certain levels of increases for the favored primary care services.

Second, until such time as better data is available, we hope that you will urge HCFA to use the rates contained in the June 18, 1997, notice. While we would not claim that such data is perfect, we think it is clearly the best data currently available. The purpose of the transition, is, of course, to lessen the

impact on the "losing" specialties by gradually phasing in the new rates over a four year period with only 25 percent of the changes implemented in 1999. In our opinion, this transition provides ample protection for losing services while additional studies or data collection efforts are conducted.

I thank you for the opportunity to offer these comments. If there is any way that the Academy can assist you in this effort, please do not hesitate to call on us.

With best wishes.

Sincerely,

ROGER I. CEILLEY, M.D.
President

Statement of the American Association of Health Plans

AAHP would like to take this opportunity to comment on the testimony of the Medicare Payment Advisory Commission (MedPAC), particularly in light of the recent release of their annual report to Congress. First, AAHP would like to highlight the success of the Medicare HMO program. Dramatic enrollment growth and low disenrollment rates demonstrate beneficiary satisfaction with the Medicare HMO program. The Medicare HMO program works for its enrollees—that is why enrollment is growing rapidly even though every beneficiary has the choice to remain in the traditional FFS Medicare program. As of January 1998, 15.9 percent—or 5.9 million Medicare beneficiaries—were enrolled in health plans, compared to 15.4 percent in December 1997 and 12.7 percent in December 1996. Five years ago, only 6.2 percent of Medicare beneficiaries were enrolled in health plans. (Refer to graph at the end of this statement titled: Percent of Medicare Beneficiaries Enrolled in Managed Care Reaches 15.9% in January 1998)

According to the Health Care Financing Administration (HCFA), approximately 90,000 Medicare beneficiaries join health plans each month. Annual growth rates for Medicare beneficiaries enrolled in the risk program have grown steadily, from 10 percent in calendar year 1990 to 26 percent between January 1997 and January 1998. Enrollment growth is strong both in areas with traditionally high Medicare risk penetration and in new markets, including the Middle Atlantic and South Atlantic regions.

The majority of Medicare HMOs offer services not covered by fee-for-service Medicare, including outpatient prescription drugs, routine physicals, immunizations, and preventive health screenings (such as eye and ear exams) in their basic package of Medicare benefits. The percentage of plans offering outpatient prescription drug coverage has more than doubled since 1993 (see chart above). As of January 1998, 67 percent of Medicare health plans do not charge a premium for the plan's basic package of Medicare benefits. In its June 1997 report, the Prospective Payment Assessment Commission (ProPAC) estimated that, on average, health care benefits offered by risk plans are about $950 more generous on an annual basis than benefits offered in the Medicare fee-for-service system. (Refer to graph at the end of this statement titled: Percentage of Risk Plans Offering Prescription Drug Coverage More Than Doubles Since 1993)

MedPAC was given a broad mandate under the Balanced Budget Act of 1997 (BBA) to examine Medicare payment policy. Given the myriad payment changes under the BBA that HCFA has begun to implement, a number of issues of concern have arisen. Our comments will focus specifically on the Commission's recommendations in the areas of Medicare's methodology for calculating payments to health plans and risk adjustment under the Medicare+Choice program.

AAHP is concerned that MedPAC's recommendations regarding both payment and risk adjustment have the potential to significantly undercut the payment rates to Medicare+Choice organizations as established by the BBA. If MedPAC recommendations had been fully implemented for 1998, in many areas, 1998 and 1999 and possibly 2000 rates could fall below 1997 rates. Moreover, payments to Medicare+Choice organizations are more constrained than Congress expected due to changes in the baseline,[1] and the assessment of a $95 million user fee in FY1998. Further undercutting payment rates to Medicare+Choice organizations will harm the beneficiaries who enroll in Medicare+Choice organizations and enjoy quality, comprehensive services.

Under the BBA, Congress effectively delinked Medicare+Choice payment rates from Medicare FFS payments. In addition, Congress set the growth rate for Medicare+Choice payments below the national average FFS growth rate—.8 percentage points below the FFS growth rate in 1998 and .5 percentage points below the FFS growth rate in 1999 through 2002. During the BBA debate, some argued that setting the Medicare+Choice growth rate below the national average FFS growth rate allows Congress to adjust for any overpayments in the program which may result from risk selection. Congress, therefore, has adjusted aggregate payments for risk selection in the program.

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[1] Under the Balanced Budget Act of 1997, it was anticipated that the per capita national average growth rate would be 5.0 percent for the traditional program and 4.6 percent for the Medicare+Choice program. The January 1998 CBO baseline has lowered the anticipated growth in spending for both the traditional program (to 4.7 percent) and the Medicare+Choice program (to 3.3 percent.)

Adjustments to the payment methodology enacted in the BBA should occur only after an evaluation of the impact of these changes on beneficiaries and participating plans. In addition, risk adjusting Medicare+Choice payments should be implemented in a manner that will improve payment accuracy and result in the least disruption possible to beneficiaries and plans participating in the program.

MEDPAC'S PAYMENT RECOMMENDATIONS

The Balanced Budget Act of 1997 made significant changes to HCFA's methodology for calculating payments to health plans participating in the Medicare program. MedPAC's March 1998 report to Congress recommends numerous technical changes to the payment methodology specified by the BBA. AAHP is concerned that a number of MedPAC's recommendations would further constrain payments to Medicare+Choice organizations, thereby limiting the expansion of choice available to beneficiaries and the additional benefits enjoyed by beneficiaries enrolled in these organizations.

It is important to note that as Medicare+Choice is fully implemented, health plans and other Medicare+Choice organizations will see significant new administrative costs such as enrollee encounter data submission requirements and information system changes. In addition, for FY 1998, HCFA intends to collect $95 million in user fees from Medicare risk HMOs, the only organizations participating in the Medicare+Choice program this year. Over one-fifth of the minimum annual update has been eroded through the assessment of the 0.428 percent user fee on Medicare+Choice organizations from January through September 1998. A number of plans have already begun to adjust their benefit offerings in response to the new payment methodology and the assessment of the FY1998 user fee by scaling back additional benefits such as outpatient prescription drugs and dental care. HCFA has asked for the full $150 million authorized by the BBA for FY 1999 to fund beneficiary information and education activities.

If the important goal of expanded choice is to be served, health plans must be able to maintain benefit offerings at levels that are attractive to Medicare beneficiaries and meet their needs. In this context, our primary concern is that MedPAC's recommendations should not inject new challenges for health plans to provide enhanced benefits with shrinking resources.

Budget Neutrality Mechanism

Under the BBA, total payments under the new methodology can be no higher than what total payments would have been under the old approach. The budget neutrality mechanism, however, is only applied to the blended rates and is not applied to the floor or minimum increase payment rates. As a result, budget neutrality cannot always be achieved, as was the case in 1998. While projections suggest that budget neutrality will be achieved in 2000 through 2003, the MedPAC report notes that Congress should create an alternate budget neutrality mechanism.

The MedPAC report suggests several possible alternate budget neutrality mechanisms, including waiving the provision that requires a minimum 2 percent increase. Such a change would have resulted in a minimum increase of 1.6 percent (instead of 2 percent) in 1998. AAHP strongly opposes such a change as it conflicts with the intent of the BBA, to ensure stability of payments to Medicare+Choice organizations and the beneficiaries they serve by ensuring a minimum 2 percent update. This minimum update will be especially important for the newer, smaller plans that will begin to emerge in 1999. In addition, the percent update provides a reasonable relationship to growth rates in the traditional Medicare program. Even the MedPAC report itself points out that significant changes under the BBA—expansion of choices, an annual coordinated enrollment period, removal of graduate medical education payments from Medicare+Choice payments, the geographic redistribution of payments, and an uncertain risk adjustment methodology—combine to make the Medicare+Choice market more "volatile."

Medicare Spending by Department of Veterans Affairs and Department of Defense Facilities

AAHP supports increasing the base rates to reflect spending on Medicare-covered services by the Department of Veterans Affairs and Department of Defense facilities on behalf of Medicare beneficiaries. Medicare HMO payments do not recognize the resource costs being expended by the Department of Defense and Veterans Affairs facilities for treating Medicare beneficiaries. At the same time, seniors who are eligible to use these facilities are included in the total count of Medicare beneficiaries residing in a county. As a result, managed care payments are too low in areas where there is extensive use of VA or DoD facilities by Medicare beneficiaries. In 1996,

ProPAC estimated that health care provided in DoD and VA facilities to Medicare beneficiaries accounts for 3.1 percent of the total resource costs across all states of treating Medicare beneficiaries. As MedPAC points out, data on the use of VA and DoD facilities is only available at the state level. AAHP strongly supports the collection of data on service use at VA and DoD facilities at the county level, and adjusting the base rate accordingly. Such data would ensure accurate payments to Medicare+Choice organizations in areas with VA and DoD facilities.

Disproportionate Share Hospital Funds

The MedPAC report also recommends exclusion of special payments to hospitals serving a disproportionate share of low-income payments from the base rates used for the local component of blended rates. AAHP strongly opposes MedPAC's recommendation that disproportionate share hospital (DSH) funds be carved out of base rates. The MedPAC report asserts that "plans are overpaid to the extent that they do not pass on DSH payments to the appropriate hospitals." MedPAC's report, however, does not provide support for the assertion that plans do not contract with DSH hospitals. In fact, a 1996 AAHP commissioned analysis found that HMOs make higher payments to major teaching hospitals and have utilization rates for these facilities that are comparable to fee-for-service. There is a strong correlation between teaching hospitals and those that receive DSH payments. AAHP commissioned The Medstat Group, a highly respected medical economics company, to analyze the use of teaching hospitals by HMOs.

Using a database of over 4 million privately insured individuals covered by large employers, Medstat found that HMOs have utilization rates at academic centers comparable to fee-for-service plans. According to Medstat, HMOs admitted a slightly larger share of their patients to major teaching hospitals than did fee-for-service plans, a finding that contradicts the Administration's assumptions that Medicare HMOs are not admitting patients to teaching hospitals. The analysis also found that HMOs pay major teaching hospitals about 12 percent more than they pay non-teaching hospitals. These findings contradict assumptions that health plans are not sending their patients to teaching hospitals and paying for the increased costs associated with these facilities. As noted above, there is a strong correlation between teaching hospitals and those that receive DSH payments.

Monitoring Changes Under the BBA

AAHP fully supports MedPAC's recommendation calling for close monitoring of plan and beneficiary participation, risk selection, plan premiums, supplemental benefits, beneficiary cost sharing, and access to care. This monitoring will be critical in identifying and assessing patterns that result from the geographic redistribution of payments under the BBA. We agree with MedPAC that HCFA should also play a lead role in monitoring the impact of the Balanced Budget Act on health plans and beneficiaries alike. We urge both MedPAC and HCFA to undertake this monitoring prior to making additional changes to the Medicare+Choice payment methodology.

MEDPAC'S RISK ADJUSTMENT RECOMMENDATIONS

AAHP has consistently supported the goal of ensuring that Medicare payments to health plans are accurate and that they fairly reflect the health care service needs of the Medicare beneficiaries who enroll. We strongly urge Congress and MedPAC to consider the interaction of the recently implemented payment methodology with its proposed risk adjustment mechanism and the effect that its proposal will have on the success of the Medicare+Choice program. Risk adjusting Medicare+Choice payments should be implemented in a manner that will improve payment accuracy and result in the least disruption possible to beneficiaries and plans participating in the program.

Risk Adjustment Should Entail Redistribution, Not Aggregate Reduction

AAHP believes that the risk adjustment methodology developed by HCFA should be implemented so that payments across Medicare+Choice plans are redistributed, without a further aggregate reduction of payment to the Medicare+Choice part of the program as a result of risk adjustment. Failure to do so will result in an unlevel playing field in many markets as growth in Medicare+Choice payment rates fails to keep pace with growth in the FFS program, leaving payments in some areas to fall even further below FFS payments. As a result, beneficiaries will have fewer Medicare+Choice options, reduced benefits and higher premiums.

Risk Adjustment Based on Inpatient Data Only

While AAHP shares MedPAC's concern regarding the limits of a risk adjustment methodology based on inpatient data only, we are also concerned about the difficulty of obtaining data from additional sites of care. Many organizations are already experiencing difficulty meeting HCFA's requirements for collecting inpatient data, in part due to the need for significant systems modifications to collect and report the required data. In addition, HCFA is still developing its systems for receiving and reviewing the inpatient data. Given the uncertainty in the inpatient data collection process, the time frame necessary for successful initiation of a data collection effort that includes data from ambulatory sites of care is difficult to predict. As an interim step, however, HCFA may wish to consider supplementing an inpatient data only model with some select outpatient data focusing on a small number of diagnoses that commonly require hospitalization. This approach could give credit to plans with programs that promote moving care out of inpatient settings in clinically appropriate circumstances. As the MedPAC report points out, "given the untested nature of the (risk adjustment) system, it is reasonable to expect significant problems as well as significant opportunities for improvement over time."

Phase-In of Risk Adjustment

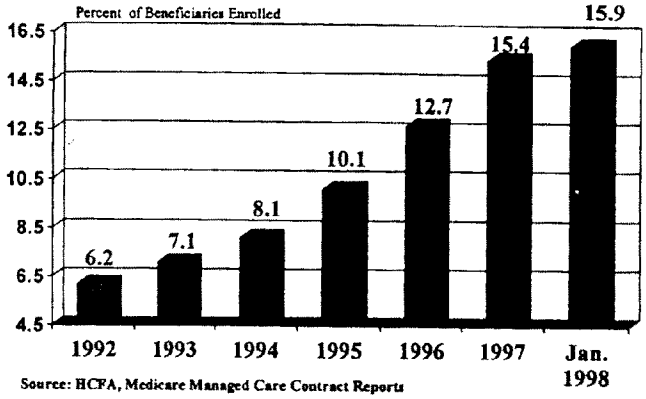
AAHP supports MedPAC's recommendation that HCFA undertake an orderly phase-in of all aspects of the new risk adjustment method. The report also recommends that "as soon as feasible, HCFA should announce operational details of its risk-adjustment system, to allow plans the necessary time to modify their contracts, accounts, and systems." The lack of operational details surrounding the risk-adjustment system has posed significant challenges and problems for AAHP members. Most plans need to make changes to their information systems to collect the data required for risk adjustment, and others may need to rewrite their provider contracts to ensure appropriate data collection. These activities can be costly and are occurring at the same time as myriad other changes to the program are being implemented.

In addition to a deliberate phase-in of the risk adjustment method, AAHP supports the notion that HCFA limit changes resulting from this method to protect beneficiaries and plans from sharp swings in payment. MedPAC notes that lack of data has created uncertainty and that HCFA is still in the process of establishing the mechanism for collecting data from plans. While HCFA does not have an existing database to simulate plan payments under the new risk adjustment methodology, efforts are underway to develop such a database. It is unclear at this point, however, whether HCFA will be able successfully to assemble such a database and to provide timely estimates of plan payments under the new risk adjustment methodology. The uncertainty surrounding HCFA's proposed risk adjustment methodology and the potential for disruption to plans and beneficiaries both argue for limiting changes in payments to Medicare+Choice organizations under the new risk adjustment methodology.

CONCLUSION

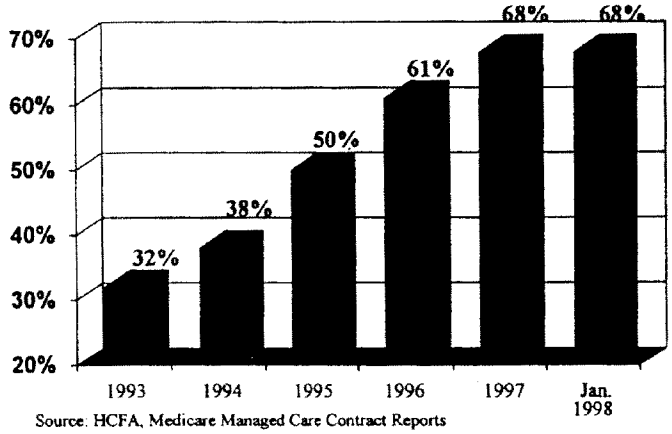
We urge MedPAC and Congress to proceed with caution to avoid volatility in the Medicare+Choice market and to encourage the expansion of choices available to Medicare beneficiaries. We will continue to work with Congress, HCFA, and MedPAC to ensure the successful implementation of the Medicare+Choice program.

Percent of Medicare Beneficiaries Enrolled in Managed Care Reaches 15.9% in January 1998



Source: HCFA, Medicare Managed Care Contract Reports

Percentage of Risk Plans Offering Prescription Drug Coverage More Than Doubles Since 1993



Source: HCFA, Medicare Managed Care Contract Reports

Statement of the American Chiropractic Association

This testimony is submitted for the record of the March 3, 1998 hearing of the Committee on Ways and Means, Subcommittee on Health, on behalf of the American Chiropractic Association (ACA), a membership association representing a majority of licensed Doctors of Chiropractic in the United States, regarding the GAO report on Medicare payment policies.

The ACA generally supports the GAO report entitled, "HCFA Can Improve Methods for Revising Physician Practice Expense Payments." It is the opinion of the ACA that the resource-based methodology used by HCFA to calculate practice expense is basically sound and that the new fee schedule should go into effect in January 1999, with a three-year phase in period, as scheduled.

Practice Expense Relative Values

Under the new system, practice expense will be more fairly allocated to those who primarily provide office-based services and, therefore, are financially responsible for overhead expenses. For example, 76 percent of chiropractic physicians are in a solo private practice. Less than nine percent of doctors of chiropractic practice in urban areas of more than one million residents and 47 percent of doctors of chiropractic practice in communities of less than 50,000. A recent national survey showed that mean practice expense for doctors of chiropractic is just under 60 percent of average gross income. On average, practice expense under the current system comprises approximately 40 percent of the fee for any given CPT/HCPCS code reimbursed under the Medicare Fee Schedule. However, the practice expense allocated to the only three CPT codes that can be used by doctors of chiropractic under the Medicare payment system comprises only 30.3 percent of the total RVUs allocated to those codes. Thus, actual practice expense for chiropractic physicians is approximately twice the practice expense reimbursable by Medicare at the present time.

Although doctors of chiropractic are slated for an increase of approximately 15 percent in total reimbursement for Medicare services under the proposed resource-based practice expense system, the total impact on net income for the profession is relatively small. The percentage of income received by doctors of chiropractic from Medicare patient fees in 1995 was 8.4 percent.

It has been intimated by some during the debate that has surrounded the practice expense issue that the increases projected for non-medical providers, such as doctors of chiropractic, account for the losses forecasted for surgical groups. This is simply not true. Reimbursement for non-medical doctors such as podiatrists, chiropractors, and optometrists comprises approximately four percent of the Medicare fee schedule. Reimbursement specifically for chiropractors comprises less than one percent of the Medicare fee schedule. In fact, elimination of the increase projected for all of these provider groups would only reduce surgical losses by two percent. As an example, HCFA has projected that under the new payment system, reimbursement for a coronary bypass procedure would fall to approximately $1770. Elimination of the increases assigned to all non-medical doctors would raise this to $1786, a difference of only $16. The projected reallocation assigned to chiropractic alone would have significantly less than a one half of one percent impact on the changes estimated for surgical and other groups.

Linking

Throughout its report, the GAO expresses its concern regarding HCFA's linking methodology and its adjustments to the CPEP data. Using its linking methodology, HCFA adjusted the CPEPs' administrative and clinical labor estimates because of the inconsistency in the estimates for the same procedures. According to the GAO, these variations in numbers indicate that some adjustments to the CPEP data are necessary.

It is clear from the report, however, that HCFA has not made any final decisions as to what their next step will be regarding the validation of the CPEP data. According to the GAO, "At this time, it is unclear what approach HCFA will take in preparing its next proposed rule, which is due in May 1998." In addition, the report indicates that HCFA officials are considering a "check" of the CPEP data by gathering direct expense data through surveys or on-site reviews. The GAO does not believe these "checks" would be practicable unless a limited number of on-site reviews were conducted to enable HCFA to identify any problems noted with the direct ex-

pense rankings. HCFA has not yet reached a final decision on a check of the CPEP data.

It is the ACA's understanding that any final decision by HCFA regarding the linking or adjustment of CPEP data will not be made public until the proposed rule due in May 1998, at which time the ACA will submit written comment.

MULTIPLE PROCEDURE REDUCTIONS

The ACA recommends that HCFA delay implementation of a multiple procedure reduction of practice RVUs until a system for procedure code-specific reductions can be developed. Although doctors of chiropractic would not be directly affected by this proposed policy, we believe that the proposed across-the-board reduction would penalize those providers who commonly perform multiple procedures that do not result in efficiencies of scale.

CONCLUSION

In summary, the ACA concurs with the GAO report that HCFA's methodology for developing new practice expense RVUs is adequate and that it is not necessary to develop a new methodology. In addition, it is understood that there may be some adjustment of the CPEP data. The ACA will reserve comment on CPEP linking until HCFA finalizes its methodology for this procedure.

We appreciate the opportunity to provide these comments.

Statement of American College of Rheumatology

The American College of Rheumatology (ACR) is an organization of physicians, health professionals, and scientists that serves its members through programs of education, research and advocacy that foster excellence in the care of people with arthritis and rheumatic and musculoskeletal diseases. The ACR is pleased to provide written testimony to the Ways and Means Health Subcommittee on reports submitted to the Subcommittee by the General Accounting Office (GAO) and the Medicare Payment Advisory Committee (MEDPAC) on Medicare payment policies.

GAO REPORT ON HCFA'S RBPE IMPLEMENTATION METHODOLOGY

ACR has had the opportunity to review the final GAO report on HCFA's methods for revising physician practice expense payments, and we commend the GAO for accomplishing this significant task within a relatively tight timeline. Furthermore, we concur with the vast majority of the report's findings. The College's testimony will focus on the following aspects of the GAO report: (1) HCFA's methodology for developing direct cost estimates; (2) Linking; and (3) Use of physician nurses in the hospital setting.

HCFA's Methodology for Developing Direct Cost Estimates

The GAO report states that "HCFA used an acceptable method to develop direct cost estimates." The ACR fully concurs with this assessment. ACR believes that the Clinical Practice Expert Panel (CPEP) methodology utilized to generate data on direct practice costs was an open and inclusive process that resulted in values that will serve as an effective starting point for developing appropriate practice expense RVUs. We reject the opinion of many stakeholders that the data is fundamentally "flawed." The intent of the CPEP process itself was to develop a body of data using a multidisciplinary, representative sample of physicians and other experts (nominated by specialty societies) with expertise regarding the practice expenses under their review. Every opportunity was provided for all affected parties to provide input. By the time the official transition to resource-based practice expenses begins in May, 1998 with the release of the proposed rule on the 1999 Medicare Fee Schedule, physicians and other interested parties will have been given over ten formally promulgated opportunities to provide input into this process. In fact, physicians themselves will have actively participated in the actual development of RBPEs through every stage of the process, including participation in the original CPEPs, in the validation panels conducted in October, 1997, and the multispecialty panel meeting convened in December. HCFA has also provided a variety of other forums for physician groups to convey their opinions to the agency. For these reasons, we believe that the agency's actions to date—and the plans for future opportunities to submit views—already fully meets Congressionally mandated requirements in the

Balanced Budget Act of 1997 that HCFA "consult with organizations representing physicians regarding data and methodology to be used."

We also fully concur with the passage in the report indicating that "Other methods for estimating direct expenses have limitations." The College agrees that the expense of alternative approaches such as mail or on-site surveys (both in time and actual cost) makes them, by definition, prohibitive. Additionally, these types of data gathering efforts are invariably plagued by low response rates, as noted in GAO's report, and are often hampered by design bias and potentially even by gaming. The report's stated concerns that activity-based or cost-based accounting do not provide the specificity needed to adjust the Medicare fee schedule, are also shared by ACR.

It has come to the attention of the College that the coalition of procedurally-oriented groups has suggested that HCFA's current approach be replaced by a cost-accounting-based methodology generated by a "public-private partnership" of HCFA and the medical specialty society community. The ACR finds such a proposal problematic in several ways. First, we believe that such an approach would result in a top-down RVS that would mirror the inequities in the current charge-based system—i.e., those services that are now reimbursed more for their practice expenses because of Medicare's charge-based system would still get more; those services that are reimbursed less would still get less. This is because the American Medical Association's Socioeconomic Monitoring Survey (SMS) data, on which the proposal would be based, itself is distorted by the current charge-based RVUs. HCFA's approach is a bottom up approach—figure out the resources that are required to perform each service, and then convert them into a relative value system (RVS), resulting in the Congressionally mandated *resource-based* relative value system.

The College also believes that HCFA has been engaging the professional medical community in a "public-private partnership" on RBPEs all along, as evidenced by the preponderance of opportunities for input afforded to the specialty societies. Finally, it is our opinion that use of a cost-accounting approach would merely maintain the status quo where procedurally-oriented services are over-reimbursed at the expense of evaluation and management services.

Linking

ACR believes that the issue of whether to utilize the redundant CPT codes reviewed by the CPEPs to link the direct cost estimates generated by the separate CPEPs remains fundamental to the development of accurate resource-based practice expenses. The College concurs with HCFA's assertion in last June's proposed rule that the relative relationships within CPEPs are correct, but the relationships between CPEPs need to be normalized to bring the relative estimates to a single scale. Accordingly, ACR agrees with the GAO report that the CPEP estimates need adjustment and that linking is desirable. In the absence of such linking, the proposed RBPE RVU system would not truly contain "relative" values.

GAO's report does raise questions regarding the specific linking formula utilized by HCFA, primarily regarding anomalies caused by the formula and the redundant CPT codes used to develop the links. While we believe that HCFA should remain open to the possibility of revising its linking methodology if credible alternate approaches are identified that can develop appropriate practice expense values, we reject the notion that the proposed linking methodology must be overhauled, reconstructed or abandoned. We therefore concur with the opinion of the Physician Payment Review Commission (PPRC) staff cited in the report that it is not necessary for HCFA to select new redundant codes, assemble new CPEPs, and estimate the linking regression on new data. It is our firm belief that the overall validity of the practice expense RVUs is dependent on HCFA adopting policies and rules to establish an appropriate relativity between the staff time estimates by the varying CPEPs. Therefore, while the College is not wedded to the specific linking model currently outlined by HCFA, we agree with the GAO report in the strongest possible terms that the CPEP estimates need some type of adjustment, and we believe a linking methodology is an appropriate approach.

Use of Physician Nurses in the Hospital Setting

The GAO report concluded that "HCFA appropriately disallowed nearly all expenses related to staff that accompany physicians to the hospital since there is no available evidence that these expenses are not already being reimbursed or are a common practice." Some surgical groups have argued that surgeons often bring their nurses into the hospital and that these costs should be reimbursed by HCFA. GAO staff has been told by surgical groups that new evidence had been given to HCFA in response to the October rule-making notice that supports the claim that this is a widespread practice. GAO staff has said that it planned to examine the evidence and determine if it should modify its conclusion. ACR recommends that the GAO

ask HCFA to independently validate any such evidence, to determine if it is the usual practice for a typical Medicare patient, before agreeing that such expenses should be allowed.

MEDPAC REPORT ON MEDICARE PAYMENT POLICIES

MEDPAC has recommended that HCFA not adopt its proposal to reduce payments for procedures provided in conjunction with an office visit or other E/M service without further study. The ACR strongly agrees with this recommendation. It is the opinion of the ACR that extending the 50% discount for multiple procedures to non-surgical services would be highly inappropriate, at best. We believe that using reductions for multiple surgical procedures performed through a single incision as a template for reducing multiple diagnostic procedures performed during an office visit or other E/M services is simply illogical. In these situations, the only savings in physician work or practice expenses that could be realized is a minor reduction in the administrative time associated with scheduling another appointment or pulling a chart, which is to say the savings in practice costs would be neglible. In light of the lack of data provided to support making such a dramatic change in reimbursement for services rendered during an E/M visit, we strongly urge HCFA to at least pilot-test the effects of such a proposal before implementation.

We also concur with the MEDPAC recommendation that a volume and intensity adjustment, or behavioral offset, should not be used. In its June 18, 1997 propose rule, HCFA stated that it intended to assume that 50% of the reductions in payments for specific procedures will be offset by an increase in volume and intensity. The effect of this assumption is to increase the amount of reductions for some procedures, and reduce the expected gain from others. The College agrees with MEDPAC's view that HCFA's experience with implementation of the RBRVS does not support the need for such a volume and intensity adjustment. Further, MEDPAC correctly that the sustainable growth rate for physician services, also mandated by the BBA, already corrects for any increase in the volume and intensity of physician services. ACR strongly urges Congress to advise HCFA that application of a volume and intensity offset to the PE-RVUs is inconsistent with requirement that resource-based practice expenses be implemented in a budget neutral manner.

CONCLUSION

The ACR concurs with virtually all of the findings outlined in the GAO report. We believe that HCFA did utilize an acceptable method to develop direct cost estimates, and that while the specific proposed formula for linking the estimates is not perfect, some sort of linking or normalization is desirable. As was indicated by PPRC staff in the GAO report, drastic overhaul of the process, or implementation of an alternative approach, is not necessary. ACR agrees with the GAO that HCFA was correct in disallowing the costs associated with nurses who accompany a surgeon into the hospital, without independently verifiable data that this is a typical practice. The College also concurs with the recommendations relating to practice expense made by MEDPAC. We believe that it would be highly premature for HCFA to proceed with its recommendation to reduce payments for procedures provided in conjunction with an office visit or other E/M service without further study. We also agree that history does not support the need for a volume and intensity adjustment, and that the institution of the sustainable growth rate system makes this adjustment unnecessary.

Statement of American College of Surgeons

On behalf of our 62,000 Fellows, the American College of Surgeons welcomes this opportunity to provide its views about imminent changes in practice expense relative values under Medicare's physician fee schedule. As you know, the College and surgeons generally have been extremely concerned about the potential consequences of the new practice expense values. In particular, we have repeatedly expressed the view that the quality and validity of the data and other information that the Health Care Financing Administration (HCFA) has compiled so far would in no way support a massive redistribution of Medicare payments.

We want to take this opportunity to compliment the General Accounting Office (GAO) for the work it has done in evaluating HCFA's proposed practice expense methodology. The College was pleased to have the opportunity to provide very extensive input during GAO's development of its February 1998 report, and we are

pleased to see this input reflected in many places in the document. Overall, we believe that, despite a very challenging timetable for GAO's work, the report sheds considerable light on many of the problems with the data and methodology that HCFA has contemplated using to determine the new practice expense values.

COMBINED EFFECT OF MEDICARE PAYMENT POLICIES

Before turning to matters directly related to resource-based practice expense values, it is important to note that Medicare policies already in place are expected to produce significant reductions in Medicare payment for surgical services. The most obvious are the adoption of a single Medicare dollar conversion factor and the use of a GDP-based formula for determining acceptable rates of growth in Medicare expenditures for physicians' services. As we understand it, the Congressional Budget Office (CBO) has projected that these new policies will cause the Medicare conversion factor to fall from $40.96 for surgical services in 1997 to $32.63 by 2002. This, by itself, would amount to a 20 percent reduction in Medicare payments.

Obviously, if the new practice expense relative values for surgical services are lower than those currently assigned, these services would sustain significant payment reductions due to the combined effect of reductions in practice expense relative values and reductions in the conversion factor. In other words, under this scenario, there would be fewer relative value units and each unit would be worth considerably less.

Following are some specific examples of what this could mean. If we assume that the proposed practice expense values published by HCFA last June were adopted and that CBO's conversion factor projections are accurate, Medicare payment for both coronary arteries bypass and cataract extraction could fall by 47 percent between 1997 and 2002. For total hip replacement, the comparable reduction would be 45 percent. And, for laparoscopic removal of the gall bladder and kidney transplantation, the payment reductions over this same time frame would amount to 34 and 31 percent, respectively. The Medicare payment trajectory for all of these services is shown on the accompanying charts. It is worth remembering that these payment reductions do not take into account the impact of inflation over this time.

The College believes that payment reductions of this magnitude would have serious consequences for surgical practices in both urban and rural areas, as well as for the faculty practice plans of large teaching institutions. They would inevitably reduce surgeons' willingness to treat Medicare beneficiaries. Even now, the College is receiving notices indicating that some surgeons have reluctantly concluded that they can no longer care for Medicare patients as a result of already-imposed payment reductions, such as the 10.4 percent reduction in the Medicare conversion factor for surgical services that was implemented this year. There also is little doubt that continued downward pressure on payments for surgical services will only intensify the pressure for private contracting under Medicare.

GAO's February report itself raises a cautionary flag about "the cumulative effect" of various Medicare physician payment policy changes. Unfortunately, GAO seems content simply to monitor the situation. The College, instead, believes that policymakers need to assess in advance the reasonableness of the policies they are contemplating, rather than simply waiting until serious complications begin to materialize.

CONCERNS ABOUT DIRECT PRACTICE EXPENSE DATA

The College has many serious concerns with the data and methodologies that HCFA has contemplated using to determine the new resource-based practice expense relative values.

First, we do not believe that the agency has the kind of data on physicians' direct practice expenses that are needed to determine accurate practice expense values. The most recent attempt to reach consensus on labor-related data for a relatively small subset of physicians' services was unsuccessful. Further, the various physician panels that have been convened over time provided significantly different direct practice expense estimates. Here are just a few examples:

- The administrative staff time estimate for a chiropractic manipulative treatment nearly doubled, from 60 minutes during the Clinical Practice Expert Panel (CPEP) process to 110 minutes in the "validation" panel meeting.
- The administrative staff time for a level 3 office visit for an established patient (CPT 99213) increased by 50 percent, from 30 minutes in the CPEP process to 45 minutes in the validation panel meeting. Moreover, during the cross-specialty panel meeting held in mid-December, primary care physicians argued that the administrative staff time for this code should be increased to 85 minutes—that is, almost double the time estimated less than two months earlier. More importantly, the previous

30 minute estimate had been used by HCFA to arbitrarily cap the administrative staff times allowed for various procedural services, because the agency assumed that this 30 minute estimate was some sort of "gold standard."

• The administrative staff time estimate for the inpatient consultation code (CPT 99253) fell by more than one third, going from 75 minutes in the CPEP process to 49 minutes in the validation panel meeting.

The estimated clinical staff time for allergy skin testing increased by more than 360 percent, going from 13 minutes in the CPEP process to 60 minutes in the validation panel meeting.

• The administrative staff time estimate for balloon angioplasty rose by more than 125 percent, going from 143 minutes in the CPEP process to 322 minutes during the validation panel meeting.

What is even more significant is that the above differences relate to high-volume services, with which the various panel members would be expected to have considerable, recent experience. In addition, none of these services involve a global service period; they all relate to a single event. The College believes this raises serious questions about the validity of the estimates obtained for low-volume services, including those provided by few or even none of the CPEP panel members charged with developing them. It also raises serious questions about the accuracy and completeness of the estimates developed for services with a global service period—that is, those services involving care that stretches from the time a decision is made that a patient must undergo a major operation until 90 days following the operation.

The GAO report acknowledges the differences in the direct practice expense estimates developed by the various panels but does not specifically discuss the implications of these differences for future rulemaking.

The College believes that even the method HCFA is using to determine the direct practice expenses associated with a particular service is flawed. It relies on the concept of the "typical patient." Under HCFA's approach, expenses are only counted if they are incurred more than 50 percent of the time a particular service is provided. In the case of services provided by both generalists and specialists, differences in the sheer volume of the services provided essentially guarantees that the typical patient approach will cause specialists to be underpaid each time they perform a service on *their* typical patient (who has been referred by another physician, is symptomatic, and for whom the surgeon or other specialist has the added administrative burden of keeping the referring physician informed of the results—all of which have consequences for practice expenses).

In short, this "typical patient" definition serves to discount or even ignore a considerable portion of practice expenses incurred by surgeons. In contrast, when HCFA determines DRG weights under Medicare's hospital prospective payment system, the agency takes into account data for *all* patients, and the weight for a DRG is based on the weighted average, not on the "typical" patient. Unfortunately, the GAO report does not address the serious shortcomings of HCFA's "typical patient" definition for purposes of determining new practice expense values.

With respect to direct practice expenses, the College also believes quite strongly that the labor costs of the physician-employed staff who accompany a surgeon to the hospital must be taken into account. So far, HCFA has refused to do so, although the agency recently requested additional information about this practice and the College was pleased to comply. Based on a survey conducted by The Lewin Group, the College is able to document that many surgical practices use their own clinical staff in non-office settings. The results of this survey (copy attached) show that in at least five surgical specialties and subspecialties—neurosurgery, ophthalmology, general thoracic surgery, congenital thoracic surgery, and adult cardiac surgery—at least 50 percent of practices use employed clinical staff in non-office settings. Further, a sufficient number of practices in other specialties use their clinical staff in this way that we believe HCFA must make an effort to take their associated labor costs into account in determining fair and accurate practice expense values. The Lewin Group data indicate, for example, that 31 percent of general surgery practices pay for clinical staff used in non-office settings. While the sample for this survey is admittedly small, the data indicate that this is a significant and real practice cost that simply cannot be ignored. The College is pleased that GAO's report specifically recommends that HCFA "determine whether changes in hospital staffing patterns and physicians' use of their clinical staff in hospital settings warrants adjustments between Medicare reimbursements to hospitals and physicians."

Concerns about Indirect Practice Expense Allocation

The College believes it is also important to note that there is still no single, agreed-upon method for allocating indirect practice expenses. GAO's February report acknowledges this. These costs account for a significant share of the practice expenses incurred by many surgeons and other specialists. In fact, as we have argued, a significant portion of labor costs should be considered indirect expenses. As far as the College has been able to determine, no independent researcher has reached HCFA's conclusion that, on average, fully 55 percent of physician practice expenses are direct and only 45 percent are indirect. For example, Pope and Burge found direct expenses to be about 36 percent of the total, while Dunn and Latimer concluded that direct expenses represented about 32 percent of the total. We believe that HCFA's 55/45 direct/indirect practice expense split, and the undifferentiated manner in which the agency has previously allocated indirect practice expenses (that is, without taking into account specialty-specific differences in direct and indirect practice expense shares) seriously and inappropriately disadvantage surgeons and other specialists that have a relatively high share of indirect practice costs.

Other Concerns

Finally, the College is very concerned that HCFA will obviously be required to make many controversial assumptions and decisions in calculating resource-based practice expense values. Overall, the College is deeply concerned about the fact that every HCFA data manipulation, statistical adjustment, or rule appears to factor out or otherwise limit practice expenses incurred by surgeons (for example, the cross-linking process, arbitrary caps on clinical and administrative labor time, and the removal of labor costs related to surgeon-employed staff involved in providing services to hospital patients). Moreover, surgeons are told that some of their labor costs will not be counted as direct costs at the individual level, but then these costs are counted by HCFA for purposes of determining *aggregate* direct expenses. In addition, surgeons have been given conflicting messages about where—and whether—to count the significant non-physician labor costs involved in getting a patient scheduled and ready for an operation.

The College is gratified that GAO's recent report devotes considerable attention to problems with many of HCFA's statistical and other adjustments. We note, for example, that GAO has correctly noted HCFA's caps on clinical and administrative staff time for many procedural services "are not supported by any data or analysis" and that "HCFA has not...conducted tests or studies that validate these changes and thus cannot be assured that they are necessary or reasonable." We note, too, that GAO is "not convinced that HCFA's linking model is free of statistical problems." In fact, GAO goes on to emphasize that it "did not expect to see such substantial and often striking deviations from the assumptions or patterns that HCFA staff had told us were the basis for their model."

Specific Recommendations

At this time, we are tempted to suggest that the work HCFA has completed so far in developing practice expense relative values should be set aside and that a new, more feasible work plan must be developed. We recognize, of course, that such a suggestion would not be permitted under the current statutory deadline. However, we do have several other concrete suggestions.

1. The College believes that real, unbiased practice expense data must be injected in the process, rather than continuing to rely on unsubstantiated and ever changing estimates. Such data could be compared with the estimates developed by the CPEPs and the validation panels. We note that GAO's report also sees value in collecting actual data.

2. The "typical patient" definition needs to be revisited. Surgeons are not simply convinced that the current approach is fair. At the very least, for some subset of codes, perhaps the practice expenses could be separately estimated for the typical patient seen by specialists and the typical patient seen by non-specialists, and then some weighted average estimate used. Another option would involve the use of code modifiers to distinguish between patients that have been referred from one physician to another (that is, from a primary care physician to a specialist) from those that have not been referred. In other words, such modifiers would recognize that different patient populations receiving the "same" service actually require the physicians involved to incur very different levels of practice expenses, in part because of differences in patient characteristics and needs, and in part because some practice expenses must be incurred just to keep the referring physician informed.

3. In the proposed rule scheduled to be issued this May, HCFA should model several different options. Among other things, the agency should examine the impact of modifying its assumptions with respect to the proportion of direct and indirect expenses (and the sizes of the respective relative value pools). For example, we believe it would be appropriate to examine the impact of treating only the clinical staff time directly related to individual services as direct practice expenses, while considering the remaining clinical staff time and all administrative staff time as an indirect expense. This approach would acknowledge the difficulty of accurately linking administrative staff time to individual physicians' services. It would also acknowledge that some clinical staff time is spent in activities that cannot be directly linked to individual services provided to individual patients (such as time spent by a nurse in quality assurance activities, office management, continuing medical education, and so forth).

4. HCFA must complete an impact analysis that compares any proposed practice expense payments with actual practice expenses incurred by physicians on a specialty-by-specialty basis. The College believes that data exist to do this. We recognize that there may be differences of opinion about what such an impact analysis might imply, but we see absolutely no reason not to do the work. In fact, we believe that such a detailed impact analysis is what the Congress expected when it enacted section 4505 of the Balanced Budget Act. The College and other physicians' organizations have taken the position that any new practice expense values should *at least* cover about the same proportion of each specialty's expenses, if the system claims to be resource-based. In fact, if the system truly were resource-based, it would cover all reasonable expenses.

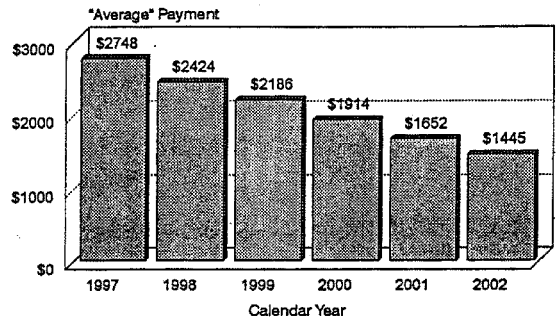
5. *At the very least*, the College believes that a reasonable ceiling and floor on the amount of change in practice expense values must be adopted. A simple phasing-in of inappropriately low values certainly would not be acceptable to the College, nor would vague promises of potential, future refinements in relative values.

The College believes that, at the end of the day, HCFA, Secretary Shalala, and the Congress will need to assess the reasonableness of Medicare payment amounts *as a whole*. Moreover, since third party payers increasingly are adopting Medicare relative values, decisions made by federal policymakers take on a more global importance. Further, as we have emphasized continually, a massive redistribution of Medicare payments is not justified given the relatively poor quality of the information and the questionable methodologies currently available to HCFA.

In closing, let me note that the College recognizes fully that the various Medicare policy changes, including the new practice expense relative values, were motivated by a desire to increase payments for primary care services. However, as the attached charts show, vast differences in the volume of services provided by generalists and specialists mean that even relatively costly services must be subjected to radical payment reductions so that payment for visit services can be increased by a modest amount. We find it difficult to imagine how surgeons will be able to continue providing high quality care to Medicare beneficiaries if the projected changes in Medicare payments for surgical services become a reality. In this regard, we assume that policymakers are prepared to acknowledge that the health care needs of Medicare beneficiaries cannot be met by primary care physicians alone. Finally, the College also recognizes that HCFA has been attempting to develop new practice expense values under very challenging circumstances. While we can sympathize with this, we know that it will be surgeons and their patients who will have to live with the final result of the agency's efforts.

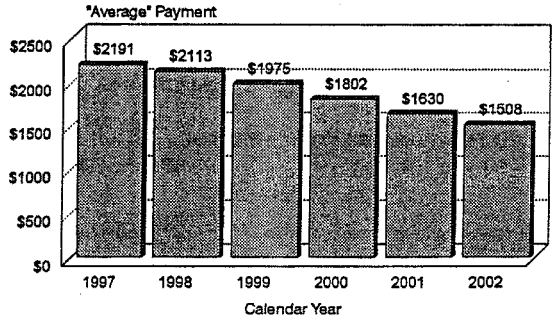
Projected Total Medicare Payments

Coronary Bypass, CPT 33512



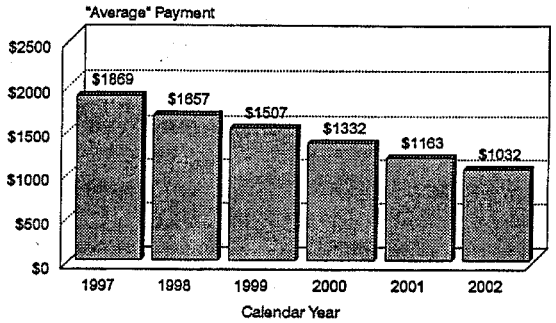
Projected Total Medicare Payments

Kidney Transplantation, CPT 50360



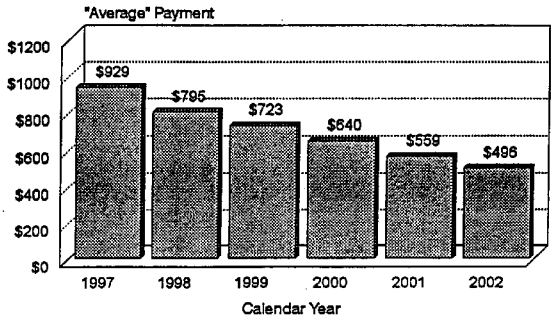
Projected Total Medicare Payments

Total Hip Replacement, CPT 27130



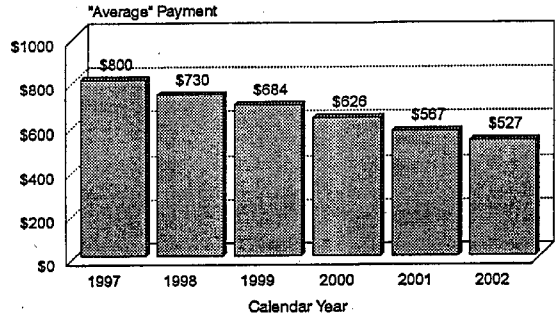
Projected Total Medicare Payments

Cataract Surgery, CPT 66984



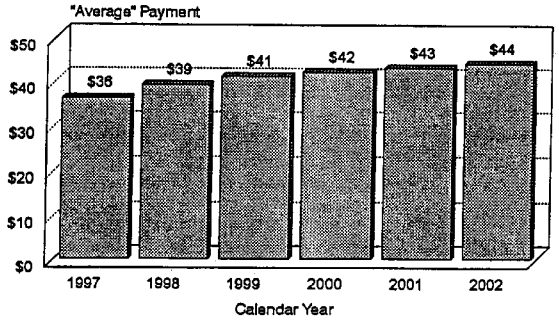
Projected Total Medicare Payments

Laparoscopic Cholecystectomy, CPT 56340



Projected Total Medicare Payments

Office Visit, Established Patient, CPT 99213



KEY ASSUMPTIONS IN ACS PROJECTIONS

Medicare Conversion Factors

1997 $40.96 (Source: Federal Register, November 22, 1996)
1998 $36.69 (Source: Federal Register, October 31, 1997)
1999 $36.06 (Source: Congressional Budget Office)
2000 $34.70 (Source: Congressional Budget Office)
2001 $33.22 (Source: Congressional Budget Office)
2002 $32.63 (Source: Congressional Budget Office)

The conversion factors projected for 1999 and beyond obviously reflect CBO's expectation that Medicare expenditures for physicians' services will exceed the applicable Sustainable Growth Rates, thereby triggering the need to make compensating, downward adjustments in the conversion factors.

Service-Specific Relative Values

The relative work values published for 1998 remain unchanged through 2002 (and the 0.917 work value adjuster continues to apply). Note that these work values do reflect the increases approved for global surgical services, beginning in 1998.

The practice expense values published June 18, 1997 are adopted, beginning in 1999, and fully phased in by 2002.

No change in malpractice values. While current law requires implementation of new resource-based malpractice values in 2000, the impact of any such values cannot be estimated at this time.

Geographic Adjustment Factors

The "average" payment amounts shown would be those paid in a locale whose geographic adjustment factors equal 1.00. Medicare payment amounts in locales with different geographic adjustment factors would be higher or lower than those shown.

PRACTICE THAT PAY FOR STAFF IN NON-OFFICE SETTINGS

	Number of Respondents	Number Who Pay for Staff in Out-of-Office Settings	Percent Who Pay for Staff in Out-of-Office Settings
Colon and Rectal Surgery	12	1	8%
General Surgery	13	4	31%
Neurosurgery	12	6	50%
Ophthalmology	2	1	50%
Plastic and Reconstructive Surgery	6	2	33%
Vascular	8	1	13%
Thoracic Surgery			
General Thoracic Surgery	13	8	62%
Congenital Thoracic Surgery	10	5	50%
Adult Cardiac Surgery	14	10	71%
Total	90	38	42%

Statement of Howard M. Levine, President, American Osteopathic Association

My name is Howard M. Levine, D.O., and I am the President of the American Osteopathic Association (AOA). On behalf of the nation's more than 40,000 osteopathic physicians and the millions of patients for whom we care, I am pleased to provide the members of the House Ways and Means Committee's Subcommittee on Health with the AOA's written comments for the hearing record accompanying its March 3, 1998 hearing on the topic of Resource-Based Practice Expenses.

The AOA appreciates the opportunity to address HCFA's practice expense proposal, as addressed by the final report by the GAO, submitted to Congress on February 27, 1998.

BACKGROUND

Before 1982, Medicare remunerated physicians on the basis of historical charges that substantially overvalued procedures performed in hospital settings while

undervaluing evaluation and management (E/M) services and other non-surgical services provided in office settings. During 1992, HCFA began to implement a new Resource-Based Relative Value Scale (RBRVS) designed to pay physicians on the basis of relative value units (RVUs) for each procedure. The work RVUs are based on the actual work required of a physician to execute a particular medical procedure. However, this is only part of the payment schedule. Physicians are also compensated for the Medicare share of their practice expenses and malpractice costs as a part of each payment under the RBRVS system. The RBRVS is intended eventually to be based on actual data for all three components of the fee: physician work, practice expenses and malpractice costs. The BBA has set a timetable for the creation of malpractice RVUs. HCFA has also substantially completed the process of establishing Resource-Based Practice Expenses (RBPE) RVUs for practice expenses. These expenses include the costs of office staff, and the equipment and supplies necessary to run an office.

In essence, the AOA believes that the HCFA proposal on RBPE meets the requirements established by the Balanced Budget Act of 1997. We believe that because of HCFA's in-depth work and collaboration with the physician community that the RBPE methodology is valid since it is based on data provided by physicians on actual physician practice costs. We therefore concur with the General Accounting Office's findings.

THE AOA'S POSITIONS ON THE GAO'S RECOMMENDATIONS ON THE RESOURCE-BASED PRACTICE EXPENSE COMPONENT OF THE MEDICARE FEE SCHEDULE

The AOA found the GAO draft report to be a fair and realistic assessment of HCFA's RBPE proposal. This topic is extremely complex and with widely varying positions put forth to Congress and to HCFA on this crucial issue. The GAO report listed a significant number of findings and recommendations that I will address below along with our corresponding AOA position(s):

1. GAO concluded that direct labor estimates and other direct practice expenses formulated by Clinical Practice Expert Panels (CPEP) are an acceptable method for contributing towards a viable RBPE system. The report recommended that HCFA should document how it will plan to adjust its (CPEP) data, the basis for this adjustment, and the effects it may have on physician practices. HCFA is also required to describe their process for future refinements and updating of this data. In its report, the GAO discounts allegations that the CPEP process was flawed because the information contributed was based on facts, not by "best guesses."

- *AOA Position:* The AOA agrees with the GAO in its review of this HCFA method.

2. GAO has clarified that alternative data gathering proposals advanced by certain groups are unreasonable and would increase costs while further delaying the implementation of the new method for determining PE payments.

- *AOA Position:* The AOA agrees with the GAO in this finding because activity based accounting alternatives reallocate practice costs to broad categories of codes and not to specific procedures, as mandated by law. This methodology is also extremely expensive and subject to sampling bias.

3. GAO recommends that HCFA, on a limited basis, should collect actual Practice Expense data to identify significant problems that may be addressed in the refinement process.

- *AOA Position:* The AOA concurs in general with this GAO recommendation, however we believe that certain caveats need apply here. We believe that HCFA should look at other sources of data, and that any survey of physician practices or on-site gathering of data needs to be carefully designed to minimize response bias that may occur. In addition, HCFA should develop an acceptable methodology for collecting such data.

4. GAO recommends that HCFA should revise its linking methods and eliminate scaling to the national survey data. GAO also recommended to HCFA that it should evaluate the possibility of assigning indirect practice expenses based on specialty-specific data (Two AOA Positions to Follow)

- *AOA Position:* The AOA concurs in general with the GAO that HCFA's proposed regression formula for linking the CPEP data is statistically sound. Even though the AOA is supportive of HCFA's proposed linking formula, we are open to considering other methods for normalizing direct practice expense data. However, this should only be done as long as the revised method addresses the problem of inflated administrative and labor costs for non E/M codes.

SCALING BACKGROUND

The GAO report recommended to HCFA that it should eliminate "scaling." Scaling is a statistical adjustment made in the CPEP data in that the proportion of direct expenses attributed to labor, equipment and supplies is consistent with the AMA Socioeconomic Monitoring Survey (SMS) data. In its June 12, 1997 proposed rule, HCFA noted in the aggregate, for all CPEPs, labor equaled 60 percent of total direct expenses, medical supplies comprised 17 percent and medical equipment equaled 23 percent. HCFA also noted that the correspondin percentages from the AMA SMS data were 73, 18, and 19 percent respectively. To equate the aggregate CPEP percentages with those for the AMA SMS data, HCFA proposed an adjustment in CPEP expenses for labor, medical supplies and medical equipment using scaling factors of 1.21, 1.06 and .39 respectively.

Essentially, this would involve multiplying the CPEP expenses for labor, equipment and supplies for each code by the given scaling factors so that the overall distribution would be equivalent to the distribution in the AMA SMS data. The impact of scaling on the direct expenses of any given code depends on the distribution of direct expenses for that code as compared to the aggregate distribution. This means that codes with a greater-than-average share of labor costs would experience an increase in direct expenses as a result of scaling, while the opposite would occur for codes with a greater-than-average share of equipment costs.

Since HCFA never explained why it must scale the CPEP data to fit with the AMA SMS data, we see no mathematical value in it. The AOA believes that HCFA should consider alternatives to scaling but would like to see more methodological details prior to making a change.

• *AOA Position:* HCFA proposed in its RBPE rule that it wants to utilize the aggregate ratio(55/45) since the adjustment would be the same across the board for all codes. Scaling indirect practice expense RVUs billed by each specialty has merit. We believe that the use of specialty specific ratios in the formula would represent a further refinement of that formula. The AOA agrees with this GAO recommendation because it has been difficult for HCFA to gather consistent data in this regard for all of the medical specialties

5. GAO recommended that HCFA should collect data from a limited number of practices to test assumptions that underlie the other adjustments or the limitations on direct costs.

• *AOA Position:* The AOA agrees with the GAO, however we believe, that HCFA should look at other sources of data, and that any survey of physician practices or on-site gathering needs to be carefully designed to minimize a response bias that may occur and for HCFA to create an acceptable methodology for collecting such data would need to be determined.

6. GAO recommends a shift of administrative expenses to the indirect side of the RBPE formula

• *AOA Position:* The AOA could agree to this proposal in theory. Because in practical terms, the CPEP and subsequent validation panels have highlighted the difficulty with trying to attach administrative costs to individual procedure codes. Accounting for multiple service codes submitted on the same claim form, or variables such as rent, utilities and administrative costs can vary widely by practice. The main problem with trying to shift these costs to the indirect category is that the formula for allocating indirect expenses would allow higher payments for the indirect practice costs of surgical services even though associated billing costs, for example, are most likely the same as those costs associated with billing for an E/M service.

7. In its report to Congress, the GAO recommended that HCFA should monitor the impact on access, focusing on procedures with the largest cumulative reduction.

• *AOA Position:* The AOA agrees with this GAO recommendation, however, we suggest that the GAO acknowledge the inherent limitations of attempting to link changes in access (which may be due to multiple variables) to specific payment changes. The AOA also suggests that the report indicate that improvements in access to primary care services should also be monitored.

HCFA'S COMPLIANCE WITH THE BALANCED BUDGET ACT OF 1997 REQUIREMENTS RELATING TO RBPE

We believe that HCFA is complying fully within the law's requirements. The BBA directs HCFA to :

• Phase-In Implementation of Resource-Based Practice Expense (PE) Payments Over Four Years, Beginning on 1/1/99;

• Use Generally Accepted Accounting Principles and "Actual Cost" Data to the "Maximum Extent Practicable"; and

• Consult With Physicians and Other Experts.

The record shows that HCFA is in the process of fully complying with the law's requirements:

• A 60 day comment period was provided on a HCFA notice of intent to issue a proposed rule on practice expenses, published in October, 1997. The notice invited comments on several issues, including how to use generally accepted accounting principles, actual cost data and the nature of the refinement process that Congress mandated for each of the four years of the transition.

• Specialty societies nominated physicians, practice administrators, and other experts to participate in panels that met this past Fall to validate the data on direct practice expenses.

• Specialty societies participated in two conferences, held in November and December, that discussed use of actual cost data and generally accepted accounting principles.

• HCFA has gathered extensive actual cost data, from annual AMA surveys on practice expenses; from data developed by the Clinical Practice Expert Panels and validation panels; and from pricing data on labor and equipment costs involved in each service.

• Physicians will be able to comment again during a 90-day comment period on the new proposed rule. Physicians were also consulted by the GAO as it prepared its upcoming report to Congress on HCFA's data and methodology.

Refinement Process

The AOA believes that there is a need for a fair and accurate refinement process. In order for HCFA to improve upon the crucial work done by the CPEPs and validation panels, there must be a more proportional representation of primary care physicians in relation to the specialists on future panels that will help conduct the refinement process.

Does the BBA Require That HCFA Initiate a New Cost Accounting Study?

No. The law does not require that HCFA initiate an entirely new cost accounting survey of physician practices. Actual cost data must be considered to the "maximum extent practicable." It is not practicable for HCFA to implement a new cost accounting study in time for the data to be incorporated into a proposed rule that must, by law, be published no later than May 1, 1998. Given the massive amount of information on actual costs that HCFA has already collected, a new study is also not needed to develop practice expense payments that are more accurate and fair than those determined by the current charge-based methodology.

Since the law requires that HCFA establish a process for additional refinements during each of the four transition years, only 25 percent of the PE-RVUs will be based on a resource-based methodology during the first year of implementation. Therefore, there will be another year to make further refinements before the resource-based methodology comprises even half of the total PE payments.

Behavioral Offsets

Two crucial issues relating to HCFA practice expense proposals that were not included in the GAO report, are expected to be included in the forthcoming MedPAC annual report. We are referring to the HCFA proposals to include a behavioral offset and a reduction in practice expense RVUs for multiple procedures performed during an E/M office visit.

• *AOA Position:* The AOA opposes the inclusion in the practice expense proposal of a 2.4 percent age point reduction, or behavioral offset, in the conversion factor to account for increases in the volume and intensity of services that HCFA claims will result from changes in net income caused by the implementation of resource-based expenses. The AOA also disagrees with HCFA's proposal to reduce by 50 percent the practice expense RVUs for additional procedures furnished during the same encounter as an E/M service

Conclusion

Thank you for the opportunity to present our views on this crucial issue before your committee. The AOA believes that HCFA is on course and is doing all that it can to ensure the implementation of an equitable Medicare reimbursement system that values all components of a physician's practice in providing medical services to the American public.

The AOA supports the findings of the GAO report and we firmly believe that this issue does not need to be revisited. Overall, the GAO believes that HCFA is complying with the BBA requirements for gathering actual data to the maximum extent practicable, using generally accepted accounting principles and by using the input of physicians and experts as needed. The GAO report reaffirms that the HCFA RBPE proposal is a realistic and viable methodology and that the rulemaking process should move forward without interruption so that RBPE RVUs can be implemented by the deadline mandated by law.

Statement of American Society of Clincial Oncology

Medicare Physician Payment Issues

The American Society of Clinical Oncology (ASCO) is the national organization representing physicians who specialize in the treatment of cancer. ASCO has 11,700 members.

ASCO strongly supports revision of the Medicare physician fee schedule to incorporate the use of resource-based practice expense components. We are pleased that the General Accounting Office has in general endorsed the methods being used by the Health Care Financing Administration (HCFA) to make this revision. New practice expense components should be implemented in accordance with the existing statutory schedule without further delay.

While ASCO does endorse HCFA's basic approach, we do, however, have concerns with two important details in HCFA's proposed implementation.

Payment Reduction for Multiple Services

ASCO opposes HCFA's plan to reduce the payment for many procedures that are furnished on the same day as an office visit. Under HCFA's proposal, the practice expense component for procedures that do not have a global payment would be reduced by 50 percent if the physician also charges for a visit. This reduction is based on HCFA's assumption that there would be a substantial overlap of costs when multiple services are provided, but in reality any overlap would be far less than the 50 percent assumed by HCFA.

Oncologists frequently furnish visit services to a cancer patient on the same day as the patient receives chemotherapy. During the visit the physician examines the patient, deals with problems that have arisen, and makes plans for further treatment. The subsequent chemotherapy consists of the administration of anticancer agents and supportive drugs and hydration by specially trained nurses.

There is very little overlap between the costs of the visit and the costs of the chemotherapy. The cost of the staff time necessary to prepare and administer the drugs and the cost of the supplies involved in that process are not reduced in any respect because the physician saw the patient before the chemotherapy began. Nevertheless, under HCFA's proposal the practice expense component for the chemotherapy, which comprises almost the entire payment amount, would be reduced by 50 percent. Oncologists would not be able to carry on their practices with such reductions. Any cost overlap that exists is limited to minor administrative costs, such as the time necessary to make the patient's appointment for the multiple services. HCFA should not be permitted to endanger the provision of medical care to Medicare beneficiaries though large and arbitrary payment reductions.

Indirect Cost Allocation

ASCO is also concerned about the method selected by HCFA for allocation of indirect costs to particular services. HCFA has proposed to allocate indirect costs (such as rent, utilities, and certain equipment) to particular services based on the total of the direct practice expense costs, physician work relative value units, and malpractice relative value units associated with each service. In making this allocation, HCFA has proposed to use the assumption, based on data from the American Medical Association, that indirect costs are 45 percent of total practice expense costs.

Much of what oncologists do involves the provision of chemotherapy to patients. This service requires oncologists to incur considerable expense for items that HCFA considers indirect costs, such as extra space for the special chemotherapy chairs, space and a ventilator hood for mixing the toxic drugs, higher disposal costs for the chemotherapy-related waste, and so forth. Because chemotherapy administration is not considered to have a physician work component, however, it appears that

HCFA's methodology allocates relatively small amounts of indirect costs to chemotherapy services.

A number of observers have recommended that HCFA should consider the use of specialty-specific ratios instead of relying on the AMA's estimation that indirect costs constitute an average of 45 percent of costs for all physicians. ASCO urges that this approach should be evaluated as a possibly better means to recognize all of the indirect costs incurred by specialties, such as oncology, that frequently furnish services that do not involve physician work components.

Statement of the Medical Group Management Association

Mr. Chairman and Members of the Subcommittee, the Medical Group Management Association (MGMA) appreciates the opportunity to provide feedback on the General Accounting Office's (GAO) report "HCFA Can Improve Its Methods for Revising Physician Practice Expense Fees." MGMA is the oldest and largest association representing physician group practices with more than 8,900 health care organizations nationwide in which just under 200,000 physicians practice medicine. MGMA's membership reflects the diversity of physician organizational structures today, including large tax-exempt integrated delivery systems, taxable multispecialty clinics, small single specialty practices, hospital-based clinics, academic practice plans, integrated delivery systems, management services organizations, and physician practice management companies.

MGMA brings a particularly valuable perspective to the practice expense issue. In addition to regular discussions with the Health Care Financing Administration (HCFA), MGMA presented material at HCFA's indirect expense meeting and participated on the practice expense cross-specialty panel. As a research-oriented organization, MGMA has collected practice expense data since 1955. Our data collection involves group practices which range in size from two to several hundred physicians. As such, we understand the magnitude and complexity of HCFA's task. MGMA represents an equal proportion of managers and administrators working within the primary care and specialty care sectors. Consequently, we are well suited to focus solely on the research aspect without particular regard to one specialty or primary care. Finally, MGMA served as a technical consultant under a subcontract arrangement with Abt Associates which contracted with HCFA to gather practice expense data.

MGMA believes that the GAO successfully explored and presented the breadth and complexities of the practice expense relative value units (RVU) adjustment debate. We further commend GAO for its outreach to MGMA and others in the medical community. MGMA strongly supports GAO's recommendation that HCFA gather data from a limited number of physician practices to use as an external validity check; MGMA has been advocating this data collection throughout the process.

MGMA's comments today focus on two areas of the report: (1) the use of expert panels to derive practice expense data and (2) the consideration of how administrative costs should be allocated.

USE OF EXPERT PANELS

- GAO's "results in brief" indicates that HCFA's use of expert panels to estimate the direct labor and other direct practice expenses associated with medical services or procedures was an acceptable method. While MGMA understands that there are limitations to other methodologies, we continue to believe that the use of panels as the only means of data collection is not sufficient for the level of information required to adjust accurately the practice expense RVUs. As well versed as today's practicing physicians are in the business of medicine, their primary contribution is focused on the clinical rather than the managerial and administrative aspects of medical practices.
- It is important to note that, although the use of expert panels can be unscientific and potentially subjective, MGMA does not discourage the use of this process to derive additional information. In fact, our August 14, 1997 comments to HCFA state that the approach is useful to the extent that panelists have access to actual practice expense data. MGMA's concern with the panels has been the manner in which they were convened and conducted.
- I. To HCFA's credit, some of MGMA's concerns emanating from the Clinical Practice Expert Panels (CPEP) have been addressed. With each panel, the Agency demonstrated its willingness to address process concerns. Specifically, we commend HCFA for reaching out to practice administrators by providing MGMA with a slot

on the cross-specialty panel and by actively seeking feedback from other practice administrators who were observing that panel.

• Although improved over time, the panel process was fraught with shortcomings. MGMA remains concerned with the subjective process of establishing administrative and clinical time. The panelists, who were primarily practicing physicians, explicitly recognized their unfamiliarity with the day to day tasks of their office staff, especially administrative staff. Some of this uncertainty ("bias") could have been substantially diminished if the panelists were given the time and know-how to collect informal data from their practices prior to the convening of the panels.

• MGMA remains concerned about panel inconsistencies. Without the specific tasks associated with each staff explicitly spelled out for the panelists and until information is collected on the "typical patient" for each specialty, inconsistencies persisted. Furthermore, insufficient time was allotted to the process, thereby prohibiting panelists to fully explore each others' views and working together to identify and eliminate inconsistencies.

• With respect to the Department of Labor's wage rates, MGMA believes that a study should be conducted during the transition period to compare the actual medical practice compensation costs to the Department of Labor's figures. We believe that in some instances the role of staff may be undervalued for today's increasingly specialized responsibilities.

Allocation of Administrative Expenses

• Financial Management for Medical Groups, by Ernest J. Pavlock, PhD, CPA and published by MGMA's Center for Research in Ambulatory Health Care Administration (CRAHCA) defines a direct cost as one "that can be traced to or caused by a particular service, product, segment or activity of the practice. For example, there are direct costs of performing a particular procedure, making a product, or managing a department or an office" (emphasis added). On the other hand, an indirect cost is one "that cannot be traceable to a particular cost objectThey are costs necessary to be incurred to support the total practice. However, they are caused by two or more cost objects jointly but are not directly traceable to either individuallyIndirect costs are also referred to as 'overhead'."

• Medical group practices, like all other business practices, must have a detailed understanding of the direct and indirect costs incurred in medical care delivery. Prompt access to relevant and reliable financial information is critical to run an effective business. Without such information, it is virtually impossible to work in today's increasingly cost conscious environment.

• In recent months, there has been a push to consider billing and other administrative costs as indirect. MGMA understands that without actual service level practice expense data some may feel forced to consider such expenses indirect. As well versed as today's practicing physicians are in the business of medicine, their primary contribution is focused on clinical rather than the managerial and administrative aspects of medical practices. Hence, it is no wonder that the panels convened thus far were unable to come to closure on medical group administration.

• MGMA believes, however, the answer is not simply to allocate the costs into an undefined category. This expansion of the indirect cost category only makes it more difficult for practices to have a handle on specific costs and masks the proper accounting and economic analysis needed in this particular field. Instead, and particularly in light of GAO's report to Congress, MGMA encourages HCFA to convene a separate panel composed of managerial and billing staff to obtain task specific information. Only after gaining additional insights can HCFA begin to determine whether and which individual tasks may need to be shifted to the indirect category.

Conclusion

In closing, we would like to thank the Subcommittee for its continued interest in the practice expense issue and for working with the MGMA and the entire medical community to ensure that the adjustment of practice expense RVUs is based on sound scientific data.

Statement of Richard Anderson, President, Society of Thoracic Surgeons

The Society of Thoracic Surgeons and the American Association for Thoracic Surgery represent the board certified cardiac and thoracic surgeons of the United States. We are pleased to provide the following information and recommendations for consideration by the Ways & Means Committee on the very important and complex issue of revision of reimbursement for practice expenses under the Medicare Fee Schedule.

First, we wish to commend Congress and this committee for the decision last year to delay the implementation of resource-based practice expenses for one year and to direct the Health Care Financing Administration to develop a revised proposal for implementation in 1999 which would "recognize all staff, equipment, supplies and expenses, not just those which can be tied to specific procedures, and use actual data on ... key assumptions."

We are very concerned that the intent of Congress is not being followed. HCFA has gathered no new data and appears still not to recognize many critical staff costs.

I. Background: What Has Happened to the Allowed Charges for Heart and Lung Surgery

Reimbursement for open-heart surgery—coronary artery bypass and surgery and other complex heart procedures—has already been reduced sharply in the last ten years. The national Medicare average allowed charge for three-vessel by-pass and graft surgery was $3,781 in 1988; in 1998, it has been reduced to $2,512. Adjusted for inflation, the allowed charge today is $1802. That is, reimbursement for this lengthy and complicated procedure, where the life of the patient is at risk, has been reduced 34 percent in present dollars; in constant dollars—the real measure—the reduction is more than 50 percent.

The allowed charge for lobectomy—removal of a part of one lung for lung cancer or other diseases—has been reduced from $1,654 in 1988 to $1,071 today—a reduction of 15 percent in present dollars and over 39 percent in constant dollars.

HCFA's 1997 proposal would have reduced the allowed charges for these procedure by another 32 and 26 percent, respectively.

The following table illustrates the reductions which have already occurred over the ten years from 1988 to 1998 and the further effect last year's proposal would have had:

	CABG ×3 (CPT 33512)		Lobectomy (CPT 32480)	
	Current $	Constant 1988$	Current $	Constant 1988$
1988	$3,781	$3,781	$1,654	$1,654
1997	$2,831	$2,058	$1,518	$1,098
1998	$2,514	$1,802	$1,420	$1,005
June 1997 HCFA Proposal (at 1998 Conversion Factor)	$1,714	$1,230	$1,071	$768

II. Are the Present Work Values Correct?

We believe that the estimates from Professor Hsiao of the Harvard School of Public Health, on which the work values were based, significantly undervalued the time required for pre and post-surgical services and underestimated both the difficulty and intensity of advanced surgical procedures on the heart and lungs.

We do not make this assertion lightly. In 1991 the Society of Thoracic Surgeons undertook an extensive study, through Abt Associates, of the time and work required for cardiac and thoracic surgery. This methodology was essentially identical to that used by Professor Hsiao, but with a larger data base. The design and methodology of this study were reviewed with HCFA before the study began and its objectivity assured by an independent review panel.

The conclusion was that major cardiac surgery procedures had been undervalued by 43 percent and many thoracic surgery procedures by 20 percent. This data was

submitted to HCFA with a request that it be utilized in final decisions or, at the very least, that the Hsiao study of these procedures be reexamined.

HCFA ignored both this data on work values and our request for restudy.

These extreme reductions in reimbursement for cardiac and thoracic surgery are occurring at a time when the average age of our patients is increasing; when complicating factors, such as prior angioplasty or comorbid conditions are more prevalent; and when hospitals have shifted costs onto surgeons. Despite these changes, cardiac and thoracic surgeons have continued to treat Medicare patients without differentiation. We do not even inquire into the insurance status of our patients. The undervaluation of work has up to this time been compensated by adequate reimbursement for practice expenses. Full reimbursement for practice expenses has been and remains essential.

III. "Opportunity Cost"

Cardiac and thoracic surgeons spend a minimum of seven years in training after medical school—longer than any other medical specialty and four years longer than family practitioners. Most cardiac and thoracic surgeons are well into their thirties before they begin practice, and many have incurred substantial debt to complete their education. Because the work is physically demanding, their work lives are also shorter than those of general medical practitioners.

In developing the concept which led to the "resource based relative value fee system" Professor Hsiao and his colleagues originally recommended including an adjustment for the value of the time lost in training—"opportunity cost" in the economists' phrase. Professor Hsiao and his colleagues estimated the amortized value of the opportunity cost of specialty training for cardiac and thoracic surgery at 9.16 percent and for general family practice at 3.52 percent. When put on a relative scale, the opportunity cost factor for cardiac and thoracic surgery was 1.05, for family practice 0.99 (JAMA, October 28, 1988).

In simplifying the RBRVS system for implementation, this opportunity cost adjustment was lost. Allowed charges for cardiac and thoracic surgery are now, therefore, six percent less than they should have been if only the time lost in training (not counting the shorter work life at the end of practice) had been recognized. We request that the original recommendation of the Harvard School of Public Health that work values be adjusted for the "opportunity cost" of advanced training be reinstated and that no further adjustment be made to the fee schedule until this is done.

IV. The Practice Cost Dilemma

In this context we approach the valuation—or revaluation—of practice costs. As the committee knows, these practice expense allowances were originally set through a formula based on historical allowed charges—those essentially set in the free market, paid by commercial insurers.

Our information shows that the current practice expense reimbursement is within ten percent of the actual practice costs incurred by cardiac and thoracic surgeons at the present time.

The American Medical Association Socioeconomic Survey shows mean practice costs for "other surgeons"—which includes cardiac and thoracic surgeons—at $252,000 per surgeon. Research we have done -and we are now undertaking a larger survey to provide more definitive information -has shown average practice expenses among our specialty of approximately $244,000.

Present practice cost reimbursement, under the 1998 fee schedule, for a cardiac surgeon who performs 200 major operations a year, with an additional 200 consults and another 200 chargeable office visits is $ 259,600 per year—within six percent of our best present information on mean actual costs.

V. Last Year's HCFA Proposal

HCFA's June 1997 proposal would have reduced practice expense reimbursement for a three-vessel bypass to $398; for a partial lung removal to $280; and for a heart transplant to $620. These were HCFA's estimates at that time of the correct allowance for all practice expenses incurred by the cardiac or thoracic surgeon, not just for the hours required for the operation and the days of hospitalization, and all other services provided in the full 90 day global period. (For a heart transplant, these allowances would also have to cover the time of the transplant coordinator, which often extends to six months before the transplant surgery is performed.)

Total practice expense reimbursement for the cardiac surgeon with the case load outlined above, under this proposal, would have dropped to $92,500 -about 38 percent of actual costs.

For comparison, the AMA Socioeconomic Survey shows that the mean practice expenses for a general family practitioner are $170,400 a year. Under the HCFA proposal, practice expense reimbursement for a general family practitioner with a case load of 6000 office visits a year (an average of 24 patients a day for 20 minute patient encounters) would be $170,000 a year -full practice expense reimbursement.

These above comparisons are approximate, and should be refined. The wide differential in the ratio of actual costs to proposed reimbursement clearly indicates that, however, the 1997 HCFA proposal was poorly constructed. Validation of any new proposal against the actual practice costs -at the very least, spot-sampling of actual total practice costs incurred by specialties -is essential before any radical changes are made in the Medicare Fee Schedule. We are pleased that the General Accounting Office has recommended such sampling to check the validity of HCFA's estimates.

This committee last year heard some very misleading statements about the practice costs of cardiac surgery. One statement compared practice expense reimbursement for an office visit to that for open heart surgery which "requires only a few hours of surgeon's time."

The reality is that reimbursement for surgery covers 90 days of service to the patient—in the operating room, in the hospital before and after surgery, and for the remaining time, within 90 days, after hospital discharge. Surgeons, unlike many other practitioners, do not charge for repeat visits within the 90 day global period. Thus the service provided to a cardiac surgical patient should not be compared to that for a 15 minute office visit.

VI. Do We Still Need Heart and Lung Surgeons?

This committee also heard last year a statement that the need for cardiac surgery—and other advanced cardiac care—is diminishing because of the improved general medical care provided since fees for primary care services were raised. HCFA has apparently accepted this assertion and is implementing physician payment reform as though increasing reimbursement for general medical care might bring about both a reduction in the cost of care and in the incidence of serious heart and lung disease requiring surgical treatment by specialists. This is not only a badly mistaken assumption, as described below, but goes well beyond Congressional intent for a relative value based payment system.

The number of primary care office visits paid for by Medicare has increased significantly since the RBRVS came into effect. Unfortunately, this has not resulted in a decrease in the incidence of heart disease nor in the need for advanced treatments, such as those provided by cardiac, thoracic, and other surgeons.

Heart disease remains the leading cause of death in the United States. Despite advances in medical care and the introduction of invasive cardiology procedures which delay and sometimes replace the need for heart surgery, about 300,000 Americans are referred by cardiologists for heart surgery every year. (Over 50 percent are Medicare patients.)

In an aging population, the prevalence of heart disease is increasing and, with that, the need for advanced medical and surgical treatment. The real story in heart disease is not that we have been able to decrease its incidence but rather that we are constantly improving the likelihood of long-term survival after a diagnosis of heart disease and even after a heart attack. This improvement in survival is the result of improvements in the total spectrum of specialized cardiac care, including that provided by both cardiologists and cardiac surgeons.

We would emphasize that cardiac surgeons have no control over their case volume. Patients are referred to us by other physicians, who have determined that their patients need surgery. We do not, and cannot, control our own volume—only our results, of which we are proud.

VII. What Would Happen to Access Under the HCFA Proposal?

At present there are no serious problems for Medicare patients to access to either general medical or specialty care. However, one must question what would be the effect upon Medicare patients with heart or lung disease if a redistribution of reimbursement from specialty care to general medical care of the magnitude proposed by HCFA were implemented.

Cardiac and thoracic surgeons do not currently distinguish between Medicare and other patients. We typically do not even know the insurance status of the majority of our patients (billing and preauthorization are handled by office staff). We treat

the uninsured or underinsured the same as private pay patients. Our commitment is to treat patients irrespective of their ability to pay.

However, the impact of reductions in reimbursement that even approach the magnitude discussed above would be substantial. Thirty-one percent of the practicing cardiac and thoracic surgeons in the U.S. are 55 years of age or older. These are the most experienced and capable individuals in our profession. If a large number of these surgeons retire, and many are already doing so, the work force may not be sufficient to treat the anticipated increase in the number of Americans who are over age 55. (As noted above, there is no evidence that improvement in preventive or other non-specialty care is reducing the need for surgery or other advanced medical procedures. The need is largely age-driven).

Because of the long lead time involved in training heart and lug surgeons, a four-year phase in of a bad proposal would not prevent the damage to the specialty of cardiac and thoracic surgery. The incentives put in place now will determine to a great extent the supply of cardiac and thoracic surgeons four and ten years from now.

Years of strenuous advanced training are essential in our profession. The early sacrifices are significant. At these reduced rates of reimbursement, will the most talented individuals—both intellectually acute and gifted with the essential hand coordination—enter into this profession?

We do not know the answer. We do know that in Canada and in some European countries, shortages of cardiac surgeons have resulted in waiting lists for operations which are currently performed in the United States as soon as the decision is made for surgery and that some patients die before they are scheduled. The General Accounting Office is correct in warning that changes in reimbursement of the significance proposed could affect coverage for Medicare beneficiaries and the quality of care that physicians are able to provide.

VIII. What has HCFA done since Passage of the Balanced Budget Act?

Since passage of the Balanced Budget Act, HCFA has held three meetings with physicians and convened one panel to discuss ways of allocating indirect costs.

They have probably met the mandate of the Balanced Budget Act that they "consult with physician organizations." But that is all. No new data or information has been gathered. We do not know what changes they intend to make in their methodology, or their means of extrapolating from the limited, and somewhat uncertain, information they now have.

The General Accounting Office has confirmed our belief that there are significant flaws and omissions in HCFA's methodology and that HCFA has not yet stated how it intends to correct these errors.

HCFA does not have, and apparently has no intention of collecting, information on what physician's real practice costs are. Without, at a minimum, spot-checking the validity of the estimates they are now working from (as GAO has recommended), economists tell us they cannot meet the mandate of developing a rule based on generally accepted accounting principles. (Even if it is conceded that the panel estimates on direct costs are an acceptable starting point, there is no justification for the manipulations HCFA made to the panel data; nor is there a way to allocate indirect costs from direct costs, without reliable information on total costs from which to determine the magnitude of indirect costs).

Without accurate information on total costs, HCFA was not, and still is not, able to determine total indirect costs, the ratio of direct to indirect costs, or the allocation of costs to individual procedures.

HCFA's methodology—starting with estimates (not measurements) of direct costs, then developing a theoretical ratio of indirect to direct costs from an overall pool without recognition of differences in this ratio between specialties, and then allocating the presumed pool of indirect costs to procedures by formulae rather than data, lacks the basic grounding in empirical information required. While the subsequent validation panels have to some degree refined the estimates of direct costs, these revisions have not cured the basic methodological flaw: the absence of empirical data.

IX. The Use of Physician-employed Staff in Hospitals

Some analyses of practice costs seem to assume that physicians who practice primarily in a hospital setting have few practice costs. The assumption seems to be that when a surgeon goes to the hospital, he or she turns out the lights, puts the telephone on message recording, and puts the staff on unpaid leave.

The reality, of course, is that our staffs are working in the office while we are in the hospital. Staff must be there to take calls from patients, to triage emergency

calls, to handle all the preauthorization, insurance billing and other administrative work of an office, at all times. HCFA staff or its research contractors are welcome to visit without appointment, at our members' offices, at any time.

But there is an additional, very important expense. Within the last five years it has become common for physicians providing highly-skilled and high intensity critical services such as heart and lung surgery to employ their own staff to assist in patient care in hospitals.

There are two reasons for this. First, under the cost-saving pressures of managed care and the hospital DRG payment system, hospitals have reduced both the number and the skill levels of hospital staff.

Second, and most important, advances in the technology and the quality control required for complex surgery have made it more important than ever that the surgical team function as a coordinated unit, not as an assemblage of individuals. Surgeons work most effectively and most safely with nurses and operating assistants who work with them consistently. Prospective payment through DRGs has caused hospitals to encourage early discharge of patients. Thoracic surgeons have worked with their hospitals to find safe and effective ways to shorten hospital length of stay which, in the past 8 years, has decreased dramatically for all patients following heart and lung surgery. However, with earlier discharge from the hospital, care responsibilities have been shifted from the hospital to the surgeon's office. Consequently, more nurses have been hired to maintain postoperative surveillance and contact with patients and to assist the surgeon during an additional number of office visits during the early part of the 90 global period. Thus far, surgeons have absorbed these new practice expenses. The drastic reductions in practice expense proposed by HCFA will result in the curtailment of these services and place the quality of care in jeopardy.

The mortality rate for coronary artery bypass surgery has declined from 4.5 percent in 1987 to 2.9 percent in 1996, at a time when the average age of the patients and the severity of their disease and comorbid factors have increased. The skill and unity of the operating team is a major factor in obtaining and maintaining quality at this level.

One issue is accountability; the surgeon is clearly and solely responsible for the selection, training, and supervision of clinical staff when they are his staff. Lines of responsibility are more diffuse if the clinical staff are employed by the hospital. Second is predis critical for all surgeons, but notably for those who, as is common, have operating privileges at more than one hospital. The surgeon must take his or her own team from one hospital to the next to maintain quality.

These clinical staff members from the surgeon's team typically work not only in the operating room, but with the patient in the hospital delivering both pre and post-operative care. This is particularly important in the intensive care unit and in the first several days post-operatively, when the patient must be carefully monitored and the surgeon notified immediately of any complication.

For these reasons, the majority of cardiac surgeons, both in university teaching hospitals and non-teaching hospitals, and a significant, and growing, number of general thoracic surgeons now employ their own clinical staff who work in with them in hospitals as well as in the office. These staff members include both physician assistants and skilled clinical nurses.

We do not have data on the number of clinical nurses who work with our members in hospitals. (We would be willing to survey membership as part of a private-public data-gathering effort.) Data on the employment of physician assistants in surgery are, however, available from surveys of The American Association of Physician Assistants and the Association of Physician Assistants in Cardiovascular Surgery.

The AAPA has estimated that 1,002 of the 31,300 practicing physician assistants in clinical practice specialize in cardiothoracic surgery. A cardiothoracic PA will assist in the care of 180–250 patients a year. This leads to the conclusion that PAs alone (not counting other clinical staff employed by surgeons) are involved in at least 200,000 cardiac cases a year.

The APACVS survey shows that 72 percent of the PAs employed in cardiovascular surgery are employed by solo or group physician practices. An undetermined number of the remaining 28 percent, who work in university teaching hospitals, are in actuality employed by the university clinical practice plan.

Data recently submitted to HCFA from the American College of Surgeons also show that 71 percent of the cardiac and 62 percent of the general thoracic practices pay for staff who work with them in non-office settings.

Data included in the APACVS survey show that virtually all of those PAs have responsibilities in the operating room. More than 85 percent have follow-up assign-

ments with those patients in critical care and other hospital postoperative care as long as these patients are in the hospital.

This data has been submitted to HCFA and, most recently, to the General Accounting Office, which has concluded that "there may have been a shift in hospital and physician practices that Medicare has not recognized in its methods for reimbursing nonphysician clinical labor expenses." We urge the Committee to monitor this issue closely, as the failure to consider these costs in any revision of practice expenses could have a severe impact on quality.

HCFA several times has noted that there is separate reimbursement for services provided by PAs as assistants at surgery. This reimbursement is not, however, available for PAs who work in the 110 teaching hospitals. Even where this reimbursement is available, it covers only the services in the operating room, not the additional services pre- and post-operatively. Of course, there is no separate reimbursement for the nurses or other clinical personnel who also work with surgeons in the hospital.

Adequate recognition of the cost of these personnel to physicians must be recognized. This is a matter not just of equity, but of quality. We intend to maintain the record of quality which has reduced mortality in CABG to current levels—we intend in fact to improve further. We do not believe HCFA should ask us to turn back to standards of care which we now know are unacceptable.

X. Development of Interim Values for 1998

It is now obvious that HCFA will not be able to meet the Congressional directive and the present deadline of May 1998 for development of a new practice expense proposal using, "to the maximum extent practicable, generally accepted accounting principles." Any expectation that it might be possible to meet this requirement through refinement of existing data should have been dispelled by the inability of the cross-specialty panel meetings December 15 and 16 to reach agreement on any point other than this one: that any extrapolations of indirect expenses should start with specialty-specific data.

The data and information now available is not sufficient to provide the basis for any rule which would significantly revise the present Medicare Fee Schedule. In addition to the lack of data on total costs by specialty, the information from the validation panels and the cross-specialty meeting has shown conclusively that the linkage of CPEP data according to the E&M codes and other revisions to CPEP estimates made in developing the June proposal were based on assumptions, not data.

We hope that HCFA will recognize and communicate to Congress its need for additional time to meet the Congressional mandate. This should be preferable, for all parties, to presenting Congress and the medical community, in May 1998, with a proposal which clearly does not meet the statutory mandate.

If Congress and HCFA believe that HCFA should keep to the current timetable, it is essential that HCFA correct at least the most obvious flaws in the methodology used and utilize the best data now available—the AMA Socioeconomc Survey—to validate its assumptions. The Practice Expense Coalition, of which we are a member, has provided HCFA with recommendations, prepared by Coopers & Lybrand, to develop such interim values.

In light of the weakness of the data now available and the serious questions which remain over methodology, HCFA should be careful not to propose changes in reimbursement this year which would have inevitable consequences on the future supply of skilled specialists. As noted above, the long lead time required to maintain an adequate work force means that consequences will flow from an ill-advised decision, even under the presumed softening of the four-year transition. Given the reductions that have already occurred over the past ten years, as well as the erosion expected in the medical conversion factor, we recommend that any further reduction in the allowed charge for advanced medical procedures be limited to a maximum of ten percent.

Conclusion

We recognize the difficulty and complexity of the tasks facing HCFA in developing a new practice expense proposal and in refining other components of the fee schedule to provide equity and justice, and to maintain the quality of medical care, particularly as this pertains to highly-advanced specialty care. The current practice expense proposal, compounding the other faults of the RBRVS system, would clearly lead to marketplace distortions within medicine, negatively affecting Medicare patients. Surgeons cannot practice if their expenses, including those of malpractice insurance, are not met. Practicing physicians will be driven from practice and fewer medical students will choose the additional years of training needed to qualify for

advanced surgical practice. With the continued aging of our population, the need for specialty care will not diminish; primary care, however well practiced, will not prevent the inevitable diseases of aging. Reduced access to specialty care is not the solution to the problem.

The Society of Thoracic Surgeons and the American Association for Thoracic Surgery pledge to work cooperatively with both HCFA and the Congress as we address the complex issues of providing quality health care to our aging population.