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REVISING PHYSICIAN PRACTICE EXPENSE PAYMENTS

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

SPECIAL HEARING

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REVISING PHYSICIAN PRACTICE EXPENSE PAYMENTS

TUESDAY, MARCH 10, 1998

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 3:30 p.m., in room SD–192, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.

Present: Senator Specter.

NONDEPARTMENTAL WITNESSES

STATEMENT OF NEIL H. BROOKS, M.D., PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

OPENING REMARKS OF SENATOR SPECTER

Senator SPECTER. Ms. DeParle, if you would come up, along with Dr. Brooks, Dr. Day, Dr. Gardner, and Dr. Nelson. All of your statements will be made part of the record.

On the Senate floor at this moment we have the transportation bill, and my amendment is now pending on reverse commuting—and may we have order in the Chamber, please—and I have to go to the Senate floor, so we will recess for just a few minutes and I will return as promptly as I can.

[A brief recess was taken.]

Senator SPECTER. We will now proceed with the hearing.

Just a word or two of explanation. The ISTEA bill, the so-called transportation mass transit bill is on the Senate floor right now, and they were about to close down the section on mass transit. I had an amendment which provided for reverse commuting to take people from the inner city to the suburbs and that required my attention.

Well, then they had a very important meeting on the House side which I just went and gave three words of support and came back here, but this is one of the problems of roller skates in the Senate, and I am sorry to have kept you all waiting here. I hear you have been told, due to the lateness of the hour, that your time might be cut to 3 or 4 minutes. Well, it has been reinstated to 5 minutes since you had to wait, 2 minutes is not a whole lot, but it is something.

So let us begin first with the medical panel, if we may.

SUMMARY STATEMENT OF DR. NEAL BROOKS

Dr. Neal Brooks, president of the American Academy of Family Physicians, you are at the top of the list. Dr. Brooks, the floor is yours.

Dr. BROOKS. Good afternoon, Mr. Chairman, I am Neil Brooks, a practicing family physician from Rockville, CT, president of the 85,000 member Academy of Family Physicians. I thank you for inviting us to testify.

The balanced budget law requires that a resource-based method for Medicare practice cost payments be in place by the year 2002, a decade after the physician fee schedule first took effect.

Between now and then we should be focused on creating a system that best serves the beneficiaries instead of having providers battle over fees. Family physicians recognize the unique role of our subspecialty colleagues. To be good family doctors we need to consult with subspecialists and refer our patients to them, but we are concerned about access to services as well, but a strong primary care base is also needed to have balanced health care.

I believe that full implementation of the fee schedule will be good for everyone and eventually improve access to medical services. This is why a switch to resource-based practice expense payments in the fee schedule is a compelling and urgent one. Practice expenses are more than 52 percent of the average family physician's fees. In my own practice it exceeds 60 percent. If we want more medical students to elect primary care specialties and want them to participate in Medicare, we need to be sure that Medicare pays primary care fairly.

Last June, HCFA published a proposal for a new practice expense method. The GAO released a report last month on the HCFA plan. The academy is pleased with this report for several reasons.

First, GAO says the HCFA proposal is acceptable and reasonable. We agree. A lot of time and effort has gone into putting it together.

In 1996 direct practice costs for labor, equipment, supplies, for hundreds of medical services were obtained from physicians, nonphysician providers, and practice administrators on panels called CPEP's.

Last fall, an entirely new group of experts reexamined the CPEP data, and then a cross-specialty panel studied the highest volume and highest cost services. These groups were representative of physicians whose direct expenses were being studied. The resulting data has the combined experience of all the members of the expert panels to back it up.

Second, GAO dismisses the idea of replacing the CPEP data with data gathered by alternative methods. Like GAO, we believe the alternatives would increase the costs of developing a new method while needlessly delaying implementation.

Third, GAO recommends that HCFA monitor the impact of the proposal on access to services, especially those with the largest reduction in payments. We believe that HCFA's monitoring access would be more balanced if improvements in obtaining primary care services that result from the new method are also reported.

And fourth, and most importantly, the GAO confirms that the HCFA proposal meets the requirements of the balanced budget law. It is clear that the Government's principal accounting agency has validated HCFA's proposal and that the GAO report should lay to rest criticisms that it is fatally flawed.

The GAO concludes that HCFA is on the right track, and we could not agree more. As good as HCFA's work is, though, however, the proposal could be improved by striking two controversial provisions. The behavioral offset should be removed from the proposal. Any changes in the physician behavior will be taken care of by the new sustainable growth factor of the fee schedule. This is supported by the Medicare Payment Advisory Commission and AMA.

We also request HCFA to delay a 50-percent reduction in practice expense payments for procedures done at the same time as an office visit. There is no evidence for this large reduction. It has the potential for having physicians fail to offer preventive services such as cancer screening concurrent with an office visit. It is a disincentive to the provision of good medical and preventive care. I do not believe that is HCFA's intent.

We urge HCFA to delay this reduction and work instead on gathering procedure-specific data so the appropriate practice expense reductions in these situations can be made.

PREPARED STATEMENT

In closing, thanks for the opportunity to speak for family physicians, and helping to ensure that we can deliver the best in medical services to our patients.

I will be glad to answer any questions.

Senator SPECTER. Thank you very much, Dr. Brooks.

[The statement follows:]

PREPARED STATEMENT OF DR. NEIL H. BROOKS

INTRODUCTION

My name is Neil H. Brooks, M.D. I am the President of the 85,000-member American Academy of Family Physicians. 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 examined in reports that Congress received last week from the Medicare Payment Advisory Commission (MedPAC) and the General Accounting Office (GAO).

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 (RVU's) for each procedure. These RVU's 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 RVU's for malpractice costs, but has substantially completed the process of establishing resource-based RVU's 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 report we have reviewed.

Establishing resource-based RVU's for the practice expense and malpractice components of the Medicare physician fee schedule is lagging behind schedule. All physician work RVU's 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 RVU's. 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 RVU's 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 RVU's 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 RVU's 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 RVU's 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 undervalued 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 pleased with the 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. The report thoroughly analyzes the complicated topic of Medicare practice expense payments, the HCFA proposal and 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 (CPEP's) 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." It should be noted that the Physician Payment Review Commission also supports the HCFA approach for gathering direct expense data for the development of resource-based practice expense RVU's. The Academy concurs with these assessments 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 there may be a need to gather a small amount of additional data through a limited survey to 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 RVU's. 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 RVU's 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 preferable to 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 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.

The Academy is supportive of HCFA's proposed linking formula. If other methods for normalizing the direct practice expense data are considered, we believe they should be thoroughly reviewed. 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 opposed by family physicians.

The report also recommends that HCFA consider certain improvements in its methodology, including the use of "scaling" to match aggregate CPEP data with data from the AMA's 1996 SMS survey, 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 med-

ical 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 0.39, 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 believes that scaling is necessary so that HCFA has an external benchmark to ensure that labor, supply and equipment costs are appropriately apportioned among the total RVU's for direct practice expenses. As the Academy commented last year, we are not convinced that scaling adds value, especially given the credibility of the CPEP data. We would, however, support the use of scaling to the extent that it can be shown to add value or greater accuracy to the overall HCFA formula for determining resource-based practice expense RVU's.

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 RVU's to the available pool of RVU's on the basis of the percentage of direct and indirect practice expense RVU's 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 been addressed by the Academy.

The GAO recommends that HCFA determine whether practice expense payments are warranted in situations where physicians bring their clinical staff into the hospital setting. GAO said there is no evidence that utilizing staff in this fashion is a common practice at this time. The Academy agrees. Any claims about using clinical staff in the hospital should be subjected to external review and validation. Even if such practices are 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 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 mentioned in the 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 RVU's 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, a position supported by the AMA and MedPAC. 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 RVU's 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 RVU's justifies the proposed 50 percent reduction.

In the short term, HCFA would simply reduce the practice expense RVU's 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 RVU's 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 RVU's 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 RVU's 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

The movement to resource-based practice expense RVU's began this year with a $330 million ''down payment'' for office-based procedures. It seems to us that the increase in 1998 practice expense RVU's for office visits is supposed to be blended with the new, resource-based practice expense RVU's 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 RVU's for office visits would be blended with resource-based practice expense RVU's for office visits beginning in 1999.

It has come to our attention that some medical specialties are urging HCFA to re-interpret the law with respect to the base year for the transition period. That is, using the 1997 practice expense RVU's instead of the 1998 down payment-adjusted practice expense RVU's as the base amount for the blend during the four-year transition period is being advanced at this time. This interpretation defies logic and would lower overall payments for office visit services from what they would be oth-

erwise 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 RVU's 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. However, if a revision such as the one proposed were accepted by HCFA, it would re-open 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 one message from my comments, let it be this: the practice expense issue does not need to be re-opened legislatively. HCFA is on the right track, according to the GAO. 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF HON. NANCY ANN MIN DePARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

ACCOMPANIED BY DR. BART McCANN, CHIEF MEDICAL OFFICER

Senator SPECTER. Ms. DeParle, the floor is yours.

Ms. DEPARLE. Thank you, Mr. Chairman. I appreciate the opportunity to be here today to discuss resource-based practice expenses under the Medicare physician fee schedule.

With me today is Dr. Bart McCann, the Chief Medical Officer who has led our practice expense efforts. He is a family physician who trained at Children's Hospital in Pittsburgh before joining the Public Health Service.

Practice expenses, as you know, Mr. Chairman, are a resource input such as the physician's clinical and administrative staff, rent, equipment, and supplies. In 1994, Congress passed legislation requiring HCFA to implement a resource-based practice expense relative value system in order to create a more equitable system for Medicare physician payment that better reflects the relative overhead expenses involved in furnishing a service.

Today, Mr. Chairman, I would like to give you an update on our implementation efforts. As mandated by the Balanced Budget Act, we are working toward a May 1 implementation date of a proposed rule. We are still analyzing data, input, and comments from many specialty societies, including those represented here today. We are also considering the recommendations made in the recent GAO report.

Converting the current system based on historic cost to one based on relative resources has been very challenging. Each year, Medicare pays about 500,000 physicians more than $40 billion for more than 6,000 different procedure codes. Average practice expenses represent about 41 percent of the total relative value for a service, or $16 billion of Medicare's total physician spending.

Our task is to establish relative values for the more than 6,000 services involved, even though data are not readily available for each service. Because the law requires the system be implemented in a budget-neutral manner, there will also be redistributions. In other words, increases for some procedures will result in decreases for others.

I want to emphasize that the new system will reflect the relative practice expense resources involved with furnishing physician's services. The new system is not a cost reimbursement system.

We have sought and encouraged the participation of the medical community in virtually every step along the way. We have consulted with hundreds of representatives of medical specialty groups. We will continue to do so.

As you know, on June 18 of last year HCFA published a proposed rule in the Federal Register announcing the proposed relative value units for practice expenses. The publication of the proposed rule elicited strong reactions. Generally speaking, family practitioners and other primary care physicians had been supportive of the approach that HCFA took. However, most surgeons and many medical specialties have challenged many aspects of our proposal.

The Balanced Budget Act made several changes in how Medicare will pay for physician practice expenses, including, importantly, delaying the implementation until 1999 and providing for a 4-year transition.

The Balanced Budget Act requires that we publish a notice in the Federal Register by May 1 and provide a 90-day comment period, and we are on track to do that right now.

One message of the Balanced Budget Act was that Congress wanted us to do more consulting with doctors, and we have done that, Mr. Chairman. We met with physician groups in October, November, and December 1997 on these issues.

In October, we hosted 17 medical specialty panels charged with validating some of the direct expense data generated through the original panel process used for our June 18 notice. Members of the panels were nominated by their specialty societies, and I think that Dr. Brooks has referred to some of that activity today.

On November 21, we held a forum on indirect practice expenses. Again, all major specialty societies were invited to send representatives, and the comments that we received were both constructive and informative.

And then on December 15 and 16 we again hosted a single cross-specialty panel with the objective to understand the differences in the way specialties provide common administrative functions such as billing and scheduling.

On October 31 of this year, through a Federal Register notice, we again solicited comments from the physician community on a wide variety of key data and methodological issues, including generally

accepted accounting principles, equipment utilization, physician-employed staff, and the refinement process.

The Balanced Budget Act, as you know, also requested an independent review and evaluation by GAO and, as Dr. Brooks has testified already GAO has supported the key elements of the methodology that we used. As we develop our May 1 proposed rule, we are carefully reviewing and considering each of GAO's recommendations.

PREPARED STATEMENT

Mr. Chairman, we are working very hard to analyze the data, including comments that we have received, and considering the recommendations that GAO has made, and we look forward to working with you and with the members of the subcommittee as we develop our May 1 proposed rule.

Thank you very much.

Senator SPECTER. Thank you, Ms. DeParle.

[The statement follows:]

PREPARED STATEMENT OF NANCY ANN MIN DEPARLE

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to be here today to discuss resource-based practice expenses under the Medicare physician fee schedule. Research performed by the Physician Payment Review Commission (PPRC) and recommendations made in their 1993 Annual Report to the Congress documented the need to change the current practice expense system and the significant redistributions that would occur under a new system. Following the PPRC recommendations, Congress passed legislation requiring HCFA to implement a resource-based practice expense relative value system beginning in 1998. The intent of the new system is to create a more equitable system for physician reimbursement which better reflects the relative practice expense resources involved in furnishing a service.

As you know, last June 18th, we published a proposed rule. The Balanced Budget Act delayed the new system for one year and made a number of other changes in resource-based practice expenses, including a report to Congress from the Secretary and publication of a new proposed rule by May 1, 1998.

Today, I will review our efforts since the passage of the Balanced Budget Act. We are busily working on development of the May 1st rule. At this point, we are still analyzing data, input and comments that we received during the activities I will describe later and considering the recommendations made in the just released GAO report. Since our new proposed rule is currently under development, I do not have details and specifics to discuss with you today.

BACKGROUND

Medicare spends about $40 billion annually for physicians' services. We pay for more than 6,000 different procedure codes under the physician fee schedule. These services are provided by more than 500,000 physicians and practitioners in settings as diverse as physician's offices, hospitals, ambulatory surgical centers, and nursing homes.

Medicare's physician fee schedule established relative values for three components of each physician's service: physician work, practice expenses and malpractice insurance. The sum of these three components represents the total relative value for a service; this total relative value is used in conjunction with a conversion factor to establish the Medicare fee schedule amount for the service. The relative size of the three components varies for each service, but on average, physician work represents 54 percent of the overall relative value, practice expenses 41 percent and malpractice insurance 5 percent. Practice expenses include resource inputs such as a physician's staff (both clinical and administrative), rent, equipment and supplies.

The relative values for physician work have been resource-based since the inception of the fee schedule in 1992. The relative values for physician work are based on physicians' estimates of the physician time and effort needed to perform a serv-

ice. Practice expense and malpractice expense relative value units (RVU's), however, currently are based on allowed charges under the old reasonable charge system of paying physicians. Relative values for these components thus largely reflect historical charges, without a direct and explicit relationship to resources used.

One example of the inequity in the current system can be seen by comparing practice expense RVU's that Medicare currently pays for the most common office visit and for triple by-pass surgery. Under the existing system, Medicare pays almost 100 times more for the physician's practice expense (overhead) for a by-pass surgery than for an office visit. In other words, a physician practicing in an office would have to do almost 100 office visits to receive the same payment for practice expenses as a surgeon performing one by-pass surgery in a hospital. Most observers would agree that the "relative" values for practice expense is out of line for both services.

The Balanced Budget Act requires that malpractice expense relative value units be converted to a new system beginning in 2000. The Balanced Budget Act also requires that practice expense RVU's be converted to a resource-based system beginning on January 1, 1999.

Converting the charge-based system to a resource-based system has been quite challenging. We must establish relative values for the large number of services involved, but practice expense data are not readily available for each service.

In addition, the law requires that we establish resource-based practice expense relative values in a budget-neutral manner. In other words, the total Medicare payments for practice expenses prior to the changeover to resource-based values should be the same as the payments under the new system. This necessarily involves a redistribution of payments across services; to the extent that there are increases in values for some services, others will decrease.

I want to emphasize that new resource-based relative values for practice expense reflect the relative practice expense resources involved with furnishing physicians' services. The new system is not a cost reimbursement system.

Since we started to develop the new system, we have sought and encouraged the participation of the medical community in virtually every step along the way. We will continue to actively encourage the participation of the medical profession and others who have a stake in the physician fee schedule as we proceed with our proposal. I have attached to my testimony the Appendix to our Report to Congress which contains a list of the major physician and other groups with whom we have consulted.

LAST YEAR'S PROPOSED RULE

As you know, on June 18, 1997, we published a proposed rule in the Federal Register announcing our proposed relative value units for practice expenses. Using the traditional accounting concepts of direct and indirect costing, we segmented the project into two parts, one involving direct costs, the other involving indirect costs.

For direct costs, we used a contractor to convene panels of physicians and others knowledgeable about how services are provided to present information on direct cost inputs, i.e., the time it takes various clinical and administrative staff to assist the physician in providing the service. The panels also provided information on the types of supplies and equipment used in providing services.

The second part of the project involved indirect costs. We needed to allocate the remaining resources, indirect expenses, to specific procedures in order to arrive at a total practice expense relative value for the service. This process was initially to be accomplished through a survey of physician practices. However, due to the very low response rate to this survey, we instead relied on existing data sources to allocate indirect expenses. The data source we used was the information gathered by the American Medical Association through surveys of its members.

Needless to say, the publication of the June 18 Notice resulted in strong opinions about our methodology, assumptions, and approach. Generally speaking, family practitioners, and other primary care physicians have been supportive of our approach. However, most surgeons and many medical specialties have challenged many aspects of our proposal. Many of the physicians and groups which were adversely affected by our proposal criticized our methodology as flawed and suggested alternatives. Some of the alternatives would have required abandoning the panel process of gathering data in favor of a brand new data gathering activity.

THE BALANCED BUDGET ACT AND OUR CONSULTATIONS WITH PHYSICIANS

I would like to describe some of the recent key events of this project. As you know, the Balanced Budget Act (BBA) made several changes in how Medicare will pay for physician practice expenses. The BBA delayed the implementation of a resource-based relative value practice expense for one year. The BBA also allowed for a four-

year transition to the new system beginning January 1, 1999. The Balanced Budget Act required that we publish a notice in the Federal Register by May 1 and provide a 90 day comment period, which is 30 days longer than our usual comment period for the annual physician fee schedule regulation.

The Balanced Budget Act requires us, to the maximum extent practicable, to use generally accepted cost accounting principles which recognize all staff, equipment, supplies, and expenses and to use actual data on equipment utilization, etc. The Balanced Budget Act also requires that we consult with organizations representing physicians on our methodology and to develop a refinement process to be used during each year of the transition period.

On October 31, 1997, we published a Notice of Intent to regulate in the Federal Register. We solicited input from the physician community on a wide variety of key data and methodological issues including general accepted accounting principles, equipment utilization, physician employed staff and the refinement process. This was an opportunity for many of the groups to provide additional information to aid us as we develop this year's proposed rule. We received a number of constructive and thoughtful comments in response to this Notice.

Since the Balanced Budget Act was enacted, we have met with physician groups in October, November, and December 1997 to discuss various practice expense issues. In October, we hosted 17 medical specialty panels charged with validating some of the direct expense data generated through the original panel process used for our June 18 Notice. The panels reviewed about 200 of the highest volume Medicare services to validate the data originally collected. These codes represent about 80 percent of Medicare physician spending. Members of the panels were nominated by their specialty societies and were given extensive information about the original panel process prior to the meetings to help them as they validated the data.

On November 21, 1997, we held a forum on indirect practice expenses. Again, all major specialty societies were invited to send representatives. We asked specialties who had specific concerns about our indirect cost methodology to present their views to the meeting and, where applicable, to provide alternatives to the approach in last June's proposed rule. Several presentations were made offering alternative approaches to the allocation of indirect costs as well as an approach which used a non traditional accounting approach to determining practice costs. There was consensus that by definition all approaches to dealing with indirect costs require an allocation formula. As with our prior meetings and discussions with the physician community, the comments were both constructive and informative.

On December 15 and 16, we again hosted a single cross-specialty panel to discuss some of the issues that were believed to have commonality among the various specialties. The objective was to understand the differences in the way specialties provide common administrative functions, such as billing and scheduling. Although there was no agreement among the specialties about many of the issues, the discussions were helpful in framing the debate and in shaping alternatives to some of the original assumptions that were made in the June 18 proposal.

Since the December panel, we have been meeting with groups proposing alternative approaches to the practice expense project. Some of these groups are advocating extensive data surveys of individual physician practices. We do not believe it is practicable at this time to do any new surveys and still meet the January 1, 1999 implementation date established in the Balanced Budget Act. Although we have not completed our internal deliberations on the refinement process we will be proposing in May, we are considering additional data gathering as part of a longer term refinement of the practice expense values.

GAO REPORT TO CONGRESS

The Balanced Budget Act requested an independent review and evaluation by the General Accounting Office (GAO) of the practice expense methodology contained in last June's proposed rule.

We are pleased that GAO supports the key elements of the methodology we used to develop practice expense relative values. GAO found that our use of expert panels is an acceptable method to develop direct cost estimates. GAO also found that assigning indirect expenses to individual procedures, such as the method we used, is an acceptable approach. As the GAO Report indicates: "There is no need for HCFA to start over and utilize different methodologies for creating new practice expense RVU's; doing so would needlessly increase costs and further delay implementation of the fee schedule revisions."

GAO also made recommendations about a number of technical issues. As we develop our May 1, 1998 proposed rule, we will carefully review and consider each of GAO's specific recommendations.

GAO recommended that we use sensitivity analyses to test the effects of two items, (1) the limits we placed on direct cost panel's estimates of clinical and administrative labor, and (2) our assumptions about equipment utilization. We are currently doing such sensitivity analyses. GAO also recommended that where our adjustments or assumptions substantially changed the rankings and RVU's or specific procedures we should collect additional data to assess the validity of our assumptions and adjustments, focusing on the procedures most affected. We will consider that recommendation for future years since it does not appear to be possible to collect any new data in time for the proposed or final rules this year.

GAO recommends that we evaluate three interrelated issues: (1) classifying administrative labor associated with billing and other administrative expenses as indirect expense, (2) alternative methods for assigning indirect expenses, and (3) alternative specifications of the regression model used to link the panels' estimates. We are currently analyzing these issues.

GAO recommends that we "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". On a related note, GAO recommends that we "determine whether physicians have shifted tasks to non-physician clinical staff in a way that warrants re-examining the physician work RVU's". We are currently analyzing these issues.

The GAO Report recommends that we "work with physician groups and the AMA to develop a process for collecting data from physician practices as a cross-check on the calculated practice expense RVU's, and to periodically refine and update the RVU's". I also note that the Balanced Budget Act also requires that we develop a refinement process to be used during each of the four years of the transition. We are currently developing our plans for refinement.

The GAO Report recommends that we "monitor indicators of beneficiary access to care, focusing on those services with the greatest cumulative reductions in Medicare physician fee schedule allowances, and consider any access problems when making refinements to the practice expense RVU's". We have comprehensively monitored access to care and utilization of services since the inception of the physician fee schedule and we will continue to do so.

CONCLUSION

I appreciate the opportunity to discuss with you today the status of our efforts on resource-based practice expenses under the Medicare physician fee schedule. We are working very hard analyzing data, input and comments that we received and considering the recommendations made in the GAO Report. We look forward to working with you, Mr. Chairman and Members of the Subcommittee, as we develop our May 1st proposed rule.

NONDEPARTMENTAL WITNESSES

STATEMENT OF ARTHUR L. DAY, M.D., UNIVERSITY OF FLORIDA, PROFESSOR OF NEUROSURGERY, AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

Senator SPECTER. I would like now to turn to Dr. Arthur Day.

Dr. DAY. Mr. Chairman and members of the subcommittee, my name is Arthur Day. I am a professor and practicing neurosurgeon at the University of Florida in Gainesville, and I appear here today wearing two hats, one as a member of the Practice Expense Coalition, and the other as a member of Organized Neurosurgery.

The Medicare physician fee schedule should accomplish two fundamental goals: First, it should ensure that Medicare beneficiaries have continued and prompt access to high quality medical care; and Second, it should provide a fair payment system based on accurate data.

The coalition is concerned that without substantial correction HCFA's current effort to develop new practice expense relative values will not meet these important objectives. My remarks today focus on four areas.

First, the GAO report. For an entirely different set of reasons, the Practice Expense Coalition and Organized Neurosurgery support the GAO report. The GAO report is entitled, ''HCFA Can Improve Methods of Revising Physician Practice Expense Payments.'' In our view, can means should, and the report identifies a number of key spots in HCFA's work that must be addressed before a final system is put into place.

Our sites of concern are incorporated into our written testimony and due to time constraints today will not be individually discussed.

The second point. What has HCFA done since the enactment of the Balanced Budget Act? Since last summer, HCFA has conducted three public meetings which on the surface appear to satisfy the BBA's requirements for consultation with physician groups. Each of these meetings, however, focused on refining methodology and data from the original June 1997 proposed rule. From our viewpoint, HCFA appears to have made no substantive alterations in last year's proposal.

Third, what should HCFA do to comply with the Balanced Budget Act? It is obvious in this debate, and reading these testimonies, that medicine is divided, the proceduralist versus primary care. Both groups interpret this data from their own perspective and with their own self-interest in mind. Within the confines of budget neutrality, what benefits one will harm the other. It may be, however, that both sides are right.

How can we reconcile this disagreement without irreparable damage to our health care system? The answer is, in our opinion, clear and accurate data, not assumptions derived from statistical theory.

To accomplish this goal, HCFA must start with total practice costs and then, using accounting methodology, allocate specialty-specific practice expenses to relative value units. The coalition has presented HCFA with a straightforward plan developed by Coopers & Lybrand as to how this can be done.

Finally, what are the consequences to a poorly designed system? If HCFA implements essentially the same proposal as last year, access to quality health care for all patients, not just Medicare beneficiaries, may be severely compromised. Such large reductions may create a two-tier health care delivery system.

For example, if the June 1997 rule had been implemented, fees for many common neurosurgical procedures will have equaled or dropped below Medicaid rates in many States. We are all aware of the access problems that Medicaid patients face.

The survival of academic medical centers may also be threatened, thus endangering medical education and research. A 1997 study conducted by the AAMC found that HCFA's original proposal would have reduced practice expense reimbursement to the University of Pennsylvania's Department of Neurosurgery by over 50 percent.

Senator SPECTER. How about to your university?

Dr. DAY. Approximately the same.

Senator SPECTER. Why do you pick the University of Pennsylvania?

Dr. DAY. I think I got that research from my staff person.

Senator SPECTER. You have a very able staff person. [Laughter.]

We will extend your time by 57 seconds. [Laughter.]

Dr. DAY. In our opinion, Congress can do two things to help prevent these adverse consequences. First, continue active oversight of HCFA to ensure that access is not compromised, and second, provide HCFA with the necessary resources to carry out the mandates of Congress in the GAO's recommendations.

PREPARED STATEMENT

Today, we, the Practice Expense Coalition in Neurosurgery, pledge our support for a public-private partnership to get this task done completely, correctly, and on time.

Thank you very much.

Senator SPECTER. Thank you very much, Dr. Day.

[The statement follows:]

PREPARED STATEMENT OF DR. ARTHUR DAY

EXECUTIVE SUMMARY

Background

In 1997, the Health Care Financing Administration (HCFA) proposed changes to the Medicare Fee Schedule that would have produced significant reductions in reimbursement for many physicians. These changes centered around the manner in which Medicare calculates physician practice expenses. Because the cuts were so severe, and because the methodology on which they were based was flawed, the Congress intervened and mandated HCFA to take an entirely new approach to devising the new payment system. The Balanced Budget Act of 1997 (BBA), among other things, required the following:

1. A one-year delay in the implementation date of new practice expense relative values from January 1998 to January 1999;
2. A four year phase-in of the new values from 1999–2002;
3. A General Accounting Office (GAO) review and evaluation of HCFA's proposed methodology, including an evaluation of the adequacy of the data and the potential impact of the proposal on Medicare beneficiary access to services; and
4. Detailed requirements for HCFA in developing new practice expense relative values, including a directive to use generally accepted accounting principles and data based on actual physician practice expenses. HCFA is also required to work closely with physicians in developing the new values.

The GAO report

Issued on Friday, February 27, 1998, the GAO report is titled: "HCFA Can Improve Methods for Revising Physician Expense Payments." The report identifies several key problem areas, and raises appropriate criticisms of HCFA's work up through the June 1997 Notice of Proposed Rulemaking, which include:

1. HCFA's failure to validate the data produced by the Clinical Practice Expert Panels. GAO recommends that HCFA validate the data using surveys of actual physician practices.
2. HCFA's use of statistical techniques to overcome the lack of common ground rules between the various panels. GAO raises serious questions about these statistical techniques.
3. HCFA's failure to use actual specialty specific practice costs to formulate "indirect" practice expenses. GAO suggested that the use of specialty specific indirect expense data would be more consistent with the requirements of the law, which requires the use of actual expense data.
4. HCFA's disallowance of certain costs, such as the costs physicians incur when they bring their own staff to facilities located outside their own office to assist in the care of patients. GAO acknowledged that there may have been a shift in hospital and physician practices that Medicare has not recognized in its reimbursement methods.
5. HCFA's lack of a detailed plan to address the concerns raised in the report. GAO raises concerns about HCFA's failure to have a specific plan to address the many problems with the current data and methodology.

If HCFA responds effectively to each of the points in the GAO report, and if HCFA follows the mandates of the BBA, the Coalition believes that the agency can design new relative values that will be generally acceptable to the entire physician community.

HCFA'S activities since the enactment of the BBA

HCFA has conducted three public meetings since the BBA was enacted the October "validation" panel meeting, the November "indirect expense" conference, and December's "cross-specialty" panel meeting. Each of these meetings focused on refining the methodology and data that were the basis for the original June 1997 proposed rule. Based on this experience, the Coalition does not think that HCFA is meeting the directives of the BBA.

What HCFA should do to comply with the BBA

If generally accepted accounting principles (as required by the BBA) are used, the process for allocating specialty specific aggregate practice expenses to relative value units should be relatively straightforward. HCFA should enter into a public-private partnership with the physician community to jointly fund and help facilitate the collection of practice expense data. The project should proceed in the following way:

1. Realize that the practice expense relative values effective in 1999 (the first transition year) will change quite a bit as the refinement proceeds and reach agreement on the process that will get us to a final product by 2002 (final implementation year);
2. Develop interim values for 1999 based on the premise: "first do no harm." Even modest reallocations of payment should not occur until HCFA has fully complied with the mandates of the BBA to use total costs and an accounting methodology; and
3. Refine the system based on the key requirements of the BBA actual data on total physician practice costs and generally accepted cost accounting standards. Coopers & Lybrand, a well known national accounting firm with significant health care industry experience, has developed a method to allocate total costs to the individual code level, using standard cost accounting techniques.

Consequences of a poorly designed system

If HCFA implements essentially the same proposal as last year, it will produce both near and long-term threats to our Medicare system, and, to the extent that many private insurers use the Medicare physician fee schedule, the entire health care delivery system. Access to quality health care for all patients, not just Medicare beneficiaries, will be severely compromised. Specifically, such large reductions may: (1) create a two-tiered health delivery system and (2) threaten the survival of academic medical centers, endangering medical education and research.

What Congress can do to ensure HCFA complies with the BBA

Congress can do two things to help solve this problem: (1) continue active oversight of HCFA on this project to ensure that the BBA's mandates are achieved, and (2) provide the necessary funding to HCFA to carry out the GAO recommendations and the mandates of Congress. The estimated costs of these tasks would be no more than $2 million.

Mr. Chairman, and members of the subcommittee, my name is Arthur L. Day, M.D. I am a professor and practitioner of neurosurgery at the University of Florida in Gainesville, Florida. I am here today on behalf of the Practice Expense Coalition, a group that represents 43 physician specialty societies, medical organizations and major medical clinics, and also on behalf of my own organizations, the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, which are members of the Coalition. Mr. Chairman, the Coalition is united by our common belief that the Medicare physician fee schedule should accomplish two fundamental goals: (1) ensure that Medicare beneficiaries have continued prompt and high quality access to medical care and (2) provide a fair payment system based on accurate and reliable data. The Coalition is concerned that, without substantial correction, the Health Care Financing Administration's (HCFA) current effort to develop new practice expense relative values will not meet these important objectives.

The members of the Coalition appreciate your interest in this issue and the opportunity to present testimony today. We recognize that the task originally given to HCFA in the Balanced Budget Act of 1997 (BBA) is complex. If properly carried out, however, the directives contained in that Act will make it easier for the agency to complete its work. Continued congressional oversight is critical to the project's successful completion.

My testimony this afternoon will focus on four areas: (1) the findings of the General Accounting Office (GAO) report, which under congressional mandate reviewed

HCFA's methodology and the reliability of the agency's data, (2) HCFA's activities since the enactment of the BBA, (3) the Coalition's recommendations of what HCFA should be doing to develop reliable data and a sound methodology to ensure that accurate practice expense relative values are developed by the year 2002, and (4) the consequences of HCFA's failure to develop a fair and accurate payment system.

The GAO report

Issued on Friday, February 27, 1998, the GAO report is titled: "HCFA Can Improve Methods for Revising Physician Expense Payments." In our opinion, this report is a reasonably balanced view of the challenges and the problems that have beset this very complex project. The report clearly validates Congress's efforts, by virtue of the passage of the BBA, to give HCFA both more time to complete the formulation of new practice expense relative values, and direction on how HCFA must develop this new payment system. If HCFA responds effectively to each of the points in the GAO report, and if HCFA follows the mandates of the BBA, we believe that the agency can design new relative values that will be generally acceptable to the entire physician community.

The GAO report identifies several key problem areas, and raises appropriate criticisms of HCFA's work up through the June 1997 Notice of Proposed Rulemaking, which include:

1. HCFA's failure to validate the data produced by the Clinical Practice Expert Panels. While GAO concluded that this process of collecting "direct" practice expense data was acceptable, it stated that HCFA should validate the data using surveys of actual physician practices.

2. HCFA's use of statistical techniques to overcome the lack of common ground rules between the various panels. The use of these statistical adjustments is a key point of controversy, because most of the redistribution in physician payment is derived from these manipulations. The GAO raises serious questions about the techniques of "linking" and other "data reasonableness" rules used in the June 1997 proposed rule.

3. HCFA's failure to use specialty specific costs to formulate "indirect" practice expenses. While the Clinical Practice Expert Panels focused on "direct" practice expenses, HCFA planned a survey of 5000 physician practices to collect "indirect" expense data. This survey was never completed, and HCFA was forced to look to other less reliable sources. Although GAO did not measure the validity of the data used, it did state that the use of specialty specific indirect expense ratios would be more consistent with the requirements of the 1994 and the 1997 statues which require the use of actual expense data.

4. HCFA's disallowance of certain costs. Many specialty physicians bring their own staff to facilities located outside their own office to assist in the care of patients. HCFA has disallowed nearly all of these costs, arguing that they are already included in the hospital payment rates. Although not every specialty uses its own staff in this way, several recent studies demonstrate that some specialties, such as neurosurgery, significantly utilize their own staff outside of the office. The GAO report acknowledged that there may have been a shift in hospital and physician practices that Medicare has not recognized in its reimbursement methods.

5. HCFA's lack of a detailed plan to address the concerns raised in the report. Throughout the report, GAO raises concerns about HCFA's failure to have a specific plan to address the many problems with the current data and methodology. Such a plan is essential if HCFA is to comply with both the 1994 and the 1997 statutes.

Mr. Chairman, at this point I would like to address each of the above issues in more detail.

1. Use of Expert Panels to Estimate Direct Costs.—In 1996, HCFA convened a number of expert panels 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.

While GAO concluded that the process itself for collecting direct cost information was acceptable, it also stated that HCFA should validate the data using surveys of actual physician practices. While this panel process can estimate this kind of information, many questions remain about the data's accuracy. The Coalition agrees with the suggestions in the GAO report that external validation is critical to confirming the specific information derived from these panels.

If the information gathered from the panels is to be an ongoing part of the practice expense data base, we believe that Congress should insist on such validation. At the very least, HCFA should survey physician practices and 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.

2. Statistical Techniques Used by HCFA.—Because of the lack of common ground rules in the CPEPs, the results understandably varied greatly. HCFA tried to correct this problem by using statistical adjustments to the data, referred to as "linking" and "scaling." HCFA also applied edits for "data reasonableness." Each technique was intended to adjust the data to establish more consistency between the results that came from each panel. The use of these statistical adjustments is a key point of controversy, since most of the redistribution in physician payment was derived from these manipulations. The very large cuts in payments for many procedures—for neurosurgery some over 30 percent—were in large measure driven by HCFA's decisions at this point in the process.

The GAO raises serious questions about "linking" and the "data reasonableness" rules that HCFA used in the June 1997 proposed rule. The Coalition agrees with this assessment. The application of these techniques greatly altered the work product of the CPEPs. These alterations were undoubtedly the greatest contributing factor to our concerns that we expressed last year—concerns which ultimately led Congress to change the practice expense law. By enacting the BBA, Congress rejected such statistical manipulation by requiring the use of actual physician practice cost data.

HCFA needs to completely revise or discard the "data reasonableness" rules and fix its "linking" methodologies. Some means must be identified to collate the expenses of quite diverse physician specialties into a coherent payment system. It is still unclear what HCFA intends to do.

3. Indirect Cost Issues.—HCFA proposes to divide physician practice expenses into direct and indirect costs. To accomplish this, separate data collection strategies were developed. While the CPEP process focused on direct costs, HCFA planned a mail survey of 5,000 physician practices to collect indirect expense data. To ensure a reasonable and accurate response rate, we urged HCFA to involve the physician specialty societies in this process. These offers were rebuffed by the agency, however, and the result was predictable. The survey was so complicated that the response was woefully inadequate by any standard—well below the response rate demanded by the Office of Management and Budget (OMB). HCFA thereafter abandoned the survey, and therefore had to use estimates of indirect expense rather than actual data. The agency also decided to allocate expense data based on a single direct/indirect cost ratio of 55/45 percent for all specialties. Needless to say, the quality and accuracy of these estimates has been highly controversial and has been refuted by several subsequent studies.

While GAO did not assess the validity of the data used in formulating these estimates, it did review allocation and definition issues. Since there is no universally accepted way to allocate indirect expenses, the GAO report recognized that HCFA's method for allocating indirect costs to the individual procedure codes was an acceptable approach. The report points out, however, that the use of specialty specific indirect expense ratios (rather than a uniform ratio for all specialties) would be more consistent with the law, which requires HCFA to use actual practice expense data.

We believe that many of the controversies related to indirect expenses could be avoided if HCFA used other widely accepted accounting techniques to allocate practice cost data. These other allocation methods do not artificially separate expenses into "direct" and "indirect" cost categories, so that the end result is more accurate and less arbitrary. If HCFA insists on pursuing its current approach, the Coalition concurs with GAO's recommendations that specialty specific ratios should be derived, based on individual specialties' actual practice expense data. We believe that Congress should insist that HCFA comply with these recommendations.

4. Disallowance of Certain Costs.—As HCFA has defined practice expenses, certain categories of costs have not been included. For example, many specialty physicians bring their own staff to facilities located outside their own office to assist in the care of patients. HCFA has disallowed nearly all of these costs, arguing that they are already included in the hospital payment rates. Certainly, not every specialty uses its own staff in this way. Several recent studies, however, demonstrate that some specialties (e.g., neurosurgery and thoracic surgery) do substantially utilize their own staff for patient care activities that occur outside of the office. These studies have been provided to both HCFA and GAO, and can be made available to this subcommittee as well.

The GAO report acknowledges that there may have been a shift in hospital and physician practices that Medicare has not recognized in its reimbursement methods. Hospitals may no longer provide the same level of staff support that they did before when Medicare established its current method of hospital expense reimbursement.

These expenses are very real to these physicians and they should be incorporated into the Medicare physician fee schedule. HCFA should therefore determine if there have been changes in hospital staffing patterns and physicians' use of their clinical staff in hospital settings, and include these costs in the new relative values.

5. Lack of Detailed Plan for Developing and Refining New Relative Values.—Throughout the report, the GAO points out that there are many unresolved issues that should be addressed prior to the May rulemaking. Even though the BBA requires HCFA to report to Congress on the status of the project by March 1, 1998, HCFA has yet to provide a detailed plan for developing and refining new practice expense relative values. This report should have included a presentation of data to be used in developing the relative values, and an explanation of the methodology. The purpose of the report was to give Congress and physician groups an opportunity to review and comment on HCFA's work prior to the May rule's publication, so that appropriate adjustments could be entertained.

The delay in producing this report reduces the opportunity for physician input to Congress. Given this year's short legislative session, Congress will have limited opportunity to review these comments or, if necessary, to intervene on the final proposal before it is implemented on January 1, 1999. Congress must be given a detailed status report prior to May, and we urge you to require this from HCFA.

HCFA's activities since the enactment of the BBA

The Balanced Budget Act of 1997 requires the agency to develop "new resource-based practice expense RVU's" that utilize "generally accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not solely those that can be linked to specific procedures " The law further requires HCFA to use "actual data" in developing the new relative value units. Through its member organizations, the Coalition has participated in three public meetings held by HCFA since the BBA was enacted the October "validation" panel meeting, the November "indirect expense" conference, and December's "cross-specialty" panel meeting. Each of these meetings focused on refining the methodology and data that were the basis for the original June 1997 proposed rule.

Based on this experience, we do not think that HCFA is meeting the directives of the BBA. Congress has implicitly repudiated the project's original direction, by enacting the new detailed requirements and oversight mechanisms. Given this new statutory mandate, the Coalition expects HCFA to significantly modify its methods of developing the new relative values.

What HCFA should do to comply with the BBA

In our view, the specifications contained in the BBA and the standards laid out in the GAO report provide the framework for a successful transition to a new set of practice expense relative values. If generally accepted accounting principles (as required by the BBA) are used, the process for allocating specialty specific aggregate practice expenses to relative value units should be relatively straightforward, and can be accomplished in the time frame provided by Congress.

The Coalition has offered to enter into a public-private partnership with HCFA that would jointly fund and help facilitate the various activities that must be completed if this change in practice expense relative value units is to be successful. 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 should proceed in the following way:

The first step is to 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 everyone should clearly see the process that will be in place to get us to a final product.

Next, the interim values for 1999 need to be determined. We recommend that HCFA develop these interim values based on the premise: "first do no harm." With such an inadequate data base, we do not see how the agency could do otherwise. We realize that the four year transition period for implementing the final relative values 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. We must be mindful, however, that important data refinements and methodological

work remain to be done, and must be done, before the completion of the transition period. Because there is still much uncertainty, we recommend that HCFA ensure that the interim system's redistribution impacts be very modest, so the many remaining issues can be worked out without causing significant disruption to patient care.

Finally, HCFA should refine the system around the key requirements of the BBA actual data on total physician practice costs and generally accepted cost accounting standards. 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, although it does have some limitations. For example, data from some specialties and subspecialties (e.g., neurosurgery) are not included in the current data base, so additional information needs to be collected. The Coalition recently presented to HCFA an outline of how the AMA data base can be used to allocate total costs to the individual code level, using standard cost accounting methods. The approach was developed by Coopers & Lybrand, a well known national accounting firm with significant health care industry experience, and is relatively straightforward. We would be happy to arrange for representatives from Coopers & Lybrand to brief you and your staff in greater detail.

This is a process that can work and can be completed in the time allowed, but it needs the concurrence of Congress and HCFA to be accomplished.

Consequences of a poorly designed system

The importance of getting this project "right" cannot be understated. For many specialties, including neurosurgery, last year's proposed payment reductions were extreme. If HCFA implements essentially the same proposal, it will produce both near and long-term threats to our Medicare system, and, to the extent that many private insurers use the Medicare physician fee schedule, the entire health care delivery system. Access to quality health care for all patients, not just Medicare beneficiaries, will be severely compromised. Specifically, such large reductions may:

Create a Two-Tiered Health Delivery System.—Many physicians simply cannot absorb these drastic reductions and continue to offer access to world-standard medicine. To demonstrate the impact of these reductions, organized neurosurgery conducted a survey of Medicaid and Medicare rates in 20 states. If the June 1997 rule had been implemented, fees for many common neurosurgical procedures performed on Medicare beneficiaries would have equaled or dropped below Medicaid rates in 16 of these states. The problems that Medicaid beneficiaries face in accessing medical care are well documented. If private insurers follow Medicare's lead (as often they do) payment inequities will further multiply, and other patients will find their medical care quality similarly diminished.

Endanger Medical Education and Research.—The dramatic decrease in Medicare payments proposed by HCFA will have a significant impact on our nation's academic medical centers. For example, a 1997 study of academic health centers conducted by the Association of American Medical Colleges found that HCFA's original proposal would have reduced practice expense reimbursement for the University of Pennsylvania's Department of Neurosurgery by over 52 percent. If HCFA's new proposal includes reductions of this magnitude, we risk undercutting these centers' ability to provide high-quality, specialized education for physicians. Moreover, these reductions could result in fewer dollars for academic medical centers to distribute to their research facilities. Such cuts could have devastating impacts on the kind of superb academic medical centers that attract our brightest and hardest-working young men and women. If we send the message that we no longer consider education and research a national priority, we will sacrifice one of our nation's greatest assets, our world-class teachers and researchers.

What Congress can do to ensure HCFA complies with the BBA

Congress can do two things to help solve this problem: (1) continue active oversight of HCFA on this project to ensure that the BBA's mandates are achieved, and (2) provide the necessary funding for HCFA to carry out the GAO recommendations and the mandates of Congress. The estimated costs of these tasks would be no more than $2 million. We fully understand that HCFA's administrative budget is very tight, and the Practice Expense Coalition is therefore prepared to enter into a public/private partnership to share in the cost of properly formulating the new practice expense relative values.

In his recent testimony before the House Ways and Means Health Subcommittee, William J. Scanlon, of the GAO stated that 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 in 1999." We agree and we hope

that your subcommittee will provide the necessary resources for HCFA to get the job done right.

Thank you for the invitation to appear before the subcommittee. I will be pleased to answer any of your questions.

STATEMENT OF TIMOTHY J. GARDNER, M.D., UNIVERSITY OF PENNSYLVANIA, CHIEF OF CARDIOTHORACIC SURGERY, AMERICAN ASSOCIATION OF THORACIC SURGEONS

Senator SPECTER. We now turn to Dr. Timothy Gardner, chief of the division of cardiothoracic surgery at the University of Pennsylvania.

Welcome, Dr. Gardner.

Dr. GARDNER. Thank you, Senator. I appreciate the opportunity to address the committee on this very important issue of reevaluation of the practice expense component of the Medicare fee special schedule.

At the hospital of the University of Pennsylvania I am responsible for the care of hundreds of patients entrusted to us for cardiac and thoracic surgery, but also for the training of surgical residents who will be the cardiothoracic surgeons of the future.

The impact projections from HCFA on the practice expense redistribution published last year is for a 32-percent reduction in reimbursement for cardiac surgery. This reduction would be added to reductions in Medicare reimbursement for cardiac surgery which over the past 10 years have already amounted to a 34-percent decrease in actual dollars. The cumulative effect of the prior reductions and the additional changes will be a 67-percent decrease in reimbursement when adjusted for inflation.

Let me give you specific figures to clarify the impact of HCFA's proposed changes. A busy cardiac surgeon with a customary workload of 200 major open heart surgeries per year would receive practice expense reimbursement of $92,000 under HCFA's proposed formula. The most recent AMA socioeconomic survey indicates that the average annual practice expenses for surgeons, including cardiac surgeons, is $248,000 a year.

A cardiac surgeon with a caseload of 200 major surgeries annually currently received $259,000 in practice expense reimbursement at Medicare rates, but the proposed $92,000 practice expense reimbursement in HCFA's reformed schedule will amount to only 38 percent of actual practice cost.

We have already heard from Dr. Day concern expressed in the GAO's analysis that HCFA's work has a flawed methodology and may result in conclusions that are not accurate or reliable, and the GAO report concluded that the proposal by HCFA may affect access to care as well as might influence physician decisions regarding the care of Medicare beneficiaries.

Now, the accomplishment of cardiothoracic surgeons, along with so many other medical specialist researchers and scientists over the last 25 years, have really been astounding, and our citizens have been the beneficiaries. We cannot expect to sustain a commitment to the kinds of extraordinary advances that have occurred in the fields such as these if it costs doctors to take care of Medicare patients.

Of even greater concern to me as a medical school professor and residency program director charged with ensuring the future qual-

ity of surgeons, is how are we going to attract individuals from among the best and the brightest of our young people who will be willing to spend 12 to 15 years of additional education after college to become cardiac surgeons, who will then begin practice at an average age of 35 years, in a specialty that is so demanding that few can remain fully active as surgeons into their sixties?

One of HCFA's stated goals in this present environment is to restore trust in the Medicare Program. That is the challenge that has been given to the providers.

If the agency expects to restore the trust of all of us in the medical community, a regulation as important as this one has to be done properly. Resource-based practice expense reform can be done properly. The agency should begin by using the best data set available, namely the AMA socioeconomic survey, to correct its current estimates and to develop interim values for 1999.

These interim values should then be refined through additional surveys of actual costs of practices, particularly the practices of specialists such as cardiac and thoracic surgeons which are neither clearly defined nor well-represented in the AMA data base. The estimates should be further refined through limited onsite data gathering, as the GAO has recommended.

We appreciate that HCFA has a heavy workload and may not be able to conduct a proper study without supplementary funding. We would therefore ask the committee to consider a modest appropriation to HCFA which is targeted to this task with specific directions that the agency must base its analysis this time on real practice costs.

I would like to close by saying that I have participated in the HCFA analysis of practice expenses, and I appreciate greatly the leadership that Dr. McCann, who I have worked with on various projects over the years, has provided to this very difficult task. I think all of us involved in the process agree that the complexity was almost beyond the scope of the group that was given the task of performing it.

PREPARED STATEMENT

I also would like to say that somehow or other there is something wrong with this becoming an argument between different medical groups. If the primary care family practice group is not being paid appropriately for their practice cost, that should be corrected, but we should not do that at the expense of specialists who will not be able to provide the same quality of care in the future.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF TIMOTHY J. GARDNER, M.D.

Mr. Chairman, members of the Committee. Thank you for inviting me to discuss the very important issue of revaluation of the practice expense component of the Medicare Fee Schedule. I am Timothy J. Gardner, William M. Measey Professor of Surgery and Chief of the Division of Cardiothoracic Surgery at the University of Pennsylvania. I am also chairman of the joint Professional Affairs Committee of the Society of Thoracic Surgeons and the American Association for Thoracic Surgery. These two organizations represent the board certified cardiac and thoracic surgeons of the United States.

Congress last year, under the Balanced Budget Act, directed HCFA to propose a rule for reimbursing practice expenses which would "utilize, to the maximum extent

practicable, generally accepted accounting principles" and "recognize all staff, equipment, supplies and expenses, not just those which can be tied to specific procedures, and use actual data on key assumptions."

Congress also asked the General Accounting Office to report on the adequacy of the data used by HCFA in developing the rule which it proposed last year. GAO was not asked to, and did not consider, whether HCFA was meeting the mandates of the Balanced Budget Act. This report has recently been submitted to Congress.

The GAO notes that HCFA's proposed rule would reallocate $2,000,000,000 annually in payments to physicians. The impact of reallocations of payments of that magnitude is obvious. Surgeons and other specialists will make decisions based on what HCFA publishes this year. Surgeons will decide whether or not they can continue to support highly qualified staff; senior surgeons will decide whether they remain in practice; medical school graduates will make their choice of specialty.

It is important to get this right—to get it right the first time. The message sent this year will drive decisions, irretrievably. If there is an interim proposal, with the expectation of future review, the Health Care Financing Administration must take care that the initial proposal not do damage that is irremediable. To count on corrections during the first year or two—on refinements that would correct mistakes and undo damage—would be unrealistic.

THE REPORT OF THE GENERAL ACCOUNTING OFFICE

The General Accounting Office has done Congress and the medical community a major service in pointing out several of the most egregious flaws in the methodology used by the Health Care Financing Administration. GAO reports that the linking process used to alter the data from the Clinical Practice Evaluation Panels was faulty; that HCFA should sample a sufficient number of medical practices to verify its data and its assumptions; that reimbursement of staff paid for by physician practices who work in hospitals should be reviewed and that a new means of deriving indirect costs should be considered. These are important recommendations. The title is central: "HCFA Can Improve Methods for Revising Physician Practice Expense Payments". In a rule of such importance, we believe "can" means "must."

The General Accounting Office also notes that the "cumulative effects of fee schedule changes could affect access to care" and that "total potential reductions of approximately 25 percent are significant and could affect physician decisions regarding their care of beneficiaries."

The issue of access is important and very difficult. Cardiothoracic surgery is the specialty which would have been most impacted by the HCFA proposal last year, with reductions for some procedures as high as 40 percent. These reductions would come on top of reductions of 34 percent over the last 10 years—reductions which are actually more than 50 percent if calculated in constant dollars. The cumulative total reductions for cardiac surgery would have been 54 percent in present dollars 67 percent in constant dollars—if the HCFA proposal of last year were enacted.

At present, cardiac and thoracic surgeons usually do not even know the insurance status of their patients. Our patients come to us by referral from other physicians, sometimes from hospital emergency rooms. We treat every patient the same.

Most surgeons would rather leave practice than be compelled to choose between private pay and Medicare patients, or even between the insured and the uninsured. And that is the point. If surgeons cannot afford to maintain highly qualified staff; if they know that quality is suffering; if payment rates are once again reduced significantly—the impact will be on the availability of highly trained surgeons a few years from now. The years of training are long and strenuous. Qualified surgeons are not created overnight. If a large number of senior surgeons retire and the attractiveness of the field to new medical school graduates is impaired, there will not be a sufficient number competent surgeons to treat the increasing number of citizens who reach the age where heart disease is prevalent 5 years from now.

Those decisions will be made on what the rule is that goes into effect next January. Vague promises of review and refinement during a "transition" period will not change this. Surgeons and new medical school graduates will base their decisions on what they see in the Federal Register, not on expectations that what they see there isn't for real and will be changed.

Given the consequences of error—of getting this wrong—we are very concerned that the intent of Congress that HCFA use actual data and include all costs is not being followed. HCFA has still gathered no data on total costs and appears still not to recognize many critical staff costs.

I. Practice costs of cardiac and thoracic surgeons

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.

A resource-based system requires that the real costs of representative practices be allocated to specific procedures. To do this, you have to have data on total costs—data which HCFA has not gathered.

In this absence, we need to look at other information available. 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—a case load higher than typical—is $259,600 per year—within 6 percent of our best information on actual costs.

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 6 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—to about 38 percent of actual costs.

Practice costs, cardiac surgeon

Practice cost/surgeon (AMA other surgery)	$252,000
Present practice expense reimbursement [1]	259,600
Proposed reimbursement [1]	92,500

[1] At a case load of 200 major cardiac surgeries, 200 consults, 200 billable office visits.

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 6,000 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, however, that the 1997 HCFA proposal was fatally flawed. Validation of any new proposal against actual practice costs 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.

II. 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 have 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 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).

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.

III. 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. This is a balance that should not be upset casually.

What would be the effect upon Medicare patients with heart or lung disease under a redistribution of reimbursement from specialty care to general medical care of the magnitude proposed by HCFA?

The impact of severe reductions in practice expense reimbursement for cardiac and thoracic surgery should be reviewed in context of cumulative changes over the last then years. Reimbursement for open-heart surgery—coronary artery bypass and surgery and other complex heart procedures—has already been reduced sharply in the last 10 years. The national Medicare average allowed charge for three-vessel bypass 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 $1,802. 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 procedures by another 32 and 26 percent, respectively.

The cumulative reductions for heart surgery would have been 54 percent in present dollars and 67 percent in constant dollars.

The following table illustrates the reductions which have already occurred over the 10 years from 1988 to 1998 and the further effect last year's proposal would have had:

[In current dollars and constant 1988 dollars]

Year	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

As noted earlier, 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 pre-authorization 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 United States 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. (There is no evidence that improvement in preventive or other nonspecialty care is reducing the need for surgery or other advanced medical procedures. The need is largely age-driven).

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—those both intellectually acute and gifted with the essential hand coordination—enter into this profession? What will attract young physicians to this

field if they cannot afford to hire the staff they know is needed to provide excellent outcomes?

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.

Because of the long lead-time involved in training heart and lung surgeons, a 4-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 10 years from now.

IV. 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 pre-authorization, 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.

One issue which has become contentious in the review of practice expenses is allocation of the expense of clinical staff employed by physicians who assist them in the hospital.

Within the last 5 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 predictability. This is 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.

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 assignments 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.

The General Accounting Office has raised two relevant issues: whether some of the work being done by clinical staff represents a shift of physician work warranting review of work RVU's; and, if expenses have shifted from hospitals to physicians, whether there should be a shift of resources from Part A to Part B. We agree that both of these issues warrant examination. We would encourage a full reappraisal of the work values for cardiac and thoracic surgery—which we believe were undervalued by the Harvard School of Public Health, and will recommend this as part of the next 5-year review.

But recognition that these are real costs of surgical and other specialty practices should not be obscured by these questions. Accounting for clinical staff employed by specialists, in the reallocation of practice costs, does not increase Medicare expenditures. It only grounds the resource-based revaluation in reality.

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.

V. 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 confidence in any rule which would significantly revise the present Medicare Fee Schedule. The GAO has outlined problems with the HCFA methodology and reported—correctly—that HCFA has not yet developed a plan to correct these deficiencies. 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 and to develop interim values which will "do no harm" (in the words of Hippocrates.) The Practice Expense Coalition, of which we are a member, has provided HCFA with recommendations, prepared by Coopers & Lybrand, to develop such interim values.

Over the next six months, this AMA data could be supplemented by limited additional surveying of specialties, such as cardiac and thoracic surgery, which are not well represented. Limited sampling as a verification check, as recommended by the GAO, would also be appropriate.

This is not a difficult or overwhelming task. Coopers & Lybrand has outlined several options for the methods to be used in allocating specialty practice costs to individual procedures. These code specific allocations would need to be weighted by the frequency with which different specialties use the same code; that is not difficult in an age of computers.

Questions have been raised whether special modifiers are needed in some situations; that is a question that could be referred to the AMA Coding Committee or the Relative Value Update Committee [RUC] but which need not delay development of an interim rule. We would be pleased to enter a public-private partnership with HCFA to develop this information; such a partnership would reduce the need for additional Federal funds.

We would request that this committee consider a relatively small appropriation to HCFA targeted to this work, with specific directions that the agency must, this time, base its analyses on total practice costs. The Practice Expense Coalition has asked Coopers and Lybrand to develop a specific recommendation for the costs of this additional work, which we will share with this committee. HCFA should be directed to carry out this work within the next twelve months.

Unless Congress chooses to extend the present deadline, an interim proposal would be required while HCFA does this work. We believe HCFA could readily develop an interim proposal, based on the AMA SES data, without need for additional funds.

I noted above that the HCFA proposal of 1997 would have reimbursed an active cardiac surgeon for only 38 percent of actual costs.

We recognize that the resource-based relative value schedule, under budget neutrality, will reimburse physicians for less than 100 percent of their costs. But everyone accepts that the reimbursement must be relative among specialties.

We do not know—HCFA may know but has not told us—how practice expense reimbursement would relate to total practice costs for all of medicine (or, in other terms, what budget neutrality would be for all specialties treated equally). But even if the correct budget neutrality factor is as low as 75 percent, the HCFA proposal is off by a factor of two to one.

Given the impact of any mistaken proposal, the limitations of the data now being used, and the need (identified by the GAO) for improvements in methodology, we believe that Congress should direct HCFA to limit the final impact of any interim proposal (calculated as fully implemented) to no more than 10 percent of the allowed charge for any procedure.

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 pre-

vent 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.

BUDGET NEUTRALITY

Senator SPECTER. How do you think we should do this, Dr. Gardner?

Dr. GARDNER. I think the question has to be asked as to whether budget neutrality in this area is an appropriate position to take, especially at a time when we are dealing with a balanced budget, sir.

Senator SPECTER. Budget neutrality is indispensable if you are going to balance the budget, unless you take it from some place else.

Dr. GARDNER. Well, I think the question is whether we are willing to run the risk of slowing or stopping the advances that we have made over the last 25 to 50 years in American medicine by not paying for the advances and providing for the access to care that our increasingly aging population is expecting.

Senator SPECTER. When you talk about advances, you are talking about family practitioners versus cardiologists? I agree with you Dr. Gardner, we should not have to play one group off against another, but the chore is how you do it.

I am impressed with your compliment of Dr. McCann, since he is one of the authors here. We will get to that in a moment or two.

A lot of people have been waiting for me in the hall, and on this occasion I will only be gone for not more than 5 minutes and I regret the interruption, but this is more of the roller skate job. I will be right back.

[A brief recess was taken.]

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

Senator SPECTER. We will now proceed to hear from Dr. Alan Nelson.

Dr. NELSON. Thank you, Mr. Chairman. ASIM appreciates the leadership shown by this subcommittee in supporting the practice expense provisions reported out of the committee last year. We are especially pleased that the Balanced Budget Act of 1998 included the Finance Committee's downpayment provision, which increased the practice expense provision for office visits beginning January 1 of this year.

The BBA also included the Senate Finance Committee's language that mandated a review by the GAO of HCFA's methodology. The BBA directed HCFA to increase consultation with physicians, and the agency has met that requirement.

HCFA is also meeting the BBA's mandate that it consider actual cost data to the maximum amount practicable.

In March 3 testimony to the Ways and Means Committee the GAO reported, and I quote, "HCFA's general approach for collecting information on physician practice expense was reasonable, and HCFA's use of expert panels is a reasonable method for estimating the direct labor and other direct practice expenses."

The GAO also found that the cost accounting methodologies, mail surveys and onsite studies of actual cost data from physician practice, all of which have been proposed by some as alternatives to the expert panel approach, have, and I quote, "practical limitations that preclude their use as reasonable alternatives to the HCFA's use of expert panels."

Now, this does not mean that the expert panel data are perfect, of course. HCFA found that it was necessary to make some adjustments to the data, including application of the statistical linking formula to reduce variations in the panel's estimates of labor costs. Without such adjustments, HCFA found that the labor costs of office visits and other evaluation and management services would be undervalued compared to most other services.

The GAO agreed with the intent and desirability of HCFA's adjustments, while at the same time noting that HCFA's linking formula might be improved.

None of the recommended improvements would cause what the GAO termed, quote, "the needless costs and further delays that would be required if HCFA started over with a different methodology."

The GAO also recommends HCFA monitor the impact of its rule on access, and we agree, but it should not be assumed that the overall impact on access is likely to be negative. In many parts of the country Medicare payments now barely cover the practice expense costs incurred by office-based primary care physicians and, as a result, some Medicare patients may not be able to easily find a new doctor if their previous doctor moves or retires.

Resource-based practice expenses by raising payments for office-based primary care services may well make it easier for internists to accept new Medicare patients into their practices and will assure a wider range of choices for Medicare beneficiaries.

Even as we debate the methodologic issues, it is important to recall why Congress mandated resource-based practice expenses in the first place. Resource-based practice expenses were being developed because Congress concluded that Medicare's current charge-based practice expense payments are not fair.

Even with the welcome 1998 downpayment that increased practice expenses for office visits, an internist would still have to provide 30 midlevel office visits requiring at least 7 hours of face-to-face contact with patients to obtain the practice expense payments that Medicare allows when an orthopedic surgeon repairs a single lower leg fracture, and the same internist would have to provide 53 office visits, requiring at least 12 hours with patients, to receive the practice expense payments that Medicare now allows when an ophthalmologist repairs a detached retina.

Such disparities are especially surprising, given the fact that the hospital bears a substantial amount of the direct cost when a surgical procedure is provided in a hospital operating room while the internist is paying 100 percent of the office expense incurred while providing care to patients in the office.

The GAO's verdict on HCFA's approach is clear. HCFA has met the BBA's requirements. The basic methodology is reasonable. Further refinements will give physicians an even higher degree of con-

fidence in the data. There are no practical alternatives that can produce better data.

PREPARED STATEMENT

ASIM believes that HCFA will be able to produce resource-based practice expenses for implementation on January 1 of next year that will more accurately reflect relative differences in the actual cost of physician services than the current charge-based relative value units. As a result, Medicare payments will also be far more fair than they are today.

Senator SPECTER. Thank you very much, Dr. Nelson.

[The statement follows:]

PREPARED STATEMENT OF DR. ALAN R. NELSON

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 Senate Appropriations Labor HHS 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:

Is HCFA meeting the spirit and intent of the provisions in the Balanced Budget Act of 1997 (BBA) relating to practice expenses?

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 report by the General Accounting Office (GAO) on HCFA's methodology for developing physician practice expense payments, which was released on February 27. ASIM's testimony also refers to recommendations that the Medicare Payment Advisory Commission (MEDPAC) has made in its March 1 report to Congress.

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

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.

HCFA's basic methodology and data are valid, although some improvements are appropriate.

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 concurs with ASIM on each of these conclusions.

REQUIREMENTS OF THE BALANCED BUDGET ACT OF 1997

The Balanced Budget Act of 1997 directs the Secretary of the Department of Health and Human Services to:

Phase-in implementation of resource-based practice expense (PE) payments over four years, beginning on January 1, 1999;

Use generally accepted accounting principles and "actual cost" data to the "maximum extent practicable";

Consult with physicians and other experts.

Publish a new proposed rule and new practice expense relative value units (PE-RVU's) by May 1, 1998, with a 90 day public comment period;

Begin moving payments to resource-based practice expenses, effective on January 1, 1998, by implementing a "down payment" that increased practice expense RVU's for undervalued office visits and reduced them for procedures whose current PE-RVU's are overvalued (based on a comparison of PE-RVU's to work RVU's).

It also directed the General Accounting Office (GAO) 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.

ASIM supported the practice expense provisions of the BBA. As you will recall, ASIM testified last year in support of two key provisions that originated in the Sen-

ate Finance Committee version of the BBA: the GAO study of practice expenses and the "down payment" for office visits. We thank the members of this subcommittee for your support of those provisions.

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-RVU's. (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 RVU's 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 (CPEP's) that developed the initial direct PE-RVU's 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 60 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-RVU's that will be published by May 1, 1998. It is likely that the 1998 PE-RVU's will also be published as interim PE-RVU's 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 physicians 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-RVU's.

By the time that the PE-RVU's 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 RVU's 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-RVU's 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 pro-

fession 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-RVU's 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 CPEP's 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-RVU's.

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

The GAO concurs that HCFA's basic methodology is fundamentally sound.

The 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 report dismissed the argument that the CPEP's 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 CPEP's 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 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 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 agrees with the GAO 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 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 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.

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. A poorly designed survey could be prone to the same limitations, such as poor response rates and underrepresentation of small primary care practices, that led the GAO to preclude using such data in the development of the proposed rule, however. 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 GAO's 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 need 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 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 within the CPEP's are generally correct, but the absolute time estimates need normalization. HCFA noted that absolute numbers within some of the CPEP's may have reflected duplicate counting of tasks that can be performed simultaneously, and that different CPEP's 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.

ASIM believes that 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 percent 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 purpose 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.

More specifically, with the exception of the panel that evaluated evaluation and management services, the CPEP's 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 report accurately quotes ASIM as believing that linking is appropriate because some of the CPEP's uniformly assigned higher labor time than the E/M CPEP. The GAO agrees that linking is desirable. The 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 noted 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 looking at an alternative to the regression formula, if there are better approaches to establishing appropriate linkages between the labor costs of E/M services and non-E/M services. However, we 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. The GAO report makes it clear that it too agrees that linking is desirable, notwithstanding its criticisms of the regression formula.

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 those of 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 supports HCFA's decision to scale the CPEP data to independent data from the AMA's Socioeconomic Monitoring Survey.

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 0.39 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, elimination of scaling likely would disadvantage internists and other primary care physicians.

Indirect costs

The 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 RVU's, direct PE RVU's and malpractice RVU's, as proposed by HCFA, is acceptable. Some physician groups had argued that the indirect costs should not be allocated using such a "proxy" formula. ASIM agrees with the GAO report's conclusion that HCFA's method for allocating indirect costs based on the proposed formula is acceptable.

We do 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 RVU's 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.

ASIM supports use of 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 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.

The American College of Surgeons (ACS) and the Practice Expense Coalition, which represents surgical groups and medical specialties that expect to experience reduced payments under RBPEs, have argued that surgeons often bring their nurses into the hospital and that these costs should be reimbursed by HCFA. The GAO indicated that HCFA is reviewing limited data it has received on how widespread this practice is, and that HCFA may reconsider its policy after review of such data. ASIM recommends that HCFA 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.

In testimony that was given on March 3 to the health subcommittee of the Ways and Means Committee, the ACS and Practice Expense Coalition cite a survey by the Lewin group that supposedly supports their contention that it is a common practice in some specialties for surgeons to bring their own nurses into the hospital. Their own data, which were appended to the ACS statement, do not provide any credible evidence to support this claim, however. This is because the response rate to the Lewin survey was so low that it is impossible to base Medicare policy on numbers that clearly have no statistical validity. For instance, the finding that 50 percent of ophthalmologists pay for staff in out-of-office settings was based on two respondents from that specialty, one of whom reported that he or she paid for staff in out-of-office settings. The 71 percent of adult cardiac surgeons that allegedly use their staff in the hospital setting was based on affirmative responses from only 10 cardiac surgeons, out of 14 total respondents from that specialty. In every other specialty that was surveyed, fewer than 10 respondents per specialty indicated that they paid for staff in out-of-office settings. In no case did more than 15 physicians in any given specialty respond to the Lewin survey. (The ACS and PE Coalition also did not indicate what the response rate was to the Lewin survey, i.e., they did not report how many physicians in each specialty were surveyed, only how many responded. Without knowing the response rate, the results cannot be viewed as being statistically valid).

Interestingly, even if one were to accept the Lewin "data" as being statistically valid, in four of the surveyed specialties only a third or fewer respondents indicated that they pay for staff in out-of-office settings, which suggests that this is not the typical practice in those specialties. By definition, a resource-based practice expense relative value scale should be based on what is typical, not what is atypical.

If the Lewin data are the best data that are available on this issue, clearly HCFA was correct in disallowing expenses for physician staff in out-of-office settings.

GAO RECOMMENDATIONS

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

1. HCFA should use sensitivity analyses to test the effects of (1) the limits HCFA placed on the panel's estimates of clinical and administrative labor and (2) HCFA's assumptions about equipment utilization. Where HCFA's adjustments or assumptions substantially alter the rankings and RVU's of specific procedures, HCFA should collect additional data to assess the validity of its adjustments and assumptions, focusing on the procedures most affected.

ASIM generally concurs with this recommendation. It is not clear, however, what additional data the GAO believes should be collected to assess the validity of HCFA's assumptions. It is also important to reiterate that GAO supported the intent of HCFA's adjustments.

2. Evaluate (1) classifying the administrative labor associated with billing and other administrative expenses as indirect expenses (2) alternative methods for assigning indirect expenses and (3) alternative specifications of the regression model used to link the panels' estimates. HCFA should determine how changes in one aspect of the methodology, such as reclassifying some labor from direct to indirect expenses, affect other aspects of the methodology, such as the specification of the regression model to link the panels' estimates of administrative labor and the method used to allocate indirect expenses.

ASIM generally concurs with this recommendation. We have some concern, however, about using the current indirect cost allocation formula to determine billing costs, should those costs be shifted into the indirect cost category. We support looking at alternative specifications for the regression (linking) formula, provided that any change in the linking methodology address the misalignment of labor costs of non-E/M services compared to E/M services. Elsewhere in its report, the GAO con-

cluded that linking is not only desirable, but that "such a linking regression may be appropriate for use in developing adjustments to the CPEP data for practice expense RVU's." (page 47 of the GAO report).

3. 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. Similarly, HCFA should determine whether physicians have shifted tasks to nonphysician clinical staff in a way that warrants examining the physician work RVU's

We believe that any data on use of physicians' nurses must be independently validated by HCFA before changes are made to reflect those costs in the physician PE-RVU's. As noted previously in this statement, the data that was submitted by surgical groups to support the contention that this is a widespread practice was based on responses of fewer than 15 physicians in any given specialty (and as few as two in one specialty). Such data are not sufficient to support a decision by Medicare to allow these expenses. We agree that changes in staffing patterns may have reduced the physician work RVU's for some surgical procedures (in cases where the nursing staff are providing services that in the past were provided by the surgeon).

4. Work with physician groups and the AMA to develop a process for collecting data from physician practices as a cross check on the calculated practice expense RVU's, and to periodically refine and update the RVU's.

ASIM generally concurs, with the caveat that survey data to validate the PE-RVU's may be biased by poor response rates and other problems that the GAO identified with a survey process.

5. HCFA should monitor the impact of RBPEs on access, focusing on procedures with the largest cumulative reduction, and consider any access problems when making refinements to the practice expense RVU's.

ASIM concurs that the impact on access should be monitored. 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 RVU's 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-RVU's of office visits in 1998 as a first step toward the expected increases that will occur when RBPEs are implemented on January 1, 1999. Congress clearly intended for the PE-RVU's, 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-RVU's would be blended with the resource-based PE-RVU's). 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-RVU's, 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 re-interpret the law in such a way as to apply the down payment only to the 1998 PE-RVU's. They argue that the charge-based RVU's, which would be blended with the resource-based PEs beginning in 1999, should revert back to the 1997 PE-RVU's that were in effect prior to the down payment mandated by the BBA.

ASIM strongly opposes any such re-interpretation 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 re-open 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.

The March 1 report to Congress of the Medicare Payment Advisory Commission (MEDPAC) supports ASIM's interpretation of the down payment provisions. Without expressing an opinion on this issue, MEDPAC factually reports that:

"The $390 million limit on reallocation of practice expense payments to office visits [from the down payment provisions] applies to 1998 only. Since 1998 practice expense values will be used during the transition to resource-based practice RVU's, the adjustment to practice expense RVU's required by the BBA will affect payment rates throughout the transition, from 1999 through 2001." (Source: Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 1998, Volume II, p. 98; emphasis added by ASIM).

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" that increased practice expense payments for office visits, an internist would have to provide 81 mid-level established patient office visits—requiring over 20 hours in face-to-face contact with patients—before he or she would receive the practice expense payments that Medicare allows for a single coronary bypass. The same internist would have to provide 30 mid-level office visits—requiring at least seven hours of face-to-face contact with patients—to obtain the practice expense payments that Medicare allows for treatment of a lower leg fracture. An internist would have to provide 53 office visits—requiring at least twelve hours with patients—to receive the practice expense payments that Medicare now allows when an ophthalmologist repairs a detached retina. Such disparities are especially surprising, given the fact that the hospital bears a substantial amount of the direct costs when a surgical procedure is provided in a hospital operating room, while the internist is paying 100 percent of the office expenses incurred while providing care to patients. Even allowing for the indirect costs incurred by surgeons in keeping their offices running when they are in the hospital and pre- and post-operative office visits, it defies logic to suggest that the practice expenses of surgical procedures done in the hospital are so much higher than those incurred by office-based internists.

The fact is that 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 re-opened by HCFA, then we will urge Congress to step in and enact a technical correction that makes it clear that the 1998 PE-RVU's, as adjusted by the down payment, will apply in the transition years.

PAYMENTS FOR PROCEDURES PERFORMED WITH AN OFFICE VISIT

MEDPAC recommends that HCFA not adopt its proposal to reduce payments for non-surgical 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-RVU's for such procedures by 50 percent 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 percent from the costs of the original procedure.

VOLUME-INTENSITY OFFSET

MEDPAC also opposes HCFA's proposal to include a volume and intensity adjustment—otherwise known as a behavioral offset—in its calculations of the PE-RVU's. In its June 18, 1997 propose rule, HCFA stated that it intended to assume that 50 percent 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-RVU's is inconsistent with the requirement that resource-based practice expenses be implemented in a budget neutral manner.

PUBLIC-PRIVATE PARTNERSHIP

The Practice Expense Coalition has recommended, as an alternative to HCFA's methodology, a so-called public-private partnership that would assign PE-RVU's to services using a cost-accounting methodology developed by Coopers and Lybrand under contract to the coalition. As we understand the coalition's proposal, PE-RVU's would be determined by determining the total costs of practices on a specialty-specific basis, based on the AMA SMS data, and then allocating those total costs to specific codes billed by that specialty using a cost-accounting methodology.

This alternative would not be acceptable to ASIM. For one thing, we do not think it is reasonable to expect that a coalition of specialties with a vested interest in the outcome of a study can enter into a partnership with HCFA that would produce unbiased results. Also, we believe that the SMS data on absolute costs is itself distorted by the inequities created by the current charge-based method for determining practice expenses. Specialties that have gained unfairly under the current methodology are likely to report higher practice revenue, higher net income, and higher PEs than specialties that have been disadvantaged by the charge-based formula. Therefore, using the SMS data to construct the PE-RVU's would perpetuate the inequities that exist in the current formula. By contrast, HCFA's methodology starts by looking at what the relative costs are of providing each procedure compared to all others on the same scale, without prejudging what the impact would be on total revenue, net income, or costs for any given specialty.

For the same reasons, the SMS data cannot be used as a validity check on whether or not HCFA's methodology covers the total costs of physician practices. Although the SMS data is useful in determining such things as the relative proportion of direct and indirect costs by specialty, it cannot and should not be assumed or expected that HCFA's methodology will—or was intended to—cover the total costs of practice for any given specialty as currently reported in the SMS data. Nor should it be assumed that every specialty should get the same percentage share of Medicare payments for their practice expenses as reported in the SMS data. The law simply requires that HCFA's methodology establish an appropriate relative relationship among all services, based on relative differences in the practice costs required to perform each procedure that take into consideration "actual costs" to the maximum extent practicable. It says nothing about covering physicians' total costs as currently reported by the SMS data.

Finally, a public-private partnership that does not include internal medicine, family practice and other primary care specialties cannot produce representative and acceptable results. As currently proposed, we doubt that that any of the organizations that represent those specialties would agree to participate in the so-called public-private partnership

We would support establishing a process to regularly involve the medical profession in future refinements, however. The RVS Update Committee (RUC), which as we noted earlier is a multispecialty committee chaired and staff by the AMA that advises HCFA on refinements in physician work RVU's for the Medicare fee schedule, intends to submit a proposal to HCFA to assist in future practice expense refinements. Although some changes in the RUC process and composition may be necessary to accomplish this, ASIM believes that the RUC model has proven to be the kind of public-private partnership that has benefited both HCFA and the medical profession, and one that may be applicable to practice expense refinements.

CONCLUSION

ASIM believes 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. 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 and statistically valid data that this is a typical practice.

None of the GAO 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. We also support the need for establishing a refinement process that allows for the collection of additional data. ASIM recommends that the Appropriations Committee support adequate funding for HCFA's efforts to develop and refine the RBPE methodology, in-

cluding sufficient funding to support the refinement efforts recommended by the GAO.

REPORT

Senator SPECTER. Ms. DeParle, why, when the report is due on March 1, did we not receive it until this morning, March 10, at 10:40 a.m?

Ms. DEPARLE. Sir, in order to get a report up to the Congress, we have to get it cleared through a number of different offices within the Administration. We should have started sooner, and I apologize for being late.

Senator SPECTER. You knew all the offices you had to have it cleared by before March 1.

Ms. DEPARLE. Yes, sir; we did. I apologize.

Senator SPECTER. It does not do the job, Ms. DeParle, because we had this hearing set for March 10 and we are not able to go through your report to have an intelligent hearing when the report is not received.

Ms. DEPARLE. Again, sir, I apologize.

Senator SPECTER. Please don't. It does not matter. What has to be done is that we need to receive the report so we can make an evaluation. We have people who have traveled long distances to come to this hearing, and we expected your report.

There has been a plea made on your behalf for more funding. If you need more funding, that is something that this subcommittee would be prepared to do. I find it unsatisfactory to have letters that are written on November 25 answered on February 13, and I suspect that it is not a coincidence that we received the report today because the hearing was held today. If the hearing had been held 3 weeks from now—I do not want to speculate on when the report would have been received, but we simply cannot do our job.

Last year—you were not there, it was not on your watch—HCFA did not meet the timetable of May 1 and the new fees were supposed to go into effect on January 1, 1998, so apologies are just not relevant to what we are doing here. You have got to tell us what you need to get the job done, then you have got to meet the timetable. That timetable was established a long time ago.

The issue which confronts the Congress is what to do by way of oversight. I agree with the comments made today about oversight. What would the GAO report, if those recommendations were followed, enable us to do, Dr. Day?

Dr. DAY. Well, I think first of all they would enable us, if data was collected, to really assess what our practice costs are so that the debates would be based on reality.

Senator SPECTER. Do you think the practice costs are not adequately assessed by what HCFA has done?

Dr. DAY. Absolutely not, especially for individual specialties within it. We are lumped into a group.

Senator SPECTER. How about that, Ms. DeParle?

Ms. DEPARLE. Well, it was my understanding that the GAO report actually said that our data collection was pretty good. In fact, I think the GAO used the word acceptable.

Senator SPECTER. How about your methodology?

Ms. DEPARLE. Given the limitations in collecting data, the GAO knew that we tried some different methods, and that they thought the panels——

Senator SPECTER. How about it, Dr. Day? Can we at least agree on what the GAO report said?

Dr. DAY. I thought they said that their process of data collection was fine, but that the actual data needed to be validated by actual practice expense data.

Senator SPECTER. Did you do that, Ms. DeParle?

Ms. DEPARLE. We did. In my testimony, sir, I spoke about the number of panels that we held this past fall to validate the data.

Now, there is another issue that is related to this and I think everybody has talked about this, which is continued refinement of the data. This is one thing the GAO recommended.

Senator SPECTER. Continued refinement? How is that going to affect the fee schedules which are established?

Ms. DEPARLE. I think what it means, sir, is that what they are saying is, the way I read it, the gist of it was that the data is about as good as you are going to be able to obtain to get this done, but you should continue to work on refining data as you go forward.

Senator SPECTER. Why? Are the fee schedules going to be changed?

Ms. DEPARLE. Yes; I think that GAO recommended we would go forward with our rule and implement it, but that we should continue to refine the data. I assume that means that we could recommend changes based upon the new data.

Senator SPECTER. Dr. Day, you did not have very long, but does your written submission specify where HCFA did not adequately handle the data?

Dr. DAY. Yes; it does, and we believe we can get that data. We have been consulting with Coopers & Lybrand, a very well-known accounting firm.

Senator SPECTER. Do you have some time when we finish today to sit down with my staff and Ms. DeParle and go over the specifics of that and see if we can have a little arbitration as to what is going on here?

Dr. DAY. I would be delighted to.

Ms. DEPARLE. Sir, if I may, I am familiar with the Coopers & Lybrand data, and I believe that Dr. Day's group has met with Dr. McCann, and he tells me that they are in the process of reviewing that data. So we can certainly meet again, but I do think that we are aware of their recommendations, and we appreciate them. It has been a helpful process.

Senator SPECTER. Aware of their recommendations and appreciate them? I am not sure that exactly comes to grips with the difference in approach. I would like you to sit down with my staff afterward and see if we can move through it.

Dr. Gardner, you are very complimentary about Dr. McCann, but you are a cardiothoracic surgeon. Cardiac surgery, according to last year's charts, would lose 32 percent, if you are a thoracic surgeon, you would lose 28 percent. Which one do you choose, or are you right in the middle? [Laughter.]

It is a tremendous reduction. I have had a lot of complaints from the losers in the 30-percent range, so substantial. Dr. McCann, why so substantial, all in one fell swoop?

Dr. MCCANN. Those numbers, those impacts were published in a rule that—we put out a proposed rule, I am sorry, last June, and it was put out for public comment. Subsequent to that, the Congress passed the Balanced Budget Act. We put that out in hopes of getting comments. It was based on the data we had in hand. Many of the comments that you have heard in this testimony today have suggested that we take a different approach and look at different options.

Senator SPECTER. Have you changed your way of living after hearing all the comments?

Dr. MCCANN. We are very sensitive to the concerns that have been raised by everyone on this panel.

Senator SPECTER. How about my question?

Dr. MCCANN. We are working at the staff level to prepare some options for our administrator to review, and that is underway as we speak, taking into account, as an example, Dr. Day's suggestion that we look at the Coopers & Lybrand approach to developing practice expense. That requires an enormous amount of computer work back at our Baltimore offices, and it is underway as we are speaking.

Senator SPECTER. Dr. Nelson, internal medicine is just in for a plus-three. Doesn't all of this pretty much boildown to where you stand on this chart as to what your positions are going to be? It would be contrary to human nature not to have it that way. If you are getting hit very hard you are obviously going to be disadvantaged here.

What is the reality of Congress providing oversight, Dr. Brooks? How do we do that?

Dr. BROOKS. Well, Senator, where the fee schedules proposed are phased in over 4 years, that gives HCFA and the other agencies time to try to reevaluate it and look and see if there are——

Senator SPECTER. Four years. Does that mean one-fourth change each year?

Dr. BROOKS. As I understand it, that is correct, so that when we are talking about these large percentage reductions my understanding is that although it is 30 percent over the total, it is delayed during that time. During that time the Congress and HCFA and the other agencies have a chance to look at that data to reevaluate it and find out if there are problems, but the fact of the matter is that there is a set amount of dollars that is going to be used.

Senator SPECTER. What internal mechanisms are there, Ms. DeParle, that you faced as to how you are going to listen to inputs of other information to make adjustments in the charts?

Ms. DEPARLE. Well, there are not any right now, but I think an important point was made by you when you talked about the transition. Under the law before the Balanced Budget Act we had to, as you put it, do this in one fell swoop, and it had to be budget-neutral.

Senator SPECTER. May I suggest you address that question very promptly, and establish a timetable immediately after you put out

your suggested changes. I also suggest you meet with the groups no later than 30 days afterward, and take into account what they have to say?

This subcommittee may be reconvened, but Dr. Gardner said it was a complexity, I think beyond—I forget what you said, I think capacity, a complexity beyond the capacity of the panel. Forget about the Senate.

Dr. GARDNER. You know, sir, the reason I gave you some of the bottom-line figures on the impact on cardiac surgery in addition to the background reductions is to emphasize the severity of the impact on our specialty, and I do not think that the cottage industry approach that HCFA was forced to take because of failure of the national survey and a lack of, perhaps what they felt was time or staffing, should be allowed to determine the course here.

Senator SPECTER. What should be done now Dr. Gardner?

Dr. GARDNER. I think we should step back and do a study that is acceptable to an accounting approach.

Senator SPECTER. Who is going to do the study, would you propose?

Dr. GARDNER. I think it should be contracted out. I think it should be contracted to a professional firm that can do this and not expect the HCFA staff to do it, and I think that we should let the cards fall where they are.

Senator SPECTER. So you want to start from scratch?

Dr. GARDNER. I think that the issues are actual practice costs, and the distribution of direct versus indirect costs, and whether that can be allocated.

Senator SPECTER. But you are saying start from scratch.

Dr. GARDNER. Yes, sir.

Senator SPECTER. But in HCFA we are supposed to have an agency to do just that, are we not?

Dr. GARDNER. Sir, my experience with HCFA is fairly superficial. I have been there a few times. My impression is they are chronically overworked.

Senator SPECTER. What about that, Dr. McCann?

Dr. MCCANN. We do have a lot to do. [Laughter.]

Senator SPECTER. Are you chronically overworked?

Dr. MCCANN. At the moment, yes, sir.

Senator SPECTER. How about you, Ms. DeParle? You have not been there long enough to be chronically overworked.

Ms. DEPARLE. It feels like it has been a long time. [Laughter.]

Senator SPECTER. Well, I would like to have you, lady and gentleman, sit down with my staff to try and deal with some of the specifics as to where you are heading, especially with what Dr. Day has said.

I know it takes a long time, but the methodology is very perplexing here as to how we are supposed to provide remedies. We are going to see these figures, and I would like to see in writing your review process so people have a chance in a formalized way to come in and tell you what they do not like and be specific, and have you rule, and if you need more help I think the subcommittee would be prepared to do it.

Ms. DEPARLE. Thank you.

Senator SPECTER. Ms. DeParle, if you would stay for a few minutes. We obviously on this subcommittee are enormously concerned with how all of this is handled, but we need some help from the professionals as to how we come to terms with it.

Ms. DeParle, I want to take up a number of questions with you on matters that have been outstanding in your Department.

Ms. DeParle, what is the status of your unit's response on the Salitron issue that I was talking to you about?

Ms. DEPARLE. Yes; I was talking to your staff about this in one of the breaks. I heard about this issue for the first time yesterday. I understand you had a recent letter in to me which I had not seen until yesterday.

As I understand the issue, what you have been interested in——

Senator SPECTER. I wrote to you on January 21, 1998, and February 12, 1998, and you saw it for the first time yesterday?

Ms. DEPARLE. Yes, sir.

Senator SPECTER. Why?

Ms. DEPARLE. I do not know why, sir. I am trying to review the congressional correspondence, but I have not seen this, and I had not heard of this issue.

As I understand it, it is a device that can be helpful to people with something called Sjogren's disease, and it has been an issue around HCFA for some time, several years in fact. The agency has performed a technology assessment but has not found evidence that the device could be useful.

I asked staff yesterday to request another technology assessment.

Senator SPECTER. I understand the regulations are very old and, doubtless, outdated.

Ms. DEPARLE. I believe you are referring to a regulation that the agency put out in 1994, yes, sir. It was a proposed rule I think, sir, that never became final.

Senator SPECTER. Would you take a look at it, and would you answer two questions for me, why you do not see your mail from January 21, and what the substantive answer is?

Ms. DEPARLE. Yes, sir; I certainly will.

[The information follows:]

SALITRON SYSTEM

With respect to the incoming letters from Senator Specter regarding the Salitron System, I did not see the February 12 letter even though I had instructed staff to provide me with copies of all correspondence from Members of Congress. Unfortunately, a mistake was made within our correspondence control system.

PROPOSED RULE

Senator SPECTER. I am told by staff that you are prepared to testify that you will withdraw the regs if you are asked, is that true?

Ms. DEPARLE. Yes, sir; I talked to Mr. Sauerwein about this during the break. From my understanding of this issue the problem relates to—or your problem relates to a regulation, or a proposed rule that was put out in 1994. It is now 1998.

We never went final with the rule, and I would not intend to go final with a rule that has been out that long, so I would be prepared to withdraw it.

Senator SPECTER. Ms. DeParle, why did you not tell me that when I asked you the question about this matter generally, without a specific question as to whether you are prepared to withdraw it?

Ms. DEPARLE. I am sorry, sir, I did not know that is what you wanted to know.

Senator SPECTER. Mr. Sourwine points out that it is in the letter. Is there any other relevant information that you have on this subject that I have not asked you specifically about? I really find this a little hard to understand. We are not in a courtroom. You are not a hostile witness. If you are prepared to withdraw the regulation, why don't you say so?

Ms. DEPARLE. Sir, the letter that I remember looking at yesterday was a letter that asked more generally about what the status was. I did not remember that you wrote a letter asking about pulling the regulation.

Senator SPECTER. The letter says, of February 12, a formal withdrawal in the Federal Register would clarify the Medicare coverage for the device is up to the regional carriers, and the decision is reached on a national coverage policy. That is what the letter says.

Ms. DEPARLE. I am sorry, sir, I was not—as I said, I did not look at this until yesterday, and I was not familiar with the specifics of the letter. I know you wrote two letters on it that I saw yesterday.

Senator SPECTER. But if you saw it yesterday, and you saw the line about withdrawal—I just do not understand, Ms. DeParle. The letter talks about withdrawal. You are prepared to withdraw it, but I have to ask a specific question before we get there.

Is there anything else about that issue which is relevant that this subcommittee ought to know about?

Ms. DEPARLE. Well, no, sir. I was just trying to say that the staff who have looked at this—again, my knowledge is from yesterday—tell me that they have tried a number of times to find a suitable use for this device, and to find some evidence that it would help people. However, they have not been able to, and so they are concerned about this particular device. That is the only other thing that I can tell you.

I requested yesterday that they request another technology assessment, because there was one done, as you probably know, back in 1990. I thought that, given your continued interest in it, that we ought to at least update our technology assessment and see what the experts were saying about the device, so I did request that. This is the only other thing I know about.

Senator SPECTER. OK.

I had written to you on January 27, or to Secretary Shalala, about the final regulations implementing the Medicare salary equivalency rule and again got a letter dated yesterday, and this is on behalf of a specific constituent, and when I receive these requests from constituents I am not intimately familiar with all of the ramifications, but really pass on the problems which are created to try to get an expert evaluation.

But as I said in my letter of January 27, I am advised that the promulgation of the final rule will cause undue financial hardship because they will have to change their reimbursement systems to comply with the rule, only to change the reimbursement system

later this year, when HCFA promulgates a second series of regulations required by the Balanced Budget Act of 1997.

Are they correct that there will be another series of regulations issued later this year?

Ms. DEPARLE. Yes, sir; they are.

Senator SPECTER. Are they correct they are going to have to revamp their reimbursement system to comply with the new set of regulations?

Ms. DEPARLE. I think I have talked to some of the same people, sir, and I believe they probably will.

Senator SPECTER. Do you think that is fair to change the regulations twice in such a short period of time to cause that kind of extra expense?

Ms. DEPARLE. This rule originally went out in March, sir, and in fact the agency——

Senator SPECTER. March 1997?

Ms. DEPARLE. Yes; the agency staff, given the Balanced Budget Act, had—and I discussed this with Mr. Sauerwein back in January, I believe.

The agency staff had originally decided not to go forward for two reasons, first, because of concerns about issuing two rules so quickly, a final rule on this and the BBA rules at the same time, and second, frankly, as you have heard today, our staff is very busy and is often not performing up to the standards that you and other Members would like on the issues that we have on our plate, so for those reasons we were not going to go forward.

However, Senator Harkin in particular felt very strongly that this rule had some savings, that it was a program integrity issue, and asked that we go forward with it, so we have done so.

Senator SPECTER. Well, is there any way to give some regulatory relief to the specific entities, constituents which are burdened by a revised set of regulations in such a short period of time?

Ms. DEPARLE. I do not know, sir, but I would be willing to talk to you and your staff about a way to do it. I am not sure there is any way to give relief and also honor the commitment to Senator Harkin.

Senator SPECTER. Well, do you have waiver authority to make adjustments on a showing of hardship in an area of this sort?

Ms. DEPARLE. I do not know, sir, but let me find out and get back to you soon with that.

[The information follows:]

HCFA'S WAIVER AUTHORITY INVOLVING SALARY EQUIVALENCY

With respect to whether it is possible to waive the salary equivalency guidelines in certain circumstances, or for certain providers, we believe that we do not have the authority to change or waive the salary equivalency guidelines regulation's effective date of April 10 for one provider or a group of providers. Existing regulations do provide for exceptions to the guidelines for unique circumstances or special labor market conditions, although any exceptions may reduce the savings from these guidelines. These exceptions are available to providers of services. For instance, the guidelines apply to payments that the Medicare Program makes to skilled nursing facilities, home health agencies, and other providers, for therapy services provided under arrangement. HCFA pays the entity (the provider) that claims the therapy costs in its cost report. This means a provider can apply for an exception if (1) That provider files the cost report with HCFA and (2) it contracts with another entity to provide therapy services, because the guidelines do not apply to therapists directly employed by the provider.

NEW REGULATIONS

Senator SPECTER. As I say, this is a constituent inquiry, and I do not know the details, but if you are going to have another set of regulations coming out, and if you agree with their representation that it costs extra expense, that seems to me something which ought not to be done if it can be possibly avoided. So I would appreciate it if you would take a look at it.

If you conclude that it is a matter of fairness—you are nodding in agreement.

Ms. DEPARLE. I will take a look at it.

Senator SPECTER. There will be double expenses for them to comply with the new set of regulations, correct?

Ms. DEPARLE. There will be more expenses. I do not know if they are double. The concern I have——

Senator SPECTER. But more expenses.

Ms. DEPARLE. Yes, sir; I think it stands to reason there will be.

My concern is that, frankly, I talked to the same groups, and I had the conversation with Senator Harkin, and he feels very strongly that because there are savings attached to this regulation, it saves money for the Medicare trust fund, that——

Senator SPECTER. Well, how much are the savings, if you can quantify that?

Ms. DEPARLE. It has been a couple of months since I looked at this, but I want to say it is several hundred million dollars, which is not huge in the realm of Medicare, but it is a substantial amount. Let me get back to you with the exact numbers.

My staff is saying $260 million.

Senator SPECTER. Over how long a period of time?

Ms. DEPARLE. Well, I think this would only have effect for a couple of years, because, as you said, the Balanced Budget Act makes some other changes.

Senator SPECTER. Well, it would not last for a couple of years if there will be another change in regulations this year, would it, and let the record show you are consulting with staff and you have $260 million figure, but over how long a period of time is that?

Ms. DEPARLE. I do not know, sir. Let me get back to you with an answer.

[The information follows:]

SALARY EQUIVALENCY RULE'S PROJECTED SAVINGS

The estimated cost savings associated with salary equivalency guidelines, involving Medicare part A and B, is $260 million during fiscal years 1998 through 2000. This estimate is based on the effective date of April 10, 1998.

REGULATIONS

Senator SPECTER. When a constituent comes and says, they just put out some regulations and there are going to be some more coming out later this year. Why do we have to change our systems twice, in an age where there is so much regulation? I miss the regulatory reform bill before governmental administrations. We are all committed, the President, Secretary of Health and Human Services, I think you, too, Ms. DeParle are committed to try to keep the regulations to a minimum point necessary to get the job done. Thank you.

Ms. DEPARLE. Yes, sir; and I understand your concerns about this one. Thank you.

CONCLUSION OF HEARING

Senator SPECTER. Thank you all very much for being here, that concludes our hearing. The subcommittee wil stand in recess subject to the call of the Chair.

[Whereupon, at 5:20 p.m., Tuesday, March 10, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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