S. HRG. 100-398, PT. 1

MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH BLOCK GRANT BUDGET ISSUES

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

JULY 8 AND 9, 1987

Printed for the use of the Committee on Finance

Part 1 of 2

U.S. GOVERNMENT PRINTING OFFICE

80-747 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH BLOCK GRANT BUDGET ISSUES

WEDNESDAY, JULY 8, 1987

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The Committee met, pursuant to notice, at 10:05 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus presiding.

Present: Senators Baucus, Bradley, Chafee, Heinz, and Durenberger.

[The press release announcing the hearing and the prepared statements of Senators Mitchell, Baucus, and Heinz follow:]

[Press Release No. 55, June 26, 1987]

FINANCE COMMITTEE TO HOLD HEARINGS ON MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH BLOCK GRANT BUDGET ISSUES

WASHINGTON, D.C.—Senator Lloyd Bentsen (D., Texas), Chairman, announced Friday that the Committee on Finance will hold a series of three hearings to examine budget issues affecting the Medicare, Medicaid, and Maternal and Child Health Block Grant programs. The hearings are in preparation for Committee markups of proposals necessary to comply with the reconciliation instructions contained in the First Concurrent Resolution on the Budget.

The first hearing will focus on Part A of the Medicare program, the second will focus on Part B of Medicare, and the third will focus on Medicaid and the Maternal and Child Health Block Grant programs.

Bentsen said that the Finance Committee will examine changes in the Medicare program necessary to reduce spending in accordance with the budget resolution, and will also examine expansions of coverage under Medicaid and Maternal and Child Health Block Grant. Possible initiatives include expanded coverage of pregnant women and children, reducing spousal impoverishment of nursing home residents, and improving quality assurance of long-term care.

The hearing schedule is as follows:

July 8, 1987—Medicare Part A;

July 9, 1987—Medicare Part B;

July 10, 1987 –Medicaid and Maternal and Child Health Block Grant.

All hearings will begin at 10:00 A.M. in Room SD-215 of the Dirksen Office Building.

OPENING STATEMENT

SEN GEORGE J MITCHELL

JUNE 8, 1987

HEARING ON FINANCE COMMITTEE RECONCILIATION

MEDICARE PART A ISSUES

If, this nation did not have a debt exceeding two trillion dollars and a projected deficit for fiscal year 1988, of more than 150 billion dollars, the focus of this hearing would be different. However those are the stark realities we face.

The savings we need to achieve in the Medicare program, although significant, represent a more equitable share of the total savings needed than those in years past. However, we are still confronted with the difficult task of finding ways to meet the savings specified in the budget resolution and at the same time ensuring Medicare recipients do not suffer a reduction in the scope or quality of services as a result.

Earlier this year I chaired a hearing of the health sub-committee of the Finance Committee, which reviewed both previous and current costs and savings in the Medicare and Medicaid programs. The witnesses included nine of the top health policy experts in the United States.

There was consensus that significant cost savings had been achieved in the Medicare program as a result of implementation of the Prospective Payment System and other actions taken by Congress in the past six years. Most of the witnesses agreed that although a significant amount of the inefficiency in the hospital system had been removed, there

was still room for additional measures to enhance efficiency in hospitals.

As Medicare reimbursement for services is refined and made more efficient, there is a concomitant need to make sure that the reimbursement system is equitable. Evidence has been presented to this committee in this and previous years that reimbursement under Medicare for rural hospitals was set inequitably low at the outset of the program. While we made some important changes in this regard in last years reconciliation bill, significant problems remain. I am firmly committed to seeing that rural hospitals receive adequate reimbursement for the services they provide to Medicare beneficiaries.

As we attempt to moderate the rate of increase in hospital service costs, we must also monitor the effect that changes have on the quality of care and on access to service for post hospital home care. Congress has mandated that Peer Review Organizations focus on the of quality of care, as well on on utilization. I continue to be concerned that this mandate is not being appropriately addressed.

Finally, as hospitals become more effective and efficient, it is clear that the need for post hospital home and skilled nursing facility services increases. We cannot allow unduly restrictive policies in regard to home and skilled nursing facility services to place the elderly at high risk of re-hospitalization, functional loss or even death. I would hope that these issues are addressed along with those that will result in cost savings. To do otherwise would be to fail in our responsibilities to our elderly citizens.

OPENING STATEMENT BY
SENATOR MAX BAUCUS
FINANCE COMMITTEE HEARING
MEDICARE PART A
JULY 8, 1987

TODAY, WE BEGIN THE FIRST OF THREE HEARINGS ON SPENDING REDUCTIONS AND OTHER REFORMS IN THE HEALTH PROGRAMS UNDER THE JURISDICTION OF THIS COMMITTEE. THE PURPOSE OF THESE HEARINGS IS TO EXAMINE THE OPTIONS WE HAVE IN DEVELOPING THE COMMITTEE'S PORTION OF THE FISCAL YEAR 1988 BUDGET RECONCILIATION PACKAGE.

I AM PLEASED THAT THE CONFERENCE AGREEMENT ON THE BUDGET RESOLUTION RESULTED IN MORE MODERATE SAVINGS TARGETS FOR THE MEDICARE PROGRAM THAN THOSE ORIGINALLY PROPOSED BY THE PRESIDENT.

OUR TARGET IS TO COME UP WITH $1.5 BILLION IN FY 1988 AND $8.8 BILLION OVER THREE YEARS. THE PRESIDENT PROPOSED TO CUT THE MEDICARE PROGRAM BY OVER $5 BILLION IN FY 1988 AND BY NEARLY $22 BILLION OVER THE NEXT THREE YEARS.

TODAY'S HEARING WILL COVER ISSUES RELATED TO THE PART A PORTION OF THE MEDICARE PROGRAM, PRIMARILY HOSPITAL AND HOME HEALTH SERVICES. TOMORROW'S HEARING WILL FOCUS ON THE PART B SIDE OF THE PROGRAM. FINALLY, ON FRIDAY, WE WILL EXAMINE MEDICAID AND THE MATERNAL AND CHILD HEALTH PROGRAMS.

ACHIEVING BUDGET SAVINGS IN THE MEDICARE PROGRAM IS NEVER EASY. THIS YEAR IS NO EXCEPTION. AS WE LOOK FOR SAVINGS, WE ALSO NEED TO KEEP IN MIND THAT SOME IMPROVEMENTS ARE NEEDED IN TARGETED, HIGH PRIORITY AREAS. BUT THESE ALL HAVE A PRICE AND WE WILL HAVE TO FIND WAYS TO PAY FOR ANYTHING THAT ADDS TO MEDICARE COSTS.

OVER 60 PERCENT OF MEDICARE SPENDING GOES FOR HOSPITAL SERVICES. SO, IT'S NO SURPRISE THAT THIS IS THE AREA WHERE WE BEGIN OUR HEARINGS TODAY.

EARLIER THIS YEAR, THE HEALTH SUBCOMMITTEE HEARD FROM SEVERAL WITNESSES WHO TOLD US THAT, IN THE FIRST YEAR OF THE PROSPECTIVE PAYMENT SYSTEM, MANY HOSPITALS DID VERY WELL UNDER MEDICARE'S PAYMENT RULES.

BUT THE EXPERIENCE IN THE FIRST YEAR WAS UNEVEN AT BEST. I AM DEEPLY CONCERNED THAT ONE OUT OF EVERY FOUR SMALL RURAL HOSPITALS LOST MONEY UNDER PPS IN THE FIRST YEAR. MANY HAD DOUBLE-DIGIT LOSSES. THIS IS A SITUATION THAT SIMPLY MUST BE CORRECTED.

I RECOGNIZE THAT MANY CHANGES HAVE OCCURED SINCE THE FIRST YEAR OF PROSPECTIVE PAYMENT. AND WE NEED TO FIND OUT HOW THOSE CHANGES HAVE AFFECTED THE FINANCIAL PICTURE FOR HOSPITALS AND THE AVAILABILITY OF SERVICES FOR SENIORS WHO DEPEND ON THE MEDICARE PROGRAM.

WE NOW KNOW WHERE THE ADMINISTRATION STANDS ON THESE ISSUES. THEY HAVE PROPOSED THAT HOSPITALS GET AN INCREASE OF THREE-QUARTERS OF ONE PERCENT FOR NEXT YEAR. FRANKLY, I HOPE THAT WE CAN DO BETTER THAN THAT, ESPECIALLY IN RURAL AREAS WHERE THE WARNING SIGNS ARE ALREADY CLEAR.

WE WILL ALSO BE HEARING TODAY ABOUT HOME HEALTH CARE CONCERNS, ESPECIALLY ON WAYS TO IMPROVE ACCESS TO IN-HOME SERVICES AND THE QUALITY

OF THOSE SERVICES. I LOOK FORWARD TO THE TESTIMONY IN THIS AREA AND IN WORKING WITH MY COLLEAGUES ON THE COMMITTEE IN THIS IMPORTANT AREA.

SENATOR BENTSEN IS ON THE SENATE FLOOR THIS MORNING MANAGING THE TRADE BILL. HE MAY BE ABLE TO JOIN US DEPENDING ON THE SITUATION IN THE SENATE OVER THIS IMPORTANT LEGISLATION.

IN THE MEANTIME, WE WANT TO MAKE AS MUCH PROGRESS AS WE CAN THIS MORNING.

I REMIND ALL WITNESSES TO PLEASE SUMMARIZE YOUR STATEMENTS AND TO KEEP YOUR RESPONSES TO QUESTIONS AS CONCISE AS POSSIBLE.

WHEN YOU SEE THE YELLOW LIGHT, IT MEANS TO BEGIN WRAPPING UP YOUR REMARKS. THE RED LIGHT MEANS STOP.

OUR FIRST WITNESS IS DR. STUART ALTMAN, CHAIRMAN OF THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION. WE WELCOME YOU ONCE AGAIN, DR. ALTMAN. PLEASE PROCEED WITH YOUR OPENING REMARKS.

OPENING STATEMENT BY SENATOR JOHN HEINZ (R-PA)
SENATE FINANCE COMMITTEE HEARING ON BUDGET RECONCILIATION
MEDICARE PART A
JULY 8, 1987

Mr. Chairman:
You have launched this ship on a three-day passage through the financing narrows of America's health care programs for her oldest and most vulnerable citizens. Our immediate challenge is to trim Medicare's sails by $1.5 billion dollars without running aground on reduced access to quality services.

All of us here are sensitive to the increasing weight of costs shouldered by Medicare beneficiaries today. We also recognize an unequal distribution of caregiving among health care providers, including the heavy burden of uncompensated care borne by many urban public hospitals. It is important to keep these two points in mind, I believe, as we attempt to trim the "fat" from several programs that have been on a starvation diet for a long time.

Mr. Chairman, the package we send out of this Committee should be cost-sensitive, most certainly. But a caveat on cost does not mean we sacrifice quality or comprehensiveness. There are several major initiatives that I would urge be considered as part of the final Committee bill.

As Chairman for six years, and now Ranking Member of the Special Committee on Aging, I have tracked a disturbing pattern of denials for home health services. Congress saw through the pattern of denials based on definitions of "homebound" and "intermittent," saw them as an attempt to deny the spirit of the law in an effort to scimp on spending. We're acting to clarify what we intend as the range of coverage under the home health benefit.

But the Health Care Financing Administration appears to have introduced a new twist to the denial game: "medical denials." Current HCFA rules permit a nurse to determine medical necessity for reimbursement purposes. I want to require that a physician make the review, and that the fiscal intermediaries provide an explanation of the medical basis for a denial.

Vaccinations to protect against pneumonia and hepatitis are now covered under Medicare. A logical extention of this preventive health benefit would be to cover the costs of influenza vaccinations--and I urge that we do so.

Two additional initiatives, Mr. Chairman, address needed reforms in nursing home quality assurance and in pacemaker utilization. Under the former, I would like to see us upgrade nurse staffing requirements, improve enforcement and provide for a ban on Medicaid discrimination. Under the latter, DHHS should be empowered to recover dollars paid under warranties for failed pacemakers and tighten implantation guidelines to reduce overutilization. I should note that these pacemaker initiatives were projected by CBO to save Medicare between $20-$30 million per year.

There are two other proposals I will bring up, Mr. Chairman, and ask my colleagues here to join with me in folding them into our final recommendation to the Senate. In the meantime, I look forward to our witnesses.

Senator BAUCUS. The hearing will come to order.

Today we begin the first of three hearings on spending reductions and other reforms in health programs under the jurisdiction of this committee.

The purpose of the hearings today is to examine the options we have in developing the committee's portion of the Fiscal Year 1988 budget reconciliation package.

I am pleased that the Conference Agreement on the Budget Resolution resulted in more moderate savings targets for the Medicare program than those originally proposed by the President. Our target is to come up with $1.5 billion in Fiscal 88 and $8.8 billion over three years. The President proposed to cut the Medicare program by over $5 billion in Fiscal 88 and by nearly $22 billion over the next three years.

Today's hearing will cover issues related to the Part A portion of Medicare, primarily hospital and home health services. Tomorrow's hearing will focus on Part B. Finally, on Friday we will examine Medicaid and the Maternal and Child Health programs.

Achieving budget savings in Medicare is never easy; this year, no exception. As we look for savings, we also need to keep in mind that some improvements are needed in targeted high-priority areas. But these all have a price, and we will have to find ways to pay for anything that adds to Medicare costs.

Over 60 percent of Medicare spending goes for hospital services, so it is no surprise that this is the area that we begin our hearings.

Earlier this year, the Health Subcommittee heard from several witnesses who told us that in the first year of the Prospective Payment System many hospitals did very well under Medicare's payment rules. But the experience in the first year was uneven. I am deeply concerned that one out of every four small rural hospitals lost money under PPS in the first year. Many had double-digit losses. This is a situation that must be corrected.

I recognize that many changes have occurred since the first year of Prospective Payment, and we need to find out how those changes have affected the financial picture for hospitals and the availability of services for seniors who depend on Medicare.

We now know where the Administration stands. They have proposed that hospitals get an increase of three-quarters of one percent for next year. Frankly, I hope that we can do better than that, especially in rural areas where the warning signs are very clear.

You will also be hearing today about home health care concerns, especially ways to improve access to in-home services and the quality of those services. I look forward to hearing testimony in this area and to working with my colleagues in this area.

Senator Bentsen, I might add, is on the Senate Floor this morning managing the Trade Bill. He may be able to join us, depending upon which amendments are up and what other business is before the Senate. In the meantime, we will make as much progress this morning as we possibly can. Because of the importance of the Trade Bill and because many members of this committee will be on the floor participating in the trade bill, I ask the witnesses to make an extra special effort to summarize their testimony, to be even more succinct, more direct, more pithy in answering questions and

making statements, so that we can be more efficient than we sometimes are.

I also will probably ask fewer questions than usual. The main point of this hearing is essentially to give PROPAC, hospital groups, and others an opportunity to say what they want to say, whatever they think, in reacting to the Administration's Prospective Payment proposals, outlier provisions, the rural/urban split, PIP, or whatever is on the minds of the witnesses.

With that, I will first turn to Senator Heinz to see if he has an opening statement.

Senator HEINZ. Mr. Chairman, I have a few brief remarks I would like to make, and I ask unanimous consent that my entire statement be a part of the record. You have correctly stated why we have launched this three-day passage through the financing of American healthcare programs that will affect our oldest and most vulnerable citizens. We have to try and save $1.5 billion this year and considerably more than that over the next three years, and I think we need to do so without running aground on reduced access to quality services.

I think we are all sensitive to the increasing weight of costs shouldered by Medicare beneficiaries today—I hope we are. We should recognize that there is an unequal distribution of caregiving among healthcare providers, including the heavy burden of uncompensated care born by many urban public hospitals.

It is important to keep a couple of points in mind, I think, as we attempt to trim the fat from several federal programs that have in many cases been on a starvation diet for some time.

I do think that what we send should be cost-sensitive—most certainly—but a caveat on cost doesn't preclude a caveat on making sure that these programs do serve those that they are supposed to serve, and I would hope that we would also address in the committee some areas that need addressing. I will cite one:

For quite some time, going back almost two years now in the Committee on Aging, which at that time I chaired, we have been tracking a disturbing pattern of denials of home health services. And Congress saw through that pattern of denials last year when the definitions of "homeboundedness" and "intermittency" were being manipulated, and we addressed that problem.

We have a new problem with home health care benefits, and that is that somewhere in the Health Care Financing Administration there is a new twist to the denial of reimbursement game; namely, the establishment of medical denials that permit a nurse to second-guess what a doctor has prescribed in the way of home health care.

We are here talking about Part A of Medicare, and I raise this subject—which is only tangentially related to Part A—because I think we need to understand that if we are going to trim in acute care any more than we already have, and even taking into account what we already have done, we create a demand for post-acute hospitalization services—home health care, nursing home care—that we must address at the same time. We can't simply say we are going to deliver less money and therefore in some sense less hospital-based care and not provide access to the alternative care set-

tings. To do so puts those who deliver hospital-based services in an impossible position.

So, those are some of the issues I think we need to address, Mr. Chairman, as we talk about cutting costs. We cannot just cut costs in Part A and say, "Well, that's all we have to do, and there are no consequences to that."

Mr. Chairman, I know you share those feelings, but I just wanted the committee to have an understanding on the record of what I think are some critical issues. I ask that the rest of my statement be made a part of the record.

Senator BAUCUS. Without objection. Thank you, Senator.

Our first witness is Dr. Altman, Chairman of the Prospective Payment Assessment Commission. Dr. Altman, I know you have worked long and hard examining the Prospective Payment System, and we very much look forward to hearing your views and whatever advice you have for us.

STATEMENT OF STUART ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, BOSTON, MA, ACCOMPANIED BY DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR, PROPAC

Dr. ALTMAN. Thank you, Mr. Chairman. I appreciate being here this morning.

I understand the constraints we are working under. Let me just deviate for a second to respond to Senator Heinz and strongly endorse his statement. I think the Commission shares his view that PPS and the Part A system can only work well if it integrates in with home care and ambulatory care, and we are very concerned about that as well. So, while it is not part of my prepared testimony, I just wanted to put it on the record early on that I think the Commission share your views, Senator.

Senator HEINZ. Thank you, Dr. Altman.

Dr. ALTMAN. Let me focus specifically on the issue that is before us, specifically hospital payments. I would like to introduce Dr. Donald Young, who is the Executive Director of PROPAC, on my left.

Hospital payment rates for the upcoming fiscal year have been a source of great disagreement this year, and I know this subject is high on your agenda today.

You will recall that the bottom line of PROPAC's April recommendation for Fiscal Year 1988 payment rates was an increase averaging 2.3 percent. Here, we made a distinction of 2.2 percent for urban hospitals, and we believe that rural hospitals should receive around 3 percent. This bottom line has not changed, although we have made a few technical modifications in some of the components we used to develop the update.

I want to emphasize that we have attempted to follow our methodology and not just accept the number we had before; so the fact that we have come up with the same bottom line was not just to keep a historical precedent, but really was the result of the model that we have worked out.

Since our April recommendation, the Department has released a Notice of Proposed Rulemaking on the 1988 PPS changes and an

update notice. And as you indicate, Mr. Chairman, the Department has recommended a .75 for both rural and urban. As we indicated, we believe that the numbers should be significantly higher and that there should be a significant distinction between urban and rural adjustments.

A more detailed explanation of our adjustment appeared in my April 7 testimony, and we have a table at the end of my testimony which summarizes and compares the two.

At this point, you are faced with a range of possibilities and you must make some tough decisions about an appropriate update. This update should ensure that the provision of quality care be equitable to the hospital industry and protect the hospital insurance trust fund—as I might add, a delicate balance, indeed.

When the subject of hospital payments arises, there is a tendency to overlook the important group of hospitals excluded from PPS, so I will begin by mentioning that we have recommended a 4.2 percent increase for excluded hospitals. This update factor is significantly higher than for PPS hospitals, because we believe these hospitals face an entirely different set of incentives and experiences than do PPS. And I have talked at length about that at other times.

We are concerned that the Secretary has suggested an update factor of only 1.9 for excluded hospitals. We believe this is too low, and I have mentioned that several times.

With regard to PPS hospitals, we have recommended, as I said, the 2.3 percent increase. Now, we believe our recommendation is quite stringent. It takes account of the fact that in the first year of PPS costs were projected much higher than they actually came out to be, and we believe that it is appropriate and necessary that some adjustment be made in the future updates to account for that.

Of the 12-percent differential, we have recommended that 5.4 percent of it be adjusted in the next three years. I want to emphasize this. We have not recommended to you that all of the 12 percent be taken away from hospitals, for two very important reasons: One is that they have already paid part of the increased differential, and, second, we believe hospitals should share it.

Now, I realize that questions have been raised about the appropriateness of using costs. I want to emphasize that our methodology is not a return to cost-based reimbursement. On the other hand, to not look at costs when trying to calculate what an appropriate increase is, it does not seem to be either equitable nor in the long term best interests of quality of care.

We need, you need, all of us need to be conscious of what it costs to provide good quality hospital care; and therefore we do look at it, although we do not do a blind mechanical adjustment that just relates the payments to the costs.

I also recognize that there has been some new information that has recently become available which indicates that in the second year of PPS costs increased about 10 percent. We support that analysis, although we have not had a long time to look at it, but I want to emphasize that that information does not change our recommendation.

It is important that you understand that our recommendation accounted for that; we anticipated those costs. We did not know ex-

actly what they were going to be, but we knew the costs per case would be higher in the second year, for two very real reasons:

The second year of PPS, we had substantial decreases in volume, and costs in-hospital per-case did not go down correspondingly. So, it wasn't that costs went up, it was that volume fell, so the costs per case went up. It was a mathematical adjustment.

The second reason is, we have already taken this into account; that is why we have recommended that, of the 12 percent increase in costs for the first year, only less than half of it should be taken away. So, I wanted to emphasize that.

Let me jump next to this issue of urban and rural hospitals. I share your comments, Mr. Chairman, and I think the Commission does, in general, that the PPS system has not worked equitably across all of our system, and particularly rural hospitals in the first few years were negatively affected.

We have attempted over a series of our reports to try to adjust for the differential. Unfortunately, we don't believe the Administration has been as kindly to that set of recommendations as we would like. In particular, we believe that it is not fair for this year's update to be the same, .75, as they have recommended, because rural hospitals did not benefit nearly as much during that first year, as you have pointed out. So, to take it all away from them does not seem to be equitable and in the best interest of quality of care.

We also are concerned that the Administration has not been willing to look hard at some of our other recommendations about rural hospitals—particularly, making appropriate adjustments for volume through the various proposals that have been available, such as focusing on the smallest and most isolated facilities. We believe the system that is now in place is too restrictive, so that very few rural isolated hospitals can qualify for this special exemption. And we believe that our recommendations that are in our report should be followed by you and that we should adjust the rural rates to be more level when it comes to overall rates with urban.

Senator BAUCUS. Could you sum up, please, Doctor?

Dr. ALTMAN. Yes. I just want to mention the other two points, and then I will conclude.

Senator BAUCUS. Very briefly, if you would.

Dr. ALTMAN. First, we again strongly recommend that you include capital in tbe PPS system to bring about equality.

Second, we would ask that you take a hard look at good evaluation of the PRO's. We believe that is the best available information for quality—which I know has been Senator Heinz' and others' concern, and we don't believe the evaluation that HCFA is doing on the PRO's will get at the quality issues.

Let me now stop and ask if you have any questions.

Senator BAUCUS. Thank you, Doctor.

According to the Early-Bird Rule of this committee, the first Senator here and therefore the first Senator entitled to ask questions is Senator Heinz.

Senator HEINZ. Mr. Chairman, thank you.

Dr. Altman, you recommended a 4.2-percent increase for exempt hospitals. Those include psychiatric facilities.

Dr. ALTMAN. Yes, Senator.

Senator HEINZ. And at the same time, you recommend 2.3 percent on average for PPS facilities. Is that correct?

Dr. ALTMAN. Yes, sir.

Senator HEINZ. Can you explain to the committee why you want that higher update for the exempt hospitals?

Dr. ALTMAN. Yes. The PPS hospitals have two advantages over the exempt hospitals: First, their total payment increase is not just the update factor; they are capable of increasing payments through productivity advances as well as through adjustments in coding. They have received payments which are higher than the update factor, as opposed to the excluded hospitals.

Our ultimate objective is not simply to pay higher rates to the excluded hospitals. And so what we are trying to shoot for is that rate for excluded hospitals which would give an appropriate payment increase, even though it looks like we are recommending a higher rate.

Senator HEINZ. Now, maybe I missed this while I was consulting with my staff on another issue, but back in April you recommended that the Secretary promptly initiate a comprehensive evaluation, a PRO quality-of-care review, activities and findings, and you indicated in your testimony that this recommendation was rejected by the Secretary.

Can you give us a brief explanation as to why you believe that additional review is necessary, and what, if anything, this committee should do, in your judgment, to further address the problems of quality of care?

Dr. ALTMAN. Yes. As I did indicate, we believe that the PROs have the best set of information that is currently available to really get at the issue of quality of care. We don't believe the HCFA evaluation will get at that. The SuperPRO is focusing much more on technical aspects of how the system is working.

It would be a shame, really—given our concerns about quality—not to make use of this information for quality purposes.

So, while we have no problem with the SuperPRO and what they are doing, we believe additional evaluations of that information should take place.

Senator HEINZ. And what should we do, specifically?

Dr. ALTMAN. Well, basically you need to instruct HCFA and others to do that independent evaluation that is different than the audits of the SuperPRO; because, without a specific mandate from you, they are not planning on doing it.

Senator HEINZ. Thank you very much, Dr. Altman.

Senator BAUCUS. Senator Durenberger.

Senator DURENBERGER. Dr. Altman, just let me make sure I understand the update-factor business.

You recommended 2.3. Was that an average update? Or how does that gibe with this piece of paper I have here that says "urban 1.9, rural 1.1," or whatever this is?

Dr. ALTMAN. Yes, sir, it is an average. Basically, we are recommending a 2.2 percent increase for urban hospitals and a 3 percent for rural hospitals, which averages for the whole country at 2.3.

Senator DURENBERGER. OK, 2.2 is urban?

Dr. ALTMAN. And 3.0 for rural.

Senator DURENBERGER. All right.

Now, just explain the effect of that. Give us a little education on what an urban hospital is. That means that all hospitals in so-called urban areas would go up 2.2 percent, but it doesn't mean that they are all going to be paid the same, does it?

Dr. ALTMAN. No, sir. As you know, the PPS now has two separate amounts which it uses to make payments, and the definitions provide for certain hospitals to be categorized "urban," and others "rural." And so, we are recommending on average that the standardized amounts go up by 2.2 percent.

Now, of course each hospital will differ depending upon the case mix, the complexity, the number of patients they treat, and so on, as well as there will be significant differences in their performance based on how efficient they are in providing that care. So, we are talking about just an average here.

Senator DURENBERGER. A lot of the larger urban hospitals—and I think about lots of beds in big cities as opposed to a 200-bed hospital in an SMSA in the middle of Minnesota or Billings, Montana, or something like that—have other adjustments as well, a disproportionate share: indirect teaching, GME, and a variety of other things.

Dr. ALTMAN. Yes.

Senator DURENBERGER. Do you have some sort of a conforming set of recommendations about GME adjustment, disproportionate share adjustment, indirect teaching adjustment?

Dr. ALTMAN. Conforming?

Senator DURENBERGER. Well, is there sort of a parallel set of recommendations for teaching hospitals, for hospitals that carry a disproportionate share of indigent, and so forth, in terms of what we should do about the reimbursements for those particular hospitals?

Dr. ALTMAN. Well, in previous years the Congress and the Administration—sometimes with our recommendation—have made special adjustments. And I should have pointed out in answer to your first question that hospitals will vary, depending on what adjustments they get in these three or four areas.

So, as a result of that, hospitals get substantially different rates because of whether they are a teaching hospital and so on, and there is no attempt in this proposal to bring them all at just 2.2. No. Each one of those adjustments were designed to meet a special problem; and while from time to time we need to take a hard look to make sure that those adjustments are still valid, in general the Commission's viewpoint is that they are. There are added costs to being a teaching hospital; there are special added costs to beinq a disproportionate share hospital. And so we have made recommendations, and you and the Administration have adopted variations in those recommendations, and we see no reason not to continue those adjustments.

Now, they may change in number, and it is possible that over time we should go back and review them, and we will go back and review them; but we have not in this proposal wiped them out and just given all urban hospitals 2.2 percent.

Senator DURENBERGER. But PROPAC, in its statutory mission to help us implement this PPS system, has not decided that our original judgment with regard to education and indigence, and a variety

of those other areas of hospital costs, are an unnecessary part of the PPS system.

Dr. ALTMAN. Oh, no, quite the contrary. As a matter of fact, I think it is the other way around: I think we are constantly looking for those appropriate adjustments that make the system fairer. Ultimately, the stability or the fairness of the system will determine whether it stays around and does its job.

Senator DURENBERGER. Thank you.

Senator BAUCUS. Thank you, Senator.

Dr. Altman, as I understand it, in comparing the differences between the Administration and PROPAC addressing the urban/rural split or differential payment, the Administration believes that there should not be a differential between urban and rural hospital payment increases because of simulations they have run and because of legislative changes that they cite on the other hand, PROPAC believes that urban hospitals should be paid a 2.2 percent increase and the rurals a 3 percent increase, based upon data reflecting actual cost differentials, data which indicate that the actual costs of rural hospitals are growing at a faster rate than those of urban hospitals. I also understand that even with the differential increase, there will still be about a 14-percent urban/rural differential.

Dr. ALTMAN. Yes.

Senator BAUCUS. I wonder if you could explain more fully why PROPAC believes there should be this differential, and in answering that, if you could address the actual cost differential.

I think there is a myth going around that the urbans are experiencing higher cost increases than the rurals. Apparently you are saying it is just the opposite. I wonder if you would expand on that, please?

Dr. ALTMAN. Yes, sir. I have in my testimony a little more detail, and I would be prepared to provide even more; but let me just briefly summarize what we believe, and that is that the Secretary has done a study, which we have not seen, which talks about the fact that if there was a further adjustment it would overcompensate rural hospitals relative to urban hospitals.

In addition, they believe that the Commission did not take into account recent changes that reduce the disparity. Well, we have looked at those changes, and we just disagree. From Congressional testimony we understand that the Secretary's rejection of urban and rural update factors are based on that simulation that you talked about.

The intent of recommending separate adjustments was to ensure that the standardized amounts that we pay, as opposed to the costs, are fair.

Now, the Administration has recommended a .75, and they don't tell us where that came from. The only way you can justify such a low number is by recognizing that there were higher costs or higher payments in the first year or the first few years. But those higher payments disproportionately went to urban hospitals. So, the only justification for the low rate is the higher payments; then you have to acknowledge that rural hospitals didn't get, relative to their costs, such higher payments. So, in my view, and I know the

Commission shares this, it is just equitably appropriate that rural hospitals receive a higher payment.

And we understand what the simulation model has done, but that does not change our recommendation.

Senator BAUCUS. So, your point really is that the rural hospitals have incurred higher costs proportionate to the payments they have received, compared with the urban hospitals. Is that correct?

Dr. ALTMAN. In general, rural hospital costs are lower. Now, they have a special set of problems, which you know much better than I do, and it relates heavily to volume, and that is: rural hospitals by and large tend to have smaller numbers of patients in their facilities, even relative to their capacity. Now, some of that cannot be handled by tbe PPS system; but some of it needs to be recognized, and our recommendation for small isolated hospitals was to do that—not to be so stringent. The Administration seems to be very stringent in its willingness to grant exceptions. My understanding is that they have only allowed the special adjustment for four hospitals, where there are potentially up to 363 that could qualify. And the reason why they have only granted that is twofold: First, they make it very tough to qualify; and, second, they use very tough criteria to allow that.

Senator BAUCUS. Do you think the 14 percent payment differential should be maintained for the next three years?

Dr. ALTMAN. We need to take a look at that, whether the 14 is the appropriate number. There probably should be some differential. I am not prepared right now to say that 14 is the absolute, correct number.

Senator BAUCUS. In 45 seconds, essentially what explains the difference between your 2.2 or 3 percent versus the Administration's 0.75 increase in prospective payment rates?

Dr. ALTMAN. I don't know. [Laughter.]

Senator BAUCUS. What is your best guess? In 30 seconds, what is your best guess? [Laughter.]

Dr. ALTMAN. I don't know, because I haven't got the foggiest idea where they came up with that.

Senator BAUCUS. Now, wait a minute. You have been around, you have to have some sense here.

Dr. ALTMAN. Yes, sir. I really do believe, with those facts and figures, they made that number up. I know where our number came from, and I think our number is correct; it will do what you asked us to do, which is to maintain the quality of care but be tough. I really don't know where the 0.75 came from.

Senator BAUCUS. Thank you.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Dr. Altman, on page 4 of your testimony you say, "We have not had significant time to analyze these new cost figures. It appears that the higher costs are related in part to significant volume declines." Could you discuss that a little more? There are significant volume declines that I think we all recognize. What is being done about that? Are hospitals being closed anywhere?

Dr. ALTMAN. Well, there are continuing numbers of closures; I don't have the numbers before me. But what happened in that second-year PPS, throughout the United States we found a much

larger decline in admissions than we have ever seen in the last decade.

Several hospital administrators claim that if those volume declines had happened under the old cost-based reimbursement, they would have been in much worse shape, that PPS allowed them to make much better adjustments with their costs; but their costs did not come down proportionally, so, by mathematically, the cost-per-case went up.

Senator CHAFEE. Well, I think we recognize that, that lower occupancy doesn't necessarily mean lower costs—clearly, it means higher costs per patient. But I was getting into a philosophical question, if you would, on whether you think the pressures to close hospitals are strong enough in this country; or do all these hospitals hang on one way or another, figuring that better times are ahead, or that they present a very specialized service that the public shouldn't be deprived of? What is this situation, as you see it?

Dr. ALTMAN. Well, without generalizing, because I realize it is easy to make sweeping statements, I think there is no question that we have developed a capacity in this country that exceeds our needs in hospitals and that we have nurtured that over a period of 20 years with a high cost-based system. And like any good institution, communities develop strong attachments to them. And I mean communities—I am not necessarily talking about "rural, isolated." I am talking about in the middle of an urban area, a five-block region can consider a hospital sacrosanct.

There is no question in my mind that what you have said is true.

Senator CHAFEE. What produces the closure of a hospital? What factors are out there that will finally make a hospital close?

Dr. ALTMAN. Well, I do think there are cost pressures. In spite of what I said, I think PPS does create the incentives to force hospital boards to take a hard look at whether they should stay in business.

Not only does it affect costs, but it affects quality. And many institutions finally realized that they just can't continue with such low occupancy. They usually are in the form of mergers—often. And it is often in the best interest of the community and the quality, and hopefully the costs.

Sometimes it works to the detriment. Often the hospitals that close are the lower-cost hospitals, and then patients wind up being sent to higher-cost hospitals. Hopefully, they get higher quality. But we don't necessarily save money by lots of these closures.

Senator CHAFEE. Pressures, I suppose, come from the third-party payors, don't they?

Dr. ALTMAN. Well, the pressure comes somewhat from third-party payors. The way our system is set up, most third-party payors really lack the clout. It is only the government, and in a few areas where you have a dominant third party payor, that a third party really has that kind of clout. In most parts of the United States third parties are what we call "price takers"—they just lack the clout to tell hospitals what to do. And maybe that is to the betterment of our system, but few third parties have that power.

Senator CHAFEE. Why would the lower cost ones be the ones to close? Not always, obviously, but why would the lower cost ones be the ones to close? They are smaller?

Dr. ALTMAN. Well, for lots of reasons. I mean, our system is very heavily quality-oriented. Quality costs money. Over time, those institutions that have closed, by and large—and I have done several studies—are usually undercapitalized, they have not renovated in many years, they lack technical, sophisticated equipment, doctors don't want to put their patients there. So, by the time they come close to closing, if you look at their cost per patient, particularly if you adjust for volume, they are meager compared to those that stay open.

We are a very quality-conscious nation, and quality and cost go together; so they are much lower cost on average.

Senator CHAFEE. Lower cost and lower quality.

Dr. ALTMAN. Yes, sir.

Senator CHAFEE. Thank you, Mr. Chairman.

Senator BAUCUS. Thank you.

Doctor, we very much appreciate your testimony.

Dr. ALTMAN. Thank you, sir.

Senator BAUCUS. Thank you for participating.

[Dr. Altman's prepared testimony follows:]

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Stuart H. Altman, Ph.D.

Chairman

Thank you, Mr. Chairman, for your invitation to testify this morning about issues related to Medicare hospital payments for fiscal year 1988. Since I have previously described for you in detail ProPAC's formal recommendations from our April 1987 Report to the Secretary of Health and Human Services, I will discuss our concerns more briefly today. I am accompanied by Donald A. Young, M.D., ProPAC's Executive Director.

Hospital payment rates for the upcoming fiscal year have been a source of great disagreement this year, and I know this subject is high on your agenda today. You will recall that the "bottom line" of ProPAC's April recommendation for fiscal year 1988 payment rates was an increase averaging 2.3% -- 2.2% for urban hospitals and 3.0% for rural hospitals. This bottom line has not changed, although we have made a few technical modifications in some of the components we use to develop the update. These technical modifications are based on more recent information.

Since our April recommendation, the Department has released Notices of Proposed Rulemaking on 1988 PPS changes and an Update Notice. Their update notice suggests an increase of 0.75% for both rural and urban hospitals. In contrast, the hospital industry has argued that the statutory update of Market Basket minus 2%, or 2.7%, should be allowed. For your information, I have attached at the end of my statement a copy of a comparison of ProPAC and HHS update factor recommendations.

At this point you are faced with a range of possibilities and you must make some tough decisions about an appropriate update. This update should ensure the provision of quality care, be equitable to the hospital industry, and protect the hospital insurance trust fund -- a delicate balancing act indeed!

ProPAC Update Recommendation

When the subject of hospital payments arises, there is a tendency to overlook the important group of hospitals excluded from PPS. So I will begin by mentioning that we have recommended a 4.2% increase for excluded hospitals. This update factor is significantly higher than that for PPS hospitals because we believe these hospitals face an entirely different set of incentives and experiences than do PPS hospitals.

We are concerned that the Secretary has suggested an update factor of only 1.9% for excluded hospitals. We believe that this update factor is too low, but we are unable to evaluate the merits of the Secretary's decisions in the absence of any supporting data or consistent methodologies in the notice.

With regard to PPS hospitals, we have recommended an update factor averaging 2.3% which we believe is stringent but not excessively harsh. In fact, our recommended update factors are likely to be stringent at least through fiscal year 1990. This is because we have recommended that the standardized amount be adjusted downward by -5.4% over the next three years to reflect cost information pertaining to the first year of PPS. We have recommended adjustments which are different for urban and rural standardized amounts -- -5.7% for urban and -3.3% for rural hospitals. I will describe in more detail some of our concerns about rural hospitals in a few minutes.

Questions have been raised about the appropriateness of using cost data to make adjustments in the PPS rates. The Commission believes that even though PPS was designed to break the direct link between each hospital's costs and its Medicare payments, the average payment should be related to what is believed to be the costs of providing appropriate hospital care. Therefore, the Commission has in the past made decisions about the level of PPS

prices based on judgments about the extent to which hospitals could increase productivity and lower their costs. Periodically reviewing more recent cost data is the best way to assess the accuracy of such judgments.

We are also aware of reports that recently available Medicare cost data show a relatively large increase in per-case costs -- perhaps as high as 10% -- between the first and second years of PPS. For several reasons, however, we do not believe that our present fiscal year 1988 update factor should be adjusted to reflect this information.

The Commission's -1.8% adjustment for FY 1988 rates was meant to correct for part of the large discrepancy between actual first-year PPS per case cost and per-case 1981 costs as they were trended to the first year to set PPS payment rates. In other words, the Commission determined that the initial PPS rates were set too high. ProPAC did not adjust for the entire differential, [illegible] that efficiency gains should be shared with the hospital industry, and that relatively lower update factors in recent years already corrected for part of the differential. We have just received the new second year PPS cost data. While we have not had sufficient time to analyze these new cost figures in depth, it appears that the higher costs are related in part to significant volume declines. ProPAC will thoroughly examine the cost data, along with other information on hospital experience under PPS in its deliberations on future updates.

While the Administration's proposed update factor does not include an explicit adjustment to reflect first year PPS costs data, as does ours, the -3.55% composite policy target adjustment factor which they use suggests that this information must have been used implicitly in arriving at their recommendation.

The Administration's reasoning in reaching their recommended 0.75% update factor is never described in any detail. This makes it difficult to comment very specifically on their recommendation. We do believe, however, that there is inadequate justification presented by the Secretary to support an increase of only 0.75%.

Rural Hospital Payment Rates and Problems

As you know, we have been seriously concerned about the equity of payments between rural and urban hospitals under PPS. We made a series of recommendations for changes which we believe will assist in developing a better balance in the rates. I have already discussed the reasons we recommended differential update factors for FY 1988. Let me respond to some of the comments offered by the Department when this approach was rejected in their recent proposals.

The Secretary asserted in his Update Notice that separate update factors, in conjunction with legislative changes, would "overcompensate" rural hospitals relative to urban hospitals. In addition, the Secretary maintains that the Commission did not take into account recent changes that reduce the disparity between payments to urban and rural hospitals.

We disagree with these assertions. From Congressional testimony, we understand the Secretary's rejection of separate urban and rural update factors to be based on simulated operating margins. We do not believe that such an analysis is relevant. The intent of recommending separate adjustments was to ensure that the standardized amounts reflect more recent information about the underlying cost differences between urban and rural hospitals. If the Commission's recommendation were implemented, the difference between the urban and rural standardized amounts after the third year of separate update factors would be about 14

percent. This percentage is almost identical to the difference in average discharge-weighted urban and rural standardized amounts computed using the first year PPS cost data.

In summary, we believe that inequities still exist between rural and urban payment rates. We reject the Secretary's suggestions that legislative changes have solved the problems. But we do believe that the biggest problems relate not to all rural hospitals, but to the smallest and most isolated facilities. And we believe that our recommendations related to clarifying exceptions criteria and expansion of volume adjustments would address some of the problems faced by these small, isolated facilities. Thus we urge your continued attention to our earlier recommendations on these subjects.

Inclusion of Capital Within PPS

The Commission strongly urges the inclusion of capital within the PPS system. We have recommended the inclusion of capital for the past two years. We believe that continuation of cost-based reimbursement for capital introduces distorted incentives for investment decision-making. In particular, we believe that the current pass-through encourages hospitals to substitute capital for labor or other operating costs even when it is not the most efficient choice. In addition, the current system fails to encourage hospital managers to evaluate interest rates or alternative financing mechanisms in making investment decisions.

We do not believe that the payment method should favor either capital or operating costs. It should, instead, encourage hospital managers to choose the optimal mix of capital and operating inputs.

Generally, we are in agreement with the specific system for inclusion of capital proposed by the Secretary. We believe that

the proposed changes are consistent with our recommendations. I believe that it is noteworthy that, after several years of careful consideration and analysis, both the Commission and the Secretary are in substantial agreement about the need to include capital and the manner in which to go about doing so. I urge you to carefully consider any action which would preclude the inclusion of capital for FY 1988.

Other Issues

I would like to mention two additional issues which we hope you will consider during your deliberations. These issues deal with recommendations we made this year which were rejected by the Secretary in his recent proposals. We believe that both of these issues are deserving of additional consideration.

The Commission has been concerned for some time about the definitions of hospital labor market areas used in the PPS system. We have believed that the current adjustment for area wage differences does not adequately account for multiple labor markets within urban and rural areas. Earlier studies supported this concern by showing substantial wage variation between inner-city and suburban hospitals within several large Metropolitan Statistical Areas.

To further address these concerns, we contracted for a major study of the definition of hospital labor market areas. We used the findings from this study in developing a recommendation this year for improvement. This recommendation would modify the current urban areas to distinguish between central and outlying areas, and modify the current rural areas to distinguish between urbanized rural counties and other rural counties within a state.

The Secretary has disagreed with this recommendation for improving the definition of hospital labor market areas. Rather,

he suggests additional study and analysis are necessary to evaluate the options and determine their impact. Because we have had a long commitment to this issues and studied it extensively, we do not believe that the Secretary's objections are appropriate. We believe that our study produced information necessary to evaluate the impact of our recommendations on hospital payment, and we disagree with the Secretary's reasons for wanting to conduct further impact analysis.

In the NPRM, the Secretary claims that "any analysis of redefined labor markets must be considered in the context of the payment effects to hospitals." We believe that refinements in the definition of labor market areas should be accepted or rejected on their technical merits rather than on the basis of their redistributive effects, as the Secretary seems to be suggesting. Other more technical concerns are also raised by the Secretary, with which we also disagree.

Finally, we are concerned that the Secretary's study of labor market areas required under COBRA is not completed. The Department has not collaborated with us on such a study, as you required, and their rejection of our recommendation does not indicate how they will approach this continuing problem.

In another area, the Secretary also rejected our recommendation that he initiate a comprehensive evaluation of PRO quality of care review activities and findings. The NPRM states that extensive and comprehensive systems are already in place to evaluate the credibility of PRO review decisions.

However, our recommendation was not intended to address the credibility of PRO review decisions. Rather, we believe that the

patterns of quality of care to beneficiaries and the impact and findings of PRO review of these patterns of care should be the focus of a substantial national evaluation. Because the PROs are a unique source of information regarding quality of care, the experiences of all the PROs should be evaluated and made public.

The Secretary indicates that ProPAC's recommendation would result in duplicative evaluation efforts. We are aware of the SuperPRO activities which audit and validate PRO review activities. However, this SuperPRO effort does not substitute for a comprehensive evaluation of the extent to which PROs are identifying, assessing, and correcting problems related to quality of care. Among other concerns, the results of SuperPRO activities, which are a very technically oriented review, are not made public or discussed within a policy context. Thus, we do not agree with the Secretary on this matter and are disappointed that he rejected this recommendation. We hope that the Secretary will reconsider his position, and that you will also consider our recommendation on this subject.

Conclusion

We appreciate this opportunity to testify on these important issues today. We will be pleased to work with you as your legislative decision-making progresses, and I would be glad to answer any questions you or members of the Committee may have.

COMPARISON OF PROPAC AND HHS JUNE 1987
RECOMMENDED PPS UPDATE FACTORS FOR FISCAL YEAR 1988

	ProPAC	HHS
ADJUSTMENT TO LEVEL OF STANDARDIZED AMOUNTS		
Average	-1.8[a]	0
Urban	-1.9	
Rural	-1.1	
FISCAL YEAR 1988 UPDATE FACTOR		
FY 1988 Market Basket Forecast	4.7[b]	4.7
Correction for Forecast Error	0.0	-0.4
Discretionary Adjustment Factor/ Composite Policy Target Adjustment Factor	0.0[b]	-3.55
Scientific and Technological Advancement	0.5	c
Productivity	-1.0	c
Site Substitution	-0.3	c
DRG Case-Mix Index	0.4[b]	0
Within DRG Patient Complexity	0.4[b]	0
OBSERVED CHANGE IN CASE-MIX INDEX (Adjustment Made to DRG Weights After Recalibration)	-0.6[b]	0
TOTAL CHANGE IN PPS PRICES (Average)	2.3	0.75
Urban	2.2	0.75
Rural	3.0	0.75

[a] A total adjustment averaging -5.4 percent to be made in three equal increments through fiscal year 1990.

[b] Estimate revised since the Commission's April 1, 1987 Report and Recommendations to the Secretary, based on more recent information included in the HHS update factor notice.

c Not specified -- included in composite policy target adjustment factor

Senator BAUCUS. Our next panel includes Mr. Jack Owen, Executive Vice President of the American Hospital Association, and Mr. Mike Bromberg, Executive Director of the Federation of American Health Systems.

Mr. Owen, why don't you proceed?

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. OWEN. Thank you, Senator.

My name is Jack Owen. I am Executive Vice President of the American Hospital Association, the Director of the Washington office. You have a copy of our statement, and I would trust that it will be part of the record.

Senator BAUCUS. It will be included.

Mr. OWEN. I would like to make some brief comments, in view of the time contraints I know you are under today.

Prospective pricing puts hospitals at risk—we have heard a lot about that—and there were two risks that every hospital had to face up to: One was, could they operate efficiently within a price that was set by the Federal Government? And second is the risk of patients needing extraordinary treatment above the DRG limits, and we have seen that happen.

A price provided by the government to the hospitals has provided predictability for the Federal Government and allowed for a profit to those hospitals who were efficient and to those who were lucky enough to get a fair mix of patients.

We have heard a great deal about hospital profits from Medicare patients; the General Accounting Office has made statements about it, the Congressional Budget Office, and even PROPAC called attention to these profits. What is most disturbing to us is that these surpluses were earned more than three years ago. This was the result of many one-time cuts which can no longer be made by hospitals, since those first years that they participated.

Since that time, Congress has consistently reduced the rate of increase per DRG to hospitals well below the market basket rate of increase. Last year, the Congress directed the rate of increase to be market basket less 2 percent, a reduction of over $800 million going to our hospitals.

I guess, Mr. Chairman, what I am saying is that, as you look at what is going to be done in 1988, the surplus you have been hearing about is gone. With a 2 percent increase, even, in the DRG rate in 1988, over 33 percent of the hospitals in this country are going to have a deficit position as far as Medicare is concerned.

HCFA data now shows the 1987 margins to be between 6 and 7 percent, not the 15.1 percent they originally estimated.

It is time to put the issue of hospital profits to rest. The issue is not what happened in 1984 but what will happen in 1988 without a fair update factor, and that is what we are most concerned about today.

The hospital market basket since 1984 has risen 13 percent, while payment increases approved by the Federal Government have totalled only 5.6 percent; so the change has already taken

place, and the dollars that were there have been reduced substantially.

In our testimony is a chart. You have at your desk a report that was done by Consolidated Consulting Group, and this report was based on HCFA's PPS figures; they are not American Hospital Association figures. You can see very graphically how the profit margin or the surplus margin is dropping across the country.

I think it is very important to urge the Senate to look at that update factor. The 2.7 percent, which is what was recommended last year by congressional action, would be of course what we would most favor; and, if we were forced to, we could go along with what PROPAC recommends, 2.3 percent.

Now, let me just make a couple of other comments, if I could, in regard to capital payment and to the problems facing rural hospitals.

Capital payment is one problem that we have been working hard and diligently with for some time. We feel, because of the ups and downs of the capital market and where hospitals are located throughout this country, the best thing the Senate can do is to go along with the House and continue the pass-through of capital for the next four years. There is a reduction in that capital payment of 10 percent in the out years, and though we don't like it, we can live with it, and it does give us predictability in the capital market, and we would hope that the Senate would continue that.

The rural hospital problem has been stressed here this morning, and there is a serious problem there. We hope that the Senate will agree with PROPAC and allow for a greater increase to rural hospitals. But in order to do that, there has to be an adequate update factor which all hospitals receive, enough of an update factor that we are not taking away money from one institution to give to another but only increasing the rate of increase to the rural hospitals, moreso than what we are doing for the urban hospitals.

Payments for medical education, both indirect and direct, we are very concerned about. We are going through one of the most severe nursing shortages that we have had in our field in probably the last 25 or 30 years, and without adequate educational funds to continue to train nurses, we are going to see a real problem in the years ahead.

I would just conclude by saying that we hope the Senate recognizes that the need for an adequate base DRG update is there and we hope also that, as you look at this, you will provide some equity to the rural hospitals as has been recommended by PROPAC.

Thank you.

Senator BAUCUS. Thank you, Mr. Owen. Mr. Bromberg?

[Mr. Owen's prepared statement follows:]

STATEMENT OF THE
AMERICAN HOSPITAL ASSOCIATION

INTRODUCTION

Mr. Chairman, I am Jack W. Owen, Executive Vice President of the American Hospital Association (AHA) and director of its Washington office. The AHA represents more than 5,600 institutional members that annually provide services to more than 10 million Medicare beneficiaries. I am pleased to have this opportunity to address deficit reduction issues affecting the Medicare program as the Committee prepares to comply with the reconciliation instructions in the Concurrent Resolution on the Budget for Fiscal Year 1988.

MEDICARE AND THE FEDERAL BUDGET DEFICIT

The prospective pricing system (PPS) was adopted by Congress as part of the Social Security Amendments of 1983 in an effort to ensure the long-term solvency of Medicare's trust fund. The purpose of the new payment system was to establish positive incentives that would reward hospitals for reducing the rate of increase in hospital costs. The opportunity to earn a surplus was the positive incentive. In return, hospital managers accepted the risk of incurring sizable deficits if costs exceeded prospectively determined prices.

The system was not enacted as part of a budget bill. The original legislation explicitly directed the Secretary of Health and Human Services to set prices that were neither greater nor less than amounts that would have been paid for services if the new payment system had not been adopted. In short, the new payment system was to be used to promote the "efficient provision of quality care," and not as a means of reducing the growing federal deficit. Since passage of the Social Security Amendments of 1983 and despite its auspicious beginnings PPS has been used repeatedly as a primary instrument of deficit reduction. For FYs 1986 and 1987, the Reagan Administration proposed legislative or regulatory initiatives that would have reduced DRG payments by $1.8 billion in FY 1986 and $455 million in FY 1987. Although Congress subsequently intervened and increased payments by more than was proposed by the Administration, its action still yielded substantial budget "savings," and thus reduced payments to levels that were less than originally called for. The end result has been that Medicare has contributed disproportionately to the federal deficit reduction effort--even though Medicare Part A is funded entirely through the payroll tax system.

That prospective pricing has achieved its original goal is unarguable. In the first year, the Health and Human Services Secretary announced that the rate of increase in program outlays had fallen to the lowest level since Medicare was created. And recent reports from the trustees of Medicare's Hospital Insurance trust fund have announced a substantial improvement in the solvency of the program. Despite this success, policies have been dictated by considerations other than Medicare's viability and funding requirements. The adoption of prospective pricing, combined with continuing concern about rising federal deficits, increases the urgency of finding a way to ensure adequate funds for benefits promised current and future Medicare beneficiaries.

PROSPECTIVE PRICING: PRINCIPLES AND PROFITS

Congress intended that PPS create positive incentives to restrain the rate of increase in hospital costs by putting hospitals "at risk" for the difference between a fixed price and costs. Hospitals that increase their efficiency earn a surplus. Hospitals unable to keep costs within the price incur deficits. That is the theory. In practice, under prospective pricing, hospitals are "at risk" for more than their own efficiency. They also bear the risk of admitting patients who require extraordinary treatment and incur extraordinary costs. For this reason, hospitals need to earn a surplus on Medicare payments. The only alternative is to shift a part of the cost of treating Medicare patients to private patients--an increasingly difficult task in today's competitive health care system.

The "savings" that are discussed each year during the debate over the federal budget are above and beyond those that the PPS was intended to generate. Those savings were never intended to be produced by arbitrary "ratcheting" of prices. Instead, savings were to be garnered by holding the annual rate of increase in prices to a level closer to the rate of increase in the hospital marketbasket. Throughout the 1970s, per case hospital costs rose substantially more than inflation in the hospital marketbasket. Holding the rate of increase in prices to the marketbasket would have produced substantial Medicare savings; limiting prices to less-than-marketbasket increases have produced even greater savings. More important, holding the annual rate of increase in costs to the rate of inflation is a challenging goal for hospital managers. To insist on more than this, year after year, jeopardizes the ability of hospitals to provide access to high quality care without depending on subsidies from privately insured or self-paying patients.

Recently, before this Committee and others, the General Accounting Office (GAO), the Congressional Budget Office (CBO), and the Prospective Payment Assessment Commission (ProPAC) have called attention to "profits" earned by hospitals during the first year under prospective pricing. These reports are troublesome for several reasons.

First, the data on "profits" under PPS that are being discussed by CBO, ProPAC, and others, and that have attracted public notice, are from 1984--the first year of operation under the system. These "profits" were earned more than three years ago. For FY 1988, Congress has directed that prices rise only by marketbasket minus 2 percent; in dollar terms this reduction will reduce any surplus by approximately $800 million.

Thus any surplus earned by hospitals in the first year will have been cut by more than half by subsequent below-marketbasket increases in prices. The data that have been presented also focus on overall or average operating margins. These averages conceal tremendous variations in individual hospital financial performance. Even in the first year of prospective pricing, significant numbers of hospitals--particularly rural hospitals--experienced Medicare operating deficits, and recent projections by the AHA indicate that the number of hospitals operating at a deficit has risen significantly. AHA projections for FY 1988 indicate that for Medicare revenue only approximately 33 percent of all hospitals will experience an operating deficit, and 15 percent will experience a deficit of greater than 10 percent.

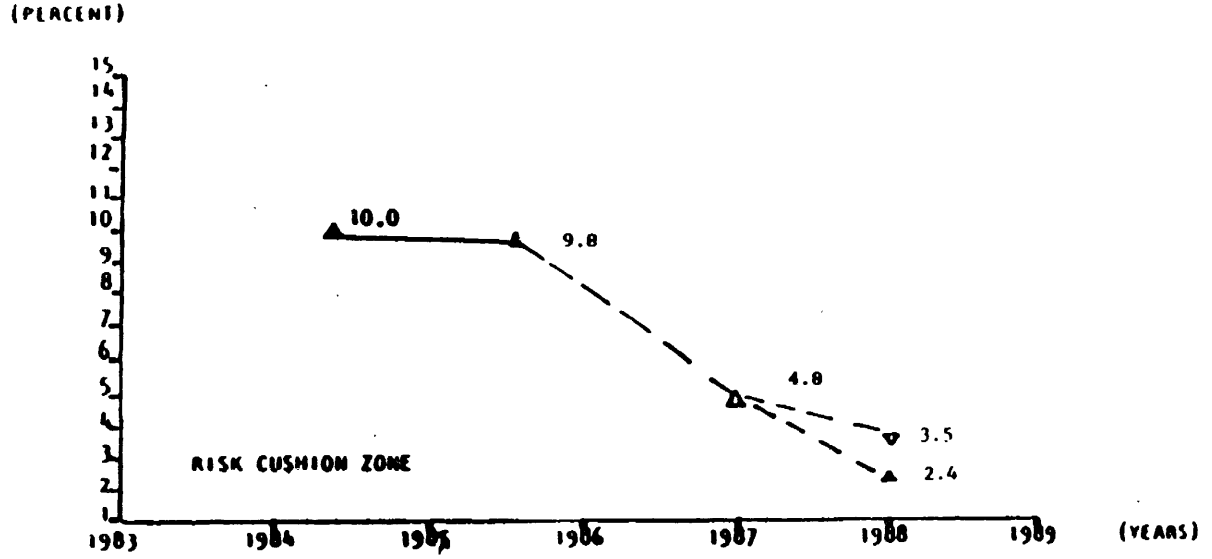
NEW DATA

Now, in stark contrast to earlier HCFA and CBO predictions, new data released by HCFA and a recently completed study on margins conducted by the Consolidated Consulting Group (CCG) indicate that hospital margins have peaked and are rapidly declining. According to HCFA's data, which is based on a sample of 4,757 hospitals for cost data from the second year of the PPS system, FY 1987 margins are now projected to be between 6 percent and 7 percent, not 15.1 percent, as originally estimated. The new data also demonstrate that even with a 1.5 percent PPS update about 40 percent of <u>all</u> hospitals are projected to have negative Medicare margins in FY 1988 and average margins for all hospitals could be in the 3 percent to 5 percent range.

The CCG study provides an analysis of how margins as reported on the cost report and estimated by HCFA have changed since the first year of prospective payment, particularly in light of newly available data on second year reported costs. According to this study, Medicare margins dropped to between 6 percent and 7 percent in FY 1987 because hospital costs per case rose 6.2 percent while Medicare revenues dropped 3.8 percent. In addition, HCFA now counts Medicare capital and medical education cost pass-throughs in its new margin calculation. According to CCG, that change in methodology lowered profit projections 1.7 percent. The results of CCG's study are displayed in Exhibit 1. It is the AHA's hope that the Committee will take the time to review this new information before making any final decisions regarding an adequate hospital rate of increase.

Exhibit One

Total Medicare Margins Based on HCFA PPS-II Data



▲ Estimated Hospital Total Medicare Margin with Update Factor = 0 in 1988

▼ Estimated Hospital Total Medicare Margin with Update Factor = 1.5 in 1988

Exhibit prepared by Consolidated Consulting Group, Washington, D.C.

FY 1988 UPDATE FACTOR

Since 1984, the increase in prices paid to hospitals under PPS has fallen far behind inflation. By 1987, the hospital marketbasket--which measures the prices paid by hospitals for the resources consumed in providing care to patients--is expected to be 13 percent higher than in 1984, the first year of prospective pricing. Yet, price updates provided by Congress have totalled only 5.6 percent.

In principle, the AHA believes that limiting increases in prices to the rate of increase in the hospital marketbasket is a reasonable goal and responsible public policy. In addition, to address the problem of differences in urban and rural rates of payment, we recommend that the rate of increase be slightly higher for rural than for urban hospitals. The AHA recommends a separate update for PPS-exempt facilities.

Recent reports by the CBO and GAO have suggested that additional budget "savings" can be achieved by reducing payments to hospitals under PPS. The AHA opposes such proposals because it would be a fundamental break with the original design of PPS. Inherent in that design was the idea that hospitals should hold annual cost increases to a reasonable level, allowing for inflation and modest technological advances during the first two years of the new system's existence.

In setting prices for subsequent years, the Secretary was granted broad authority to set a ". . . percentage increase [in prices] . . . which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." (Sec. 1886(e)(4) of the Social Security Act). Nowhere in this directive is any comparison of payments to costs as determined on the Medicare cost report even mentioned as a factor to consider in setting prices. The emphasis is on establishing a reasonable rate of increase within which hospital managers should strive to hold costs.

Hospitals have worked hard to respond appropriately and effectively to the new incentives of, and the risks imposed by, the prospective pricing system. The possibility of incurring losses for reasons that have nothing to do with hospital efficiency requires hospitals to develop surpluses that can be used to offset losses during periods when an extraordinarily large number of high-cost patients are admitted. Clearly, as the new data on margins demonstrate, those margins are rapidly eroding and that downward trend will have serious consequences for the quality of health care in this country.

CAPITAL PAYMENT

Over the past two years, the government and the hospital field have attempted to develop an adequate and equitable method for folding Medicare capital payments in PPS operating prices. Despite the best efforts of all parties to identify a solution, no fair system has yet been proposed. Because none of the capital proposals presents an adequate and equitable method of paying for these expenses, maintaining the current capital cost pass-through is the most appropriate approach, particularly because Congress already has established limits for Medicare capital payments for the next two years.

Therefore, Congress should defer action to incorporate capital in PPS and prohibit the Secretary of Health and Human Services from issuing regulations that accomplish such an objective. Without specific congressional action to bar implementation of those regulations, HHS rules will take effect automatically and radically change the method Medicare uses to reimburse hospital capital expenses.

Developing an equitable capital payment policy is difficult because there is a wide diversity among hospitals regarding their capital cost cycles. Hospitals make major capital expenditures or commitments, such as replacing or modernizing physical plant or major fixed equipment, very infrequently. At the point that a commitment is made, a hospital's capital costs are fixed for

a considerable period of time and, unlike operating expenses, are generally beyond the hospital's control. Thus, differences in where hospitals are in their capital cost cycles result in wide differences in their capital commitments (or amounts of debt) and, consequently, in their immediate and future capital needs. The differences among hospitals in capital requirements are further complicated by the fact that this variation cannot be accounted for by commonly used hospital characteristics such as location, ownership, size, teaching status, geography, labor costs, or intensity of care.

The approaches that have been proposed to fold capital payments in PPS to date would be disadvantageous to a significant portion of hospitals. None of these proposals adequately recognizes individual hospital capital needs either in the calculation and update of the capital add-on amount or in the length and structure of the transition. Hospitals most adversely affected by these incorporation proposals would be those institutions that have recently incurred major capital commitments and those that must undertake major projects soon. Among the latter group of hospitals are institutions that most depend on government payers--those facilities serving substantial numbers of poor and elderly under Medicare and Medicaid. Many of these hospitals have old physical plants that are greatly in need of capital for the purposes of renovation and modernization.

A switch from the pass-through for capital to prospective payment would severely penalize some hospitals for past decisions they cannot change. Unlike operating costs, hospitals can do little to change capital costs once incurred. A radical change in Medicare's capital payment rules under which hospitals have been making capital investment decisions would cause significant, undeserved financial hardships.

Another potential difficulty inherent in capital incorporation is that lender uncertainty about debt repayment will increase. It is absolutely critical that hospitals avoid defaults because they would have serious repercussions affecting the entire health care field. It is also noteworthy that many hospital capital projects are backed with federal guarantees such as the Federal Housing Authority Section 242 program. Greater uncertainty means higher interest costs, which for some hospitals mean loss of access to capital markets altogether. Moreover, eliminating the pass-through could affect the ability to refinance, which reduces Medicare capital payments for interest.

Under the continued pass-through, hospitals would be better assured of being able to meet current debt service requirements. Thus, there would be less likelihood of hospital bond defaults. In addition, financial markets would have more confidence in the ability of hospitals to meet their financial commitments. This would help hospitals acquire needed capital at reasonable rates and, consequently, would help keep costs down for the industry as a whole.

Several months ago, the AHA completed an analysis of an approach similar to that proposed by the Administration. That analysis indicated that incorporation would sharply increase the number of hospitals experiencing substantial shortfalls between their capital payments and capital costs. Even with the split transition for fixed and movable equipment:

- Nearly 30 percent of all small hospitals (fewer than 1,000 admissions annually) and more than 30 percent of large hospitals (8,000 or more admissions annually) would experience a capital shortfall of at least 10 percent or more;

- Nearly 20 percent of small hospitals and more than 15 percent of large hospitals would experience a shortfall of 30 percent or more;

- Approximately 40 percent of mid-sized hospitals would experience losses of 10 percent or more, and approximately 24 percent of these hospitals would experience losses of 30 percent or more;

- About 18 percent of all rural hospitals and about 25 percent of all urban hospitals would experience a loss of at least 30 percent; and

- More than 20 percent of all non-teaching and more than 25 percent of all teaching hospitals would experience a shortfall of at least 30 percent.

The AHA is currently completing an analysis of the proposed rule on Medicare capital payments published on May 19, 1987 and will be pleased to provide the Committee with an updated impact analysis when available.

The AHA will continue to devote significant resources to the development of a fair and adequate method of paying for capital by Medicare. On the basis of currently available information, the AHA has concluded that the only method of paying for capital that provides reasonable assurances of adequacy and equity is a continuation of the pass-through. Because Congress already has established Medicare capital payment limits through FY 1989, maintaining the capital pass-through will be neutral in terms of budget savings. This position has the broad support of the hospital field and reflects a strong consensus among hospitals in all parts of the nation that none of the proposed methods of paying for capital that has been proposed would result in either adequate or equitable payment.

INDIRECT MEDICAL EDUCATION

The Administration has proposed a reduction in indirect medical education payments. This proposal is based, in part, on more recent data and, apparently, on data from first-year cost reports. No change in the indirect medical education factor should be made at this time. The factor was originally included in PPS to compensate for the limitations of DRGs as a measure of case mix. Payments for indirect medical education costs are actually intended to reflect differences in the types of services provided in teaching and non-teaching hospitals, not simply to reflect effects of teaching on operating costs. Thus, changes in the formula that result in lower payments will require teaching hospitals to make substantive changes in services they offer and resources they employ.

In addition, the implications for teaching and referral hospitals of moving to the 100 percent DRG national rate have not been determined. The transition to national rates was expected to substantially change the distribution of revenues among hospitals. Movement to national rates is expected to cause many hospitals that reported a positive margin in the first PPS year to slip into a loss position--even with the indirect medical education formula at its current level. Until the ability of hospitals receiving indirect medical education payments to continue operating as regional referral centers under national rates has been verified, it would be unfair to demand greater reductions in costs from these facilities than from other hospitals.

The adjustments intended to achieve greater equity between urban and rural hospitals recommended by ProPAC, and those supported by the AHA, require urban hospitals to accept a smaller increase in prices than will be provided to rural hospitals. It would be inappropriate to further reduce payments to urban hospitals by limiting payments for medical education costs.

DIRECT MEDICAL EDUCATION

The Administration also has proposed a further reduction in payments for the direct costs of medical education. These reductions would be made before limits on medical education payments enacted in 1986 are fully implemented. Further payment restrictions would be premature before the impact of those previously enacted limits on medical education and patient care in teaching hospitals has been evaluated.

It would be particularly damaging to implement those provisions in the Administration's proposal eliminating reimbursement for costs of educating nurses and other allied health professionals. Recently, and despite the slower rate of increase in hospital employment, hospitals have again encountered a severe shortage of nursing personnel. Over the past several years, the demand for registered nurses has grown steadily. To limit the funding available to support education programs would compound the problems of recruiting sufficient numbers of qualified professional staff, both today and

in the future. Before making further changes, Congress should consider the results of an HHS study, mandated by P.L.99-272 and due July 1, 1987, with respect to Medicare-approved educational activities related to nursing and other allied health professions.

SOLE COMMUNITY PROVIDERS

The AHA recommends that any rural hospital that is the only hospital located in a county or located within a reasonable number of miles or travel time be designated as a Sole Community Provider (SCP). The AHA concurs with ProPAC's recommendation that the special treatment given SCPs be clarified. The AHA has developed, however, a specific approach to be used to recognize the difficult operating environment of these hospitals. This approach should be considered as an alternative to existing SCPs. The sole community provider would be permitted to select one of two payment options. The election would be for three years. The payment options would be:

- Current law retaining the 25-percent national/75-percent hospital specific rate blend; or
- Full national rates with low-volume adjustment protection. The low-volume adjustment would provide reimbursement for a percentage of loss on Medicare participation measured by total Medicare inpatient revenues less total Medicare inpatient expenses. This adjustment would be available to hospitals with 2,500 or fewer total annual discharges.

PERIODIC INTERIM PAYMENT

The Administration has proposed to eliminate the periodic interim payment (PIP) program for disproportionate-share providers. This recommendation is not based on any evidence that these providers would be able to finance the increased working capital that would be required by the delay in payment resulting from loss of PIP. The continuation of the PIP program for small rural and for disproportionate-share providers was based on a concern that these hospitals might experience substantial disruptions in operations if their cash flow were interrupted. Many disproportionate-share hospitals treat substantial numbers of the poor and provide significant levels of uncompensated care. The increased costs of financing working capital would be a significant burden for these facilities. Thus, PIP should be continued for all hospitals eligible under the law as currently written, including PPS-exempt facilities.

TRANSITIONAL CARE

One effect of the implementation of PPS has been to make both providers and beneficiaries aware of the growing need for sub- or post-acute care. Hospitals report growing difficulties in placing patients in nursing homes and/or with home health agencies. To ensure the availability of such services, Congress should amend Title XVIII to permit hospitals to provide all levels of care, not simply acute inpatient hospital care. Specifically, current use of "swing beds" should be expanded to include urban as well as rural hospitals, and the current bed limitation (fewer than 50) should be eliminated. By allowing hospitals to provide skilled nursing care to Medicare beneficiaries for limited periods of time, the quality and continuity of care would be increased at minimal cost to Medicare. Such an action also would contribute to the continued viability of rural hospitals and help assure access to needed medical services to Medicare beneficiaries living in rural communities.

APPEALS AND EXCEPTIONS

PPS, which is based on national averages, is by design unable to make exceptions and take into account variations in individual hospital conditions. Currently, hospitals have no avenue for appeal that considers the most serious misapplications of the system. Therefore, HHS should be required to use existing authority, which permits broad discretion, to make exceptions

for and grant adjustments to hospitals able to demonstrate that their treatment under PPS is unreasonable. An example of a situation that might be well served by an exceptions process is use of the nearest Metropolitan Statistical Area (MSA) wage index when a hospital can demonstrate that it pays wages that are affected by such competition.

CONCLUSION

As originally designed prospective pricing won the broad support of the hospital industry. An essential feature of that design was the opportunity for hospitals to earn a surplus if hospitals were to assume the risks inherent in prospective pricing. With the release of new HCFA data it is clear that hospital margins have peaked and are rapidly declining. In light of this new data it is imperative that hospitals receive an FY 1988 update factor that is fair and adequate. This will enable hospitals to continue to provide high quality care to Medicare beneficiaries at the same time that the Medicare program has experienced the lowest rates of increase in expenditures since it was created.

STATEMENT OF MICHAEL D. BROMBERG, ESQ., EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HEALTH SYSTEMS, WASHINGTON, DC

Mr. BROMBERG. Thank you, Mr. Chairman.

Let me first say that I support everything that Jack Owen has said, and for that reason I am going to limit my remarks primarily to one subject, the DRG update.

I would like to refer you to the last page of our testimony, which is Exhibit Two, which has two charts on one page, the one at the bottom tracing the profit margin decline of hospitals, and the chart at the top of that page tracing the 1983 Prospective Payment Act's promise of a market-basket increase, compared to what hospitals have actually gotten.

If you look at that difference between the top line and the bottom line on the first chart, the market-basket versus the update factor, I think I would be the first to admit that a lot of that difference in the early years was fat, waste, and inefficiency, and it explains why the law has been so successful and, in part, why the Medicare Trust Fund has a 10 to 15 year longer life than previously thought. The Congress deserves credit for that, and so does the industry, and so does the Administration.

But at some point in that differential between the top line and the bottom line, we have become very worried about what we call "cutting the bone" or quality or access to services.

The difference between the top line and the bottom line is $600 per case. I would like to try to put that into perspective for you all by giving you an example of what would happen if you were managing a hospital:

The average standardized rate is $3000 per case for inpatient PPS. With costs rising at a conservative estimate of 5 percent a year—that is just price, not intensity; it is probably closer to double that, but if we just say that the market basket is rising by 5 percent a year—that is $150 per patient.

The Congress basically, in the last couple of years, has given us less than a 1 percent annual increase and is talking about something in that range for the next couple of years, or about $30 per case. Well, if you have to absorb as a manager, or eat, $120 per patient, you can probably do it for a year or two when there is fat and waste in the early years and the incentives work, and you can probably do it for another couple of years; but at some point it is impossible to absorb, and that is what the chart at the bottom shows: What is going to happen to profits if this continues?

Now, we have supported and do support—and I know it is politically popular and I should say a lot of great things now about rural hospitals and disproportionate share hospitals. And believe me, we do support them. But I want to talk for a minute about the forgotten hospital, the typical hospital, 80 percent of the hospitals, that little 200 to 300 bed non-teaching, non-disproportionate share hospital. It could be rural, by the way. It could be a 100-bed rural hospital, too, that doesn't get these extra benefits.

If you look at these profit-margin data that are now coming out, you should subtract another 1 percent for these forgotten hospitals. Because, this chart really applies to the average of all hospitals.

When you take out all these special adjustments which that typical forgotten urban or rural hospital doesn't get, they are another full percentage point lower.

My point simply is that, while we should continue disproportionate share, and we should do more for the rurals—we were for no rural/urban difference back in 1983, I might add—you can't keep doing it solely at the expense of that typical forgotten hospital, or something bad is going to happen to the system.

The only other point I want to make on the update is to say that the hospital industry realizes you are under budgetary pressures and, notwithstanding what was a good decision in the Budget Conference, you still have a high target to meet, and I think we want to work with you to offer reasonable alternatives to finance those targets other than the update.

One, in particular, would be our willingness to discuss changes in the prompt-payment methodology, which could get very high savings by stretching out averages, ceilings, floors—we are open to all discussions. But we would much rather have you do it that way than do it on the update, because of what this chart implies will happen.

If you can't do any of that and you continue year after year to do this to us, at some point someone is going to have to admit that Medicare can't keep its promise, which is more care for more people for less dollars. It just can't go on forever. And at some point you are going to have to consider unpleasant alternatives such as raising taxes or means testing, or at least allowing hospitals to charge for what Medicare is not paying for, in the form of premiums such as you are now doing with catastrophic, I might add. It is not an out-of-the-world idea.

I just want to add two other thoughts. On capital, I want to support what Jack says but just add to it: You are about to pay us 90 cents on the dollar for capital costs. I can't think of a stronger incentive not to overspend capital and also a stronger reason why you don't need to do anything in the capital area in terms of prospective payment. Anyone that takes 90 cents on the dollar and overspends is going to get their just desserts without more regulation.

Finally, I would like to add two things: One, uniform reporting is an idea which in concept we would be glad to work with you on; but we think you ought to look at it and study it, because we are very concerned about potential $100,000 per-hospital costs in converting information systems, and we think it can be done in a much more streamlined way.

Finally—it is not a subject for this hearing, because it is happening so quickly—I would hope that the Chairman and the members of this committee will look into this proposed regulation coming down from the Administration to no longer pay for the bad debts of Medicare patients. I think it is an outrageous provision which Congress has a chance to block before September 1, and I would hope that you will look into that.

Thank you, Mr. Chairman.

[Mr. Bromberg's prepared testimony follows:]

STATEMENT OF

MICHAEL D. BROMBERG

EXECUTIVE DIRECTOR

FEDERATION OF AMERICAN HEALTH SYSTEMS

The Federation of American Health Systems is the national association of investor-owned hospitals and health care systems representing over 1,400 hospitals with over 172,000 beds. Our member management companies also manage under contract more than 350 hospitals owned by others.

PPS Hospital Update Factor

When prospective payment was enacted in 1983, our association strongly supported the legislation. In fact, we first urged Congress to enact some type of prospective payment system as early as 1966 because we believed that positive incentives could improve efficiency. The DRG system has accomplished that objective. Expenses have been cut and the Medicare Trust Fund has a longer life expectancy.

The hospital industry supported a bill in 1983 which provided for fixed DRG prices. These prices which were to be increased annually by an agreed upon market basket index reflecting the annual increases in the cost of goods and services purchased by hospitals.

For three years in a row, the Administration and Congress have amended that law to cut by more than 50 percent the rate of increase promised to hospitals.

The rationale or excuse for cuts in the DRG update in fiscal years 1985 and 1986 was the serious federal budget deficit. Hospitals responded to that argument by agreeing to participate in any fair, across-the-board budget deficit reduction plan. Hospitals pointed out though, that defense spending was rising while Medicare was being cut at a rate nearly double its share of federal outlays.

In 1986 and today the argument is being made that hospital profit margins were too high in 1984 and 1985, and therefore rates should be rebased. Rebasing, however, is not consistent with the intent of the prospective payment legislation. Review of the 1983 floor debate clearly shows that the law was based on a new incentive to increase hospital efficiency by reducing costs. But, in contrast to original intent, hospitals have been rebased every year since

1983 through cuts in the promised rates of increase. Now new data show that margins have declined rapidly to the point where about 40 percent of hospitals will soon be operating at a financial loss on their Medicare patients.

According to a recent study by Consolidated Consulting Group, new HCFA data indicate that Medicare profits are much lower than previously estimated and are declining rapidly. Original HCFA data (PPS-1) projected fiscal 1987 profits at 15.1%. New (PPS-2) data estimate FY 1987 profits at 6.2%. Medicare profits for FY 1988 would be 3.0% if hospitals receive a 0% update and 4.4% with a 1.5% update factor (see Exhibit One). When all Medicare revenues and all Medicare costs (not just operating costs and passthroughs) are included in the margin calculation, total Medicare margins for FY 1988 would be about 3.0% with a 1% update factor. At this level of average Medicare profit margin, almost 40 percent of hospitals will lose money (have a negative margin) on their Medicare business.

While government profit margin data have been disputed by the industry for understating the true cost of services, even the government's own data now show that most hospitals face a loss situation by the end of 1988. The graph attached to this testimony illustrates the problem facing hospitals (See Exhibit Two).

The typical hospital admission carries a standard DRG payment rate of approximately $3,000. The cost of goods and services to hospitals is increasing at about 5 percent annually, or $150 per patient. If Congress continues to provide DRG rate increases of only 1 percent per year--or about $30 per case--the typical hospital will incur costs of $120 more than it would receive from Medicare per patient each year, or $360 over three years.

Such drastic reductions in hospital payments could jeopardize the entire Medicare program. Hospitals cannot absorb cost increases of 15 percent over the next three years, while receiving payment increases of only 3 percent.

There is simply no way that most hospitals can cut their costs anywhere near that amount and still provide the quality of care that Medicare beneficiaries should have.

Furthermore, the distributional effects of Congressional action, e.g. increased payments to disproportionate share hospitals, are

such that certain types of hospitals will enjoy significantly higher profit margins than average community hospitals. HCFA data, assuming a 1.5% update factor for FY 1988, projects a national average PPS hospital margin of 4.4%, with non-disproportionate share hospitals averaging 3.4% compared to profit margins of 6.4% for urban disproportionate share hospitals with more than 100 beds and 10.8% for urban disproportionate share hospitals with less than 100 beds, while rural disproportionate share hospitals would experience margins of 12.7%

While we support special adjustments for disproportionate share providers, there is a danger that continued budget neutral increases for these hospitals, without adequate updates for all hospitals will jeopardize the typical urban and rural community hospital.

We urge the Committee to provide an adequate rate of increase at or near the market basket minus 2 percent enacted last year for fiscal 1988 and to return to a full market basket increase for fiscal years 1989 and 1990. The hospital industry is ready to work with the Committee to find other proposals for reaching the deficit reduction target for fiscal year 1988, including reasonable changes in the prompt payment methodology for Medicare claims. Failing some method for providing adequate updates, we would urge Congress to simply admit that it cannot finance its past promises to the elderly and either raise taxes, increase copayments, establish a means test or consider authorizing hospitals to charge those beneficiaries who are able to pay, in order for hospitals to achieve adequate updates.

If nothing is done to change the trend toward inadequate payment updates, hospitals will be forced to reassess their support for the program. Patients will realize and react to the simple fact that they are the ones who suffer the consequences of Congress authorizing inadequate payment for services.

Medicare Capital Payments

During the past two years, the government and the hospital industry have attempted to develop an adequate and fair method for folding payments for Medicare capital costs into PPS operating prices.

Despite the efforts of all parties to identify a solution, no fair system has yet been proposed. The difficulty in developing an equitable capital payment policy arises from the fact that capital cost percentages vary substantially among hospitals. Some hospitals have large amounts of debt while others have very little, depending upon where a hospital happens to be in its capital spending cycle. The amount of capital costs varies greatly over time for individual institutions because major capital expenditures for replacing and modernizing physical plant or major fixed equipment occur infrequently. For example, a hospital having recently initiated or completing a large capital project may have capital costs amounting to over $2,300 per discharge. However, by comparison, an older facility that faces a major project in the future could have current capital costs amounting to less than $50 per discharge.

Thus, the approaches suggested so far to fold capital payments into PPS prices would prove inequitable for a significant portion of hospitals given the differences among hospitals and where they are in their individual capital cost cycles. The critical questions are: 1) whether the average capital amount will be adequate to meet the hospital's capital needs; and 2) whether the transition will adequately recognize individual hospital capital costs such that hospitals can satisfy their capital obligations.

Neither the plan proposed by the Administration in their capital regulation, nor the plan outlined by the Prospective Payment Assessment Commission, adequately answers these two critical questions. Each would result in a sharp increase in the number of hospitals that would experience substantial shortfalls between their capital payments and capital requirements.

There is No Need to Incorporate Capital Payments into PPS Prices

Part of the sense of urgency to replace cost based payment for capital has come from concern that the continuation of the status quo would set off a capital spending boom. This fear is greatly exaggerated and not supported by experience. The rate of increase in hospital capital spending has declined from over 20% in 1981 to

8.8% in 1984. The projected increase in cost per case for FY 1988, including the reductions in capital payments passed by Congress last year, is believed to be significantly lower still -- 2.9%. We believe the Medicare prospective payment system will restrain capital expenditures beyond the expectations of many policy analysts. The reason is that while capital costs (depreciation, interest and return on equity) are now excluded from Medicare's DRG rates, the operating costs associated with new capital expenditures are not.

Some of these capital-generated operating costs would normally be recovered under an intensity index, but the Medicare prospective payment rates were increased only a net 4.15% in fiscal 1985, 0.50% in fiscal year 1986, and 1.15% for fiscal 1987. Since new capital spending generates higher operating costs, but Medicare's payment for operating costs is fixed by diagnosis, there is little incentive to invest in cost increasing technology. Additionally, the reductions in capital payments to hospitals enacted in OBRA last year will result in hospitals receiving only 90 cents for each dollar of capital costs by fiscal 1989. These reductions in capital payments, combined with operating cost restraints, are sufficiently strong so that hospitals will not find it in their interest to expand high cost acute care capacity.

Since the status quo would not generate perverse behavior, and since capital costs vary so widely among hospitals, we do not think that it is necessary to change capital payment policy. Congress should act to continue the current reimbursement system for Medicare hospital capital payments.

Uniform Reporting

During various hearings on hospital profit margins, many members expressed the need and desire for more timely and accurate reporting of hospital fiscal data. Many have felt that decisions made about the hospital update factor were made in a vacuum, because Congress only had access to data several years old, and not reflective of the current fiscal condition of hospitals. The recent release of PPS-II data cited earlier, demonstrates that earlier reports of high Medicare profit margins were misleading with the more recent data

showing dramatic declines. Thus, we would agree that Congress should have access to more current information. However, we would note that hospitals already submit comprehensive Medicare cost reports, on a timely basis, within 90 days of the close of the cost report year.

A new, more comprehensive Medicare cost report is not the solution to this problem. Completely reprogramming hospitals for a new uniform reporting or accounting system would cost at least $100,000 per hospital, to say nothing of the cost for additional personnel needed to fulfill additional reporting requirements. If anything, Congress should consider a streamlined report which more accurately reflects the costs incurred by hospitals in treating Medicare patients. Furthermore, the fiscal intermediaries and the Health Care Financing Administration must be encouraged to process the information provided by hospitals, more quickly. We would be happy to work with the Committee to develop a less burdensome system for publishing more current data.

Conclusion

The Federation of American Health Systems supported the enactment of a prospective payment system as a way to provide hospitals the correct incentives for providing quality care at an efficient price. Most significantly, the response of hospitals to the new incentives under PPS has resulted in enormous savings to the Medicare program, and prolonged the life of the Medicare trust fund well beyond the next decade.

Hospitals have contributed more than their fair share toward deficit reduction. We urge you to take a more balanced approach toward reducing the deficit. We are willing once again to provide alternatives for helping the Senate Finance Committee to achieve its budget reconciliation target and still provide hospitals with an equitable increase in their Medicare payments.

Exhibit One

HCFA HOSPITAL PPS MARGINS -- OLD VS. NEW
(FY, PERCENT)

	Old	New	
FY 83/84 (PPS - I)	14.8%	14.8%	
FY 1987	15.1% *	6.2% **	
		Projected Rate of Increase	
		0.0%	1.5%
FY 1988	____	3.0% **	4.4%**

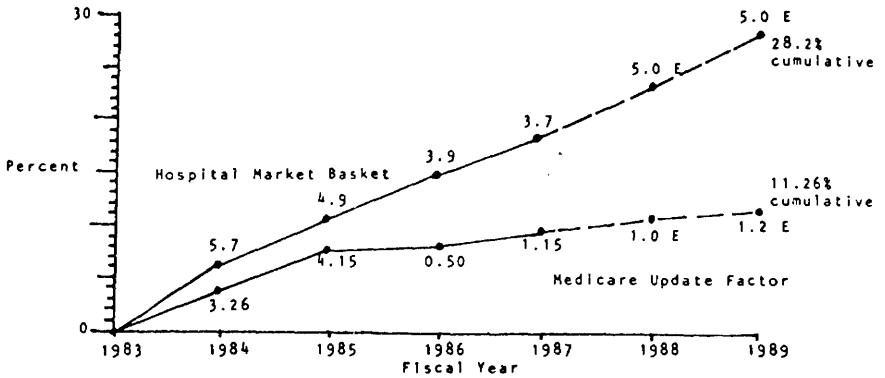
* Federal Register, Vol. 51, No. 170, September 3, 1986, page 31601 (1986 = 1987)

** Projections based on PPS - II data.

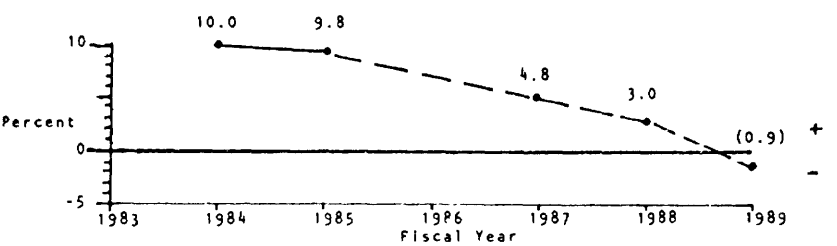
Exhibit prepared by Consolidated Consulting Group, Washington, D.C.

Exhibit Two

UPDATE FACTOR VS. INCREASE IN HOSPITAL INPUT COSTS,
FY 1984-1989



PROJECTED TOTAL MEDICARE MARGINS



If the annual increase in Medicare's DRG payment rate is limited to 1.1% for FY 1988-89, the average hospital in 1989 will lose 1¢ for every $1.00 received from Medicare for inpatient cases.

Senator BAUCUS. Thank you, gentlemen.

Mr. Bromberg, do you agree with Dr. Altman's basic point that there should be about a 14 percent differential between urban and rural Medicare payments?

Mr. BROMBERG. As I said, in 1983 we came before the committee and said, "We don't want any differential; pay them both the same." We didn't even want nine regions. We wanted simple rates.

Senator BAUCUS. What about today?

Mr. BROMBERG. Today I would think that differential ought to be reduced, certainly to that level if not more. And it costs very little to give rural hospitals those extra benefits. So, from a budget point of view, we would be more than willing to see that differential shrunk even below 14.

Senator BAUCUS. Thank you very much.

I regret that there is a vote in progress now. Senator Durenberger will return to chair the remaining portion of this hearing, so there will be about a two or three minute recess until Chairman Durenberger returns.

[Whereupon, at 10:52 a.m., the hearing was recessed.]

AFTER RECESS

Senator DURENBERGER. Just so I get on the right track, I understand you have both completed your testimony, is that correct?

Mr. OWEN. Correct.

Mr. BROMBERG. Correct.

Senator DURENBERGER. And you have been responsive to questions from the Chairman?

Mr. BROMBERG. Yes, sir.

Senator DURENBERGER. Was one of them on capital?

Mr. OWEN. No.

Mr. BROMBERG. No.

Senator DURENBERGER. Let me, then, ask both of you just to clarify for all of us your positions on capital. I do this, I think, principally so we can make a record as we look to the future.

The reality, as I think most of us know, is that we have struggled and struggled and struggled with this issue, and that nobody will argue with the fact that, if it were possible to incorporate into any kind of a prospective payment system for any kind of a service, to be able to incorporate into that the known, predictable and necessary capital requirements to produce the service, no one would oppose recommendations for percentage or other adjustments.

However, I take it we have a somewhat difficult situation when we are going into an existing industry whose capacity does not necessarily conform to future demands, where the capital investment has been predicated on one kind of a reimbursement system rather than the one we now have in place.

And so, for at least last year, our efforts to come up with a formula for phasing into a capital adjustment fell flat, and we copped out for the sort of current reimbursement minus whatever.

I take your recommendation here to be that the House judgment this year to continue that process is agreeable to you. Is that sort of a temporary position? Or, what is the current position of the two associations on capital reimbursement?

Mr OWEN. Let me start, and then Mike can pick up.

I think we agree with you, Senator, that in the long run we would like to see it as part of that; that was the goal that we started out with

The problem, as you mentioned, has been the different spots where everybody is in the capital structure. More importantly, however, capital tied to an inadequate DRG rate has gotten a lot of hospitals very frightened that in the long run, incorporation is not a good move, unless there is some way in which the DRG rate itself is made fair and equitable and not tied so much to a budget deficit.

The problem that we have had right along is what kind of predictability can we get in this capital situation, that it goes year by year and becomes a problem.

Last year, your action to continue it for a period of time of three years, unless the regulations came out to change it, was at least a start toward that predictability. And now what the House has done by extending it to four years, even though it is 90 cents on the dollar—as Mike says, not the kind of thing that makes us extremely happy—it does provide predictability both to the hospitals and to the financial markets, to know what is going to happen.

I think that in itself is very good, and maybe within these two or three years coming up we can reach a point where we get more predictability in that operating price so that there is a lot more confidence in how capital will be treated.

At this point in time, I think there is almost 100 percent agreement by hospitals across the country to continue the pass-through as the way to go for the next few years. Now, maybe Mike would like to add to that.

Mr BROMBERG. Well, I would just simply say that I think, yes, the position of the industry has changed. We prefer to keep the pass-through, and our best argument for it is that the capital costs are coming down by themselves. The data shows that it has been nowhere near the projections of what capital is going to be. And therefore, the basic reason for doing this in the first place seems to be slipping away.

However, the second position, I think, is that if you want to do capital and you don't agree with us, we would be willing to work out a plan, and always have been.

The problem with all the plans submitted by all sides so far has been that the transitions don't give enough help, no matter how long they are, because of the vast difference in commitments made that can't be changed—that is, that can't be changed as operating costs can be. Therefore, the only kind of plan that we all could agree to last year—which was maybe too new to be considered and maybe some day should be brought back to the table—is a plan that grandfathers old capital for a certain number of years and puts new capital in the system right away, and then some date down the road, 10 years or so, everybody is on prospective. I think we could all live with that.

But the flaw in the plans has been the inability for the transitions to provide adequate protection. It really just hurt too many hospitals that couldn't do anything about it, as they could have on the operating side.

Senator DURENBERGER. Let me go to the urban/rural differential issue. I certainly appreciate the endorsement of the PROPAC recommendations in this regard, and I think everybody here does, and I trust there are many on the House side that feel the same way about it; but there are some other issues as well that relate to that. One is the wage index issue. That has been a troublesome one for some period of time, and I would just ask you if you believe it is necessary for us to continue the process of improving and updating the wage survey data, to the extent that that helps in the area of fairness as between different hospitals.

Mr. OWEN. Well, I think, yes, that is definitely necessary. Any of those kinds of equity adjustments ought to be continued.

Mr. BROMBERG. Particularly the problem that we have with counties that have lines running through them, and the hospital is on the wrong side of the line but its labor force is coming from the other side of the line. That is the one we get the most complaints about. It seems to have a lot of merit. So, if anything more could be done to have adjustments for those rural hospitals that are getting their labor from urban markets, and beef up the provisions in the law on that, it would be very helpful.

Senator DURENBERGER. The current hospital-cost reporting system provides data which appears to be anything but current, and as a result we are faced with differing estimates of the financial condition of hospitals.

Let me ask you, Mr. Owen, do you agree with Mr. Bromberg's position that a streamlined rather than a more comprehensive cost-reporting system can provide us with the information we need? If so, how would either of you streamline the system while still providing the needed information?

Mr. OWEN. I agree that a more streamlined system is better than getting some very complicated, intensive kind of reporting form that is probably not going to be used, anyway.

There are a couple of ways it could be done, I think. One might be the possibility of some kind of quarterly reports issued by the fiscal intermediary using data that hospitals report annually. This mechanism would ensure the provision of more timely data for considering either update increases or whether the costs of providing health care are going up.

We know pretty much from year to year what is happening, and you could do this on a quarterly kind of report, on what is now being reported to the fiscal intermediaries HCFA by hospitals, and streamlining some of these is a much faster way of getting this information.

Setting rates without having adequate information is a very difficult thing indeed, and I am sure that Dr. Altman in his job as Chairman of PROPAC must find it extremely difficult to come up with recommendations, not having the data that is necessary.

Mr. BROMBERG. I would just add to that that I think the data is there already, and I think it is current; it is just not being sent to Washington and being used.

Every hospital in the country files a cost report within 90 days of the end of its fiscal year, and they send it to their fiscal intermediary. But the lag between the intermediary receiving that cost

report and HCFA receiving it can be months and months, if not years.

All they would have to do is take 10 elements off that report and telephone it into HCFA's computer, and it would be there.

But what we are concerned about is this obsession with devising some brand new form. We don't know if it is in lieu of or in addition to, and we are afraid of the costs.

Hospitals have spent a lot of money with their computer systems in the last few years, getting ready for DRGs. And we are afraid that all of that cost is out the window and we would have to start all over again.

We think the data is there—it is sitting out there in the field, either in a sample basis or, if you want to, on a 100-percent basis. You know, the use of a telephone will get that data to Washington a year or two sooner.

Senator DURENBERGER. Along this same line, I have made some recommendations about improving the outlier pool payment system. Do you have any problems with the recommendations?

Mr. OWEN. No, I think that is a very important issue. The closer you more to a national rate, and the more important the outlier becomes. The outlier was put in there, as you know, primarily to take care of some of the differences that occur in the severity of cases. And when we had a hospital-specific larger portion, the outlier was built into that hospital-specific side. But as you move more toward a national rate, you have to depend more on the outlier, and I think we are going to be in serious trouble if those outliers aren't used adequately and properly so that the hospital which is taking care of these serious cases has an opportunity to be paid an adequate amount of money. And the outlier is the way to do it.

Mr. BROMBERG. Particularly for small and rural hospitals. An outlier can really cripple a small hospital; whereas, a larger one may be able to absorb it. So I think your proposals are very effective in that area.

Senator DURENBERGER. Do either of you have any recommendations for us for obtaining spending reductions or reductions in the growth of spending in areas that you would recommend to us because no one else has thought of it before? Or some spending reduction that you don't oppose? [Laughter.]

Mr. OWEN. Well, I think we both would agree that delaying the payment, although not very popular with many of our hospitals, but a delay in the payment cycle might be one way that we could live with it without creating too much of a hardship for our hospitals. That seems to be one of the few ways that you could get some savings.

Mr. BROMBERG. I would agree with that and add to it. Senator Heinz made a comment at the beginning of the hearing that hospitals represented 60 percent of the costs of Medicare. The other body, in its wisdom, produced 87 percent of the cuts on hospitals. I think equitable distribution of cuts goes with the equitable burden of taking care of patients as something you should be concerned about.

Second, after a long hard-fought budget resolution at which 1.5 became the number instead of a much higher one, I hope it stays there. And I hope we don't see the revenue side fall short and ev-

erybody come back to Medicare, as we have heard rumors might be the case again. That fight to keep it at 1.5 I hope won't get thrown out the window because revenues in defense don't come to the table.

I think really before you ask the question—and we have always been willing to tell you where in Medicare you could find the money—there is a question that precedes that, which is: What about the rest of the programs? And is Medicare taking too much of a hit? Without going into it in detail, I think you know our position.

Senator DURENBERGER. Well, you know there is the appearance, if you look at what has been happening over the last few years—and this is a general question—that, while the use of hospitals in general has gone down, the severity of the cases that are coming in has gone up. So, the costs keep going up.

If you look over on the Part B side, there is a whole lot of increase in volume over there and very little, if any, constraint in expenditures such as we have on this side. I would wonder out loud why it is that the two hospital associations haven't made some recommendations to us about constraints and the growth in Part B reimbursement.

Mr. BROMBERG. It is very hard for a supplier of a service to tell you to go after their customer.

Senator DURENBERGER. Jack, do you have anything to add?

Mr. OWEN. No comment. [Laughter.]

Senator DURENBERGER. All right, gentlemen; thank you very much.

Mr. OWEN. Thank you.

Mr. BROMBERG. Thank you.

Senator DURENBERGER. Next we have a panel consisting of Mr. Charles M. O'Brien, Jr., the Administrator of Georgetown University Hospital, on behalf of the Association of American Medical Colleges; Ms. Kay Hollers, Chairwoman of the Government Affairs Committee of the National Association for Home Care, from Austin, Texas; and Ms. Cynthia Polich, the President of Interstudy, Excelsior, Minnesota.

All right, in the order of introduction you may begin. You know the rules as far as summarizing your statements. All of the statements will be made part of the record, and we welcome all of you.

Mr. O'Brien?

STATEMENT OF CHARLES M. O'BRIEN, JR., ADMINISTRATOR, GEORGETOWN UNIVERSITY HOSPITAL, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, DC

Mr. O'BRIEN. Good morning, Mr. Chairman.

My name is Charles O'Brien. I am the Director of the Georgetown University Hospital and a member of the AAMC Council on Teaching Hospitals Administrative Board. The formal remarks of the Association are included for the record; I would like to highlight some of the points that we want to emphasize.

The Association of American Medical Colleges represents all of the nation's medical schools, 85 academic societies, and over 350

teaching hospitals participating in the Medicare program, and welcomes the opportunity to testify this morning.

With regard to most of the issues before the committee, we agree with the position taken by the American Hospital Association. However, the AAMC has a special responsibility to comment on the Medicare payment issues that have an educational label.

In the 1988 budget, the Administration would eliminate payment for the educational costs of residency training and expenses for nursing and allied health programs as an allowable pass-through. The AAMC believes that both of these changes are ill-advised.

It is clearly recognized that hospitals that educate our nation's health professionals generate additional expenses that need to be financed. Last year's COBRA legislation required studies that would examine the cost of educating both physicians and allied health professionals. The AAMC believes that any consideration of major changes in the financing of direct medical education should wait until these results are available. Therefore, the AAMC firmly is opposed to the Administration's proposal to modify the payments in direct medical education.

I wish to turn our attention now to the second Medicare payment with an educational label, and that is the indirect medical education.

While the resident-to-bed adjustment is called "the indirect adjustment for cost accompanying medical education," it is, in fact, a proxy measure to provide appropriate compensation for the added patient service costs borne by teaching hospitals. This was recognized in 1983 by the Senate Finance Committee report, which stated:

> This adjustment is provided in the light of doubts about the ability of the DRG case classification system to account fully for factors such as severity of illness requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents. The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.

Thus, the resident-to-bed adjustment helps correct for the fact that too few variables are used to set prices in the current system. Nevertheless, its "medical education" label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in costs between teaching and non-teaching hospitals.

The AAMC has found the medical education label has led to much misunderstanding of the purposes of this adjustment. Last year, the AAMC worked with the Senate Finance Committee staff, and analysts from the Congressional Budget Office, to re-estimate a statistically appropriate percentage for the indirect medical education adjustment.

The Association reviewed this CBO analysis and concluded that the study was conducted properly. Therefore, the AAMC did not challenge the CBO analysis, which showed a newly calculated curvilinear rate adjustment should be set at 8.7 percent, with a somewhat lower percentage if a disproportionate share adjustment was added to the formula. As set forth in our testimony submitted for the record, this cut was substantial.

I am familiar with the observation that teaching hospitals have fared well under the new payment system. It should be noted, however, that data on teaching hospital margins were reported for the first two years of PPS, when hospitals were paid primarily on the basis of their own historical costs. Given the implementation of fully national rates, the small increases of the last two years, and the substantial cut to the indirect medical education adjustment last year, it appears that the future is not nearly so bright as the recent past for teaching hospitals.

For example, the fiscal year which began seven days ago in my own institution, we are conservatively projecting a 5.4 percent reduction in revenue compared to last year. This decrease assumes no change in the volume of discharged Medicare patients. We assume a similar decrease the following year, when we move to 100 percent of the national rate. At the same time, we are expecting major expense increases in nursing salaries and other allied shortage areas and malpractice insurance.

This being the case, the AAMC recommends the indirect medical education adjustment be retained at its current level. The AAMC is aware, however, that the size of the adjustment has been challenged in some quarters. This being the case, we would call to the committee's attention the DHHS "Study of the Financing of Graduate Medical Education" conducted by Arthur Young, which recently was completed.

It is clear that, based on this study, the adjustment under no circumstances should be reduced below 7 percent.

Mr. Chairman, this concludes my remarks. I would be happy to try to answer any questions you would have.

Senator DURENBERGER. Thank you.

Ms. Hollers?

[Mr. O'Brien's prepared testimony follows:]

Charles M. O'Brien, Jr.
Administrator
Georgetown University Hospital
and
Member, Council of Teaching Hospitals Administrative Board

The Association of American Medical Colleges (AAMC) which represents all of the nation's medical schools, 85 academic societies, and over 350 major teaching hospitals participating in the Medicare program, welcomes the opportunity to testify on the Administration's Fiscal Year 1988 budget proposals for Medicare. With regard to most of the issues before the Committee, the AAMC supports the positions taken by the American Hospital Association. However, the AAMC has a special responsibility to comment on the two Medicare payment issues that have an educational label.

Direct Medical Education Costs

To provide clinical training for residents, nurses, and allied health personnel, hospitals incur costs beyond those necessary for patient care. Under prospective payment, reimbursement for these expenses has continued, albeit with modifications enacted in the Consolidated Omnibus Budget Reconciliation Act (COBRA) last spring.

In its 1988 budget, the Administration proposes two major changes in the Medicare pass-through for direct medical education costs. First, educational costs included in residency training would be eliminated. While detailed language on this proposal has not been made available, informal discussions with staff at HHS suggest the Health Care Financing Administration will propose that expenses for faculty salaries, faculty benefits, and faculty support costs be eliminated. Second, expenses for nursing and allied health programs would be eliminated as allowable costs in the pass-through.

The AAMC believes both of these changes are ill-advised. Hospitals providing our nation with health manpower education in addition to patient services need revenues beyond patient care payments to support the added responsibilities. It is inappropriate to pretend that residency programs can be operated without faculty to train and supervise residents. It is equally

inappropriate to ignore the costs of nursing and allied health education programs. As the Department of Health and Human Services stated in the Secretary's 1982 report Hospital Prospective Payment for Medicare (pp. 47-48):

> The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.

In 1983, Congress supported the Department's position that it was not appropriate to include clinical training costs in DRG payments and approved continuing to pay costs of graduate medical education separate from the DRG based per case payment. This policy is as valid in 1987 as it was in 1983.

Detailed information on educational costs is presently being developed in Congressionally-mandated studies. Last year, the COBRA legislation established the Council on Graduate Medical Education. Through COBRA, Congress directed the Council to study the costs of graduate and undergraduate medical education and the Federal policies concerning changes in the financing of those programs. The Council will report its recommendations to the Secretary in January of each year for the term of its charter. Additionally, COBRA requires the Secretary to study approved allied health educational activities reimbursed by Medicare and report to Congress on those findings by December 31, 1987. The AAMC believes that consideration of any major changes in the financing of these activities should be delayed until the results of both the Council's and the Secretary's studies are available.

In the COBRA legislation, this Subcommittee carefully examined Medicare payments for direct medical education. The AAMC worked cooperatively and openly with the Committee and its staff, and did not oppose the termination of the open ended commitment of the Medicare program to graduate medical education.

Regulations to implement this change, effective for fiscal years beginning on or after July 1, 1985, have not yet been promulgated. Given the Congressionally mandated studies that are underway, the major policy change made last year, and the fact that the absence of regulations has resulted in no assessment of the impact to date under the new payment methodology, the AAMC believes it is entirely inappropriate to make any changes this year in Medicare payments for direct medical education costs. Thus, the AAMC is firmly opposed to the Administration's proposals.

The Indirect Medical Education Adjustment

When prospective payment was being considered early in 1983, the Congressional Budget Office (CBO) compared the systems's impact on teaching and non-teaching hospitals. CBO's February, 1983 assessment showed that 71% of teaching hospitals would lose money compared with TEFRA, while only 32% of non-teaching hospitals would lose money. A copy of the table setting forth this projection is included as attachment A to this testimony. It should be noted that this impact assessment assumed the original indirect medical education (IME) adjustment of approximately six percent.

At least four factors have been identified which contribute heavily to this projected adverse impact.

- o First, the scope of services and therefore average costs of a hospital generally vary with bed size. This was recognized in the TEFRA limits where hospitals were compared using bed size groups. Under TEFRA, larger hospitals had higher limits. HCFA's use of an approach for prospective payments that sets prices approximating the costs of a 255 bed hospital disadvantaged teaching hospitals.

- o Second, when HCFA estimated the factor for the IME adjustment, two variables were included in the analysis -- hospital bed size and urban area size -- which were not included in the payment system. As a result, the computed adjustment was understated.

- Third, the Medicare payment system provides only 470 DRG's for recognizing differences between patients. If each hospital an equal distribution of patients in each DRG, the average payment for each DRG, and thus the amalgamated average payment for all DRG's would not be a problem. However, teaching hospitals do not receive a random mix of patients. Teaching hospitals receive the sickest, most difficult and most costly cases.

- Finally, hospitals in large metropolitan areas have higher average costs than those in smaller cities, and within a metropolitan area central city hospitals have higher average cost than suburban hospitals. Teaching hospitals are heavily concentrated in the central cities of major metropolitan areas. Because the prospective payment system does not adjust for the higher costs of central cities, teaching hospitals are hurt by the average pricing system of prospective payments.

While the resident-to-bed adjustment is called the "indirect adjustment for cost accompanying medical education," it is, in fact, a proxy measure to provide appropriate compensation for the added patient service costs borne by teaching hospitals. This was recognized in the 1983 Senate Finance Committee Report which stated:

> This adjustment is provided in the light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.

Thus, the resident-to-bed adjustment helps correct for the fact that too few variables are used to set prices in the current system. Nevertheless, its "medical education" label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in cost between teaching and non-teaching hospitals. The AAMC has found the medical education label has led to much misunderstanding of the purposes of this adjustment.

Last year, the AAMC worked with Senate Finance Committee staff and analysts from the Congressional Budget Office to re-estimate a statistically appropriate percentage for the IME adjustment. The Association reviewed the CBO analysis and concluded the study was conducted properly. Therefore, the AAMC did not challenge the CBO analysis which showed a newly calculated curvilinear adjustment should be set at 8.7% with a somewhat lower percentage if a disproportionate share adjustment was added to the formula. The table below sets forth the size of the cuts that resulted from this action for hospitals with resident per bed ratios ranging from .1 to .5. At a minimum it should be noted that teaching hospitals with a resident-to-bed ratio of 0.1 will experience a 32% reduction in the adjustment.

INDIRECT MEDICAL EDUCATION ADJUSTMENT

Resident-to-Bed Ratio	Payment Adjustment		Percentage Cut in Adjustment
	Pre-COBRA	Post-COBRA	
0.1	11.59%	7.87%	32%
0.2	23.16	15.33	34
0.3	34.24	22.42	35
0.4	46.32	29.20	37
0.5	57.90	35.69	38

The AAMC is familiar with observations that teaching hospitals have fared well under the new payment system. It should be understood that these data on teaching hospital margins were reported for the first two years of experience

under prospective payment when hospitals were paid primarily on the basis of their own historical costs and prior to the implementation of the reductions to the payment system adopted under COBRA. To the degree that profits were generated, they resulted more from the hospital specific payment component than the federal component adjusted for indirect medical education costs. Given the implementation of fully national rates, the small rate increases during the past two years, and the substantial cut to the indirect medical education adjustment last year, it appears that the future is not nearly so bright as the recent past for teaching hospitals. Therefore, the AAMC would hope that the status of the indirect medical education adjustment would not be an issue for debate once again this year.

The AAMC is aware however, that the size of the adjustment has been challenged in some quarters. This being the case, we would call to the Committee's attention the DHHS-funded, "Study of the Financing of Graduate Medical Education," conducted by Arthur Young and Company, which has recently been completed. Chapter 5 of Report II in that study uses uniformly reported financial data in teaching and non-teaching hospitals to estimate an appropriate resident-to-bed adjustment. This study is based on data collected in 1983 and 1984 and is the first effort of which we are aware that provides an independent assessment of the indirect medical education adjustment.

The table in attachment B sets forth the results of this research. It should be noted that the results estimate a resident-to-bed adjustment of 0.688 (i.e. 6.89%) to 0.758 (i.e. 7.58%) depending on the number of variables used in the regression equation. Importantly, each of these equations use a metropolitan city size variable that is not present in the current payment methodology. If this variable were to be excluded, the percentage for the resident-to-bed adjustment would be higher.

Given the fact that the current payment methodology does include a "disproportionate share" adjustment, it would be important to include this variable in the analysis. This is first accomplished in column three by use of a "Medicaid" index. This index represents the hospital's Medicaid/no pay

caseload as a percentage of total discharges, and while it is not the same as the "disproportionate share" formula, it is an adequate proxy. Thus, column three is the most useful column to study for evaluating present Medicare payment policies. The results in column 3 show an adjustment of 6.94% is justified if adjustments were also made for severity and metropolitan city size. It must be understood that the 6.94% figure would be higher if the severity index and metropolitan city size variables were not included.

The foregoing analysis is based on a relatively small sample of 45 hospitals. All other analysis is based on averages that suggest a wide range of results. As indicated earlier the future for teaching hospitals under the Medicare Prospective Payment System is not as bright as the past. The future is also very uncertain given the move to the full implementation of national rates. This being the case the AAMC once again recommends that the indirect medical education adjustment be retained at its current level.

The AAMC is well aware of the complexity of the statistical and methodological basis for this discussion. However, we have had excellent working relationships with the Committee staff as well as some Committee Member's staff. We would be pleased to review this matter in detail with all staff members who may have an interest.

Conclusion

Teaching hospitals are a diverse group of highly complex institutions performing medical education and research for the nation and providing both basic and tertiary patient care. The current emphasis on re-examining national policies in light of more limited public resources places teaching hospitals and their vital activities at significant risk if their special nature and role are not supported. As policies and expectations change, teaching hospitals will continue to adapt and evolve. If national policies on health care delivery and payment recognize the distinctive characteristics and diversity of teaching hospitals, their fundamental missions can be preserved. If the characteristics of teaching hospitals are not recognized and valued, simplistic public policies may damage the ability of these institutions to fulfill their responsibilities.

ATTACHMENT A

TABLE 1. ESTIMATED AVERAGE PENALTIES AND BONUSES UNDER THE ADMINISTRATION'S PROPOSED DRG-BASED PAYMENT SYSTEM, BY TYPE OF HOSPITAL a/

	All Hospitals		Hospitals That Would Gain		Hospitals That Would Lose	
	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements b/	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements c/	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements d/
All Hospitals	100	0 e/	61	+23	39	-12
Bed Size						
Less than 50	26	+32	86	+41	14	-10
50-99	23	+17	73	+32	27	-10
100-299	34	+2	50	+21	50	-11
300+	17	-6	30	+17	70	-13
SMSA						
SMSA	52	-4	43	+20	57	-13
Non-SMSA	48	+19	81	+29	19	-6
Region						
Northeast	15	-4	45	+19	55	-12
North Central	28	-4	60	+21	40	-13
South	37	+8	72	+26	28	-9
West	20	-2	57	+23	43	-13
Teaching Status						
Teaching	18	-7	29	+18	71	-13
Nonteaching	82	+7	69	+24	32	-10
Ownership						
Nonprofit	57	-2	55	+20	45	-12
Government	31	+9	78	+29	22	-12
Proprietary	12	-1	48	+22	52	-13

SOURCE: Preliminary CBO estimates based on Medicare Cost Reports for 1980.

a. Assumes an average payment level needed to keep outlays at the same level as under TEFRA in fiscal year 1984. Average gains and losses are incremental to those under TEFRA, which are assumed to be the average for each group. Effects of phase-in and adjustments for exceptionally costly cases are excluded, but an adjustment for teaching hospitals is included.

b. Average calculated for all hospitals.

c. Average calculated for hospitals that would gain.

d. Average calculated for hospitals that would lose.

e. Because aggregate reimbursements were assumed to be the same as under TEFRA, increases in payments to some hospitals would be exactly offset by decreased payments to others.

ATTACHMENT B

REGRESSION RESULTS FOR INDIRECT COST MODELS

VARIABLE	ESTIMATED COEFFICIENTS*			
	REGRESSION NUMBER			
	1	2	3	4
ln Residents Per Bed	0.758 (.27)	0.723 (.28)	0.694 (.29)	0.688 (.28)
ln ORG Case-Mix Index	1.09 (.25)	1.08 (.31)	1.02 (.35)	1.01 (.35)
ln Nurse Wage Index	0.446 (.49)	0.415 (.49)	0.514 (.51)	0.851 (.55)
ln Technician Wage Index	−0.07 (.61)	−0.05 (.62)	−0.12 (.63)	−0.43 (.65)
Size 1	0.201 (.11)	0.213 (.11)	0.208 (.11)	0.299 (.13)
Size 2	0.008 (.10)	0.017 (.10)	0.013 (.11)	0.066 (.11)
Size 3	0.019 (.12)	0.026 (.12)	0.015 (.12)	0.032 (.12)
ln Severity Index		0.580 (.92)	0.614 (1.05)	0.476 (1.06)
ln Medicaid Index			0.037 (.04)	0.039 (.04)
ln Beds				−0.110 (.08)
R Squared	.64	.65	.66	.68
Intercept	7.334	7.136	7.144	7.402

*Values in parentheses are standard errors of coefficient estimates.

STATEMENT OF KAY HOLLERS, CHAIRWOMAN, GOVERNMENT AFFAIRS COMMITTEE, NATIONAL ASSOCIATION FOR HOME CARE, AUSTIN, TX

Ms. HOLLERS. Thank you.

My name is Kay Hollers. I am the owner and President of Wellstream Health Services in Austin, Texas, but I speak to you today for the 5,000 member agencies of the National Association for Home care.

We thank you for allowing us to testify today, when, as you know, the need for home health services is growing rapidly, due to many of the factors that have already been described today—the changes going on in the hospital industry. And yet, the access to and funding for the Medicare home health benefit are decreasing.

Senators Bradley and Mitchell, joined by nine other members of this committee, have introduced S. 1076, known as "The Medicare Home Health Services Improvement Act of 1987." The bulk of my remarks today will underscore the importance of getting the provisions of this bill incorporated in Budget Reconciliation, and I will go through some of those key provisions for you.

One of the things that has proven to be an enormous problem for us, that the bill addresses, is the whole area of claims denials and the appeals of those claims denials.

One of the provisions of 1076 would require that the fiscal intermediaries provide adequate explanations to us when they deny claims. Now, we understand that Senator Heinz and Claude Pepper are additionally working on further legislation to deal with the preparation of the reviewers that make those kinds of denials—a problem that has been chronic with our industry but seems to be entering an acute phase.

The second provision would require that penalties be assessed if appeals are not handled in a timely fashion and would assess penalties after 60 days. It would require that FI performance be evaluated by HCFA not only on their aggressiveness in denials but on their appropriateness, and the amount of overturn of appeals be factored into evaluating their performance.

This bill also requires that HCFA be required to comply with the Federal Administrative Procedures Act, an important issue, so that we may all know about changes in policy in a timely fashion, so that we can better manage our agencies.

We support the provisions of this bill that deal with quality of care issues. There are many. Three key ones among them are requiring standards for the training of paraprofessionals used in home care, revising the certification process for home care so that it focuses more on the actual quality of patient care rather than so much on structural and procedural assessments, and requiring that a patient bill of rights be incorporated for Medicare home care consumers.

The bill also requires a HCFA study on the appropriateness of the different rural and urban cost limits. We, too, have rural/urban cost limit problems in home health. Many of our agencies may serve four to five counties and truly have a mix of rural and urban factors influencing costs in the agency; and currently an agency is categorized as either urban or rural. There is no way to

have any kind of perhaps proportional mix in establishing cost limits. The bill would also address another problem relating to the cost limits. It would require HCFA to use a wage index based on data obtained on wage factors in home health agencies, rather than assuming that the hospital-based wage index fits our industry, which it does not, always.

The fifth issue addressed in this bill is recognizing occupational therapy as a qualifying skilled service, qualifying the beneficiary for home care rather than requiring them to become eligible through their need for nursing, speech or physical therapy, in order to get occupational therapy.

In addition to those provisions in S. 1076, we are very interested in provisions that would allow our proprietary members to retain return on equity capital, at least until such time as we get a prospective payment for home care, a similar provision to that which was used in the hospital industry. We lost return on equity Monday, and that is going to cost many of our members as much as $10 million for the industry.

We urge prompt enactment of S. 1127, the Medicare Catastrophic Loss Prevention, which clarifies the Medicare definitions of "intermittent care" and "homebound," words that the FI's use and reinterpret to beat us over the head in our denials process.

That concludes my remarks, and I would welcome any questions.

Thank you.

Senator DURENBERGER. Thank you very much.

Ms. Polich?

[Ms. Hollers' prepared testimony follows:]

TESTIMONY OF

Kay Hollers, President
Wellstream Health Services, Inc.
Austin, Texas

on behalf of the

NATIONAL ASSOCIATION FOR HOME CARE

Mr. Chairman and Members of the Committee:

I am Kay Hollers, President of Wellstream Health Services, Inc. in Austin, Texas. I also serve on the Board of Directors for the National Association for Home Care (NAHC), and am the Chairman of NAHC's Government Affairs Committee. NAHC is the nation's largest professional organization representing the interests of home health agencies, homemaker-home health aide organizations and hospices, with approximately 5000 member organizations. On behalf of these organizations, I would like to commend you for holding this important hearing.

The population of Medicare beneficiaries needing home care continues to grow. Not only are the numbers of frail elderly increasing as the population ages, but elderly patients are discharged in more acute stages of illness than in past years because of quicker releases under the Medicare prospective payment system. Such patients may require highly skilled services which were formerly capable of being provided in hospitals or nursing homes but can now be provided in their homes.

Yet, just as the need for home care has dramatically increased, coverage for these services under Medicare has actually decreased. According to a report by the Senate Special Committee on Aging (1986), recent policies of the Health Care Financing Administration (HCFA) "to restrain beneficiary protections, combined with vague and confusing guidelines for providers, result in reduced access to home health care for Older Americans." The report noted that although hospital discharges to home health have increased 37 percent since prospective payment for hospitals was implemented, the growth in home health services since then has slowed. A 1987 General Accounting Office survey of hospital discharge planners revealed that 86 percent "reported problems with home health care placements" for Medicare beneficiaries. Fifty-two percent of those surveyed cited "Medicare program rules and regulations" as "the most important barrier" to these placements. It is no coincidence that HCFA's own statistics show that the percentage of home health claims denied under the Medicare program rose from 1.2 percent in 1983 to over 6.0 percent in 1986. And this figure does not include the many patients who are effectively denied Medicare coverage because home health agencies, incapable of assuming the costs of non-covered care, avoid Medicare claims submissions. The problems have only increased since the report was released, with denials for home health services up to 9 percent in the most recent period. Denial rates in individual states have been as high as 30 percent.

This year, Senators Bradley and Mitchell, joined by nine other Members of this Committee, introduced S. 1076, the Medicare Home Health Services Inprovement Act of 1987 to improve the availability and quality of home health services under the Medicare program. This legislation, which currently has 21 co-sponsors, contains a number of provisions which NAHC urges this Committee to incorporate in this year's budget reconciliation package:

Clarifications of "Intermittent Care" and "Homebound" Definitions

Currently, definitions of key eligibility criteria such as "homebound" and "intermittent care" vary tremendously depending on the fiscal intermediary's (FI) interpretation. S. 1076 would ensure uniform definitions of these terms. This Committee has already incorporated a modification of the clarifications of these terms as set forth in S. 1076 in the Catastrophic Health Insurance bill. NAHC commends the Committee for this action and for recognizing the importance of including these provisions in the catastrophic health package. We have additional report language we would like to work with the Committee on to assure that HCFA administers the benefit appropriately.

Provisions regarding Appeals of Denials

Currently, a beneficiary, with the assistance of a home care agency, can request a "reconsideration" of a home care claim for Medicare reimbursement after it has been denied. If the denial is upheld, the beneficiary can appeal the matter to an administrative law judge (ALJ). Often, an appeal or a reconsideration of a claim denial can take six to nine months as there is no incentive for FIs to expedite the reconsideration process. Further, when an FI denies a claim, an explanation is given to the provider and beneficiary that is written in language that is extremely difficult to understand, so patients and providers are often unaware of why coverage has been denied. In addition, when the performance of FIs is monitored by HCFA, FIs are rewarded for claims denied, without regard to whether that denial was ultimately reversed. Thus, FIs are rewarded for aggressive but not appropriate administration of the Medicare home health benefit.

The provisions in S. 1076 directed at the appeals process are an important step in improving the current system. Those provisions would require the FI to provide adequate explanations for denials, would require that penalties be charged if reconsiderations are not conducted within 60 days of receipt of an appeal, and that FI performance on appeals be made part of HCFA's overall appraisal of the FI. These provisions would provide an incentive to FIs to make prompt reconsiderations and would help beneficiaries and providers to understand the denials.

Requirements for Publication of Policies

HCFA has promulgated numerous major policy changes that restrict the Medicare home care benefit through written and verbal directives, manuals, and guidelines, rather than through the regulatory process, depriving affected parties of the opportunity to know in advance of changes in policies and to comment on these changes. S. 1076 would require HCFA to comply with the Federal Administrative Procedures Act. This would permit a thorough review of changes in policy by providers, beneficiaries, and interested members of Congress. It would only add an estimated 70 pages per year to the Federal Register, and would promote a more rational administration of home health agencies and the Medicare program.

Quality of Care Provisions

This Congress has focused attention on the issue of quality of care, an issue critical to home care providers and the beneficiaries they serve. Home care services are provided behind closed doors in private homes to millions of people who by definition are the vulnerable members of our society due to their inability to care for themselves. The care is rendered in a setting which is not subject to public scrutiny. The very nature of the services places unique responsibilities on providers of care.

S. 1076 contains provisions designed to improve the quality of home care services, including creating standards for training of paraprofessionals, a revised certification process that focuses on the quality of patient care and a patient bill of rights for home care consumers. We urge you to incorporate these important measures.

Cost Limits Provisions

Currently, home health agencies participating in the Medicare program are reimbursed at cost, subject to cost limits. These cost limits are based on a hospital wage index and there are different cost schedules for rural and urban areas.

If an agency is designated by HCFA as either urban or rural, but serves a mix of urban and rural patients, the reimbursement for the services of these agencies may not accurately reflect the costs of the services provided, and may serve as a disincentive to provide care to patients for whom agencies are reimbursed at lower rates. S. 1076 would require a HCFA study on the appropriateness of the different rural/urban cost limits and on possible changes in the calculation of these limits to more fairly reflect the proportion of urban and rural patients served by an agency.

In addition, S. 1076 would require HCFA to use a wage index based on data obtained from home health agencies, rather than on a hospital-based wage index. This would more accurately reflect home health agency costs.

Occupational Therapy

Under current law, occupational therapy services are available only after the beneficiary has otherwise qualified for the Medicare home care benefit. Only the need for skilled nursing care, speech or physical therapy qualifies a beneficiary for home health benefits. S. 1076 would recognize occupational therapy as the fourth skilled service which would qualify beneficiaries for the home health benefit.

Preserve Return on Equity

In addition to the provisions of S. 1076 just discussed, there is another crucial issue which NAHC would urge the Committee to address in the context of budget reconciliation. The Health Care Financing Administration has published a final rule to eliminate the Medicare return on equity capital for all proprietary providers other than hospitals and skilled nursing facilities, and to eliminate the exception to the home health agency cost limits for new agencies, 52 Federal Register 21216, June 4, 1987.

The rule became effective on July 6, 1987, and has an estimated fiscal impact of $10 million a year on home health agencies and certain other providers (comprehensive outpatient rehabilitation facilities, providers of outpatient physical therapy and speech pathology services, independent organ procurement agencies, histocompatability laboratories, and rural health clinics).

We urge you to take immediate action to rescind this regulation, and retain return on equity until a prospective payment system is implemented for home health agencies, and then phase it out gradually, as Congress has done for hospitals. Such action is necessary in order to preserve access to home health services for Medicare beneficiaries.

NAHC is getting telephone calls from home health agencies who will be forced out of business as a result of this precipitous action by HCFA.

The abrupt total elimination of return on equity capital used in the provision of Medicare-covered services would prompt many investor-owned agencies to discontinue service to Medicare beneficiaries or to reduce drastically the number they do serve. NAHC believes that this would be detrimental to the home health community and to beneficiaries, who benefit from a competitive mix of different providers.

Those proprietary agencies that elected to remain in Medicare would have a greater incentive to borrow to meet their capital needs, incurring interest costs that would be borne by the program. These increased costs would reduce, if not outweigh, the cost savings that HCFA projected from eliminating a return on equity to home health agencies. Moreover, NAHC maintains that the Medicare program should not, after 20 years, shift its policy in such a way as to favor debt over equity financing of capital needs.

Finally, to the extent that profit-seeking agencies continue to serve Medicare beneficiaries at less than cost, including the opportunity cost of capital, other payors will be forced to subsidize Medicare services, in derogation of the proscription against cost-shifting contained in 42 U.S.C. 139x(v)(1)(A).

It should be noted that HCFA has the authority to pay a return on equity to home equity to home health providers, despite statutory silence on the issue.

Equity capital is more important to home health providers than ever, as providers are forced to rely on capital resources in order to meet payrolls and other operating expenses during delays in Medicare payments, particularly on the increasing number of claims not processed under recent prompt payment requirements. (Sixth Omnibus Budget Reconciliation Act of 1986, P.L. 99-509, Section 9311).

As noted earlier, return on equity for hospitals for inpatient services was maintained until a prospective payment system had been implemented for hospitals, and is being currently phased out gradually over a period of three years (Consolidated Omnibus Budget Reconciliation Act of 1986, P.L. 99-272, Section 9107). Return on equity is still allowed for skilled nursing facilities. As a matter of equity, it should be maintained for proprietary home health providers.

Summary and Conclusion

We urge the Committee's consideration and approval of inclusion of these modest changes which, together with those included in the catastrophic health package, will help to assure the availability of high quality home health services to Medicare beneficiaries who need them, as well as assure appropriate administration of the home care benefit by HCFA. We would be pleased to work with the Committee in this endeavor.

Thank you for the opportunity to be here today to discuss these important issues with you. I would be happy to respond to any questions you may have.

STATEMENT OF CYNTHIA POLICH, PRESIDENT, INTERSTUDY, EXCELSIOR, MN

Ms. POLICH. Thank you.

My name is Cynthia Polich. I am President of Interstudy, a nonprofit health care research firm involved in promoting competition and quality in the health care marketplace.

Over the last two years we have been involved in evaluating Medicare enrollment in HMOs. We come at the issue from the point of view that Medicare enrollment in HMOs should be promoted as a way to contain Medicare costs, reduce out-of-pocket payments from the elderly, and improve access and coverage of health services.

Most recently, we conducted a survey of HMOs with Medicare risk contracts. The purpose of the study was to shed some light on two questions that have been points of contention for the Medicare risk contracting program since its inception: First, are HMOs being reimbursed adequately? And consequently, is the program enjoying wide success, or on the brink of failure?

In this survey, over half of the HMOs reported that their contracting experience was somewhat or very unfavorable. Only 56 percent felt confident that they would renew their contract in 1988.

The most significant problem cited by the respondents was the inadequate method for determining their Medicare capitation rate—otherwise known as "The AAPCC."

The problems with the AAPCC are both conceptual and technical. First, the AAPCC does not adequately reflect real costs or utilization. It is in the best interests of the HMO, the enrollee, and the government for capitation to better reflect expected costs. HMOs need to be protected from adverse selection. Government must be assured that it is not overpaying HMOs for the care of healthier-than-average beneficiaries. Enrollees must be protected from inadequate rates that threaten quality of care.

Second, since rates vary by county of residence, there can be great discrepancies in payments for two HMO enrollees that live in adjoining counties, even though the HMO's cost of caring for those enrollees are the same. This problem is particularly exacerbated in rural counties.

Third, unlike the PPS system, HMOs do not receive extra payments for catastrophic or outlier cases. This is particularly troublesome for new plans and plans with a relatively small enrollment. It may not only jeopardize the financial viability of risk contracts but may also be a barrier to entry for new plans.

There are also problems for HMOs operating in rural areas. Because these areas have historically had poor access to comprehensive services, Medicare beneficiaries have a level of unmet needs not generally seen in urban areas. The result is higher than expected utilization, and higher costs in the early period after enrollment.

Based on these findings, Interstudy recommends several modifications to the Medicare reimbursement process. I have outlined many recommendations in my written statement, and I will highlight just three here.

First, we recommend that a Medicare capitation task force be created to improve reimbursement rates. In conjunction with HCFA, this task force should design a new method for calculating Medicare rates. This method should include an adjustment for the case mix or health status of Medicare enrollees, to protect both HMOs and the Government from the effects of bias selection. Second, the new rate-setting method should more adequately adjust for geographic variations in costs, including the potential of moving away from using the county as the geographic unit, so that difference in rates for contiguous counties are reduced. Third, the method should provide more equitable rates for HMOs that serve rural Medicare beneficiaries. And fourth, the method should move away from a capitation rate based upon fee-for-service reimbursement and utilization, so that rates more accurately reflect the costs of providing services in a managed-care system.

That is a long-term agenda, however. Over the short term, several changes are needed. As I mentioned, I have outlined several recommendations in my written statement and would like to highlight two.

First, we need to establish a minimum AAPCC rate equal to approximately 80 percent of the national average of the AAPCCs for urban counties. The AAPCCs for some counties, particularly rural counties, are extraordinarily low. One HMO in Minnesota reported that the average rate for an urban and a rural county in their service area varied by 76 percent, while the cost of caring for those enrollees varied by only 10 percent.

Second, a major barrier to entry for many HMOs is the risk of catastrophic costs. This is particularly true for small HMOs and HMOs in rural areas where the risk pool is small. Hospitals are buffered from these outlier cases by receiving reimbursement above the usual Medicare PPS rate. HMOs should be protected in a similar way. Specifically, when an individual HMO enrollee meets the hospital determination of a day or cost outlier, the HMO should be reimbursed at the fee Medicare would have paid the particular hospital being used.

This ends my prepared remarks, and I would be happy to answer any questions or elaborate further on our recommendations.

[Ms. Polich's prepared testimony follows:]

Cynthia L. Polich
President
InterStudy

The number of Medicare beneficiaries enrolled in Health Maintenance Organizations (HMOs) has soared in recent years. It is estimated that as of April 1987, enrollment reached nearly one million elderly persons.

The rise in Medicare/HMO enrollment has been met with both praise and criticism. Proponents suggest that HMOs are well-designed to provide care to older persons that is more appropriate and less expensive than care in the fee-for-service sector. At the same time, concerns have been raised about the adequacy of capitation rates and the scope and quality of care currently provided in Medicare HMOs. Though the dramatic growth in the number of risk contracts suggests that the trend is strong and will continue, others suggest that inappropriate rates and other questionable policies seriously threaten the success of current and future Medicare risk contracts.

Prompted by the ongoing scrutiny and controversy surrounding the Medicare/HMO program, InterStudy undertook a national study to examine these issues from the HMO perspective.

The purpose of this study was to shed some light on two questions that have been points of contention for the Medicare risk contracting program since its inception: Are HMOs being reimbursed adequately, and consequently, is the program enjoying wide success or on the brink of failure?

On the one hand, problems with the program are evident. In this survey, over half of the HMOs reported that their contracting experience was somewhat or very unfavorable, and only 56% felt confident that they would renew their contract in 1988. Inadequate rates and other problems appeared to significantly hinder the efforts of several HMOs to successfully serve Medicare beneficiaries. Consequently, many respondents indicated that major program changes are needed soon to prevent large numbers of HMOs from terminating their current risk contracts or deciding against entering the program.

At the same time, however, the number of HMOs entering into risk contracts has risen dramatically since the first TEFRA contracts were implemented in early 1985, and these numbers continue to grow. Also, as of late 1986, less than 10% of HMO and CMP risk contracts had been terminated, and these terminations affected less than 40,000 beneficiaries. Further, several reports assert that at least some HMOs are enrolling a healthier-than-average population and are therefore being overpaid for the services they provide.

If one conclusion is clear from these conflicting reports, it is this: HMOs vary tremendously in the degree to which they experience financial gain or loss from their risk contracts. This survey indicated that many of the factors one might assume are related to success, such as model type or plan age, may not be significant. Much more research is needed to determine what variables are important. In the meantime, care must be taken not to overgeneralize or make sweeping recommendations based on the experience of just a few plans.

The termination of a few contracts, for instance, does not mean that the program is doomed and that older persons should be discouraged from enrolling in HMOs. Likewise, rapid, continued growth in the number of risk plans should not be taken as a sign that HMOs and Medicare beneficiaries are sufficiently satisfied with the program. The termination of even one HMO, for example, can have significant implications. Contract terminations send a message to Medicare beneficiaries and the HMO industry alike. That message of instability and unreliability only serves to discourage HMOs from continuing or pursuing risk contracts in the future and discourage Medicare beneficiaries from enrolling.

InterStudy's survey results suggest that a major problem with the Medicare risk contracting program is the AAPCC -- the capitation rate paid to HMOs. The problems with the AAPCC are both conceptual and technical. First, several studies suggest that the AAPCC does not adequately reflect real costs or utilization. Both adverse and favorable selection contribute to the discrepancy between AAPCC rates and actual costs. (Adverse selection occurs when HMO enrollees are less healthy than area beneficiaries not enrolled in an

HMO and results in underpayments to the HMOs. Favorable selection, conversely, occurs when HMO enrollees are healthier than average, resulting in overpayments.) There is much debate about whether HMOs are experiencing favorable or adverse selection. Regardless of the accuracy of these claims, however, it is in the best interests of the HMO, the enrollee, and the government for capitation rates to better reflect expected costs. HMOs need to be protected from strong adverse selection. Government must be assured that it is not overpaying HMOs for the care of healthier-than-average beneficiaries. Enrollees must be protected from inadequate rates that threaten quality of care. In addition, inadequate rates should not discourage the enrollment of the frailest elderly in HMOs. It is these individuals who may be most benefited from enrollment in an HMO -- the potential for cost savings is high and the managed care concept is essential for maintaining high quality care. Yet, the current capitation system rewards HMOs for enrolling healthy Medicare beneficiaries.

Second, since rates vary by county of residence, there can be great discrepancies in payments for two HMO enrollees that live in adjoining counties, even though the HMO's costs of caring for those enrollees are the same. This problem is particularly exacerbated in rural counties.

Third, since rates are based upon the utilization and costs for Medicare beneficiaries in the fee-for-service system, geographic areas that have below average medical care utilization will also have low AAPCCs. This is a problem since the premise behind giving HMOs 95% of the AAPCC was that HMOs would reduce utilization by being more efficient health care providers. In areas that are already efficient, HMOs may be unable to offer care at 95% of a low base rate. The result is that HMOs tend to avoid risk contracts in areas with low fee-for-service utilization and low AAPCCs.

Fourth, unlike the PPS system, HMOs do not receive extra payments for catastrophic (or outlier) cases. In addition, it is difficult for plans to obtain the reinsurance necessary to protect them from high cost cases. This is particularly troublesome for new plans and plans with a relatively small enrollment. It may not only jeopardize the financial viability of a risk contract, but may also be a barrier to entry for new plans.

There are also problems for HMOs operating in rural areas. Because these areas have historically had poorer access to comprehensive services, Medicare beneficiaries have a level of unmet need not generally seen in urban areas. The result is higher-than-expected utilization in the early period after enrollment.

Recommendations

Based on survey results and subsequent analysis, InterStudy recommends the following long and short term modifications to the Medicare reimbursement process. First, InterStudy recommends that a Medicare Capitation Task Force be created to study and improve reimbursement rates. It is recommended that the responsibilities of the task force include, but not be limited to:

- o reviewing the calculations and methodology used by the Office of the Actuary to determine the capitation rate;
- o assessing alternative methodologies for determining the capitation rate;
- o identifying issues and problems affecting the success of Medicare capitation and recommending solutions to those problems.

It is further recommended that this Task Force work with HCFA to specifically address the following reimbursement issues:

- o Including an adjustment for the case mix or health status of Medicare enrollees so that the capitation rates more accurately reflect the actual risk of providing services to both healthy and frail Medicare beneficiaries and so that participating organizations have an incentive to enroll those who are sick;
- o More adequately adjusting for geographic variations in cost, including the potential of moving away from using the county as the geographic unit so that differences in rates for contiguous counties are reduced;

- Setting more equitable rates for participating organizations that serve rural Medicare beneficiaries and for geographic areas with conservative practice patterns.

- Moving away from a capitation rate based upon fee-for-service reimbursement and utilization so that rates more accurately reflect the cost of providing services in a managed care system;

- The potential of competitive bidding among participating organizations to further improve the cost-effectiveness of the Medicare risk contracting program;

- The need for catastrophic reinsurance among Medicare risk contractors;

- Methods for ensuring access and quality of care for Medicare beneficiaries [illegible] groups;

- Data on the use, cost, and quality of services provided to Medicare beneficiaries in prepaid plans and the fee-for-service system; and

- The long term cost saving potential of using prepaid health plan options for Medicare beneficiaries.

In the short-term, there is a need for technical enhancements to the AAPCC to protect the viability of the risk program. The following includes a series of recommendations which should be put into effect until long-term changes in the capitation methodology can be made.

- Require HCFA's Office of the Actuary to fully disclose the methodology and assumptions for the calculation of the AAPCC. At present, the methodology for calculating the AAPCC is very mysterious. Few individuals or participating organizations fully understand how the AAPCC is calculated and what assumptions are made during the process. Further, HCFA's Office of the Actuary has repeatedly declined to fully disclose the methodology and assumptions

underlying the AAPCC, in spite of the fact that they have made numerous unilateral changes to the methodology without notice to, or input from, the interested public. Consequently, eligible organizations are unable to replicate the AAPCCs for counties which they serve and are unable to make any predictions on the level of the AAPCC for subsequent years. It is important that the Office of the Actuary provide the AAPCC calculations to HMOs in a format which they can follow from start to finish. This document should be transmitted free to all participating organizations with the ratebook, as well as to anyone who requests.

2) Speed up the calculation of the USPCC and county AAPCCs. Each year, the Office of the Actuary calculates the USPCC. This is a national estimate of the total per capita cost of the Medicare program for the coming year. The county AAPCCs are based upon this estimate and are given to the participating organizations prior to the beginning of the contract year. At present, participating organizations are not always notified soon enough about changes in the AAPCCs. Potential and current contracting organizations must have the time to adequately evaluate their willingness and ability to participate in the Medicare risk contracting program and to set adequate premiums for the coming year. Preliminary estimates of the USPCC should be available by July 1 with preliminary county AAPCCs released no later than August 1. Final county AAPCCs should be provided to counties no later than September 7.

3) Include an adjustment in the AAPCC for Medicare beneficiaries who are also disabled. Such an adjustment will result in payments that more accurately reflect the actual costs of providing services to these Medicare/HMO enrollees.

4) Mandate an audit of the data elements used by the Office of the Actuary in calculating the AAPCC. AAPCCs for contiguous counties vary as much as $80 per enrollee per month. Researchers are unsure if this is the result of low physician supply in certain counties, a healthier population, lower fee schedules, different hospitalization patterns, or other factors. One possibility is that the claims incurred by rural residents for care rendered in urban hospitals is not being attributed back to the legal domicile of the

beneficiary. This recommendation calls for an audit of the claims process to see if this is a weak point in the system. In addition, the GAO should review the attribution of retroactive claims adjustments to prior years, the data collection process, the effectiveness of data exchange within the Department of Health and Human Services, and the computer systems and programs used.

5) Establish a minimum AAPCC rate equal to approximately 80% of the national average of the AAPCCs for urban counties. The AAPCCs for some counties, particularly rural counties, are extraordinarily low. It is unclear why such low rates exist. It could be due to the fact that those counties have very efficient practice patterns, with low costs and utilization. More likely the case, however, is an inadequate supply of providers and poor access to care. The current low rates discourage HMOs from enrolling individuals from these areas. In addition, when they do enroll, those beneficiaries will likely have high levels of unmet need which will result in higher than expected costs for the HMO. One HMO reported that the average rates for two counties in its service area varied by 76%, while the costs of caring for enrollees from these counties varied by only 10%. It is necessary to increase the rates in the lowest counties to a level that is reasonable to provide the full package of Medicare benefits.

6) Eliminate the ACR for premium setting. The ACR has become meaningless, complex, and easily manipulated process, wasting both the resources of the HMO and HCFA. This process was originally mandated to control the premiums set by the HMO in order to protect the consumer from excessive charges. With increased competition between HMOs and other payors, artificial control of the rates is no longer necessary. HCFA, for example, has recommended that the ACR process be eliminated for areas that have at least three HMOs competing for Medicare enrollees. It is assumed that the competition among the plans will be sufficient to keep premiums down. In fact, this has been the case in the Twin Cities metropolitan area where competition between several HMOs for Medicare enrollees has kept the premiums extraordinarily low, some believe too low. Even in areas without several HMOs, however, the ACR is no longer warranted because HMOs do not compete solely with each other for Medicare beneficiaries.

Medicare beneficiaries can choose between HMOs, PPOs, standard fee-for-service Medicare coverage, and/or Medigap coverage. Because of this competition, HMOs must provide reasonable premiums and quality service packages to attract enrollees.

7) Pay HMOs and CMPs outlier payments for Medicare enrollees receiving inpatient hospital services which meet the definition of cost or day outliers for the Medicare PPS system. A major barrier to entry for many HMOs is the risk of catastrophic costs. This is particularly true for small HMOs and HMOs in rural areas where the risk pool is small. These plans simply do not have the critical mass of enrollees to offset the tremendous risk of catastrophic cases. This is also a problem because it is difficult to obtain catastrophic reinsurance for Medicare risk contracts. The large, established HMOs are able to self-insure, but the small, new HMOs are often unable to do so. It is the small number of high-cost cases that often determines an HMO's or hospital's overall costs. Hospitals are buffered from these "outlier" cases by receiving reimbursement above the usual Medicare PPS rate. This recommendation suggests that HMOs be protected in a similar way. Specifically, when an individual HMO enrollee meets the hospital determination of a day or cost outlier, the HMO should be reimbursed at the fee Medicare would have paid the particular hospital being used.

8) Eliminate the 50% Rule one year after PRO/QRO ambulatory care review is implemented. The 50% Rule stipulates that HMOs with risk contracts have no more than 50% of their enrollees Medicare or Medicaid eligible. This rule was put into place as an indirect quality assurance measure. It was assumed that if the HMO could maintain 50% commercial enrollment, then they were meeting a market test for quality. Not only is the 50% Rule an insufficient indicator of quality, but it may also inhibit the development of plans designed specifically to meet the unique health care needs of an aging and chronically ill population. The cap was apparently set to prevent the development of a two-tiered system based on age, i.e., a health system for the elderly that would be different from the system for younger persons. It is feared that the system for older people would be an inferior one. If quality is assured

through a direct mechanism, however, such a dual system may be desirable. In fact, the development of programs designed especially for the elderly may be necessary to ensure adequate health care for older persons. Research strongly indicates that the health of older persons differs significantly from that of younger persons. The prevalence of chronic multiple conditions is much higher among the elderly, while the health problems of younger persons almost exclusively relate to acute conditions. Thus, separate innovative systems designed to meet the unique health care needs of the young and the old should not necessarily be discouraged. Removing the 50% cap and allowing Medicare-only HMOs, may encourage the development of innovative and cost-effective geriatric care centers. This recommendation suggests eliminating the 50% Rule one year after PRO/QRO review of ambulatory care is implemented. As a direct method of quality assurance, PRO/QRO review of HMO care is much preferable to the current 50% Rule.

The various problems reported by the HMOs, and the program changes recommended, are not meant to suggest that HCFA, reimbursement rates, or any other policy are solely responsible for a plan's success or failure. It is acknowledged that there are differences among HMOs in their ability to control utilization, manage services effectively, provide quality care, negotiate with providers, and attract and retain Medicare beneficiaries. HMO risk contracting is based in part on the theory that competition will weed out HMOs that are poorly managed or provide poor quality care. Undoubtedly, the poor financial experience of some HMOs is due in part to problems within the HMO.

Yet, it is crucial that TEFRA policies encourage competent HMOs to succeed. Many HMOs have apparently entered into risk contracts with careful plans, quality programs, and competent management, only to find that adverse selection and inadequate reimbursement rates are threatening their contract. In some cases, apparently, even the best plans have had little chance to do well. The failure of risk contracts has serious negative implications for the federal government who expects to save money, for HMOs who would like to serve the elderly, and for older persons who can be adversely affected by plan terminations. It is clear that the number of contracting failures must be minimized, and that competent, quality HMO plans be encouraged to serve the Medicare population.

Senator DURENBERGER. Let me thank each of you for the thoroughness of your prepared statements and the brevity of your presentations, as well. I think it has been very, very helpful to us.

Senator Bradley is going to try to get over here and ask a set of questions, in particular for Ms. Hollers. If he doesn't make it, you can expect to get them in writing, and we are going to need them for the record.

In general, other than the specifics of your testimony, do any of you have any recommendations for the committee as to areas of spending increases in the Medicare program, or specifics on spending reductions that we might look at, since this is the Reconciliation hearing, and we are going to have to end up reducing the increases? So, if you have any suggestions on increases or decreases, we would appreciate them.

Does anything have any specific?

Mr. O'BRIEN. Just briefly, on capital, I think I would echo what Jack Owen said, and that is that I think the ability to arrive at an equitably defined addition to the PPS system of capital doesn't seem to be there. We believe that the 10 percent reduction on the capital pass-through is an adequate disincentive for people to, if you will, make it up on volume, to go on capital expenditures that really aren't necessary. I think there is just too much variation in the industry, in terms of the capital cycle, the locations, et cetera, that make going to a PPS or a DRG rate for capital at this point not very attractive to anybody.

Senator DURENBERGER. Any other recommendations?

Ms. HOLLERS. I think, obviously we would like to see a broader home care benefit; but failing that, for the short term, for this year, realistically, if we could get some relief from the way the current regulations are being administered and interpreted. I think home care holds a lot of potential for helping to fill in the gaps tbat are being created by what is going on as this system readjusts to PPS.

And I think what we would plead for this year is, free us up to try to make the contribution that we can make in not spending less total Part A dollars but spending them in the most appropriate level of care.

So, I don't really want to argue for increases; just let us grow with the rate that I think we would be growing, given some of these artificial constraints being relieved.

Senator DURENBERGER. Ms. Polich?

Ms. POLICH. I think the most promising long-term method for containing overall costs in Medicare is further enrollment in prepaid health plans, whether it be HMOs or CMPs or other types of health plans.

In the short term, however, it may be necessary to authorize spending increases in order to encourage the expansion of this program, particularly the two recommendations that I made today. Making a minimum capitation rate would increase rates for certain areas, particularly rural counties. Also, providing outlier payments would increase costs to the Medicare program in the short term. I believe the implementation of these recommendations would encourage more health plans to enter into Medicare entry

into the market of risk contracts, particularly in areas that currently have extraordinarily low AAPCC rates.

Senator DURENBERGER. Senator Heinz?

Senator HEINZ. Thank you very much, Senator Durenberger. I wish I could say "Mr. Chairman."

Senator DURENBERGER. So do I. [Laughter.]

Senator HEINZ. Well, we have a majority right here. [Laughter.]

Senator DURENBERGER. We don't have a quorum, though. [Laughter.]

Senator HEINZ. And we would be unlikely to have both. [Laughter.]

Mr. O'Brien, you indicated that Arthur Young had done a study for DHHS which suggests an adjustment level for indirect graduate medical education of 6.9 percent. And you said that would be reasonable if there were adjustments for severity of illness and metropolitan city size, if those were included.

Now, we have already mandated that there be a study of how to do severity of illness. We have in place an adjustment for the higher cost of operation in metropolitan areas. And in light of those efforts, which are in one case responsive—the second case—and in the other, good faith, why should we pay more than a level found appropriate by Arthur Young?

Mr. O'BRIEN. Well, I think in the first instance the severity of illness, which personally I think is one of the major areas, is not in place yet. There is not an adjustment for that. And that is one of the proxies for the indirect medical education.

Senator HEINZ. I understand that, but where is Arthur Young wrong?

Mr. O'BRIEN. Well, they factored in their formula that 6.9 was the appropriate indirect medical education adjustment, in addition to which they added a severity of illness adjustment and the adjustment for the urban areas; so that 6.9 was exclusive of an adjustment for severity of illness. At the current time there is no adjustment for severity of illness. In other words, if the regression formula included these two factors—metropolitan area size and severity—the adjustment would, in fact, be higher.

Senator HEINZ. Are you saying that Arthur Young thought 6.9 is right if you do the severity of illness and——

Mr. O'BRIEN. The other two. Right.

Senator HEINZ. Well, we have done half, or one of the two things. How much weight should we give the fact that the severity of illness is not yet implemented?

Mr. O'BRIEN. I think it is a fairly significant one. I think the AAMC would certainly be anxious to work with the staff of the committee to try to get it at an appropriate level that meets our needs as well as meets the budget targets that you all have to work with.

Senator HEINZ. Now let me ask you about another study, this one done by the researchers of the National Center for Health Services Research and Health Care Technology Assessment, which this spring published a study, the results of which affirm that teaching hospitals spend more to treat patients than nonteaching hospitals, but the study goes on, apparently, to debunk the common belief that teaching hospitals actually have more seriously ill pa-

tients. Does this mean that our basic assumption for having an adjustment for indirect medical education is flawed?

Mr. O'BRIEN. I don't think so. I personally am not familiar with the study. I believe that the studies that are underway on the severity of illness may or may not support that contention.

Senator HEINZ. But in order to save time, would you please take a look at this study and let us have your comments on it?

Mr. O'BRIEN. Certainly.

Senator HEINZ. Because if they are accurate, it would appear to undercut the argument for a major positive adjustment for indirect.

Mr. O'BRIEN. I will be pleased to review the study and make certain that the AAMC confers with your staff.

Senator HEINZ. Ms. Hollers, I want to thank you for bringing up the issue of denials of home health care under the guise of medical necessity or lack thereof. And you are quite right, there is legislation that is before this committee, S. 1076, introduced by Senator Bradley, myself, and others, that will deal with giving a written reason for the denial and speeding up the denial process, requiring that they take place within 60 days. And I do intend to try and encourage the committee to not only look at but support the inclusion of requiring that denials made by reason of medical necessity be reviewed by a qualified physician.

Now, let me tell you why I came to that conclusion. They are done right now by nurses—I assume they are RNs. Obviously, I think one reason I assume HCFA does that is that it is cheaper to use a nurse than a doctor. The rationale beyond that is that, since what is being prescribed by the doctor is skilled nursing care, a skilled nurse should be able to judge whether that care is appropriate. That is what HCFA would argue if they were here. Why are they wrong? Or are they right?

Ms. HOLLERS. Well, I think they are wrong and have been wrong. I mean, this is like all denial problems; it is a problem that we have had for a long time. It is in order of magnitude, that we are seeing enormous numbers of these now.

I think they are wrong for two key reasons. It is not so much a nurse looking at a nurse's behavior, in terms of a peer review activity. Most of the nurses I have met who are reviewers are very well-intentioned people, but for the last 10, 15, or 20 years what they have been is claims reviewers, not nurses; and we all know what happened in the last 10 to 15 years in the terms of technology, particularly in community care technology.

So the whole issue of whether they are even qualified to do peer review of nurses in community care is to some degree questionable. But what they are reviewing is not the quality of nursing care. As they told me over and over again, "It is not that what you did was inappropriate or wrong in terms of nursing or in terms of what the patient needed; I am reviewing whether it was medically necessary and whether it meets the coverage criteria of the Medicare program."

Well, if coverage criteria is the only thing, then what we are talking about is an insurance adjuster, not a medical issue. But if it is medical necessity, you are quite right—what they are saying is that the physician ordering care and reviewing care is wrong.

Senator HEINZ. So, you have nurses, under the present system, making judgments that are supposed to be made by doctors?

Ms. HOLLERS. And that have already been made by doctors.

Senator HEINZ. And which have been made by doctors.

Ms. HOLLERS. Yes.

Senator HEINZ. If they are a fiscal intermediary over in Philadelphia, as indeed they are in my home State of Pennsylvania, and there is a doctor over in Pittsburgh who has prescribed skilled nursing visits three times a week for four weeks to attend to X, Y, and Z, that intermediary is operating without a chart, only with a very limited form, a 485, 486, 487, and they are saying, "No, that doctor over in Pittsburgh doesn't know what he is doing." Is that basically what is taking place?

Ms. HOLLERS. Yes.

Senator HEINZ. Now, HCFA would cite the GAO study that a number of us asked GAO to do in 1984, which study says two things, and rather perplexing things: On the one hand it says HCFA could make more in the way of denials and be technically within the scope of the law; and, second, there are a lot of unmet needs—a lot of unmet needs. The unmet needs are clearly in the area of what we call "personal care needs" as opposed to skilled nursing needs. Skilled nursing needs are what the law sanctions, and there is no argument that skilled nursing needs, if properly identified and prescribed, should be reimbursed.

In your judgment, are the denials that are being made under the guise of medical necessity, the cases that are being denied, is there any possibility that some, all, a few, many of them are indeed being made because personal care services are being prescribed for delivery by a skilled nurse when they shouldn't be?

Ms. HOLLERS. I don't have personal knowledge of all of the denials currently being made, like in Pennsylvania, et cetera. But it is my understanding, from the people I have talked with, that we are not seeing currently personal care denials; we are getting a lot of personal care denials indirectly through the process of technical denials—like if you say the nursing care is not justified, that wipes out all of the home health aid service that was rendered, because the nursing care was the qualifying service.

So, yes, it is cutting back on personal care. But the reason being given for the denials is the lack of medical necessity for the nursing visit. And we are seeing a much sicker client now than we were even when the GAO study was being done.

So I can't prove this, but it is my clear personal belief that the people being denied now would never have been questioned by that GAO study.

Senator HEINZ. All right.

One last question for Ms. Polich. I am one of those people who strongly supported the development of Medicare risk contracts to make HMO services more widely available under Medicare; but I have discovered that there has been some reluctance on the part of people involved in HMOs to acknowledge that there can be some problems with HMOs because of the nature of the reimbursement system.

Let me ask you, in the abstract and in theory, if you prefer, would you agree or disagree with the proposition that because of

the way we structure payments to HMOs that they can't avoid having an incentive that is more present for them than others to cut corners on patient care?

Ms. POLICH. I would agree with that but might phrase it differently. I think that HMOs have a clear incentive to be more efficient; they have a clear incentive to reduce unnecessary care, to shorten lengths of stays in hospitals. On the far end, some HMOs may not care about anything but the bottom line in those cases, it may result in negative quality of care.

And that is why I think it is so important that the program that was passed here, the PRO and QRO review of inpatient and ambulatory care in HMOs be implemented as sooom as possible. The sooner this occurs, the better it will be for all of us who want to promote risk contracting in HMOs and to make sure that all of those HMOs that are out there doing a terrific job and really providing excellent quality care are not damaged by a few bad apples in the barrel that are creating a lot of problems.

Senator HEINZ. Let me ask you about an exchange that Senator Wilson had with a Health Maintenance Organization witness at a special Committee on Aging hearing last January, a hearing which I chaired.

"Senator Wilson: Some might argue that because you receive a set amount each month, regardless of what happens, that you have got an incentive to under-serve, to try and cut corners.

"HMO Witness: I think that is a genuine concern, Senator. For instance, I mentioned a total hip replacement can be a very, very costly service to give someone, and that could be deferred by the HMO. There is a whole host of problems which you buy with the capitation program."

Isn't there a clear incentive for an HMO to say to someone, "Look you are 68, but don't do a hip replacement; it is not a good thing to do"?

Ms. POLICH. It depends on the individual patient's needs. Obviously, doing a hip replacement now versus doing it a few years from now could have implications for costs, too.

In some of work that was done looking at lengths of stays in hospitals, it was found that length of stays for particular diagnoses were actually longer for HMOs than for Medicare beneficiaries under fee-for-service; the reason being that the HMO was responsible for all the costs, the entire episode of illness. The HMO found through its own research that, if they kept the person in the hospital for a couple of extra days, it actually reduced their costs by reducing the chances for readmission and also increased the quality of care.

So I would caution against thinking that reducing lengths of stay in hospitals or reducing the amount of care received is necessarily equated with poor quality. Yet, I think it is certainly very possible under a capitated payment system. Again, that is why I think a direct quality assurance review mechanism is necessary under capitation.

Senator HEINZ. One quick question, if I may, Mr. Chairman, is this:

Regarding the Medicare Peer Review Organization, do you believe that they have received adequate funding and adequate in-

struction to commence and carry out effectively their mandated reviews of HMO quality of care?

Ms. POLICH. No, I don't.

Senator HEINZ. Why?

Ms. POLICH. It is too early to judge how the program well be implemented but I'm concerned that the requests for proposals that were given to PROs and potential contracting organizations were not specific enough. I don't believe that it was really clear what the intentions of HCFA were regarding the kinds of processes they wanted.

In the RFPs, for example, it was implied that they were seeking innovation; yet, in my opinion innovation was not at all sought, and in fact HCFA had a clear idea of what they wanted, it was just unclear in the Request for Proposal.

I don't think there has been adequate direction. I think a lot more needs to be done to make sure that that system is adequate—particularly on the ambulatory care side. Since nothing has been done in that area, much work is needed—both research and demonstration—to ensure that whatever we put into place is adequate to assure quality in most settings.

Senator HEINZ. Thank you very much.

Senator DURENBERGER. I would just make one observation on the question that you asked about the hips, and so forth. I suppose you are correct in recalling that it was in 1982 that you really brought us the CMP, as you recall. A lot of us recall your being down there on the floor when some of us said, "Hey, we are not ready for it yet." So, you are correct in identifying yourself as the author of that.

Now I think I probably represent the State that has gone bonkers with this thing, and where we are doing it all over, which is why we have these recommendations on AAPCC.

But one of the obvious things, that is clear when you have four million folks being exposed to a lot of marketing on the difference between the fee-for-service system and prepaid system is that at the end of the fee-for-service system you contribute something to the decision to get your hip replaced. Under the prepaid system, it looks like once you sign up with one of these HMOs you can now avail yourselves of all the wonderful things that you have heard from every one of your relatives and you have read in every magazine is available thanks to medical technology.

And so, that is what happens. I mean, the minute somebody signs up on one of these new plans, they want a hip, they want an ocular implant—you know, there are a wide variety of things. And it becomes difficult for the HMO under that setting to try to channel that demand into something that is appropriate. And I am really glad you raised the question.

Bill Bradley?

Senator BRADLEY. Thank you very much.

I would like to talk a little bit with you, about oversight of the home care benefit—in particular, I have gotten a lot of complaints about quality, poorly-trained staff, patient abuse, neglect, those types of sordid events. Please focus on federal quality standards, if you could.

I would like Ms. Hollers to do that. In particular the Medicare conditions of participation—whether they are adequate, or whether they provide only a kind of paper compliance.

You know, the question is not whether on paper quality care is being provided, but the question is do we have tangible proof that quality care is in fact being provided. My question to you is: Should we upgrade this kind of assurance monitoring, and are outcome measures feasible? In other words, focusing as we do in S. 1076 on patient outcomes, not simply on the paper criteria.

Ms. HOLLERS. I think it is clear that the Medicare conditions of participation as they are currently written are primarily structure-and-process kinds of conditions, and they do indeed look at paper compliance.

I think that there is no question that we as an industry are very concerned. I think many of the complaints you have heard are not even necessarily from occurrences that happened within organized home health agencies. Nonetheless, we are aware that most everything that goes on in the community gets painted under the broad umbrella of "home care," and it is up to us to make sure that that reputation stays as unsullied as possible.

So, we would support everything that you can do to try to assure real quality assessments under the Medicare compliance process.

Senator BRADLEY. And would patient outcomes be a legitimate thing to look at?

Ms. HOLLERS. I think patient outcomes are legitimate. I think the difficulty that everybody in the evaluation field has with patient outcomes is the linkage between patient outcomes and quality of care. And I am speaking now theoretically; I am not opposing outcomes. I think everybody desires outcomes as the optimum measurement.

Obviously we know, particularly in a hospice-oriented program, however, the fact that the patient died is not a negative outcome. So, you have to look at outcomes of care in less than ultimate senses. But that doesn't mean that we don't support them and that we don't think they can be devised. It is going to be a time-consuming and tedious process, but one that needs to be undertaken.

In the meantime, I personally think that one of the strongest efforts that we could make is in the training area, particularly with paraprofessionals, because I am sure that most of the complaints that you have gotten involve paraprofessionals. We are using thousands of these people all across the country to render most of the basic hands-on care. They are in very difficult to supervise environments. It is much different when you don't have these people on the floor of a nursing home or in a unit in a hospital. They are going alone in many cases into people's homes, and so supervision is difficult; although, I am convinced that most of my colleagues try very hard to do good supervision. We are going to have to make sure that these people carry with them much better training than, frankly, many of them do now. That is something that we support, and we really want to work with you to try to make that work, because I think it will help a lot.

Senator BRADLEY. Do you think that it would be helpful if every home care agency had to conduct patient-outcome surveys on an annual basis, and reveal the results?

Ms. HOLLERS. Yes. It is difficult to overwhelmingly endorse something without details. But, yes, in general I think that would help.

Senator BRADLEY. What about some intermediate sanctions, somewhere short of not participating in the program?

Ms. HOLLERS. Conceptually, I support intermediate sanctions. If we really get to the point that we are measuring quality of care, then I think we have to be certain that our sanctions are sanctions that try to correct the quality questions.

Now, in a sense, we have intermediate sanctions. You are cited, you have a plan of correction, you have time to correct the citations that have been issued. There is nothing inherently wrong with that system. I think that there needs to be some way that we can assure that people will have to truly produce a quality product, and the best way to do that probably is through intermediate sanctions; because I suspect that if you simply remove people from the Medicare program, they will just continue to run their home care outside the government system.

Senator BRADLEY. Right. And how about intermediate sanctions, including such things as civil fines, or denial of Medicare reimbursement? Are those reasonable intermediate sanctions?

Ms. HOLLERS. Once the whole system is built to where it hangs together, those could be reasonable sanctions.

Senator BRADLEY. Do either of the other two witnesses want to comment on this issue?

Mr. O'BRIEN. No.

Ms. POLICH. No.

Senator BRADLEY. All right. Let me ask one last question of Ms. Hollers.

One of the problems that I find is that so many seniors who are in a home setting do not know what recourse they have.

Ms. HOLLERS. That is right.

Senator BRADLEY. They don't know whether what they are getting is quality or not quality, or what they do if an incident occurs that offends them but they can't respond to in any institutional way. Would a hotline be a help as well? And would an ombudsman be helpful?

Ms. HOLLERS. Only if people were aware that those things existed. Under the licensure law in Texas—to take it back to something that I am immediately familiar with—one of our State requirements is that we inform clients the first day of service of the mechanism for filing a complaint with the State health department. Now, that mechanism is there, and it is there in every State. You know, you can appeal directly to the Medicare surveyors. And you can file those complaints.

I think what you are seeing is that people are not necessarily informed of that process. So, even though I wouldn't object to a hotline or an ombudsman, it might be less expensive in the short run to simply assure that people are aware of the procedures that already exist, and see if that doesn't help relieve the problem.

Senator BRADLEY. On the appeals process, do you think that we could improve on that process?

Ms. HOLLERS. I think we can enormously improve on it, and the very first step is letting us know the basis for the denial to begin

with. Then, the second thing is getting a timely review of that appeal, once it is filed.

The FIs, as I am sure has been brought to your attention, will use everything. You know, it is almost looking, in some cases, like it is the easiest procedure to just deny 30 percent of care and then see who is going to bother to appeal, and see if they can figure out the basis or even arguing the appeal. If you can't tell the basis for the denial, it is hard to build your case when you take it to appeal.

Senator BRADLEY. Is it legitimate to say that you should have some penalties for reconsiderations that exceed 60 days?

Ms. HOLLER. Well, every home health agency I know is a very labor-intensive business that is running on a very tight cash flow. And believe me, as these things drag out, we are being severely penalized.

I would like to see something that would spur the FIs into timeliness; and if it takes penalties, then, yes.

Senator BRADLEY. Fine.

Thank you all very much for coming today and giving us the benefit of your thoughts. It has been very helpful.

The committee hearing is adjourned.

[Whereupon, at 12:01 p.m., the hearing was concluded.]

MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH BLOCK GRANT BUDGET ISSUES

THURSDAY, JULY 9, 1987

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:11 a.m., in room SD-215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV presiding.

Present: Senators Rockefeller, Baucus, Daschle, Chafee, and Durenberger.

[The prepared statements of Senators Mitchell and Heinz follow:]

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STATEMENT OF SENATOR GEORGE J. MITCHELL

COMMITTEE ON FINANCE

MEDICARE PART B -- RECONCILIATION HEARING

JULY 9, 1987

We have a difficult task ahead of us in reconciliation. We must save 1.5 billion dollars in Medicare this year. In considering savings from Part B, we must focus on equitably distributing the reductions among physicians and other Part B services. Changes that we make should also have the effect of improving the reimbursement system by making it fairer.

I would like to point out a few of the inequities of the current system:

The Medicare prevailing charge for an initial brief office visit is over $70 in some regions, and lower than $7 in other regions;

For bypass surgery, the high is over $5,000 and the low is under $2,500;

I recognize that there is some variation in practice costs between regions and some differences in exactly which services are included in a procedure, but I find it hard to believe that these variations could result in a ten-fold difference in reimbursement levels.

In particular, reimbursement for rural physicians and for primary care services is too low. By contrast, reimbursement for a few high technology procedures in certain areas is too high. As I have said, our goal should be to eliminate the inequities.

The plight of physicians in rural areas is well-known. Given the reimbursement variation I described earlier, it is no surprise that rural areas have great difficulty keeping existing physicians in their communities or attracting new ones. In our efforts to find savings in the Medicare budget, we must be sure to improve this situation.

Similarly, basic primary care services are under-paid relative to technical services. This situation makes it less attractive for physicians to provide the basic diagnostic and follow-up services that can reduce the more expensive and sometimes more harmful technological care.

Finally, a few specific services are apparently over-paid in certain parts of the country. This apparent error in reimbursement is based on historical charges, rather than the relative value of the services provided. In correcting this error, we must be careful not to unfairly reduce payment for these services in areas which are not over-paid. Thus when we consider cuts in reimbursement, we must avoid "across the board" cuts which indiscriminately affect all physicians, especially those who have relatively low levels of reimbursement. Instead, we should take this opportunity to make the system more equitable.

In conclusion, in our effort to save 1.5 billion dollars from Medicare, we must make every effort to make the system fairer rather than indescriminately cutting payments to all physicians.

OPENING STATEMENT BY SENATOR JOHN HEINZ (R-PA)

SENATE FINANCE COMMITTEE HEARING ON BUDGET RECONCILIATION

MEDICARE PART B

JULY 9, 1987

Mr. Chairman:

I suspect we reconvene this morning still hundreds of millions dollars short of our goal for savings in the Medicare program. Yesterday we probed to leach waste from hospital payments. Today, we put our Committee microscope to physican reimbursements and look for signs of malignant growth. I personally believe that some savings can be achieved under Part B of the program.

Congress fessed up to the historic error in our way of reimbursing hospitals when we replaced the cost-based system with prospective payment in 1983. Expecting hospitals to be prudent providers on a cost-based system was like sending a kid into a candy store with a blank check--and being surprised when he came out with a bellyache. It is time we own up to a similar mistake in paying doctors for treating Medicare patients.

We currently reimburse physicians according to an antiquated system that was flawed at conception. I see at least two symptoms of faulty reimbursement -or put positively, two avenues to explore for savings.

First, physicians' fees for some services vary as greatly as 300 to 400 percent from state to state and even urban to rural location. A recent study from the Center for Health Economics Research in Needham, Massachusetts, for example, found the cost

of a coronary artery bypass graft to be 31 percent higher in Hartford than in Birmingham; a total hip replacement costs 55 percent more in Hartford than in Milwaukee. And these remarkable differences in fees were calculated after adjusting for legitimate cost-of-living variations. The most plausible explanation is that Medicare overpays in some regions.

Adjusting for geographic variations is probably a long-range option, but one we must begin to look at now.

Second, Medicare overpays for some procedures. To use pacemaker implantations as an example, 1985 testimony before me as Chairman of the Special Committee on Aging established the current level of reimbursement to be excessive. The $1,000 to $2,000 fee was set when implantation involved an incision in the chest and major surgery. One expert witness suggested a $500 payment more accurately reflects the complexity of the procedure today. A recent report from the Physican Payment Review Commission lists a number of other "overvalued" surgical procedures.

Mr. Chairman, I believe we should pay doctors fairly. But we should reevaluate some fees and set reimbursement levels that squarely reflect changes in technology.

On the issue of adjusting payments to more accurately reflect levels of service, I hope we will address the need to reimburse primary care doctors more adequately for the care they provide. We continually undervalue the preventive health role of these physicians--not to mention their hands on healing.

I am eager to hear from today's witnesses and remain confident that savings opportunities will emerge.

Senator ROCKEFELLER. This hearing will come to order. I apologize for the lateness, but there were a few votes on the floor. It is an honor for me to chair this hearing at the request of our chairman, Senator Bentsen, and to fill in for him this morning. As you know, he is fully occupied on the floor with the trade legislation, which is very complex.

This morning's hearing is the second in a series of three hearings on the Finance Committee's agenda, this week, in fact, to examine issues possibly arising in the reconcilation process that may affect Medicare, Medicaid and other programs. Specifically this morning we will look at Part B of Medicare, the Supplementary Medical Insurance Program. Our goal is basically to determine whether changes or approaches can be designed in this part of Medicare to contribute our deficit reduction.

We have, obviously, some very tough work ahead of us. Congress just approved a conference agreement on the budget which seeks $1.5 billion savings in Medicare for 1988, and a total of $9 billion over the next three years. The stated assumption is that these savings will be generated by taking action affecting providers, not beneficiaries. Therefore, once again, we must at least look at the rate of increase for payments for providers, and even at the possibility of reducing fees in certain circumstances.

As part of its overall proposal for Medicare, the Administration has offered some specific recommendations for ways to achieve savings in Part B. In January, we received the President's budget plan which proposed the so-called RAPS proposal affecting the system for reimbursing radiologists, anesthesiologists and pathologists, and another across the board cut in payments for cataract surgery.

I am sure I am not the only member of this committee to hear some rather strong objections to some of these ideas; nevertheless, today we have a group of distinguished witnesses who should be able to help us with the formidable task of examining Part B of Medicare. This committee looks to them for both a list and an analysis of options for what might be included in this year's reconcilation package in this area.

Are there ways to modify spending under Part B to contribute to the $1.5 billion Medicare savings that must be accomplished to reach our goals for 1988? The idea is already on the table, so to speak. What are the best? What are the worst? What should be considered in some other version?

Senator Durenberger, do you have any commments that you would wish to make?

Senator DURENBERGER. No, I don't. Thank you, Mr. Chairman.

Senator ROCKEFELLER. All right. Onto the first panel. We will begin with Dr. Reinhardt, who is here a lot, and a well-known expert on health care and the Medicare program. He is here as a Commissioner of the Physician Payment Review Commission to share his and the PPRC's views and recommendations concerning Part B.

Dr. Reinhardt, it is a pleasure to see you again and we look forward to hearing what you have to say. We have received your written testimony.

I might suggest that this is a difficult day. We will go on the early bird—there being only two early birds for the moment—

system in terms of questions. There will be votes, I think, on and off, but let us proceed to our witness. Dr. Reinhardt.

STATEMENT OF UVE REINHARDT, PH.D., COMMISSIONER, PHYSICIAN PAYMENT REVIEW COMMISSION, PRINCETON, NJ, ACCOMPANIED BY DR. PAUL GINSBURG, EXECUTIVE DIRECTOR, AND DR. TERRY HAMMONS, DEPUTY DIRECTOR

Dr. REINHARDT. Thank you very much, Senator.

Senator ROCKEFELLER. May I ask if Senator Daschle has any comments that he would like to make? Excuse me, Dr. Reinhardt.

Senator DASCHLE. No, I do not. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Dr. Reinhardt.

Dr. REINHARDT. Thank you very much, Mr. Chairman, for giving the Physician Payment Review Commission the opportunity to testify at these hearings. And I would like to stress that I am testifying today in my capacity as a Commissioner and in place of its Chairman, Dr. Philip Lee, whose schedule precluded him from being here.

I am accompanied by Dr. Paul Ginsburg, the Executive Director, and Dr. Terry Hammons, the Deputy Director of the Commission. Dr. Ginsburg is an economist, as you know, and Dr. Hammons is a physician. And occasions may arise where technical questions had best be answered by them because they know the details better.

As you mentioned, Mr. Chairman, your committee has been provided with a written statement containing my full testimony, which I assume would become part of the record.

Senator ROCKEFELLER. Yes.

Dr. REINHARDT. And here I would like simply to summarize that statement.

That statement has three major sections. One, a section on short-term options to achieve the budget savings for Medicare you are seeking for fiscal year 1988. The second section deals with incentive payments for primary care services in rural areas and urban areas judged to be underserved at this time. And the third section deals with recommendations the Commission has concerning the Administration's proposal to compensate radiologists, anesthesiologists and pathologists by DRGs rather than by the traditional fee for service.

Now with respect to the first section, the recommendations for short-run budget savings, the Commission explored four options: First, to reduce the annual update of prevailing charges by the Medicare Economic Index, known as MEI; second, reducing prevailing charges for selective procedures judged to be overvalued relative to other procedures; third, setting lower customary charges for new physicians; and, fourth, reducing prevailing charges for services in geographic areas where charges exceed national or State averages by a substantial margin.

Now because time is short, in a nutshell, our recommendations are as follows: Under budget reduction options, the Commission views the first two, the reduction of the Medical Econonic Index update and the reduction of prevailing charges for overvalued procedures, to be the most appropriate for meeting the 1988 budget target. We favor those because both of these options are consistent

with our conception of long-range reforms that should be made in physician compensation under Medicare.

The Commission does not support the third option, which would be to reduce payments to new physicians because that option is not consistent with the long-range reforms that we had laid out in our March report.

Finally, the Commission strongly supports the concept of reducing geographic variation in physician fees that cannot be explained by cost-of-practice differences. But in the short run, we deem this option not to be technically feasible because the information needed to implement that option rationally is not available at this time.

Those then in a nutshell are our recommendations.

In connection now with the first option, reducing the update of prevailing charges by the Medical Economic Index, the Congressional Budget Office had forecast an increase of 3.2 percent, effective January 1, 1988. This update could be reduced, or indeed even eliminated, but if that option is taken, the Commission recommends that primary care services—defined as office visits, nursing home visits, and home visits—be exempted from that reduction.

We recommend exempting primary care because increasing its relative value, which is implicit in that, would be in the direction of long-run reform that we favor.

In connection with the second option, reducing pevailing charges for selected procedures, we have appended to our statement a list of procedures we have analyzed with a methodology developed by the Commission. Roughly, what this methodology implies is that we compare the relative valuation of procedures paid under Medicare with the relative valuation that you find in other fee schedules used in this country. And the criterion is that if the Medicare relative value exceeds that of all of the other fee schedules in this list, then we judge it potentially overvalued.

The Commission does not recommend specific cuts, nor does it even explicitly recommend that any cuts be made. We view that a political decision, but the methodology is one we would submit to you.

I see my time is up and I would be happy to respond to questions.

Senator ROCKEFELLER. Thank you, Dr. Reinhardt.

Senator Baucus has just arrived. Do you have any comments that you want to make, Senator Baucus?

Senator BAUCUS. Not at this time.

Senator ROCKEFELLER. All right.

Dr. Reinhardt, one of your recommendations for budget reductions is to reduce payments for a group of procedures that the Commission believes to be overpriced. Are you confident that the charges that you are comparing for these procedures are for the same bundle of related services?

A recent article by Janet Mitchell in Business and Health, for example, noted that such a reduction would be smaller for surgeons whose comprehensive fee includes fewer pre- or post-operative visits.

Dr. REINHARDT. This is one of those technical questions and a very pertinent question that I would like to defer to Dr. Hammons, who worked on this list and who is a physician.

Dr. HAMMONS. As you know, there are variations in the number or content of services paid under a surgical bundle. We do not have the information to determine exactly where the variation is and how much there is. The methodology we used abstracted from that, however. Let me give you an example.

We compared the relative valuation for one surgical procedure to another procedure within Medicare, and we then compared that, in turn, to the relative valuation within a particular payer's fee schedule. Therefore, if Medicare or a payer had a consistent difference in the amount and number of services bundled, it would not affect the comparison of relative values.

The degree to which it hits individual physicians who bundle more or less, let's say, within Medicare, one cannot determine at this point. That is one of the major reasons we don't believe we could do a rational reduction in geographic variation, for instance. So within the limits that we have, we have tried to avoid either analyzing the data in such a way that that would affect the results, or recommending a policy that would interact negatively with that factor.

Senator ROCKEFELLER. All right.

In that same article—for Dr. Reinhardt, Dr. Hammons, or anybody—Janet Mitchell also noticed that an across the board reduction will reduce fees in low-fee areas, as well as high-fee areas, and thus may discourage new physicians from locating in these low-fee areas, obviously a subject of some interest to my State of West Virginia.

Is there a better approach that would reduce fees only in high-fee areas or must it, by definition, be across the board?

Dr. GINSBURG. In the recommendation of the Commission, this is recognized, and the Commission has suggested that Congress follow the precedent that it established last year with cataract surgery; that those areas with prevailing charges substantially below the national average be exempted from this reduction.

On the other hand, outside of those areas with particularly low charges, by singling out procedures that appear to be paid most generously, or perhaps most excessively, by Medicare, the chance of discouraging physicians who specialize in these procedures to enter these areas is much more limited than for across-the-board reductions in Medicare reimbursement that affect less profitable procedures.

Senator ROCKEFELLER. All right. Thank you.

Now I think, Dr. Reinhardt, that you addressed this by ruling out the third of the four recommendations. But there was a recommendation for a higher update for primary care services that defines these primary home care services as office visits, home visits, and then nursing home visits. And I thought that you, in your testimony, omitted then removed nursing home visits. In case I misheard you, why are nursing home visits included if you still do include them? Are they not more closely related to a hospital visit where a physician can make rounds and visit many patients in a short time?

Did I hear you correctly exclude those?

Dr. REINHARDT. Yes. Nursing home visits were perceived to be more in the nature of the routine office visit, quite distinct from a hospital visit. I think that was the reasoning.

Dr. GINSBURG. On a number of occasions, Dr. Robert Butler, another member of the Commission, has commented about what he sees as an access problem, that patients in nursing homes have difficulty getting physicians to come and see them there. And the overwhelming majority of patients in nursing homes are not there to recover from hospitalization, but are there for long-term chronic care.

Senator ROCKEFELLER. Does that argue against what Dr. Reinhardt just said, that in nursing homes there is a hospital-like patient-to-patient continuity? And you are suggesting some patients might have difficulty getting doctors there?

Dr. REINHARDT. I said it is more of the primary care contact in the office. I did not mean a hospital.

Senator ROCKEFELLER. Oh, I understand.

Thank you very much.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, thank you.

Dr. Reinhardt, let us just explore the economic premises here, and maybe you can just, as an economist, talk to us a little bit about what we should be sensitive to in terms of human behavior as it is impacted by expectation of reimbursement.

I would assume that if we put a cap on a reasonable reimbursement, or we reduce the reasonableness of reimbursement, the natural reaction for a provider of services is to try to increase the volume of service, but there are other things, such as scale back on packaging and things like that. But as we deal here with medical services, is it not true that the natural instinct, if you are not getting paid a fair price, is to try to increase your volume in some way since your prices averaged, and so forth, try to get in more business and all that sort of thing?

And if that is the case—and I am just giving you sort of the obvious. So you talk to us rather than me talk to you—then as we go about this business of deciding where we restrain growth or where we try to stimulate growth in reimbursement, do you find that the recommendations of the Commission conform with your view of economics in the medical practice?

Dr. REINHARDT. That is indeed a broad philosophical question. The Commission is basically concerned, I think, when you look at its work, much more with the question of whether the fee schedule we now have is fair and efficient in terms of the signals that it gives.

The signal America now gives to your people is, we need more surgeons and we need fewer primary care physicians. Basically, that is the signal that we speak to people, in part, through the financial incentives we give them. And year after year in the last decades we have said, we need more specialists—although everyone agrees we probably have too many surgeons—and we need fewer primary care physicians, although everyone agrees we probably need more.

And much of the work of the Commission is really addressed to redressing this non-sensical signal giving that we do.

As to the question of volume, that is another very serious issue. I received yesterday a letter from an opthalmologist who told me—and I would be happy to share it—that one of the dangers of reducing the fees for cataract surgery is that it might trigger unnecessary operations. And they would be triggered to cover overhead. Now that is really a very ominous statement coming from a physician.

The imagery here is that the fixed cost of the overhead of a physician is rent, automobile, malpractice insurance, and staff, and then on top, some imagined proper income for the physician. You call that whole thing "overhead" and then divide it by the fee to see the kind of procedures you need to do. I think that is an extremely dangerous way for physicians to look at the world and I am sure most of them do not share that view.

Ultimately, as we move towards a fee schedule in America, which I suspect we do, we will have to address the issue of volume as any other country that uses fee schedule does. That does not mean regimentation, but it will mean review and dialogue with the profession.

Senator DURENBERGER. We have a couple of other related issues to that. One is balanced billing and the participating physician or the assignment issue. I take it you have dealt with it to some degree.

The other is the business that we are sensitive to, particularly the people that are here today, and I think most people on the Finance Committee, that is, the problem of underserved areas. If we are using a reimbursement system that has charged historic charges as a base, we are not playing fair, because we do have a surplus of physicians in America, except in a lot of the areas that we represent. And economics again will tell you that in rural areas where the average income is half of what it is in a metropolitan area, or in a ghettoized part of an urban area, you cannot charge the same thing that you can charge in the suburbs or a lot of other places. And yet, the fee system, again, is somewhat averaged out geographically, and everything. So when we try to do our subsidy for rural or underserved, or if we do it across the board, the rich get richer and the poor just get average. The same thing is true in reverse, is it not? If we cut across the board, you do not increase the Medical Economic Index, or you are cutting the poor more than you are cutting not so poor.

Dr. REINHARDT. Well to address that question, our testimony does include a section on incentive payments for primary care services in underserved areas, where we looked and discussed in the Commission alternative ways of identifying underserved areas, and felt the most practical method would be to use the health manpower shortage area designation at least because we know they have been used and are accepted. And we then calculated what it might mean to increase, say, fees for visit there by 10 percent. And actually the money involved would not be that substantial.

So we would encourage Congress to consider options to reward those physicians more.

Senator DURENBERGER. Thank you.

Senator ROCKEFELLER. Senator Daschle.

Senator DASHCLE. Thank you, Mr. Chairman.

Dr. Reinhardt, I would be interested in having an elaboration from you with regard to your reasons, or the Commission's reasons, why the fourth option is not acceptable: reducing prevailing charges for services in geographic areas where charges exceed national and State averages by a substantial margin.

As I look through your testimony, the closest I can come to some direct relevance later on in your testimony to that particular option—it is on page 11—where you say, "While the Commission strongly supports the concept of reducing geographic variation that is not explained by cost of practice differences, it believes that short-term changes are not feasible at this time, but should be possible a year from now." That is interesting. Could you elaborate?

Dr. REINHARDT. One of the remarkable features of our reimbursement system now is that, in fact, we know less about it than would be desirable to make quick policy changes. For example, coding of procedures across the United States is not uniform, which is a major problem in identifying areas that charge a lot. That point has already been alluded to. And there are other issues that the staff people perhaps ought to address.

But I think it is not an issue of desirability. Everyone agrees there probably is unjustified geographic variation, and that it should be addressed. It is just within a short time frame to do it so that you can look people in the eye and say, this is reasonable. We do not know how to do that.

Senator DASCHLE. In essence, what you are saying is that a year from now if this committee finds itself in a similar position, this could be a viable option.

Dr. REINHARDT. Oh, yes.

Senator DASCHLE. And you would be much more willing to recommend it.

Dr. REINHARDT. Absolutely. Yes.

Dr. GINSBERG. I think right from the beginning the Commission began with a very strong interest in this issue of geographic variation, and, frankly, when it started looking into what was known about it, was really appalled in how little analysis and research was available.

The Commission began right away to develop its own analytical plans, and I think that by next year, that not only will we know a lot more about the nature of the pattern of variation but we will have a cost of practice index, which would give us more confidence that what we are doing would be fair and not perhaps creating other problems while solving some.

Senator DASCHLE. Judging from your position on the first two options which you can find some support, I assume by that that the option which includes reducing prevailing charges for selected procedures is one where you already have established that confidence. Is that the case?

In other words, there seems to be a differentiation between geographic areas and selected procedures, wherein, you have much more confidence in determining the variances among selected procedures versus the variances among geographic areas.

Upon what information are you basing that? Is that a study of similar scope?

Dr. REINHARDT. One of the problems with geographic variation is adjusting for variations in practice cost, including malpractice cost, which varies quite enormously across States and even within State regions. You do not have this problem in connection with these procedures because you are dealing only with relative values of roughly the same procedure. There may be some coding problem, but it is probably not a large one. But you do not have this massive problem of variations in practice cost. And that is the bit of information in particular that is lacking.

Senator DASCHLE. The complexity or the uniqueness of any given operation, in other words, does not vary substantially from one operation of the same kind to the other?

Dr. REINHARDT. Well if you look at a particular operation, and you look at how a relative value scale of the two large insurance companies in America that we are using pay for it, we would assume that to be the same procedure as the procedure that is billed to Medicare. So that is a reasonable assumption there. But to assume that the practice costs in San Francisco are the same as in San Diego, that is a much more heroic assumption.

Senator DASCHLE. Let me ask one final question. I see the yellow light is on. I do not see anywhere in your statement where you affix any associated savings with either of the options that is specific to that particular option. Have you analyzed from a savings point of view what those savings might be? And do you concur with the staff assessment of savings in this regard?

Dr. REINHARDT. I think we could for the first option. And I will ask Paul Ginsburg to comment on it. For the second one, we cannot, of course, because we do not recommend a specific cut.

Dr. GINSBURG. As far as savings estimates go, that is the job of the Congressional Budget Office. Whereas the commission's staff tries to indicate the order of magnitude of savings from particular options, the Commission does not want to do its own detailed savings estimates. Certainly, the Congressional Budget Office has come to us with questions about details of our options and we have helped them in that way. But we have no reason to doubt their estimates.

Senator DASCHLE. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. Reinhardt, as I understand it, you are saying that the present payments send a wrong incentive in the sense that we are rewarding specialists relative to, say, the primary care physicians. And it is your view that perhaps the signals should be reversed. Perhaps one way to do that is when we enact the update that the tilt will be a little more toward payments to primary physicians rather than to specialists.

The question I have is, really is that going to make a difference? I mean, do not specialists today receive so much more in higher fees compared to the primary physicians; that we would have to make a very radical shift in the relative payments to the primary care physicians as opposed to the specialists, the radiologists, for example?

Can we really make that much of a difference effectively with the changes you have in mind in the relative payments?

Dr. REINHARDT. I almost feel tempted to give you two answers, those of a professional economist who must believe, by his training, that even small changes move people, and those of a regular human being who knows that is not true. [Laughter.]

Senator BAUCUS. Are you a regular human being? [Laughter.]

Dr. REINHARDT. I am a regular. I agree with you. These changes, in and of themselves, will not solve these problems. You have to have more massive doses.

If you ask me, what would you do to get people into rural areas, physicians into rural areas, to practice there, I would give them an excuse from federal income taxation, and say, there, that is a big chunk. And you would probably solve that problem and it would not cost a lot in terms of revenue. But it is a big powerful signal that you would give.

But at least we are thinking in the Commission of a long-run strategy of where would we like this to come out, say, by the year 2000. And we recommend these changes basically as a compromise between two things: (a) to stay on target to where we believe the fee schedule ought to be in the year 2000, and yet to help Congress find ways to have some budget savings. It is really more in that spirit. It is not offered as a way, if you do this you will solve this world problem.

Senator BAUCUS. So as I hear you, you are saying essentially that if we adopt your recommendations, we should not expect to see a significant shift in physicians moving to rural areas or a shift in a greater number of physicians practicing primary care as opposed to specialist care.

Dr. REINHARDT. That would be my assessment. Although occasionally such gestures have symbolic value. For example, if young physicians know that Congress is kindly disposed to them and is likely to be so in the future, that may have a symbolic value that goes beyond the mere incentive.

I personally am not that convinced that physicians are that responsive to monetary incentives anyway. There is room for sociologists in this game. I think there are many other professional imperatives.

One reason physicians become specialists, I think, is because they find it intellectually challenging.

Senator BAUCUS. Where are you in your relative value recommendations? As I understand it, maybe not too soon the Commission intends to come up with recommendations of setting relative values for fees on some nationwide basis. How far along are you? Second, what have you decided and what have you yet to decide? Are the differences philosophical or are they technical? Give us if you can a flavor of where you are.

Dr. REINHARDT. Well the Commission in its March report—and we are a young Commission—basically has not gone further than endorsing the concept of relative value scale as probably the preferred way that Americans will adopt.

Now there is a large study underway, a joint study between Harvard University and the American Medical Association, to develop a cost-based relative value scale that is, however, adjusted also for complexity, risk, and so on. And that is not due until 1988. Once

we can examine the results of this study, the Commission will be able to make recommendations on a relative value scale.

The major issue I see to be resolved is, supposing we have such a relative value scale, and even if we make proper regional adjustments for practice cost, will you then force mandatory assignments upon physicians? This is a major philosophical issue that the Commission has not taken up at all. And if you ask me personally, speaking not as a Commissioner but just as a health policy analyst, that is something I would have to think through a lot before I personally could make a recommendation. And the Commission would not be at this time ready to make a recommendation on that.

Senator BAUCUS. Back to my first question. How much would incentives have to change, in your view, to achieve a significant shift so that physicians tend to sufficiently go to serve underserved rural areas?

Dr. REINHARDT. Well there are two factors. For one, the increase in number of physicians has been shown in research produced by the Rand Corporation to have moved physicians into areas that were previously underserved by both primary care specialists and specialists. So the move towards this area is, in fact, already underway.

If you want to accelerate it, I personally believe, particularly for rural areas, the easiest thing would be to designate certain areas where there would be tax abatement. Of course, that would be tinkering with the tax code again, which pernaps we do not want to do. But that would be one way to do it.

Senator BAUCUS. Any other ideas?

Dr. REINHARDT. Well, we recommend 10 percent in such areas, but you could make it 30 percent.

Senator BAUCUS. Do you think 10 percent will make a difference?

Dr. REINHARDT. I personally believe 10 percent is too little. I wish we had the money to make it more.

Senator BAUCUS. How much will 30 percent cost? Do you have any idea?

Dr. REINHARDT. Well, probably——

Dr. GINSBURG. Depending on the details, we thought 10 percent would range from a negligible amount up to $20 million for a full year, like 1989. So I would just triple that for 30 percent.

Senator BAUCUS. Thank you.

Senator ROCKEFELLER. Dr. Reinhardt, I just have two final questions. One to follow on the question by Senator Baucus. What you indicated is really very depressing that you are not sure that incentives can be effective any longer. People are intrigued intellectually and otherwise by special challenges. If they won't practice in underserved areas, that would be just about the very worse news one could imagine not only for Montana but also for West Virginia.

At our medical school, West Virginia University, we have tried to direct as adults to you underserved areas in our state—you know, serve your State and we will help you get thank school. And it has worked to some degree, but mostly it has not worked.

What is the ethic going on? I mean, people go into medicine because of a lot of reasons, and one of them obviously is to serve, the desire to serve, and there is something about primary service in difficult areas which would appear in the scope of human nature to

be attractive at least for a number of years. I mean, people will often do such things for a number of years, and then go on to more intellectually stimulating things. But there is still a "VISTA" instinct out there among some folks. But, essentially, you are saying incentives are not destined to work, except perhaps in fairly generous amounts, which we may not be able to afford. It worries me.

What is the makeup of the younger doctor coming in? What messages—what other messages if there are any, other than financial—can we send them that give hope for underserved areas?

Dr. REINHARDT. Well I personally do not think this casts aspersion at physicians. They are basically pretty much the way most other professionals. I am a professional teacher, and yet you do not find me practicing my craft in the area where I would be most needed, which might be in a inner city; in Newark I teach at Princeton, because I find that comfortable.

So I find it very hard to cast stones at physicians for not doing the ethical thing that as a teacher I also ought to do. I think it is human nature that professionals would like to live in cities with cultural facilities and so on.

I think another area that I think this country abandoned far too soon is the National Health Service Corps. I thought it was a fine idea in many, many ways. It was not very expensive; it did so many good things. It also financed the education of young physicians. But I would encourage you to dust that one off again. Studies of the National Health Service Corps found these physicians just as productive, if you made adjustments for age and newness of patients. That was a good idea, to get physicians into these areas. And some of them would stay.

We might encourage medical schools to recruit more physicians from those areas who know what it is like to live—and like to live in the country. There are many areas of a more cultural nature or that really help, like the National Health Service Corps, that can address this problem than small changes, like 10 percent rewards for practicing in rural areas.

But I would encourage you to have another look at the National Health Service Corps. It was a fine idea.

Senator ROCKEFELLER. Good.

Your recommendations would save about what?

Dr. REINHARDT. The recommendation?

Senator ROCKEFELLER. That you made for us in obtaining Medicare saving that the Commission made.

Dr. REINHARDT. In dollars?

Senator ROCKEFELLER. Yes.

Dr. GINSBERG. We really have not totaled them up. A number of our recommendations are not that specific. For overvalued procedures, we did not prescribe a particular reduction. We just assumed that each committee, after it makes its decision about what part of the $1.5 billion budget reduction it wants to get from Part B, and decides how many other options it wants to pursue, would decide what percentage to reduce overvalued procedures by.

The Commission sees its role in the budget process as just trying to point out to Congress which short-term changes would be consistent with the direction of long-term reform that the Commission

has set out. I do not think the Commission sees itself as really in the midst of the budget process.

Senator ROCKEFELLER. Senator Durenberger?

Senator DURENBERGER. No questions, Mr. Chairman.

Senator ROCKEFELLER. Senator Daschle?

Senator DASCHLE. No questions, Mr. Chairman.

Senator ROCKEFELLER. Senator Baucus?

Senator BAUCUS. Thank you. You were very helpful. I appreciate it.

Senator ROCKEFELLER. Yes. That is for sure. And I would hope, Dr. Reinhardt, that you and your colleagues would stay for the other panels if it is possible so that we might call on you should that be necessary. Are you in a position to do that?

Dr. REINHARDT. We would be certainly happy to do that, yes.

Senator ROCKEFELLER. We respect you very much here. Thank you very much.

The next panel consists of Dr. James Sammons, representing the American Medical Association. Dr. Sammons, I guess I could venture that the AMA has some reasonably strong opinions and some very helpful ideas about these Part B issues.

The committee, insofar as I understand it, had not as of last night received your testimony. So we will be glad to hear it. And we welcome you.

[The prepared statement of Dr. Reinhardt follows:]

Statement of the
Physician Payment Review Commission

On March 1 of this year, the Physician Payment Review Commission submitted its first annual report to Congress. The report outlined the nature of the problems in the current system of paying physicians for services delivered to Medicare beneficiaries, enunciated goals for physician payment policy, and suggested a strategy for long-range reform. The report also noted the likelihood of short-term policy changes and stressed the importance of their being consistent with long-term directions.

Consequently, when the Commission was asked for advice on how to meet budget objectives for fiscal years 1988-1990, it regarded the task not as a distraction from its long-term mission but as an opportunity to suggest first steps. In particular, the Commission sought to develop short-term options that would move the pattern of relative payments in the direction of greater rationality, while continuing to protect beneficiaries and avoiding making the program more difficult to administer and to understand. After I discuss budget options, I will describe to you the work that the Commission has done on its previous recommendation for an incentive payment for primary care services delivered in underserved areas and its thoughts on the issue of payment for the services of radiologists, anesthesiologists, and pathologists.

BUDGET OPTIONS

As part of the process for evaluating short-term policy alternatives to achieve budget savings, the Commission identified three options for consideration and invited groups representing physicians and beneficiaries to present their views on these and other possible options at a public hearing on May 27, 1987. Twelve groups participated in the hearing and seven additional groups submitted written comments. From this process, we obtained useful suggestions and gained a better appreciation of the difficulties of satisfying diverse interests when reductions from projected increases in expenditures are called for, something members of Congress are very familiar with.

The Commission considered a number of options that could be implemented quickly enough to reduce the projected increase in Medicare payments for physicians' services during fiscal year 1988. They included:

- o reducing the annual update of prevailing charges by the Medicare Economic Index (MEI);
- o reducing prevailing charges for selected procedures judged to be overvalued relative to other procedures;
- o setting lower customary charge limits for "new" physicians;
- o reducing prevailing charges for services in geographic areas where charges exceed national or state averages by a substantial margin.

Reduce Update of Prevailing Charge Screens by MEI

Since the mid-1970s, increases in prevailing charges have been limited by the MEI, which measures increases in practice costs. The update to take effect on January 1, 1988 is projected by CBO to be 3.2 percent. This update could be reduced. If this option is taken, the Commission recommends that primary care services, defined as office visits, nursing home visits, and home visits, be exempted from the reduction. The Commission's suggested definition of primary care services refers to types of services rather than physician specialty.

The advantage of this option is that it would spread the burden of budget reduction over a large portion of physicians serving Medicare beneficiaries, but initiate movement towards a realignment of relative values for different services. Reducing outlays through changes in the MEI would apply to a broad range of procedures--representing 87 percent of Medicare physician payments. Since it applies only to charges constrained by the MEI, it would not affect those services for which prevailing charges have increased less rapidly over time. It would also have no effect on those physicians whose charges are low relative to others in their locality. It would not increase the administrative complexity of the program.

By protecting primary care services from this budget reduction, the option would change relative payments in a direction that the Commission advocates for long-range reform. The Commission has been concerned that physicians are paid less well for primary care services than for other services, and that this distortion limits beneficiary access to these crucial services and is unfair to those physicians providing such services. Indeed, the Commission has received numerous reports from physicians indicating that Medicare payments for office visits barely cover overhead costs.

The disadvantage of this option is that it would not address other distortions in the patterns of relative payments. Outside of primary care, there are distortions in relative payments among different services and among geographic areas. The MEI reduction would affect procedures and areas that have relatively low payments as well as those with high payments. Physicians with low charges relative to others in their locality would not be affected, however.

Reduce Prevailing Charges for Selected Procedures

The Commission believes that changes in relative payments for different types of services will be an important aspect of major reform in Medicare physician payment. Modest reductions in prevailing charges for procedures that appear to be most overvalued would be an interim change consistent with the expected direction of major reform.

The Commission has developed a method to identify procedures that appear most likely to be overvalued by Medicare in comparison with other physician services. The method compares relative payments by Medicare to a series of other relative value scales that have some of the attributes of the relative value scale that the Commission envisions as a part of long-term payment reform. This future scale is likely to be at least partially based on resource costs, reflect market considerations, and be developed with substantial input from physicians.

The Commission has identified five relative value scales that have been developed by methods that reflect these considerations. They range from a resource-based

scale developed by Professor William Hsiao using methods similar to his current study for HCFA, to the relative value scale negotiated over the past 17 years within the Ontario (Canada) Medical Association, to scales in use by two large insurers and a large multispecialty group practice, all of which were developed with substantial input from panels of physicians.

The procedures most likely to be overvalued have Medicare relative values that are consistently higher than in each of the other RVSs, and substantially higher in most. The following eight procedures meet this criterion:

Coronary artery bypass surgery
Total hip replacement
Cataract extraction with intraocular lens implant
Intraocular lens insertion
Suprapubic prostatectomy
Transurethral resection of prostate
Diagnostic dilatation and curettage
Carpal tunnel release

The Appendix describes the analysis and results in detail.

The Commission is aware that prevailing charges for these procedures are lower in some localities than in others. In order to avoid reducing charges for physicians in localities that already have relatively low charges for these procedures, the Commission recommends that any reduction in prevailing charges not apply to localities where prevailing charges are less than 75 percent of the national mean for the procedure. In addition, since the option affects only prevailing charge screens, physicians whose charges are relatively low for the locality would not be affected.

If prevailing charges were reduced for one or more of these procedures, balance billing of beneficiaries could increase. The Commission was divided on whether to recommend limits on balance billing for such procedures.

The major advantage of this option is that it takes a step in the direction of long-term reform. By targeting payment reduction to those procedures deemed likely candidates for reduction in the future, the benefits of reform could be realized sooner. Also, focusing cuts on procedures considered relatively overvalued entails lower short-term risks of reduction in access to care and of financial protection for beneficiaries.

The principle disadvantage of this option is that it would make changes with the benefit of less data and input from physicians than will be available in development of a relative value scale as part of comprehensive reform of Medicare physician payment. The risk is that a procedure's payment is reduced now but then must be increased when a fee schedule is developed and implemented. The magnitude of this risk would depend on the size of the reduction made.

In recent testimony before the Commission, representatives of several physician groups criticized this process of identifying overvalued procedures. In particular, they argued that relative payments from a Canadian province are not appropriate for comparison with Medicare[1], and that the results of the Hsiao study are subject to error. Some were concerned that Medicare payment policy would be based on this work that is much less thorough than that in progress for comprehensive reform of Medicare relative payments.[2]

The Commission has carefully evaluated these criticisms. It concluded that, on balance, this analysis is sufficient to support modest reductions in prevailing charges for a limited number of procedures. I would like to note, Mr. Chairman, that most of those testifying before the Commission stated that some procedures are overvalued by Medicare. Several said that although they were uncomfortable with the method for identifying overvalued procedures, that those indicated by the method were, in fact, overvalued.

Customary Charge Limits for New Physicians

Under current law, new physicians (and others without a historical profile for a

procedure) are initially given a customary charge for a procedure equal to the 50th percentile of customary charges in a locality. Whereas this was initially substantially below the prevailing screen, after years of constraints on prevailings, this level is close to the applicable prevailing screen in many cases. Thus, new physicians can often be paid as much as many established physicians. The Administration has proposed limiting customary charges for new physicians to 80 percent of the prevailing charge.

The advantage of this option is that it attempts to meet an equity concern voiced by some physicians that young physicians are often compensated more highly than more experienced physicians. While it is doubtful that the Medicare reimbursement system has contributed to this, the impact of this option would change the pattern of relative payments. Nonetheless, physician groups that commented to the Commission did not express support for this option.

Moreover, the option would not appear to contribute to long-term reform. Whereas extensive discussion has been devoted to the issues of variation in payment by type of procedure, by specialty, by geographic area, and by patient type, few have advocated variation by level of experience of the physician. The limit on customary charges could be a major problem to many new physicians who would be paid as much as 20 percent less than under current law. Those with large debts and those choosing to practice in geographic areas with low charges or in specialties with relatively low earnings, such as primary care, could be particulary affected. Indeed, the option could seriously discourage entry into primary care in underserved areas. While the Commission does not favor this option, it recommends exempting primary care services if it is pursued.

Reduce Prevailing Charges in Geographic Areas with Highest Charges

Given the extensive geographic variation in Medicare payments that does not appear to be fully explained by variation in costs of practice, budget savings could be achieved by reducing prevailing charge screens in areas with relatively high charges. A number of physician groups have suggested such an approach as preferable to other options to reduce expenditures.

Concentrating budget cuts on high-priced areas is most consistent with some physicians' concepts of equity and might pose less risk of reduced access to care than across-the-board alternatives. Like the overvalued procedures option, it would be consistent with the direction of long-term reform that the Commission has recommended.

However, a number of technical issues limit what can be done for fiscal year 1988. Most acknowledge the need to adjust for cost-of-practice differences before making geographic comparisons, but such an index is not yet available.[5] Also, carrier coding practices vary, so that geographic comparisons are subject to error. Finally, with the exception of a limited number of procedures, HCFA does not have the data to calculate national or regional means.

These technical problems limit the potential for policies to reduce geographic variation in allowed charges. Their existence limits the number of procedures to which the policy can be applied and the degree of stringency. The combination severely limits the 1988 budget savings that could be achieved.

The Commission believes that with a year of work, more significant steps could be taken to revise the pattern of geographic variation. At least a preliminary version of a cost-of-practice index should be available by next year. The national Part B claims files for 1985 are just becoming available and are reported to be substantially more reliable than previous files. HCFA has been gathering some data from carriers on coding practices and prevailing charges. We plan to urge HCFA to expand and accelerate these activities substantially, so that the technical ability to deal with geographic variation is not so limiting.

One physician group has suggested that these limitations could be overcome by reducing prevailing charges for localities in a state that exceed the state mean by some percentage. This would avoid many of the technical obstacles to pursuing a national or regional approach. But this interim approach could reduce payments in some areas where payments would ultimately be <u>increased</u> as part of a long-

term reform. In states like Iowa, Kansas, and Nebraska, for example, which have multiple localities but generally low charges, prevailings in their highest charge localities could be reduced despite being below the national average. The 17 states without multiple localities would not be affected by this approach, irrespective of the level of their charges. Without very stringent limits, the budget reductions from this approach would be small. The likelihood that some localities would experience large percentage reductions on the majority of physician services would raise awesome questions concerning assignment.

Other Options

A number of other options have been suggested to the Commission and were considered by it. Many appear to have merit, but are not candidates for this year's budget process because they cannot be implemented rapidly enough, they require more analysis, or the judgment that is required to implement them properly leads budget analysts to decline to estimate their savings. An example is coding. The Commission's report recommended a number of improvements in coding, but they will take time to develop and implement and require substantial judgment, making them not amenable to estimating budget savings. Thus, the Commission is proceeding with its work, but cannot develop an "improve coding" option for the fiscal year 1988 budget process.

Recommendations

Of the budget reduction options considered, the Commission views the first two--MEI reduction exempting primary care services and prevailing charge reduction for overvalued procedures--to be the most appropriate for meeting 1988 budget reduction requirements. Both are consistent with long-range reform and are technically and

administratively feasible. The Commission does not support the new physicians proposal because is not consistent with long-range reform and raises some administrative concerns. While the Commission strongly supports the concept of reducing geographic variation that is not explained by cost-of-practice differences, it believes that short-term changes are not feasible at this time but should be possible a year from now.[4]

INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES IN UNDERSERVED AREAS

In its first annual report, the Commission recommended that Medicare pay an increment beyond approved charges for primary care services delivered in designated underserved areas. The additional payments would be financed by the budget reduction items discussed above. The major issues related to implementation of this recommendation concern identifying eligible underserved areas, how to structure the incentive payment, and whether it should apply to all claims or only to assigned claims.

The Commission considered several methodologies for designating underserved areas, including those currently used by the Public Health Service (PHS), and concluded that the most feasible approach was to use the existing Health Manpower Shortage Area (HMSA) designations. These are used by the PHS for the placement of National Health Service Corps personnel. The HMSA designations are preferable to the use of Medically Underserved Areas (MUA) because they are updated more frequently, are focused on redressing imbalances in the availability of primary care physicians, and are divided into four categories of need, thus affording additional flexibility in targeting the program consistent with the availability of resources.

The technical complexity and associated costs of identifying physicians by practice location is greater for urban areas than for rural areas. Non-metropolitan HMSAs generally are whole counties or towns within counties while urban HMSAs often are groups of census tracts within large metropolitan areas. Two alternative implementation strategies are to limit program implementation to rural areas or to have a phased implementation plan that would add physicians practicing in urban HMSAs as the technical issues of matching designated areas with physician practice location are resolved.

The annual costs associated with the Commission's recommendation, using HMSAs to identify eligible physicians and paying an increment of 10 percent for office

visits irrespective of physician specialty, are estimated to range from a negligible amount to $20 million in FY1989, depending on how many HMSA categories of need are included in the program and decisions on the construction and applicability of the incentive payment. Costs for FY1988 would be much lower, depending upon the number of months that the program would be in effect.

The Commission has identified some other decisions that need to be made. The incentive payment could be in the form of either an increment to the allowable charge or an increase in the prevailing charge screen. The incentive could be limited to assigned claims or applied to all claims. Resolution of these issues will depend on administrative considerations, whether physicians whose charges are not constrained by Medicare screens should receive the incentive payment, the level of resources available, and other considerations.

PAYMENT OF RADIOLOGISTS, ANESTHESIOLOGISTS, AND PATHOLOGISTS (RAPs)

Considerable attention has been focused on reforming payment for services of RAPs to Medicare beneficiaries. Many have been concerned that both the volume and price of these services are excessive. There may be substantial inappropriate utilization of services provided by RAPs, both inpatient and outpatient. Concerns about price reflect the apparent absence of market forces to constrain them. Many hospitals have exclusive contracts with groups of RAPs, affording neither the patient nor his or her attending physician an opportunity to shop for a lower price. Furthermore, patients are rarely consulted about the choice of a RAP physician, yet are at risk for substantial balance bills. Medicare beneficiaries' balance bills may be particularly large for the services of anesthesiologists, since their charges are often well above the Medicare prevailing charge, and their rates of assignment and participation are among the lowest of all specialties.

The Administration has proposed to pay for inpatient RAP services on the basis of DRGs. DRG payment would allow control over expenditures for these services, and if the payment were made to the hospital, would protect beneficiaries from balance bills.

The Commission does not support this option. While it is very concerned about payment for RAP services, it does not believe that paying for these services through DRGs is the most effective way to address these concerns. DRG payment would place RAP physicians at risk for inappropriate utilization of these services, but most inpatient utilization of these services is determined by attending physicians, not by RAPs. All payments for inpatient laboratory tests, including those to physicians, are already paid through DRGs under part A. Much of the inappropriate utilization of RAP services appears to be in outpatient settings, and RAP-DRGs would not address this.

The appropriateness of prices for these services can be addressed through fee schedules for these services. Finally, considerable work would be required to implement RAP-DRGs. The questionable advantages they promise may not justify this use of large amounts of scarce resources within the Department of Health and Human Services.

However, I would like to emphasize that the Commission recognizes the problems with payment for RAP services. The Commission is particularly concerned about the effects of exclusive contracting arrangements between hospitals and physicians--not just for RAPs, but also for others such as emergency physicians and cardiologists who interpret EKGs. We will examine closely the effects these arrangements have on the beneficiary's ability to choose a physician who will take assignment, and the implications for Medicare assignment policy for these services.

To summarize, the Commission intends to look very closely at the payment for services of RAPs and other hospital-based physicians, but we believe that these problems can best be addressed through modification of fee-for-service payment for these services rather than RAP-DRGs.

CONCLUSION

In conclusion, I appreciate the opportunity to provide the Commission's advice on how to deal with the short-term issues that you will be facing in the next few weeks. We feel that opportunities exist to discharge this year's budget responsibilities in ways that move policy in the direction of long-term reform.

The Commission looks forward to further work that will help the Congress achieve a comprehensive long-term reform of Medicare physician payment.

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[1]It should be noted that the results of the analysis are not changed by omitting the Ontario relative value scale.

[2]Another criticism was that data from only four states were used to estimate relative values for Medicare. Since then, reliable national data have become available and have been incorporated into the study. The results did not change as a result of more comprehensively based relative values.

[3]The Omnibus Budget Reconciliation Act of 1986 mandated development of such an index by the Secretary of Health and Human Services. A preliminary version is due on January 1, 1988 and a final version by December 31, 1989.

[4]Commissioner Jack Guildroy prefers the overvalued procedure option to the MEI option. Commissioner Oliver Beahrs does not support the overvalued procedure option.

STATEMENT OF JAMES SAMMONS, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, CHICAGO, IL, ACCOMPANIED BY HARRY N. PETERSON, DIVISION OF LEGISLATIVE ACTIVITIES

Dr. SAMMONS. Thank you, Mr. Chairman. And let me, first of all, extend our apologies about the glitch that occurred in the delivery of our testimony. You do have it now and we apologize for the problem last night.

I am Dr. James H. Sammons, the Executive Vice President of the American Medical Association. And with me today is Mr. Harry N. Peterson, who is the Director of our Division of Legislative Activities.

The focal point of this and similar hearings in recent years has been on meeting budget targets. Unfortunately, the hearings have not centered on the strength and quality, or even the viability, of the Medicare program. Hearings have not even questioned whether cuts should be made, but only where and how much.

Further budget cuts, following upon a seemingly endless series of cuts made in the last eight years, will have a substantial adverse series of repercussions for the future.

Organizations representing major parties involved in the Medicare program have gone on record to ask publicly that this Congress end the practice of subjecting the Medicare program to a disproportionate share of cuts to meet arbitrary budget targets. Medicare already has been subjected to over $52.7 billion in cuts through the reconciliation process since passage of the initial Reconciliation Act in 1981.

An analysis of Medicare spending, approximately 6.5 percent of the federal budget, compared with total federal spending, is particularly revealing. Actual Medicare spending for fiscal years 1980 through 1986 compared with OMB projected spending shows that, in fact, $11.4 billion was cut from this program. During the comparable period, total federal spending, however, actually increased by $125 billion.

With all of the cuts that have been taken to date and even with those now proposed, the future for the Medicare program remains bleak. The Medicare trustees themselves now state that the program will go bankrupt by the year 2002. This committee should address the need for long-range Medicare reform so that the promises of previous Congresses of assured access to quality health care services are preserved.

As a starting point for that real reform review that will stabilize financing and assure the continuity of health care coverage for coming generations of our nation's elderly, the AMA has developed a proposal that deserves serious consideration. We urge you to take the lead in essential Medicare reform, and we urge careful review of our initiative.

Change is inevitable, and we note that certain fundamental changes, such as varying individual responsibility based on resources, not deemed politically feasible under Medicare until recently, are now incorporated into legislation receiving serious consideration.

There is increasing recognition that when the wealthy ride the coattails of government largess, they divert resources essential to provide needed care for the less affluent.

The AMA is particularly concerned that further cuts added on top of the severe reimbursement and fee freeze of 1984 and the "maximum allowable actual charge" constraints that were passed by Congress last year, will prove to be counter-productive. The rush to achieve budget savings through controls on physician payments will create further inequities and will make more tenuous the link experienced between what Medicare will pay and what well-trained, experienced physicians may properly charge for their services.

Proposals to achieve further savings from Part B of the Medicare program must be carefully considered and weighed against the reasonable goals for reimbursement reform set by the Physician Payment Review Commission, including access to care, quality of care, financial protection for beneficiaries, and equity among physicians. Our concern is that the budget proposals now under consideration will violate these principles.

In conclusion, the AMA recognizes the budget pressures for physician payment reform. However, such reform will affect both physicians and the patients we serve, and it is essential that a rational methodology for reimbursement system reforms be developed.

To this end, we have taken a lead role in the development of a resource-based relative value study by acting as a subcontractor in the Harvard University study that is being financed by HCFA and will be completed in 1988. With the initial results of this study due in one year, the prudent act is to await the results of that research.

Mr. Chairman, I expect to answer your questions and the questions of the Committee on some of the specifics of the proposals that you are considering. Our statement for the record provides ample reasons why a proposal such as paying for the inpatient services of radiologists, pathologists and anesthesiologists based on DRGs, application of inherent reasonableness limitations, reductions in the Medicare economic index, and limits on the prevailing charge levels for new physicians should not be adopted.

I strongly believe that the most important point for you to consider is the future of the entire Medicare program. The proposals under consideration today do little, if anything, to improve the program and may do a great deal of lasting harm.

The AMA is legitimately concerned that further cuts at this time will prove imprudent, as they could result in diminished access to the level of care our patients both deserve and expect.

Mr. Chairman, the time to put aside the seeming continual hacking at the Medicare program is now. I will be pleased to try and answer whatever questions the committee may have.

Senator ROCKEFELLER. Thank you, Dr. Sammons. I thank you very much.

There are some health policy experts who would argue that when Medicare reduces or limits payment rates that physicians will increase the volume of services that they provide. For example, a physician might ask a patient to return for an additional post-operative visit. Now I am not asking you to agree with doing that. I am asking whether or not you think that is in some cases,

or generally, or potentially an accurate assessment, or not? And then depending on what you feel, what kinds of control over unnecessary visits are feasible to protect the Medicare program?

Dr. SAMMONS. Mr. Chairman, I don't profess to believe that all physicians are perfect any more than any other group of 500,000 people. But that oft-quoted comment by a number of people outside of the profession is totally inaccurate. That is not the way that doctors view their patients whatever the changes are. That is not an appropriate role for physicians. And however few that number is that do that, we would certainly be first in line to say it is too many. But it is a very small number. It is so small, it is even hard to project how small it is.

No, I do not agree that that is a common activity by physicians at all. That is not their primary motivation.

Senator ROCKEFELLER. Fair enough. Thank you, sir.

Now we are faced with the task of this reduction in the Medicare budget, and we have to do it next year and we have to save $1.5 billion. That is not academic; that is now mandated.

Most of these reductions will probably come from Part A hospital payments. But in all fairness, should we not reduce Part B payments by some amount also? What is your view on that? And depending if your view is, in part, favorable, how would you recommend that we do it? And I want to press you on this point.

Dr. SAMMONS. All right. Let me suggest to you that the last page of our full statement contains some 12 areas that identify Medicare savings as well as revenue-generating proposals.

I would point out to you that at this point in time some 81 percent of all Medicare physicians—that is, those who treat Medicare patients—accept some assignment, and I would also point out that over 70 percent of all charges that are being paid by Medicare today are being paid by assignment, and that about 61 percent of charges for Medicare patients are from physicians who are not full-time participants of the par, non-par system.

I would submit to you that we have been taking our licks, if you will. We have paid our pound of flesh, beginning all the way back in 1971, and have gone through a whole litany of reductions, and restraints and restrictions. And I have a document which I would like to add to the record, Mr. Chairman, that addresses that very issue.

Senator ROCKEFELLER. It will be done.

Dr. SAMMONS. Thank you, sir.

[The document follows:]

Historical Perspective - Physician Reimbursement under Medicare

Since the inception of Medicare, Congress and the Department of Health and Human Services (formerly the Department of Health, Education and Welfare) have taken actions that have resulted in reductions in Medicare reimbursement for services provided by physicians for Medicare beneficiaries. The result of these actions has been that physician reimbursement under Medicare consistently has been compressed to a point where the maximum Medicare reimbursement rate, the "prevailing charge," usually does not reflect the actual prevailing charge for a service in a community. This is borne out by the fact that as of the end of calendar year 1984 only 18.3% of all claims were submitted at levels either at or below Medicare prevailing charge screens. The following details past actions that have limited physician reimbursement under Medicare:

In 1969, the prevailing charge was lowered from the 90th percentile to the 83rd percentile of customary charges.

In 1970, the prevailing charge was lowered to the 75th percentile of customary charges.

For the second half of the 1971 fiscal year, physician's customary charges were based on the physician's median charge during the 1969 calendar year.

In August 1971, nationwide wage and price controls were imposed. While these controls were lifted seventeen months later for most of the economy, they still were retained for physicians for an additional fifteen months -- until May 1974.

In 1972, Congress established further restraints through use of an economic index as a means to limit the rate of annual increase in prevailing charges. In 1976, the economic index was used to set the prevailing charge limits using fiscal year 1973 charge screens that were based on physicians' charges during calendar year 1971.

In 1984, the Deficit Reduction Act modified physician reimbursement in the following ways:

The act created two classes of physicians, "participating" physicians who agreed to accept all Medicare claims on an assigned basis and "non-participating" physicians who may continue to accept assignment on a claim-by-claim basis;

Medicare maximum reimbursement levels for physician services, customary and prevailing charge levels, were frozen for the period of June 30, 1984 to September 30, 1985 (If no freeze had been imposed by the Deficit Reduction Act, the economic index would have allowed a 3.34% increase of the prevailing charge level on July 1, 1984.);

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The act eliminated the increase in fee profiles that should have occurred on July 1, 1984 and delayed from July 1 to October 1 any future annual increase or update in fee profiles, with the next increase scheduled for October 1, 1985; and

Fee increases for services provided Medicare beneficiaries by "non-participating physicians" above the level charged for the iod of April, May and June of 1984 were prohibited during -month period. (Participating physicians were allowed to increase their fees for Medicare beneficiaries, but they are not allowed to collect this increased fee because of the agreement to accept assignment on all Medicare claims.)

The Emergency Extension Act, passed on September 30, 1985, froze physician payment levels at the rates in effect on September 30, 1985 for 45-days. (This Act prevented a 3.15% economic index increase from being applied to Medicare prevailing charge levels on October 1, 1985.) This act also rolled back the actual charge levels allowed physicians who "participated" in FY85 but who had not agreed to "participate" in FY86 to their charge levels in effect during the period of April, May and June, 1984. This Act effectively prohibited the scheduled October 1, 1985 increase in fee profiles from taking place. At the close of the first session of the 99th Congress, the extension act was again extended, and physician fees and reimbursement levels were frozen through March 15, 1986.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), P.L. 99-272, further extended the Medicare reimbursement freeze. COBRA incorporated the following modifications: i) The freeze on Medicare reimbursement and charges for non-participating physicians was continued through December 31, 1986. ii) The freeze in the customary and prevailing charge level for participating physicians ended on May 1, 1986, with the prevailing charge increase set at 4.15%. iii) Physicians who participated in the first year but not in the second were (on May 1) allowed a customary charge level increase to reflect actual charges made between April 1, 1984 and March 31, 1985.

The Omnibus Budget Reconciliation Act of 1986 (OBRA), P.L. 99-509, made substantial modifications in physician reimbursement under Medicare and in fee limits that may be charged for services provided Medicare beneficiaries. Reimbursement - Both participating and non-participating physicians are to receive an equal 3.2% update in Medicare prevailing charge levels beginning January 1, 1987. For fee screen years beginning on January 1, 1987, prevailing charges for non-participating physicians will be set at 96% of the prevailing charge levels allowed participating physicians. Fees - The freeze on actual charges of non-participating physicians expired on December 31, 1986 and was replaced by the following system of charge limitations, effective January 1:

If the physician's actual charge for any given service is at or above 115% of the prevailing charge (as determined from year to year), the actual charge for that service may be increased by no more than 1%. If the actual charge is less than 115% of the prevailing charge, that charge may be increased by the greater of 1% or as follows:

January 1, 1987 - charge increases are limited to 1/4th of the difference between the actual charge and 115% of the Medicare prevailing charge;

January 1, 1988 - charge increases are limited to 1/3rd of the difference between the actual charge and 115% of the Medicare prevailing charge;

January 1, 1989 - charge increases are limited to 1/2 of the difference between the actual charge and 115% of the Medicare prevailing charge; and

January 1, 1990 and subsequent years - actual charges may be increased to 115% of the Medicare prevailing charge.

The Secretary is to impose sanctions against non-participating physicians who knowingly and willfully bill beneficiaries an amount exceeding the maximum allowable actual charge (MAAC). Where a non-participating physician does not have actual charges for the base period (April - June, 1984), maximum allowable charges are to be set at the 50th percentile of the customary charges for the service of non-participating physicians in the locality during the 12-month period ending on June 30 of the previous year.

OBRA imposed a prevailing charge level reduction of 10% in 1987 plus another 2% in 1988 for cataract surgery. A limit of 4 base units for anesthesia services related to cataract surgery also was set. Actual charges for these services is limited to 1/2 the amount by which the charge exceeds 125% of the new prevailing charge in 1987 and to 125% of the prevailing charge in 1988 and thereafter.

OBRA also authorized the Secretary to review the ten most costly Medicare procedures and apply "inherent reasonableness" authority to reduce the payment and fee level. Where "inherent reasonableness" authority is applied, non-participating physicians will have to reduce their actual charge, over a two-year period, to no more than 125% of the new Medicare prevailing charge.

OBRA modified the participating physician program by creating additional incentives for physicians to participate.

January 5, 1987

Dr. SAMMONS. So I would have to say no.

Senator ROCKEFELLER. Yes.

I have to say that increasing the tobacco excise tax may be one way to raise revenue, but it is not precisely responsive to the question that I asked.

Dr. SAMMONS. But it is in this sense, that we do not believe that the Medicare program should continue to suffer these cuts. If you are not going to be able to suffer the cuts, then you have got to raise revenue. And I understand that you are from West Virginia, but that is still one way to raise revenue. [Laughter.]

Senator ROCKEFELLER. No. I, in fact, favor increasing the excise tax on tobacco.

Dr. SAMMONS. I know you do, but you have got some farmers that probably don't.

Senator ROCKEFELLER. Yes. That is true too.

But my point is that if part of our savings have to come out of Part B, that will not be done by raising the excise tax on tobacco. And if you are willing to accept any sacrifice, where might it be? Maybe you could take us to several of those on your list of 12.

Dr. SAMMONS. Well, let me put it in this perspective, Mr. Chairman. Clearly, at the moment there are considerable restraints that are already going to force down Part B payments. They are already in place and these are going to continue. The PPRC has suggested—and we totally concur with them—that when this matter of reduction in prevailing rates is looked at, that it is disproportionate to apply it on a nationwide basis. The rural areas get hurt a lot worse than the city areas. That is a fact; no question. But those things have been done.

The Congress passed such nationwide cuts last year, and the Congress is looking at it again. Now last year, you also passed a law (P.L. 99-509) that puts some very clearly defined procedures in place that the Secretary will have to follow if he or she is to use inherent reasonableness authority. Now the Administration proposes to remove, certainly to broaden or to relax those restraints and constrictions and we do not agree with that.

If inherent reasonableness is to be used as a method by which adjustments will be made in the fees, it ought to be done under the law that was passed in 1986.

Senator ROCKEFELLER. Thank you, Dr. Sammons.

Senator Durenberger?

Senator DURENBERGER. Dr. Sammons, I think we all know that a lot of the cutting into physician reimbursements is now taking place over on this side of the Capitol.

Dr. SAMMONS. That is correct.

Senator DURENBERGER. And anyone who has ever attended a conference committee or participated in certain elections knows that. But we have a responsibility here to, in one sense, meet the needs of all the elderly in America in terms of the availability of physician services. And as part of that, it seems to me legitimate to listen to those who suggest to us that geographic variations in reimbursement ought to be attended to in some fashion. Or maybe we are not doing it very well as we go at this. But there are some very substantial differences in reimbursement for the same service

between urban and rural, as you pointed out, and particularly between certain regions of the country.

Now what is your general view about, say, start with something like my recommendation, which is to increase primary care physicians, or particularly rural physicians by the MEI plus 2 percent to pay them extra for office visits, nursing home visits, and so forth? Would you favor an approach like that that would recognize that in the adjustment here we might add more of an adjustment to what are either underserved areas or that part of the profession that has a shortage like the primary care physician?

Dr. SAMMONS. Well, first of all, Senator, I would urge that the MEI be applied across the board to both physicians participating and nonparticipating physicians. The inequity that results from differential treatment in itself is counterproductive in rural areas.

In addition to applying that across the board for both par and non-par, we would certainly have no objection to an increase in the rural areas. Clearly, those are areas that need to be addressed. Clearly, they have to be addressed in a somewhat different fashion than the other parts of the country. And if you don't do something to stop the flight of rural physicians and the closure of rural hospitals, then I will submit to you that the Congress will have made a serious mistake in the health care of a great many elderly people who do not live in metropolitan statistical areas.

Senator DURENBERGER. The Administration has recommended that we limit the customary charges for new physicians to 80 percent of the prevailing charge. What is your view on that?

Dr. SAMMONS. We are bitterly opposed to that. In the first place, there is no rationale to discriminate against a young physician, or for that matter, an older one who is going into a different form of practice or adding new services. And when they start talking about 80 percent of something, that sounds pretty good, until you look at what the reality is. And the reality is that that 80 percent is frequently less than the 50 percentile of the customary charge which Medicare now accepts and authorizes payment for.

The young physician or the new physician, whichever the case may be, is placed at a very marked disadvantage under that kind of a financial reimbursement methodology.

Mr. PETERSON. Just to emphasize what Dr. Sammons has said, eighty percent of the prevailing charge is now often or can be below the fiftieth percentile of the customary charges of physicians. And currently the test is the fiftieth percentile of the customary charge. Even the existing criteria has some very bad effects. So if you go to the new criteria of eighty percent of the prevailing charge, you are going to make that even worse. That is our concern.

Senator DURENBERGER. Thank you.

Senator ROCKEFELLER. Senator Daschle.

Senator DASCHLE. Dr. Sammons, I was interested in the reference that you made to Senator Rockefeller's question with regard to your recommendations for savings. You addressed the Appendix 4 in your statement, indicating that approximately $28.6 billion could be achieved if we would implement each of these recommendations.

Could you tell me which of the 12 directly and somewhat detrimentally would affect physicians?

Dr. SAMMONS. Well, in the particular instance of Appendix 4, Senator, I cannot tell you any one of those that is going to directly detrimentally affect physicians other than the entire cuts that you are proposing in the Part B program today. And I say again that I think that what you need to be looking at is not how to cut $1.6 billion out of the Medicare program, but how to find additional revenue to pay for that $1.6 billion.

Senator DASCHLE. But your suggestion here of cutting $28 billion out of Medicare and the way that I see it, each one of the 12 recommendations would make quite severe changes with regard to the beneficiaries. Each one of these is a beneficiary cut. How do you respond to that? How is it that the AMA would respond by providing recommendations to cut the beneficiary benefits but offer no suggestions with regard to the way you could provide some savings?

Dr. SAMMONS. We have been cut, Senator, successively in one form or another since 1971. And if you continue to cut this program, and if you do not address the entire program, you are going to produce an even greater difficulty in providing service to these people.

Now, yes, I will admit that some of these things involve the beneficiary, but I would be the first to tell you that one of the main reasons that we think you ought to look at the whole Medicare program is that what the Congress has done in the last 20 years has put the lower end of the income scale of the Medicare beneficiaries at great risk.

Senator DASCHLE. That sounds incongrous, Dr. Sammons——

Dr. SAMMONS. No, it does not.

Senator DASCHLE [continuing]. What you just said. Hear me out. You just said that what we are doing has had a very detrimental effect on the beneficiaries, especially at the lowest scale. So what does the AMA propose but a $28 billion menu of reductions directly affecting those very people. Now explain that to me.

Dr. SAMMONS. No, Senator. If you will read the line before that, it says "Medicare savings and revenue." And indeed there are some savings that will occur to the Medicare program, but there are revenue generators in there as well. And if you really want $1.6 billion by itself, you could simply include the State and local employees that were hired before 1986 under Medicare and you would get your $1.6 billion right there.

Senator DASCHLE. That is another beneficiary proposal. I am still waiting for one that directly affects doctors.

Dr. HAMMONS. You are not going to find us saying that we have not already paid our pound of flesh because we have, again and again and again. And you have in place restraints that are going to take more out of that flesh already. You don't need any additional restraints. You have got them in there now.

Senator DASCHLE. Where did the figures come from?

Mr. PETERSON. Senator, may I add on your question?

Senator DASCHLE. Sure, Mr. Peterson.

Mr. PETERSON. Because I think the inference from your statement was that all of that is what is on this page, in this Appendix

here, would directly come out of beneficiaries of the Medicare program. And I would submit to you, if you look at these, that that is not the case. Some of them cut across the entire segment of the population, and physicians would certainly be included in that group.

Senator DASCHLE. I think you need an imagination, Mr. Peterson, to come up with that conclusion. Time does not allow adequate——

Mr. PETERSON. For instance, one of the recommendations here is to increase the tax base, and that would include the non-earned, non-wage income.

Senator DASCHLE. So, in other words, by being taxpayers physicians would be affected.

Mr. PETERSON. The purpose of this, Senator, is to——

Senator DASCHLE. Well, that is going out on a limb.

Mr. PETERSON [continuing]. Is to preserve the Medicare program so that it remains intact and viable for the beneficiaries of the program.

Senator DASCHLE. Let me just ask, the savings that you said for number 7, repeal of mandated assignment for office clinical laboratory procedures, there is a savings here of $35 million. Could you give me the basis for that calculation?

Mr. PETERSON. I would have to go back to the derivation of that specific number.

Senator DASCHLE. What is the just philosophical concept of how one would save money?

Mr. PETERSON. Philosophically—I understand that you will hear also from ASIM, who will be addressing that question because they are very much directly involved—I think it was the last go around in the Congress, it said, in effect, that Medicare would assume a greater proportion of the cost for these laboratory services performed in the physician's office. And that was a change from the prior procedure. So this is suggesting a return to what existed before and that would accomplish the saving in the program.

Senator DASCHLE. Well I would sure like to see for the record. I am out of time now; I could pursue this a little bit more, but perhaps for the record you can give your overview on that.

Mr. PETERSON. We will indeed.

Senator DASCHLE. Thank you, Mr. Chairman.

[The information follows:]

REPEAL OF COVERAGE LIMITATION CLINICAL DIAGNOSTIC LABORATORY TESTS PERFORMED IN A PHYSICIAN'S OFFICE

A provision incorporated in the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, requires acceptance of assignment for clinical diagnostic laboratory services provided in a physician's office as a condition for coverage. This provision was incorporated into the Act by the Conference Committee without benefit of hearings before Congressional committees or subcommittees with jurisdiction over Medicare. It has caused substantial confusion where physicians provide in-office clinical diagnostic laboratory services. Medicare beneficiaries who benefit from the services are unduly discriminated against because a medically necessary service may not be covered if an assignment is not accepted.

Repeal of this requirement will generate program savings. Prior to the 1986 modification in the law, non-assigned claims for clinical laboratory services provided through a physician's office were reimbursed at 80% of the allowed fee schedule amount, with beneficiaries liable for applicable coinsurance. Assigned claims for the services were paid at 100% of the fee schedule amount. Based on a conservative estimate, the Medicare program would save approximately $35 million annually by repealing the mandatory assignment provision.

- American Medical Association -
Department of Federal Legislation, Division of Legislative Activities

Senator ROCKEFELLER. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. Sammons, you heard the testimony of Dr. Reinhardt that the Commission felt that the rural underserved areas need a 10 percent differential when we enact the MEI update. Would you agree with that?

Dr. SAMMONS. Well as I said to Senator Durenberger, first of all, we would urge that the MEI update be uniform for both participating and nonparticipating physicians because you have not had in the rural areas as well as in the cities. Beyond that, we would have no objection to whatever the Congress feels that it can provide, so long as it does not injure the program in other areas. And indeed, I do agree that the rural physician today in this country has been subjected to pressures since the beginning of this program that has placed them in a disadvantageous position.

Senator BAUCUS. Do you think a 10 percent differential is sufficient?

Dr. SAMMONS. Oh, I don't know that I can answer that question?

Senator BAUCUS. Are you a human being or are you an economist? [Laughter.]

Dr. SAMMONS. I thought I was a regular human being until I heard you describe it. I practiced in a rural area for a very long time and I do understand and appreciate the pressures. I am not sure that I know that 10 percent will solve it, but I certainly believe that the incentive is necessary. I certainly believe that it does add more to that than simply being a gesture, although I would agree with Dr. Reinhardt that sometimes the gesture is more important than the amount.

Senator BAUCUS. Just what is your gut guess? Is 10 percent sufficient or not? I mean is it going to make a difference or not? Do we need 30 percent to make a difference if this is the route we go?

Dr. SAMMONS. I would say somewhere in between.

Senator BAUCUS. What about the Health Service Corps? Shouldn't we reinstate that and give more grants to those physicians who practice in rural areas?

Dr. SAMMONS. We have supported the National Health Service Corps, Senator, for many years. As a matter of fact, we were one of their agents for recruitment from day number one of that program. Our present policy is that the Basic Corps program should continue at its present level, or at the last level. We do not believe that it necessarily needs to be expanded beyond the number of physicians that it recently had, but we certainly would support a continuation of what was a very good program, as Dr. Reinhardt says.

Senator BAUCUS. What about the present tilt favor of specialists at the expense of primary care? Do you think reimbursement is too titled in favor of the specialists?

Dr. SAMMONS. If you don't mind, let me redefine the question because, first of all, family physicians today are specialists. And internists, and OB-GYN people, and cardiologists and pediatricians, they are all specialists. So what we really are talking about here is the need to have some differential based on procedure rather than by specialty.

In the rural areas, you obviously are going to be dealing more with what we define as primary care, which includes family prac-

tice, internal medicine, pediatrics, and OB-GYN, than you are going to be dealing with other subspecialties and other general specialties. And by procedure, we would indeed support an increase for those primary care procedures that fall within that area. And in rural areas, clearly, that would be necessary.

Senator BAUCUS. Do you have a difference in definition of primary care, different from Dr. Reinhardt?

Dr. SAMMONS. I don't know what Dr. Reinhardt is using. But primary care to the AMA is what I just said. It is family practice, internal medicine, obstretics, gynecology and pediatrics.

Senator BAUCUS. Dr. Reinhardt, would you agree that that is your definition of "primary care"?

Dr. REINHARDT. Essentially by procedure, normally in our work we actually have that definition.

Dr. SAMMONS. I think we have the same definition of primary care.

Senator BAUCUS. So you do agree. Do you agree then that we should change incentives around a little bit here?

Dr. SAMMONS. Do it by procedure and not by specialty.

Senator BAUCUS. Do you agree with that, Dr. Reinhardt?

Dr. REINHARDT. I would normally begin the work by the policy handlers who intend to go over this, but the Commission is more focused on the procedure.

Dr. SAMMONS. He agrees with me.

Senator BAUCUS. OK. [Laughter.]

Mr. PETERSON. Senator Baucus, I think that the dialogue has usually centered around procedures with respect, for instance, office visits as against surgical procedures.

Senator BAUCUS. Could you speak up, please. Pull your microphone closer.

Mr. PETERSON. I say, the dialogue that has occurred so far has been around the procedures, for instance, office visits, as against a more technical surgical procedure. I think that what is being referred to here as the primary care services, are the office visit, the visit to the home, and the visit to the nursing home, et cetera. And it is in that sense that we are talking about a potential increase for those procedures.

Senator BAUCUS. So it is office visits more.

Mr. PETERSON. That type of——

Dr. SAMMONS. Or nursing home, or whatever the base visit is. But if you do it by procedure then you don't get yourself bogged down with any controversy about which speciality physician provides the service. And whichever physician makes that service available and carries out that procedure—whether it is an office visit or a nursing home visit et cetera—they should be included.

Senator BAUCUS. Isn't the specialist now overcompensated?

Dr. SAMMONS. I am sure that there are some doctors in this country who overcharge. There is a great difference between overcharging and being overpaid. And I don't know that we have——

Senator BAUCUS. Does Medicare over-reimburse any specialties?

Dr. SAMMONS. I don't think that I would agree that it does, no.

Senator BAUCUS. Relative to others.

Dr. SAMMONS. Oh, now that is the reason we got into the relative value study with Harvard University. You see, we do not agree

that some of the RVSs that PPRC has looked at—the two that they got from the insurance companies, and one from Ottawa, which is totally unrelated to this—we do not agree that that is the right answer, but we do agree that when we have developed the relative value study now underway that whatever those inequities are they will be more readily addressed in this RVS than in any other RVS that has ever been put together. And that will solve your problem.

Senator BAUCUS. Thank you.

Senator ROCKEFELLER. A final question from me, Dr. Sammons. The reason that Senator Baucus and I are pressing on this, and Senator Daschle also, is that it is fairly difficult to ignore the inflation in physician-related costs. Another way of asking what Senator Baucus asked is do you recognize or know of any procedures for which Medicare payments are significantly higher than the cost of those procedures?

Dr. SAMMONS. Well I think all Medicare payments, Senator, should pay above the out of pocket cost. Otherwise, there would be no physician component in there at all. The problem that I have with your question is the definition. And, clearly, the RVS is trying to reduce whatever that differential is to a reasonable scientifically arrived at, if you will, level of difference. But I think that all payments, whether it be by Medicare or private insurers or out of pocket, clearly there is a part of that payment that is above the cost of running the office. Otherwise, the doctor could not make a living.

Senator ROCKEFELLER. The Commission has a list of eight or nine procedures that it says receive excessively high payments from Medicare. Could you comment on those?

Dr. SAMMONS. It is our view, as I said earlier, that we think if there is going to be this type of procedure by procedure review that it ought to be done under the terms that were placed in the bill last year by the Congress, and that the Secretary should be instructed to do those reviews. We do not agree at all that taking any single procedure, arbitrarily saying we will cut it by this or that amount straight across the board, straight across the country, we do not agree that that is an appropriate way to address the issue.

The Secretary was given restraints and given procedures in your bill last year. They have never been carried out. They have never been used. The Congress did its own cut last year, but HHS has never used that. And it is our view that those procedures and all others ought to be subjected, if they are to be seriously considered, they ought to be subjected to what you put in the bill last year. And until we get our RVS in 1988, that is the only viable option if you are going to do this procedure by procedure. But I suggest to you that as close as we are to the RVS, that that is truly not an appropriate way to handle these problems because at some point in time somebody is going to have to try and clean it up.

Senator ROCKEFELLER. Thank you.

My apologies for not seeing you come in, Senator Chafee. My deepest apologies to you.

Senator CHAFEE. Thank you, Mr. Chairman.

Doctor, the RVS study is due in 1988?

Dr. SAMMONS. Yes, sir.

Senator CHAFEE. Do you know when?

Dr. SAMMONS. July.
Mr. PETERSON. July 1.
Dr. SAMMONS. July 1, of 1988.
Senator CHAFEE. Last year I was chairman of the conference with the House on physician reimbursement in connection with the reconcilation bill and it was a very, very difficult process. We spent an extraordinary amount of time on this issue—I think we spent close to two weeks trying to resolve this problem.

Is medical liability insurance problem particularly difficult for those who deal with Medicare patients? I am quite aware that there has been a horrendous rise in liability insurance rates for those who are obstetricians and others. What about those who are dealing with the elderly, has there been a precipitous rise in their rates? For a physician who deals with primarily Medicare patients, what portion of his income would you say had to go out for liability insurance?

Dr. SAMMONS. Well, Senator, clearly, we are dealing with a population that is growing, that is, the Medicare population. And in the last six years it has grown something like 20 percent, according to the HCFA. So that the impact of that growth spread among physicians who treat Medicare patients is substantial.

Now, if you then look at the various specialties, and if you look in areas of very high concentration of Medicare populations, i.e., Florida, for example, the orthopedist, the cardiologist, the neurosurgeon—that is, an evasive cardiologist—the people who are the high risk group in terms of the complexity and seriousness of the procedure are paying very disproportionate premiums, and the Medicare population is in fact helping pay that disproportionate share. You are paying 40 percent there about what is being spent in that arena at this point in history, i.e., through the Medicare program. Therefore, whenever these rates increase, Medicare's out of pocket expense, assuming that there is some increase in the payments of Medicare services, is going to have to absorb an increasing part of that professional liability premium.

Senator CHAFEE. Have you seen any State that, from your experience and from looking at things from the AMA point of view, has adopted legislation that has truly been successful in reducing or at least slowing the rate of growth of liability insurance?

Dr. SAMMONS. Yes, Senator, I think we have. Not in reducing the present level of premium, because I don't think that is ever going to happen.

Senator CHAFEE. No, I wouldn't expect it to be reduced, but how about slowing the rate of growth.

Dr. SAMMONS. Slowing the rate. And I think you can look at California in the last 12 months. See an improvement certainly in California since the Supreme Court decision. I think you can look at Indiana over a period of years, since Secretary Bowen was the Governor, in fact, and enacted legislation. And I think you will see some slowing. That has been much slower than other areas of the country.

Where tort reform has truly addressed the big ticket issues, yes, I think you can see that.

Senator CHAFEE. Are there companies that are made up of physicians who self-insure each other in effect?

Dr. SAMMONS. Oh, yes, some 40 of them.

Senator CHAFEE. California has something like that.

Dr. SAMMONS. Well, California has three physician-generated, as I recall, companies, but there are 32 in the whole country, Senator.

Senator CHAFEE. I looked over the list of recommendations you had, and I do want you to know that most of those have been around here for quite a while and have not gotten very far. So I don't think we are going to see your number one, which, in effect, is a means test for Part B, the indexing of the Part B deductible, and State and local employees. The only one that probably has a pretty good chance is your number nine, increase in the tobacco excise tax. But I don't think that will be devoted to Medicare. That will go into the general revenues. So this is a kind of a warmed over list you have given us.

Dr. SAMMONS. Well, Senator, we have got another piece of proposed legislation for you that takes a look at the whole Medicare program. But let me remind you that 75 percent of all of the money that is paid out of Part B or in Part B comes from general revenue. Only 25 percent of what Part B is paying comes from the trust fund. So if you do pass the increased excise tax on tobacco, maybe by indirection if not by direction, you will have helped the Medicare program no end.

Senator CHAFEE. Well we also look on it as a health measure as well as a revenue measure. Thank you. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Dr. Sammons.

We are at the seven minute mark on a vote, so we need to recess this hearing for just a few moments until I can return.

Dr. SAMMONS. Thank you, Senator. It has been a pleasure to be with you. We appreciate the opportunity.

Senator ROCKEFELLER. Thank you, sir.

[The prepared written statement of Dr. Sammons follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Finance
United States Senate

RE: Budget Reductions - Medicare Part B

Mr. Chairman and Members of the Committee:

I am James H. Sammons, M.D., and I am the Executive Vice President of the American Medical Association. Accompanying me is Harry N. Peterson of our Division of Legislative Activities.

Unfortunately, the focal point of this and similar hearings in recent years has been on meeting budget targets. It has not centered on the strength and quality -- or even the viability -- of the Medicare program. Hearings have not even questioned whether cuts should be made, but only where and how much.

Medicare Outlook

Mr. Chairman, further budget cuts, following upon a seemingly endless series of cuts made in the last eight years, will have substantial adverse repercussions for the future. Organizations representing major parties involved in the Medicare program -- the elderly (AARP), nursing (ANA), providers (AHA & FAHS), and physicians (AMA) -- have gone on record to ask publicly that this Congress end the practice of subjecting the Medicare program to a disproportionate share of cuts to meet arbitrary budget targets. Medicare already has been subjected to over $52.7 billion in cuts through the reconciliation process since passage of the initial Reconciliation Act in 1981.

An analysis of Medicare spending, approximately 6.5% of the federal budget, compared with total federal spending is particularly revealing. Actual Medicare spending for fiscal years 1980 through 1986 compared with

Office of Management and Budget (OMB) projected current services spending for that period shows that $11.4 billion was cut. During the comparable period, total federal spending actually increased by $125 billion over OMB projected current services spending. (See appendix I.)

With all of the cuts taken to date and even with those now proposed, the future for the Medicare program remains bleak. As you are well aware, the Medicare Trustees state that the program will go bankrupt in the year 2002. There is increasing recognition that Medicare is flawed in its pay-as-you-go financing mechanism and its reliance on a government administered program. This Committee should early address the need for long-range Medicare reform, so that the promises of previous Congresses of access to quality health care services for our nation's elderly and disabled are preserved.

As a starting point for real reform that will stabilize financing and assure the continuation of health care coverage for coming generations of our nation's elderly, the AMA has developed a proposal that deserves serious consideration. We urge you to take the lead in essential Medicare reform, and we invite this Committee to review this initiative. (A booklet summarizing the AMA's proposal is attached to this statement.)

Change is inevitable and we note that certain fundamental changes, such as varying individual responsibility based on resources -- not deemed politically feasible under Medicare until recently -- are now incorporated into legislation receiving serious consideration. (This Committee has reported legislation for catastrophic coverage for the elderly with an income-tested supplemental premium. Congress as a whole also accepted this concept for Social Security when it began taxing a portion of cash benefits.) There is increasing recognition that when the wealthy ride the coattails of government largess they divert resources essential to provide needed care for the less affluent.

Fiscal Year 1988 Budget Cuts

The AMA is particularly concerned that further cuts (including those for physician services) -- added on top of the severe reimbursement and

fee freeze of 1984 and the "maximum allowable actual charge" constraints passed last year -- will prove to be counter-productive. We fear that the rush to achieve budget savings through controls on physician payments will create further inequities and make more tenuous the link between what Medicare will pay and what well-trained, experienced physicians may properly charge for their services.

Proposals to achieve further savings from Part B of the Medicare program must be carefully considered and weighed against the reasonable goals for reimbursement reform set by the Physician Payment Review Commission (PPRC): access to care; quality of care; financial protection for beneficiaries; equity among physicians; reductions in the growth of SMI outlays; understandability; orderly change; and pluralism. Our concern is that the Part B budget cutting proposals now under consideration will violate these principles.

As an interim measure prior to total reform of Medicare, the physician payment system should be shifted to a resource-based fee schedule as part of an indemnity plan.

DRG-based Payment for Radiology, Anesthesiology, and Pathology Services (RAPs) Provided to Hospital Inpatients

Congress examined the payment for hospital-associated physicians at the time that Medicare was created and properly recognized their role under Part B of the program. In our statement to this Committee prior to the enactment of Medicare (May 11, 1965), the AMA stated that the services of pathologists, radiologists, physiatrists, and anesthesiologists should be reimbursed on the same basis as other physicians. That statement certainly is true today.

> The services of pathologists, radiologists, physiatrists, and anesthesiologists are professional medical services performed by physicians. The fact that their practice is largely in the hospital is incidental. These are not hospital services, and they do not belong in a program designed solely to offer hospital benefits. All physicians want to be responsible to their patients to the limit of their competence; they cannot be restricted by decisions of non-medical personnel on what services should and should not be performed in medical facilities.

A DRG-based approach to physician payment is inconsistent with the above Congressional treatment and recognition of such physician services and today remains totally untested. Every indication is that such a system will be detrimental to both access and quality. As the DRG payment for physician services would be based on an "average" for the mythical "average" patient, the program will increase the already tremendous hospital-driven economic pressures for withholding care in the hospital.

- Incentives caused by hospital DRGs already have limited the availability of services, as evidenced by nursing and other services having been pared by hospitals. RAP DRGs will create new incentives to limit access to physician services as well.
- By basing payment for both physicians and hospitals on DRGs, all of the economic incentives will be weighted against the patient, i.e. by providing fewer services, the hospital stay becomes more "profitable."
- DRGs do not pay only for services actually rendered; they in fact reward for services not performed. This mechanism will reinforce existing hospital incentives to reduce available care and avoid severely ill patients.
- RAP DRGs are unnecessary as a means for controlling utilization. Medicare now has the authority to deny payment where it determines that a service is not "medically necessary."
- Beneficiaries who use little or no services will be penalized by having to pay higher coinsurance than under the current system, while those who use substantial RAP services will benefit from a fixed coinsurance that is unrelated to the services received.
- Access to care in rural areas will suffer. RAP physicians will be discouraged from providing services in areas distant from their primary site of practice. Many rural hospitals already experience hardships due to the existing DRG payment methodology. It is dangerous to further expand the DRG payment to services provided in hospitals already in crisis.

In addition, experts on physician reimbursement issues outside of the medical community have indicated strong concerns over physician DRG proposals. Finally, the proposal developed by the Administration and adopted by the House Ways and Means Health Subcommittee is not responsive to Congressional direction and is certainly premature. Congress has rejected and should continue to reject such major physician payment reform not backed by appropriate study.

- o Congress in 1983 called for a study and report on MD DRGs -
  - The report, due in 1985, has not been given to Congress. However, a draft of the unpublished HCFA report states: "DRG based payment to physicians is inadvisable because it would be difficult to put in place, complex to administer and unpredictable in its impact." (Emphasis added.)
- o Congress in 1986 created the Physician Payment Review Commission to study and report to Congress on physician reimbursement -
  - In testimony to the House Energy and Commerce Health Subcommittee, the Commission has urged rejection of this approach.
- o Congress in 1986 called for a study and report on RAP DRGs -
  - This report was due by July 1, 1987, and has not been released.

Without even providing the study report mandated by Congress, the Administration has submitted its proposal that would have the Congress authorize RAP DRGs but leave all of the elements of substance and implementation up to the discretion of the Secretary. Congress should not give such carte blanche authority to the Secretary. Furthermore, the fact must be highlighted that this proposal will not achieve any savings while at the same time it certainly would create substantial upheaval in the manner that radiologists, anesthesiologists and pathologists provide patient care.

House Concurrent Resolution 30 and Senate Concurrent Resolution 15, with widespread bi-partisan co-sponsorship (322 House and 45 Senate cosponsors as of July 8, 1987), clearly state that it is neither feasible nor desirable to implement any method of payment for physicians services based on DRGs. We urge all of the members of this Committee to join with us, the American Hospital Association, the Federation of American Health Systems, and your colleagues in rejecting physician DRGs through support of this Resolution.

Reduction in the Medicare Economic Index (MEI)

A proposal to limit the amount of increase allowed by the MEI in Medicare prevailing charges would be inequitable and harmful to both quality of care and access to care. The existing MEI has serious flaws that are recognized in the initial report from the PPRC to Congress. The

current MEI fails to measure accurately the expenses of providing medical care and has been used as an arbitrary tool to hold down the amount that the Medicare program reimburses. Largely because of the application of the MEI since the mid-70s, the Medicare allowed amount is below what is commonly allowed under private health insurance programs.

Physicians who held the line on their charges for Medicare beneficiaries over the last few years will be the ones who face the most severe penalties by an across-the-board MEI reduction or freeze. Further reductions in reimbursement will only serve to drive some physicians away from the Medicare program, depriving beneficiaries of the full range of access to medical care services.

We urge you to reject a reduction in the MEI increase for next year and to allow equal percentage increases for all physicians. Failure to allow equal increases will only exacerbate the current 4% differential in prevailing charge levels for participating and non-participating physicians authorized by last year's Reconciliation Act (OBRA): it would penalize those beneficiaries who elect to receive care from non-participating physicians, and it would act as a further disincentive for physicians to accept claims on an assigned basis.

The AMA endorses the requirement contained in last year's Reconciliation Act requiring the Secretary to study the extent to which the MEI "appropriately and equitably" reflects economic changes in he provision of physician services.

"Inherent Reasonableness" Reductions

The AMA has concern about the use of "inherent reasonableness," as it is a further means to make piecemeal cuts with no comprehensive review of the entire reimbursement system.

If the process is to be utilized, its development should be through the regulatory process as now stated in the law. This would clearly allow broad public involvement through the notice and comment rulemaking process. Furthermore, the Congressionally established PPRC has a key

role to play in this process as the law specifically requires the Commission to participate in the regulatory process. The consensus process set forth in the PPRC 1987 report to Congress may prove to be a valuable tool as part of the established process of developing regulations set out in OBRA.

It would be a substantial disservice to the program's beneficiaries as well as the physicians involved if the established process is ignored and arbitrary cuts are imposed without consideration of the public's views. Arbitrary cuts as adopted by the Ways and Means Health Subcommittee would affect practitioners in all areas of the country, regardless of whether costs are high or low. These cuts would be particularly hard felt in those rural areas where the prevailing charge level already fails to reflect the real costs of providing care, and the further cut will make it even more difficult to attract physicians to these areas of the country. We also question the validity of the process used by the PPRC to identify procedures for these cuts and we urge rejection of this approach. (A copy of our analysis of the PPRC methodology, Appendix II, is attached.)

"New Physician" Limitations

The AMA opposes the proposal (set out in the Administration's budget) to set customary charges for new physicians at "about 80%" of the prevailing charge level rather than the 50th percentile of area-wide customary charges. This proposal is inequitable because Medicare's prevailing charge has been held down by modifications in the program over the past 18 years, including the application of the MEI. The full "prevailing" charge level, let alone 80 percent of this amount, does not reflect the actual cost of providing a service, and is often below the 50th percentile of area customary charges.

Moreover, it would be totally unfair to arbitrarily set a physician's customary charge at 80% of the prevailing charge level simply based on the year in which that physician entered practice or decided to provide a

"new" service. (The proposal fails to even set a cut-off time period when a physician ceases to be "new.") This proposal would be contrary to established "incentives" to have physicians sign up as participating physicians. It certainly would discourage "new" physicians from treating Medicare beneficiaries and from establishing practice in areas currently underserved, as it would be next to impossible for these physicians to recoup the start-up costs of practice, educational expenses and even their basic practice costs when treating Medicare beneficiaries.

Inequities in the Maximum Allowable Actual Charge (MAAC) Program

Since the creation of the MAAC program, it has been increasingly apparent that it is causing unintended, but nevertheless extensive, inequities and distortions for practitioners. The American Medical Association, in concert with the American Society for Internal Medicine and others in the medical community, calls for repeal of the MAAC program. In the interim, we recognize that some of the inequities caused by the application of the MAACs could be eliminated through minor program modifications.

Basing each physician's MAACs on his or her own current established customary charge profile (charges submitted from July 1, 1985 - June 30, 1986) would help correct many of the inequities caused by the law, without circumventing Congress' intent that MAACs for established physicians continue to be based on charges in effect during the fee freeze. The change would provide a more accurate MAAC--based on the physician's own established charge--for services that were not provided during the current base period, such as newer services and services provided before and after the period from April-June 1984. This will eliminate the unjustified rollback experienced by many physicians for some of their charges and make program enforcement more realistic. It also will base the MAACs for physicians who entered practice from July 1, 1984-June 30, 1986 on their own established customary charges, thus eliminating other unfair rollbacks in established fees.

By modifying the base period for MAAC calculations, physician profile information will be more current, accurate, and inclusive than the April-June 1984 charges, and carrier administration and expense will be eased. We also are asking that physicians be provided with access to MAAC information in a timely fashion for making future participation decisions. This could eliminate the situation we experienced in 1987 when physicians were not provided with MAACs in time to make an informed decision on whether to participate. This simple requirement actually could result in an increased participation rate. (A copy of our proposed modifications to the MAAC program, appendix III, is attached.)

Other Budget Savings

The AMA believes that revisions to the Medicare program can be made that will result in a substantial infusion of revenue along with the generation of savings. The changes recommended by the Association will not result in loss of access, a diminishing of quality, or great inequities on any segment of society. One of the proposals, in addition to raising revenue, would go a long way to improving health care status and preventing a leading cause of illness. We urge the Committee to call for an increase in the tax on cigarettes from 16¢ a pack to 32¢ with the increased revenue directed to the Medicare program. This would help offset increased Medicare costs and could reduce cigarette consumption among price conscious consumers such as teenagers. (Appendix IV, Medicare savings and revenue proposals supported by the AMA, is attached.)

CONCLUSION

In conclusion, the American Medical Association recognizes the budget pressures for physician payment reform. However, such reform will affect both physicians and the patients we serve, and it is essential that a rational methodology for reimbursement system reforms be developed. To this end, the AMA has taken a lead role in the development of a resource-based relative value study by acting as a subcontractor in the Harvard University study that is being financed by HCFA. With the

initial results of this study due in one year, the prudent act is to await the results of this research.

The AMA is legitimately concerned that further cuts at this time will prove imprudent as they could result in diminished access to the level of care beneficiaries both deserve and expect.

Mr. Chairman, we will be pleased to respond to questions you or the Committee members may have.

3101p

[Whereupon, at 11:28 a.m., the hearing was recessed.]

AFTER RECESS

Senator ROCKEFELLER. The hearing will come back to order, please.

The third panel consists of Dr. Thomas Connally of the American Society of Internal Medicine; Dr. James Jones, Chairman of the Board of Directors of the American Academy of Family Physicians; Dr. Paul Ebert, Director, American College of Surgeons; and Dr. Bruce Spivey. Is that correct?

Dr. SPIVEY. Yes, sir.

Senator ROCKEFELLER. You are Executive Vice President, American Academy of Opthalmology. Gentlemen, we welcome you. And I have a problem—which is that I will need to leave—which will become acute in 14 minutes. [Laughter.]

In 14 minutes, I have to be downstairs on the floor. I welcome your testimony. You may want to submit it for the record. Let's do the best we can. If another member comes, then all problems are solved.

Dr. Connally, why don't I go to you first, sir.

STATEMENT OF N. THOMAS CONNALLY, M.D., MEMBER, GOVERNMENTAL ACTIVITIES COMMITTEE, AMERICAN SOCIETY OF INTERNAL MEDICINE, WASHINGTON, DC

Dr. CONNALLY. Senator, I am Thomas Connally. I am an internist in private practice here in Washington and a member of the Government Affairs Committee of the American Society of Internal Medicine.

We believe that short-term changes in physician reimbursement should follow the same principles and move the payment system in the same direction as long-term reform. We have stated in the past that the Physician Payment Review Commission's annual report to Congress seems appropriate and desirable. The challenge now is for Congress, physicians, beneficiaries, and others to find a formula to obtain budget savings that are consistent with the goals and findings of the Commission's report. It is also essential that Congress look again at the MAAC, the maximum allowable actual charge program, and make appropriate revisions in this.

Our major recommendations are that your committee strongly look at suggestions which we understand are going to be offered by Senator Durenberger that would increase the Medicare payments for office, nursing home, and home visits by the Medicare Economic Index plus 2 percent. If cuts in the Medicare Part B expenditures are required, Congress should support the recommendations of the Physician Payment Review Commission to exempt certain primary care services provided by physicians in virtually all specialties.

Selected reductions in prevailing charges for certain overvalued services are far more consistent with the goals of long-term reform than across-the-board reductions in prevailing charges for all services.

The fact that certain primary care and cognitive services are grossly undervalued under Medicare's existing system of payment has been borne out by several important studies. A random survey

of ASIM members nationwide in 1986 revealed that Medicare prevailing charges in most localities for a routine return visit are set at a level that barely exceeds if at all the overhead cost of providing that service. Therefore, physicians who currently provide that service at the Medicare prevailing charge level receive virtually no compensation for their time or effort involved in providing this service.

This finding, although disturbing, is not entirely surprising given the fact that physicians in recent years have absorbed the dual blow of historical undervaluation of their primary services as well as the freeze. Therefore, although further resource cost studies will be useful in demonstrating that primary care services are undervalued—and we expect that the Harvard study will bear this out—it is not necessary for Congress to wait for this.

By allowing appropriate increase in payments for cognitive services, Congress would begin moving the system in the direction of changing current financial incentives to encourage a more cost effective style of medical practice. As a result of the distortion in the relative values of cognitive and procedural services, a physician who orders or performs an array of expensive tests is well compensated.

Senator ROCKEFELLER. Dr. Connally, I fear for your health, sir. You can relax a little bit. You are trying to read too fast.

Dr. CONNALLY. All right. I am trying to get you out in 14 minutes. [Laughter.]

A physician who spends time with a patient carefully assessing his or her needs for further tests and procedures is generally penalized for that type of practice. Logic and scientific research tell us that reducing incentives to provide technology intensive care will result in fewer tests being ordered, fewer procedures being performed, and in all probability, fewer hospitalizations. For all these reasons, we strongly urge Congress to allow at least the full Medicare economic index and prevailing charges for cognitive services, such as those nursing home, office visits and home visits.

If Congress concludes that it is necessary to reduce the fiscal year 1988 expenditure, then interim selective cuts in payments for certain overvalued services would be preferable.

Conversely, an across-the-board reduction or freeze in Medicare prevailing charges for all physician services would perpetuate the existing distortions in the CPR payment methodology. It would further diminish the value that Medicare places on time consuming cognitive services and undermine the ability of physicians to continue to provide those services for their Medicare patients.

Our second recommendation has to do with amendments to OBRA to make minor technical changes in the Medicare's maximum allowable actual charge program so as to base future MAACs on each physician's own Medicare-recognized established charges, thus eliminating unintended distortions and inequities.

When Congress enacted the MAAC provisions, the intent was that those physicians whose charges generally have lagged behind their colleagues would have the opportunity to catch up, and vice versa. Unfortunately, the MAAC ratings were based only on a 3-month period back in 1984, and, in brief, it has caused a great deal of distortion. We think that you can eliminate these distortions

which are causing an increased amount of confusion and disillusionment among the physicians by changing the base period of time for the MAAC to July 1985–June 1986, a full year rather than the previous 3-month period that you have.

A lot of physicians had no profile, no services, or were dealing under a different relative value system or a different system of nomenclature for their services at that time. And it makes it very difficult to base what we are doing now going back that far and on such a short period of time.

We have a long discussion of all these items in our written statement and if you have questions we will try to answer them for you.

Senator ROCKEFELLER. Dr. Connally, thank you very much. Dr. Jones, do you have some comments, sir?

[The prepared written statement of Dr. Connally follows:]

STATEMENT

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE

SENATE FINANCE COMMITTEE

ON

FISCAL YEAR 1988 BUDGET ISSUES UNDER MEDICARE PART B

JULY 9, 1987

INTRODUCTION

My name is N. Thomas Connally, MD. I am an internist in private practice in Washington, DC and a member of the Government Affairs Group for the American Society of Internal Medicine (ASIM). ASIM appreciates the opportunity to share with the Committee the views of internists throughout the country on proposals to cut FY 1988 spending on services covered by the Medicare Part B program and on Medicare's Maximum Allowable Actual Charges (MAAC) program.

ASIM believes that short-term changes should follow the same principles and move the payment system in the same direction as long-term reform. As ASIM has stated in the past, the Society believes that principles and goals identified in the Physician Payment Review Commission's (PhysPRC) March 1, 1987 Annual Report to Congress are appropriate and desirable. The Society particularly supports the Commission's goal that "reforms in the levels and methods of payments should increase equity among physicians, so that similar payments are made for similar services among similarly qualified physicians. Payments for different services should broadly reflect relative cost, market conditions, and other appropriate factors." The Society also strongly agrees with the Commission's finding that "current differences in relative charges for physician services

provide distorted signals to physicians and cause serious inequities among physicians" and that "fee schedules under Medicare should be designed in such a way that the relative payments for services would differ from the pattern of allowed charges under the current system." Although ASIM has had serious concerns that the Administration intends to use "inherent reasonableness" simply as a measure to achieve short term budget savings, instead of bringing about greater rationality into the payment system, the Society generally agrees with the Commission's March 1 statement that inherent reasonableness should have the following goals:

- o to address distortions in allowed charges that have arisen from the application of customary, prevailing and reasonable (CPR) reimbursement principles, and

- o to achieve short-term budget savings in ways that are most consistent with long-term policy directions than are across-the-board reductions in payments.

As the Commission noted in its March 1 report, however, the application of inherent reasonableness should increase allowable charges for some services as well as reduce allowable charges for others.

The challenge now for the Commission, Congress, physicians, beneficiaries, and others is to find a formula to attain budget savings that is consistent with the goals and findings expressed in the Commission's March 1 report to Congress. It is also essential that Congress review the MAAC program and make appropriate revisions so that it is consistent with the Commission's objectives of bringing greater understandability and rationality into the payment system. The following recommendations, ASIM believes, are the most consistent with the Commission's and Congress' long-term policy objectives,

These inequities may affect styles of practice because they provide inappropriate financial incentives that influence such decisions as what services to employ in the care of patients, where to practice, and whether to specialize. These distortions can also reduce access to care and quality of care as well as increase Medicare program costs." The fact that certain primary care and cognitive services -- such as office, nursing, and home visits--are grossly undervalued under Medicare's existing system of payment has been borne out by several important studies, including the 1985 Massachusetts resource-based relative value scale (RBRVS) study cited by the Commission as one indicator that certain services under Medicare may be overpriced. Significantly, that study found that certain cognitive services are undervalued by two to three-fold compared to surgical services.

Moreover, a random survey of ASIM members nationwide in 1986 revealed that Medicare prevailing charges in most localities for a routine return visit are set at a level that barely exceeds, if at all, the overhead costs of providing that service. Therefore, physicians who currently provide that service at the Medicare prevailing charge level receive virtually no compensation for their time and effort involved in providing the service. This finding, although disturbing, is not entirely surprising, given the fact that physicians in recent years have absorbed the dual blow of the historical undervaluation of their primary care, cognitive services coupled with a freeze on payment levels at a time when their costs have risen steadily. As a result of the congressionally imposed Medicare fee freeze, Medicare payment levels for non-participating physicians in 1987 are only 3.2 percent higher than what physicians were charging in 1983 -- a four year gap between Medicare payment levels and physician charges.

Therefore, although further resource cost studies will be useful in demonstrating that office, nursing, and home visits and other cognitive services are relatively undervalued

given the rather limited choices available today.

RECOMMENDATIONS

1. The Committee should support a proposal expected to be offered by Senator Durengerger that would increase Medicare payments for office, nursing, and home visits by the Medicare Economic Index (MEI) plus two percent. If cuts in Medicare Part B expenditures are required, Congress should support the recommendations of the Physician Payment Review Commission to exempt certain primary care services provided by physicians in virtually all specialities -- office, nursing and home visits -- from any reduction in the Medicare Economic Index (MEI) update for physicians' services. Selective reductions in prevailing charges for certain overvalued services is far more consistent with the goals of long-term reform than across-the-board reductions in prevailing charges for all services.

The Commission noted in its testimony before the Ways and Means Committee that "by protecting primary care services from this budget reduction, the option will change relative payments in the direction that the Commission advocates for long-term reform. The Commission has been concerned that physicians are paid less for primary care services than for other services, and this distortion limits beneficiaries' access to these crucial services and is unfair to those physicians providing such services."

This conclusion on the most appropriate way to achieve short-term savings is consistent with the Commission's earlier finding, as expressed in its March 1 annual report to the Congress, that "the CPR method has generated a distorted price structure that leads to inappropriate patterns of medical care and inequities among categories of physicians.

compared to other services, it is not necessary for Congress to wait until the conclusion of the Harvard resource cost study to determine that these specific cognitive services--in an absolute and real sense--currently are undervalued under Medicare's CPR methodology. The simple fact that payment levels barely exceed, if at all, the overhead costs associated with these services should be sufficient for Congress to conclude that further after-inflation cuts are unwarranted, unfair, and undesirable for both patients and physicians.

By allowing an appropriate increase in payments for cognitive services such as office, nursing, and home visits, Congress would begin moving the system in the direction of changing current financial incentives to encourage a more cost effective style of medical practice. As a result of the distortion in the relative values of cognitive and procedural services, a physician who orders or performs an expensive array of technology-intensive services is well-compensated. A physician who spends time with a patient, carefully assessing his or her need for further tests and procedures, is penalized for that style of practice. Logic and research both tell us that reducing incentives to provide technology intensive care will result in fewer tests being ordered, fewer procedures being performed, and in all probability, fewer instances of hospitalization.

For all these reasons, ASIM strongly urges Congress to allow at least the full Medicare Economic Index (MEI) increase in prevailing charge levels for cognitive services such as office, nursing, and home visits in the next January 1, 1988 update. If Congress concludes that it is necessary to reduce FY 1988 expenditures for Part B physicians services, then interim selective cuts in payment for certain overvalued services would be preferable.

Conversely, a uniform across-the-board reduction or freeze in Medicare prevailing

charges for all physician services would perpetuate the existing distortions in the CPR payment methodology: further diminish the value that Medicare places on time-consuming, cognitive and primary care services; undermine the ability of physicians to continue to provide those services to their Medicare patients; and be inconsistent with the Commission's and Congress' own objectives for long-term reform.

2. Congress should amend OBRA to make minor technical changes in Medicare's maximum allowable actual charge (MAAC) program so as to base future MAACs on each physician's own Medicare-recognized established charges, thus eliminating unintended distortions and inequities resulting from the MAACs.

OBRA established a complex formula for determining how much non-participating physicians may charge Medicare beneficiaries each year, based upon a comparison of the physician's charges and Medicare's prevailing charges. For a MAAC to be determined based on an individual physician's actual charges, the physician must have charged for services provided during April through June of 1984. In all instances where Medicare is not able to identify the physician's actual charge in April-June, 1984, the MAACs are established based on the 50th percentile of the customary charges of all other non-participating physicians in the locality during the 12-month period ending on June 30, 1986, rather than on the individual physician's own established pattern of charges.

When Congress enacted the MAAC provisions, the intent was that those physicians whose charges generally have lagged behind that of their colleagues would have the opportunity to gradually increase their fees by a greater degree than those whose charges fell above the community average. Unfortunately, what has happened in the real world is far removed from that which was intended. Based on the thousands of letters and phone

calls ASIM has received from internists, it is apparent that some physicians are being forced to reduce charges for certain services, because they did not provide those services in April-June 1984 (the three month base period used to calculate the MAACs), were not in practice at that time, or the Medicare program converted to a new coding system following the 1984 base period. Other physicians received a "windfall" increase above their 1986 charges. Neither result is logical or justifiable. In fact, ASIM can think of no law or regulation in recent years that has created such a high level of frustration, confusion, discontent and disillusionment among the physician community.

We make that statement based not just on some intuitive sense of what is going on in physicians' offices across the country. Instead ASIM knows this to be true because thousands of internists have told us so. They have told us in thousands of phone calls and hundreds of letters that the ASIM office has received since physicians became aware of this program back in late December. Those calls and letters continue today, at a rate of at least ten calls or letters a day. At one point even with five of our staff attempting to respond, and doing nothing else but respond, we were over 48 hours behind in answering phone calls and several weeks behind in answering letters.

Ironically, it is not only the physicians that are frustrated and confused by the program. The Medicare carriers--those responsible for implementing the program--seem equally confused and frustrated. At least four Medicare carriers--in Florida, West Virginia, Ohio, and New York--have given out ASIM's member-only toll free hotline number to any physician who called the carrier with questions on the MAACs, presumably because the carriers thought that perhaps ASIM understood and could explain the program. Although we appreciate their confidence in our ability to make some sense out of this mess (but not, of course, the higher phone bill), there is something very wrong when those who are charged with implementing the law cannot even begin to explain it to those affected.

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The confusion and frustration within the physician community is not limited only to those who practice in internal medicine. On June 12, thirty-two medical organizations representing hundreds of thousands of physicians in all specialities signed a joint letter to Congress expressing their concerns about the MAAC program and asking for legislative relief. A copy of that letter has been provided to the Committee members along with this statement.

Much of the discontent, disillusionment, and inequities resulting from the MAACs can be corrected by making one simple change in OBRA: base each physician's MAACs on his or her own Medicare-recognized established customary charge profile (i.e. actual charges submitted from July 1, 1985 — June 30, 1986). This change will help correct many of the worst distortions and inequities caused by the law:

- o It will provide a more accurate MAAC -- based on the physician's own established charge -- for services that were not provided during the base period, such as newer services and services provided before and after the period from April-June 1984. This will eliminate the unjustified rollback experience by many physicians for some of their charges and make program enforcement more realistic.

- o It will base the MAACs for newer physicians who entered practice from July 1, 1984 - June 30, 1986 on their own established customary charges, thus eliminating unfair rollbacks in their established fees.

- o It will eliminate unfair "windfall" increase in fees above December 31, 1986 levels for those physicians who did not have April-June, 1984 charges and

whose charges fell below the 50th percentile of customary charges.

- It will correct many of the problems resulting from carrier conversion to the the HCFA Common Procedure Coding System (HCPCS). Since all carriers were on the new HCPCS system by October 1985, the 12 month period ending June 30, 1986 includes actual charges for all or most of the new HCPCS codes. Therefore, there will be little need to attempt to match old pre-HCFCS codes with the new codes if the more recent charge data is used. Some coding problems may still persist, however, so the existing process that allows an opportunity for individual physicians to ask for a review of errors resulting form the conversion to the new codes should be continued.

- It will simplify administration of the program by Medicare carriers. Instead of maintaining two profiles -- the April-June 1984 base period charges and the current customary charges -- for each physician, Medicare carriers would only need to maintain the current customary charge profile, which they were already required to calculate for the January 1, 1987 profile update. In addition, since that profile is more current, more accurate, and inclusive than the April-June 1984 charges, carrier administration and expense will be eased. HCFA officials have stated that this change is feasible and would eliminate or minimize some of the problems they have experienced in implementing the program.

- It will correct these distortions and problems while protecting beneficiaries from fee increases as Congress intended. The vast majority of services by physicians -- those for which charges were incurred in April-June 1984 -- would have MAACs under the new methodology that would not differ from

those assigned under current law, since actual charges for services furnished from July 1, 1985 through June 30, 1986 were frozen by law at the April-June, 1984 levels. Moreover, HCFA officials have confirmed that for those other services that would receive new, more accurate MAACs based on the July 1, 1985 - June 30, 1986 charges, there should be little or no overall increase in beneficiary out-of-pocket expenses or programmatic expenditures, since any increase in charges that were unjustifiably rolled back should be balanced out by appropriate reductions in charges that were inappropriately increased under the existing MAAC rules. In any event, no charge would be increased above December 31, 1986 levels, except to the extent that incremental increases are already permitted under OBRA based on a comparison of the physician's customary charge and prevailing charges.

In addition to revising the base period for calculating the MAACs, ASIM supports two other minor charges:

- Provide physicians with access to MAAC information in a timely fashion for making future participation decisions. In 1987, physicians were not provided with MAACs in time to make a decision on participation and the MAACs that eventually were provided often were inaccurate.

- Make the proposed changes in the MAAC methodology retroactive to January 1, 1987, so that physicians are not penalized for the failure of carriers to provide accurate and timely information and for the use of a flawed methodology to determine MAACs. This would not require carriers to issue new 1987 MAACs or allow physicians to resubmit bills to beneficiaries based on the new MAAC methodology. Instead, it would

simply assure that physicians are not sanctioned inappropriately for charges made in 1987 as long as they would have been in compliance with MAACs based on their July 1, 1985 - June 30, 1986 customary charges.

3. The Committee should consider the potential adverse impact on the quality and availability of patient care of continued reductions in expenditures for physicians services under Medicare.

ASIM recognizes that the Committee has been given a difficult charge: to identify potential areas of savings in FY 1988 Budget. The Society cautions the Committee, however, to carefully consider the impact of continued reductions in expenditures on physician services under Medicare on the quality and availability of medical care provided to patients.

As you know, the Medicare program has been forced to absorb major reductions in projected outlays over the last several years in order to meet budget targets established by Congress. Although ASIM recognizes the urgency of reducing the federal deficit, the Society is concerned that continued cuts in expenditures on physician services under Medicare will sooner or later have a detrimental effect on the quality and availability of patient care. Already, as noted earlier, physicians are finding it increasingly difficult to provide time consuming, high overhead cognitive services -- such as office, nursing, and home visits -- at the payment levels permitted by Medicare. Thus far, the commitment of physicians to continue to provide their patients with the best care possible has minimized any real damage to the quality of patient care resulting from the budget cuts.

But sooner or later, continued reductions in spending will force physicians to change their practice styles, by spending less time with patients, seeing fewer Medicare patients,

reducing acceptance of assignment, or discontinuing certain services in their offices because they no longer can afford to provide them at Medicare's payment levels. No physician wants this to occur. But unless there is a redirection of national priorities and resources towards improving the quality and availability of care provided to Medicare patients, ASIM fears that this will be the eventual outcome of continued budget cutting. The Society urges the Committee to act as a positive voice for resisting unnecessary and dangerous short-term cuts in Medicare payments for patient care.

OTHER ISSUES

ASIM is aware that some members of Congress are concerned that instead of taking assignment for laboratory services, some physicians are billing patients directly for these services. In such instances, no Medicare payment is permitted. Some have suggested that this problem be corrected by mandating civil penalties for physicians who do not take assignment on lab services.

The Society shares the concern over the adverse financial impact direct billing may have on some patients. It is important for Congress to recognize, however, that many physicians are billing patients directly because they have determined that they cannot afford to provide in-office laboratory services to all their Medicare patients at Medicare's approved fee schedule amount. Therefore, in order to prevent an interruption in access to those services, they have concluded that direct billing is their only option.

Consequently, mandatory civil penalties for physicians who do not accept assignment for laboratory services requires a trade-off: the benefit of protecting patients from total out-of-pocket liability for unassigned laboratory services is achieved at the potential cost of reduced access to in-office lab services. ASIM respectfully suggests that there is

another alternative that avoids this trade-off: restoring Medicare benefits (at 80% of the approved fee schedule amount) for laboratory claims submitted on an unassigned basis, while allowing 100 percent of the fee schedule amount for assigned claims. This would greatly reduce patient liability for unassigned claims; maintain a strong incentive for physicians to accept assignment whenever possible; and allow physicians to continue to provide in-office testing on an unassigned claim basis in those instances where Medicare's payment levels are insufficient to cover the costs of providing those services.

CONCLUSION

ASIM strongly urges you to support the above proposals. For the past several years, physicians and beneficiaries have become increasingly concerned that as Congress works to reduce the budget deficit, important health policy objectives are being sacrificed. By protecting office, nursing and home visits from additional cuts and reforming Medicare's MAAC program, the Committee will be taking an important step towards restoring our faith that Congress is indeed interested in the overall objective of bringing reason and fairness into the Medicare program.

G-BD-0827e

STATEMENT OF JAMES G. JONES, M.D., CHAIRMAN, BOARD OF DIRECTORS, THE AMERICAN ACADEMY OF FAMILY PHYSICIANS, GREENVILLE, NC

Dr. JONES. Yes. Thank you very much, Mr. Chairman. My name is Jim Jones. I am a country doctor from North Carolina. And with all due respect to the learned Dr. Reinhardt, I find that intellectually stimulating.

I am here today though representing the American Academy of Family Physicians, 59,000 strong, if you include our resident and student members. We are here and we appreciate the invitation to be here because it is our members who provide those services that you have been talking about this morning. We appreciate the fact that we have been able to submit written testimony.

I would like to just highlight some of those for you, and hope that the committee members will have ample opportunity to look at the comments that we have submitted.

We recognize that you have an awesome task to try to find some way to balance the huge deficit that you are faced with, and at the same time provide high quality health care for elderly Americans. We recognize that.

We believe that we have been trying to help you get that job done because we believe we are the physicians who provide those services and a route of access, particularly in rural America and other areas. We believe that we have been doing that at a reasonable cost.

We believe that there may be some ways to make some Medicare savings and our written testimony will make those suggestions for you, we hope.

I believe that there are two principles, and I hope that there are two principles that the committee will use in crafting new legislation that will address whatever reform is going to come. I am sure they are two that are already important to the members of the committee. One is that every American in the Medicare age population should have access to high quality health care. We believe that and I am sure you believe that.

Second, we believe that the principles of new legislation ought to address the fact that there ought to be more equity in payment in physicians. And already this morning you have heard testimony to that effect.

In that regard, we particularly like to applaud Senator Durenberger for the legislation that he is proposing that would have some effect, we believe, to increase access to rural Americans in particular by allowing the full MEI plus the 2 percent.

Primarily, we would like for you to address this unconscionable disparity between the payment of physicians procedurally oriented and those cognitively oriented. The services that are offered by family doctors and other generalists who, by and large, do their work by providing what the Physician Payment Review Board has talked about as ambulatory and preventive care, we don't believe that those should receive any further reductions, absolutely. We think that would be to the detriment of the program, and to the detriment of the individuals getting that payment.

These are not the services that are contributing to the big outlays. The services that we are providing are services that are designed to be preventive, provide and maintain good health in the recipients in the Medicare program, to make them mobile and functional and to allow them to stay at home. Reducing premiums is not going to hurt doctors so much as it would hurt the elderly Americans, in our opinion.

So the major task it seems to me to make some sort of adjustment maybe even some reduction in those overpriced procedures that have been cited in the testimony that you have heard already, or at least to freeze those, while at the same time drafting some kind of strategy that would increase the primary care physician's payment, assuring that all Americans would have access.

Briefly, I would like to tell you that I run a training program for family doctors. One of our recent graduates wrote just last week to tell me that he had taken over the practice of an older physician, who had been caring for many elderly people. But because of the new regulations of MAAC, he found that he was going to have to accept half of what that doctor had been charging, roughly, and that doctor had barely been able to see Medicare patients because the payments were already so low.

He wrote and said, as much as it troubles me to say this to you, my teacher, I am going to have to not see Medicare patients. I simply cannot afford it because my overhead is nearly 50 percent and now they are asking me to see them for 50 percent less. So the $20.00 office visit; I just cannot see them for $10.00.

So, in summary, we hope that there will not be an across-the-board reduction in physician payment. We believe that there probably ought to be a specialty by specialty perhaps or certainly even the prevailing charges ought to be looked at in terms of capturing those doctors who deliberaly overcharge and rewarding those who are trying to help you do the job you want to get done, and that is to maintain a reasonable cost for high quality health care for all Americans.

I appreciate the opportunity to speak before you, and I would be pleased to answer any questions.

Senator ROCKEFELLER. Thank you, Dr. Jones, very much. Dr. Ebert.

[The prepared written statement of Dr. Jones follows:]

TESTIMONY OF THE

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Presented by

James G. Jones, M.D.

Chairman, Board of Directors

Mr. Chairman, my name is James Jones, M.D., and I serve as Chairman of th Board of Directors of the American Academy of Family Physicians. The Academy is the national medical specialty organization which represents more than 59,000 family physicians, family practice residents and medical students.

On behalf of the Academy, I am pleased to have the opportunity to appear before the Committee to share the views of our members on the subject of Medicare physician payment policies. In the following statement I would like to discuss with you several strategies for short term budgetary savings in the Medicare program, including those which have been considered by the Physician Payment Review Commission, from the standpoint of family physicians and their patients.

At the outset, I would emphasize that continuing to target Medicare payments for physician services may have a substantial adverse affect on access to critically needed curative and preventive services. The Academy believes that two goals should govern reform of physician reimbursement; access to quality health care by the Medicare population and equity in payment for physicians. Efforts by Congress to address the budget deficit should be crafted in a manner which is not contrary to these goals. Dollars should not be saved at the expense of the health of the Medicare beneficiary.

The Academy is strongly supportive of the efforts of Senator Durenberger to provide the full MEI update plus 2 percent for physician visits in rural areas (non SMSA) and the same adjustment for routine office visits, home visits and skilled nursing facility visits in all areas of the country. Such increases would be consistent with long term reform aimed at reducing the disparity in Medicare payment for these primary care services as compared with procedurally oriented services, and would help to increase access to these services, particularly in rural areas.

Further reductions or limitations in Medicare Part B payment <u>will</u> have a detrimental effect on family physicians and their patients. The types of

services provided by family physicians -- ambulatory based, preventive oriented-- are cost effective and already are reimbursed at very low levels. These are not the services which account for large Medicare outlays. These are not the services which are driving up the cost of the program. These are the types of services which are aimed at keeping people healthy, active and mobile and potentially reducing acute care costs. Yet access to these services will be reduced by further cuts in Medicare payment.

The Academy therefore believes that Congress should apply any reductions in Medicare Part B payment selectively, to take into account the disparities in payment that currently result for primary care as opposed to procedurally oriented services. In this way, short term changes in Medicare will move in the direction of longer term reform.

One proposal to accomplish this is to target the Medicare Economic Index through a freeze or reduction in the amount by which prevailing charges are updated for all but primary care services. An across the board freeze or reduction in the MEI would disproportionately hurt family physicians and their patients. The services already reimbursed at inappropriately low levels would be subject to the same payment reductions as higher priced services. A selective adjustment in the MEI to allow the full MEI for primary care services would be a more equitable approach. A definition of primary care services which we would suggest, and which has been used previously in the context of a similar proposal, would include office, home and skilled nursing facility visits. A provision of this type would not favor one specialty over another, yet would permit an increase in the reimbursement for those services which tend to be reimbursed at lower levels relative to technically and procedurally-oriented services.

The second strategy which we would like to address is the "inherent reasonableness" option that would reduce prevailing charges for a list of procedures regarded as outliers. One method of accomplishing this would apply a uniform percentage reduction in the adjusted prevailing charges for the procedures targeted; the suggested percentage reduction is 10 percent.

One concern we have with this approach is that all of the prevailing charges for each of the procedures identified as outliers would be reduced. Because prevailing charges vary tremendously for a given

service, the Academy believes that rather than the application of an across the board reduction, PPRC should develop a methodology to identify and reduce the prevailing charges for a procedure that are high relative to other prevailing charges for the same outlier procedure. Such an approach would target the high priced provider rather than all providers who perform a given service, whether or not the charges for the service are inappropriately high.

Another interpretation of the inherent reasonableness concept has been suggested to reduce the magnitude of the variations in fees for Medicare similar services. The proposal would, in the case of each physician service reimbursed in a state, limit payment to no more than a certain percentage above the average prevailing charge in a state. In a state with multiple localities, this new limit may reduce payment in those localities with the highest prevailing charges.

A weighted national average of state average charges also could be calculated and payment limited to no more than some percentage above this national average, reducing payment in areas with prevailing charges significantly above the national average charge levels.

This approach may have merit as it does address the above noted concern about the potential inequity of an across the board reduction in the prevailing charge levels for a procedure identified as an outlier. It also raises a potential additional budget savings. In many localities Medicare carriers determine different prevailing fees for different types of specialists providing the same services, which results in separate prevailing charges for family physicians. If this proposal were to be implemented so that an average prevailing charge is established for a given service based on the prevailing charges for all physicians providing the service, we believe this might be a reasonable approach. However, we would not support the establishment of a specialty by specialty average prevailing charge as this would result in placing a cap on the prevailing charge for family physicians which would be different -- and generally lower -- than the cap on the prevailing charge for other specialists providing the same service.

The American Academy of Family Physicians has been adamantly opposed to the establishment of dual prevailing charges under the Medicare program. In June 1986 the U.S. Supreme Court ruled that two lower courts did have

jurisdiction in determining that the Medicare regulation allowing different prevailing fees for different types of specialists providing the same service, is in violation of the Medicare statute. We believe that as a result the Health Care Financing Administration has a responsibility to revoke this regulation and to provide for a single prevailing fee for the same service, regardless of the specialty of the physician providing the service. Establishment of a single prevailing fee for a given service is technically feasible in the near term and could be consistent with the above recommendation.

The third option that we would like to address would change the basis of reimbursement for new physicians. This option was proposed in the President's budget and essentially would limit the physician's reimbursement to 80 percent of the adjusted prevailing rather than the 50th percentile of customary charges, as is currently the case.

We note that this proposal is projected by the CBO to result in savings of $114 million in 1988 and we therefore, assume that limiting new physicians to 80 percent of the adjusted prevailing rather than the 50th percentile of customary charges will further reduce Medicare reimbursement for services provided by so called "new physicians." We believe that arbitrarily targeting this group for further reductions is inappropriate.

The single aspect of the recently implemented MAAC requirements which has generated the greatest outcry of dissatisfaction among our members is the requirement which limits new physicians to the 50th percentile of customary charges. In many instances, this provision has resulted in very substantial reductions in the amount which such physicians receive for caring for Medicare patients and has resulted in MAACs which are substantially below the charges which these physicians have ever made for providing the particular service.

This strategy poses particular problems for family practice. Reimbursement for family physicians under Medicare currently is disproportionately low for physicians who have been practicing for many years. The customary charges which currently are used in the calculation of reimbursement for new family physicians therefore are low. Low prevailing charges, which reflect the impact of years of specialty and geographic differentials limit what family physicians are reimbursed for their services. We therefore believe that it would be highly

inappropriate to save Medicare dollars by imposing restrictions which will provide disincentives for physicians to train and practice family medicine. Faced with debts for their medical education, the high costs of establishing a medical practice, including payment of high malpractice insurance premiums, students already are turning away from family practice. Should the Medicare reimbursement for new physicians be reduced to achieve a short term Medicare cost savings, the direct result may well be to further discourage physicians from training in family practice and other primary care specialities or to provide a substantial disincentive for such physicians to provide care to Medicare beneficiaries.

To address this and other inequities with the MAAC program, the Academy has joined with several other medical organizations to ask Congress to adopt an amendment which would do the following:

- Base each physician's MAACs on his or her own current established customary charge profile (i.e. actual charges submitted from July 1, 1985 to June 30, 1986).

- Provide physicians with access to MAAC information in a timely fashion for making future participation decisions.

- Make the proposed changes in the MAAC methodology retroactive to January 1, 1987.

These changes to the MAAC program would eliminate the unfair rollbacks in their established fees experienced by physicians who entered practice from July 1, 1984 - June 30, 1986, and by established physicians who did not provide a particular service during the April-June 1984 current base quarter. In addition, the amendment would simplify administration of the program by Medicare carriers by requiring that they maintain one, instead of two, profiles for each physician. We would encourage the committee to incorporate these changes into the budget reconciliation package.

In summary, the American Academy of Family Physicians does not believe that Congress should target Medicare payment for physician services in its efforts to achieve budget savings in FY 1988. Primary care services,

which are cost effective, already are reimbursed disproportionately low relative to procedurally oriented services. Further budget reductions which do not address this disparity in Medicare payment policy will further discourage beneficiary access to these services.

As the committee develops its strategies for reducing Medicare spending the American Academy of Family Physicians would suggest that consideration be given to an adjustment in the MEI which takes into account primary care services, or an adjustment in Medicare reimbursement for those services and to those providers for which payment is inappropriately high or inappropriately low, through the inherent reasonableness authority. Further, the Academy strongly urges that the committee reject efforts to save Medicare dollars at the expense of new physicians and, instead, adjust the MAAC limits for these physicians to reflect their actual charges.

We have appreciated the opportunity to share our views with you today and look forward to working with you in developing your Medicare payment recommendations. I would be pleased to answer your questions at this time.

STATEMENT OF PAUL A. EBERT, M.D., DIRECTOR, AMERICAN COLLEGE OF SURGEONS, CHICAGO, IL

Dr. EBERT. I am Dr. Paul Ebert, Director of the American College of Surgeons, and we have approximately 48,000 members who represent all the surgical specialties.

I will just try to highlight several comments. Over the past two years, the college has been very much aware of the problem of geographic variation in charges. What is a surgical bundle? And it has been referenced several times today. Who really requires an assistant at surgery? And if one was to come up with a relative value scale, we would strongly support the concept that it initially be on a State-wide basis since that will, generally speaking, address the issue of geographic variations.

Now we have been somewhat concerned with the Physician Payment Review Commission's report and recommendations to you. And that we do not feel that it is logical to reduce the MEI for many reasons. As stated by Dr. Jones, the overhead of physicians are quite high in primary care. The medical malpractice liability issue is extremely high among most of our fellows, and it is even required, as you know from the newspapers, that some areas of the country now has had to reduce services in some of these high risk areas.

So in the same light we find that selecting nine procedures to make a specific reduction does not really address the question of inherent reasonableness. We find, when we look through the legislature, it is very difficult to find an accurate interpretation of this statement. And, consequently, we would like to suggest that inherent reasonableness, although may be applied from procedure to procedure, the inherent reasonableness concept could just as easily be applied within each procedure. In other words, could we address those that are overcharging for a specific procedure?

And the College recommended that Congress consider the concept that could we not on a State-wide basis adopt a mean charge and then pay a certain amount for each procedure within that sum level above it, whether it is one standard deviation, two standard deviations. The amount of that savings could be then calculated by whatever Congress decided was the target that could be reduced.

Thus, we find that that would apply better to the entire profession. And if there is truly undercharging by rural physicians, this, of course, would address those individuals who are overcharging or charging the higher fees.

Thus, we think the goal of this approach is much more reasonable than to simply select by techniques that we are not too comfortable with why 9 procedures are considered overprices on a very short basis. And we think this was more of an expeditious recommendation rather than based on any particular sound data.

I would just like to make two other comments based on some of the discussion that was forwarded this morning.

There is often the concept that there are an excess number of surgeons. And if one looks at actual data, it is rather interesting that there are fewer surgeons of all surgical specialties coming out of training today than there were in 1975. Now I admit the reduction may be small, but it certainly seems to be in a proper direc-

tion based on what other people's opinions are regarding manpower needs of surgery.

The second is that if one looks at the number of operations performed in Medicare beneficiaries, you also find that the total number of operations in the 1984 data that is available through the Congressional Office of the Budget, that there is less total number of operative procedures performed in patients than there were prior to this. So it is a little difficult for us to see why one should target the procedural aspects of surgical operations and select the particular nine without any particular idea that these are being overused within the community.

We thank you for the opportunity of submitting this testimony. I think this will highlight the areas of my comments.

Senator CHAFEE. Thank you very much, Dr. Ebert. We are going to have a chance to discuss this a little bit when we get to the questions.

Dr. Spivey, is it?

Dr. SPIVEY. It is.

[The prepared written statement of Dr. Ebert follows:]

STATEMENT

of the

AMERICAN COLLEGE OF SURGEONS

to the

Committee on Finance
United States Senate

Presented by

Paul A. Ebert, M.D., F.A.C.S.

RE: Budget Reconciliation Proposals for the Medicare Part B Program

Mr. Chairman and Members of the Committee, I am Paul A. Ebert, M.D., F.A.C.S., the Director and a Fellow of the American College of Surgeons, on whose behalf I appear today. The College's 48,000 Fellows appreciate this opportunity to share with you our views regarding physician payment under Medicare.

As you know, the American College of Surgeons is a voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high quality care for the surgical patient. The College provides extensive educational programs for its Fellows and for other surgeons in the United States. In addition, we promote standards for surgical practice, disseminate medical knowledge and provide information to the general public.

As part of its ongoing efforts, the College has devoted considerable resources to the issue of physician reimbursement and has developed a comprehensive set of physician payment proposals, approved by the College's Board of Regents in October 1986 and previously communicated to the Members of this Committee. These proposals respond to specific problems with the Medicare program that have been identified by Congress. In developing these proposals, the aim of the College was to identify ways to establish a more rational basis for paying for physicians' services under the Medicare program without compromising beneficiaries' access to high quality

medical and surgical services. Moreover, the proposals recommend incremental, statewide changes that will be least disruptive to Medicare beneficiaries and physicians. It is the College's view that these proposed changes could help contain Medicare's costs as well.

Following is a summary of the College's proposals:

o We propose the development of a statewide Medicare Relative Value Scale to determine prevailing charge levels within each state. We believe this would be one way to address the issue of geographic variations in fees without precluding future use of a national payment approach.

o We also propose that definitions for the services that Medicare pays for be standardized for payment purposes. For example, we believe it would be important to standardize what services are included in a basic service package, such as a surgical bundle, and to reduce the number of coding distinctions recognized for payment purposes (i.e., collapsing codes).

o The College has developed a definition of an assistant at surgery as well as guidelines in terms of when an assistant should be used. We believe this proposal could result in cost savings for the Medicare program and not deprive patients of access to an assistant when assistance is medically necessary.

The College also would like to take this opportunity to share its views concerning the two options recently recommended by the Physician Payment Review Commission (PPRC) and currently under consideration by the House Ways and Means Committee for addressing short-run Medicare budgetary problems. We believe that the Congress created the PPRC to provide carefully considered advice on physician payment reform and not to engage in federal budget reconciliation exercises. We are most concerned by the PPRC's hurried deliberations in arriving at its current recommendations.

One of the Commission's proposals calls for reducing the Medicare Economic Index (MEI) update in the prevailing charges for physician services scheduled for January 1, 1988, but allowing the full update for office visits, nursing home visits and home visits.

The College does not support a reduction in the MEI update. Past limits on physician payment under Medicare and significant increases in practice costs, especially for professional liability insurance, argue against additional regulation of Medicare physician reimbursement. Nor do we support the idea of exempting selected physician services from a reduction on the grounds that such a differential payment policy is not justified.

The PPRC's second recommendation would reduce prevailing charges for a list of selected procedures which are judged by the Commission to be overvalued with respect to other physicians' services. The Commission has, in fact, developed its own interpretation of the inherent reasonableness of physicians' fees. However, the PPRC's inherent reasonableness methodology differs remarkably from procedural requirements in current law, enacted as recently as last fall. These statutory provisions already permit the Secretary of Health and Human Services to increase or decrease the reasonable charges for specific physicians' services when certain tests are met and provide for an orderly process allowing for public comment. The College sees no need to circumvent these requirements and strongly opposes the Commission's inherent reasonableness recommendation.

In arriving at their recommendation, the Commission relied on a comparison of Medicare payment amounts in four states during 1984 and the relative values for 31 selected procedures as defined in five relative value scales (RVSs). The College believes that the methodology used by the PPRC to prepare this list is significantly flawed and not suitable for national policymaking. Moreover, the approach does not meet the high analytical standards that we should expect from the Commission in making judgments about Medicare physician payment policies.

The College has several specific concerns about the PPRC's approach. First, we seriously question the procedure selection process, which, due to the very limited information available, confines itself to an examination of only 31 procedures. This approach completely ignores the issue of volume and the aggregate outlay impact on the Medicare program of spending for all other physician services. The 31 procedures were looked at simply

because it was convenient to do so, and because adequate time was not taken and adequate data were not available to permit a more systematic and careful review.

Secondly, the College has concerns with the particular RVSs chosen to determine whether selected procedures were overvalued. For example, we fail to see the relevance of using a Canadian RVS arrived at through negotiations between Canadian physicians and their government as a basis for making judgments about Medicare payment levels. The Commission also relied on the use of another RVS developed by William Hsiao, Ph.D. of Harvard, who testified before PPRC that the scale could be subject to as much as 25 percent error. In addition, procedure complexity, which is one important determinant of value, is based solely upon interviews with 110 physicians, all of whom practice in Massachusetts. Further, very little information was made available by the PPRC on the three other scales, and it is not clear whether they are representative of the United States. Moreover, the five scales themselves show significant variability in the value they assign to individual physician services, even in the case of common procedures like the repair of inguinal hernia, where the highest value assigned is 43 percent higher than the lowest value assigned. For diagnostic colonoscopy, the highest assigned value is 87 percent above the lowest; for laser photocoagulation, it is 126 percent; and for insertion of an aortic balloon pump, the highest assigned value is 162 percent above the lowest. This kind of variability certainly does not inspire confidence in the use of these five scales to judge whether a given procedure is over- or undervalued, or by how much.

Mr. Chairman, the American College of Surgeons believes there are several ways to interpret the inherent reasonableness concept. In our testimony to the PPRC on May 27, we recommended an approach that would limit Medicare payment for a service to no more than a certain percentage above the average prevailing charge in a state. Another approach is to limit, on a statewide basis, Medicare payment for a service to no more than a certain percentage above some average charge or charges for that service. In essence, the concept is predicated on setting a payment limit in addi-

tion to the customary and prevailing charge limits under current law. The magnitude of the payment adjustments under this proposal, of course, would depend on the amount of estimated savings expected from these kinds of changes in Medicare's physician payment rules. I should point out that our suggestion received the support of many of the groups that testified before PPRC on May 27.

This approach is one way to deal with the tremendous variation in Medicare payment levels, even within a single state, for individual services and procedures. The goal of this approach is to reduce the magnitude of fee variations in an orderly manner until further work can be done by the PPRC and the Health Care Financing Administration on the variations problem. This approach could be accomplished in a number of different ways to deal with any technical data limitations or administrative concerns, and the amount of savings would depend upon final specifications. The College has suggested that the concept be applied first on a state-by-state basis, with the new payment limit set at some level above the statewide average charge or average Medicare payment amount. However, we clearly support expansion of this approach to provide for broader-based limits on a regional and/or national basis as it becomes possible to do so.

We believe this approach has merit for several reasons. First, it can be applied to all services and procedures paid for by Medicare. Second, data needed to implement this approach on a statewide basis are readily available. Third, the approach will affect the payment level of those physicians whose fees are substantially higher than the average, while physicians at or below the average, including most physicians practicing in rural areas, remain unaffected. For these and other reasons, the College supports the use of this approach if short-term budget savings must be achieved.

Mr. Chairman, the American College of Surgeons appreciates your invitation to testify at this hearing, and we hope that these remarks prove helpful to you in the difficult deliberations which lie ahead. The College stands ready to provide any additional assistance which you may need.

STATEMENT OF BRUCE E. SPIVEY, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF OPTHALMOLOGY, SAN FRANCISCO, CA

Dr. SPIVEY. Thank you, Senator.

My name is Bruce Spivey. I am an opthalmologist in practice in San Francisco, and I, as Executive Vice President of the American Academy of Opthalmology, represent over 15,000 members, about 93 percent of the opthalmologists in the country.

Now I will try to be brief. I know the time is going rapidly. And I think it may be more productive for us to answer questions that you might have.

I would like to make three points. Cataract surgery is successful. It is delicate. I don't think it should be penalized because it is successful or frequently employed. The population is aging. So far, we have not found a way to retard the development of cataracts in the population, and it is a procedure that will continue probably to increasing frequency.

Last year—in fact, over the past four years—substantial reductions in payments to a variety of physicians regarding cataract surgery have occurred, and I will enumerate those in a minute. But we have a 10 percent cut this year, a total of 12 percent, and I think that we need to look and see the implications of those cuts before more come.

Finally, I think HHS, at least in my opinion, is signaling providers that, or Medicare is signaling the public that quantity and not quality of care, especially in terms of unbundling cataract post-operative care, is occurring.

I would like to pick up on what Dr. Ebert said about bundling in a minute.

We are for developing a rational, equitable physician payment system, and we, in a self-serving way, admittedly, are here today saying we gave last year in cataract surgery. We would like to see the opportunity for observing those cuts before more are employed.

Part of our problem really is that, probably as ophthalmologists, we have trivialized cataract surgery. In order to make our patients not so apprehensive, we have said it is quick. It is drop by the office. And that has not been actually how the procedure is employed. With the new technology, it is more difficult; it is more time consuming than it used to be.

Now regardless of that, we have about a million cataract procedures performed a year, and, as I say, it will probably increase. We have had a 12 percent reduction in the surgeon's fee. There is a cap on actual charges. Cataract is the only Medicare procedure subject to a specific rollback in the physician's actual charges. The use of assistance in that surgery has essentially been eliminated; the payment to anesthesiologists providing active analgesia for cataract surgery has been cut significantly. Cataract surgery has gone to an outpatient setting almost exclusively. You have to be too sick for cataract surgery if you are going to have it in the hospital. You have to go to the intensive care almost to have cataract surgery in a hospital. It just does not happen any more.

That hospital outpatient reimbursement has been reformed and this fall the PROs are likely to require prior approval prior to any

cataract surgery. And, therefore, we think as a substantial reduction over the past few years, cataract surgery is significantly less expensive to the Medicare program and to its beneficiaries.

We have some other concerns about the method of choosing overpriced procedure. Obviously, you have seen a spectrum of opinion right in this very panel and I will not proceed on that. But we have in our written testimony details of our concerns.

Now I think there are some ways that you might be able to reduce Medicare outlays. We think that savings could be achieved by Congressional direction to HHS to maintain the integrity of the global surgical fee. Currently, HHS allows post-operative care for cataract surgery alone. And somebody told us that. It was not a Freudian slip. [Laughter.]

That cataract surgery alone is unbundled and allowed to be provided separately by non-physicians. The fragmentation is costly to Medicare. We think it is unethical. And, medically, I think it is unwise. I think that natural referral patterns—

Senator CHAFEE. I must say, I did not quite understand what you were saying about the post-operative care being under the control of non-physicians.

Dr. SPIVEY. Thank you for asking. Yes. HHS has allowed an unbundling in the post-operative period. In ophthalmology, we believe that there should be a global surgical fee that would allow total care under the single price for the cataract surgery for a period of 90 days. What HHS has allowed is that payment to usually optometrists who referred the cataract patient in in the first place to follow that patient and to receive additional payment for that patient over the course of those 90 days, which should really be included in the global surgical fee.

Senator CHAFEE. Do you think that ought to be a saving?

Dr. SPIVEY. Yes, sir.

Senator CHAFEE. All right. Anything else?

Dr. SPIVEY. Well, I do support the fact that we must reduce overcharges. There is no comment, no doubt, no question about that.

Senator CHAFEE. Well, how do you suggest doing it though?

Dr. SPIVEY. I think there are a variety of ways in terms of the overcharging. We have already begun doing that in cataract surgery. I think that could occur across the board. There has been a cap placed on the maximum allowable charge in cataract surgery.

Senator CHAFEE. But that was done by the government.

Dr. SPIVEY. Well, I think that is what we are talking about what the government is going to do here.

Senator CHAFEE. Yes. But you think we can do more?

Dr. SPIVEY. I think you can look across the board to those people who are, in my view, charging way beyond what the rest of the surgical community in case of procedures, or medical community in large, charges.

Senator CHAFEE. As I mentioned earlier, I was chairman of the conference last year in reconciliation when we got into this very issue of the cataract charges, and one of the forces that was driving us in connection with cataract surgery was the wide geographical discrepancy in charges. And even now, sometimes there is a fee of $2,200.00. It seems to range from $2,200.00 down to $1,100.00. Is

there any way you can explain that? And if we were to reduce the cataract fees in the high charge areas, how could we best do it?

Dr. SPIVEY. Well, is there any way I can explain it? I can explain it in the same way all surgical variations in fees across the United States exist.

Senator CHAFEE. Variation in liability insurance, I suppose?

Dr. SPIVEY. I would explain it on a historical basis and a number of other more practical situations. And I don't want to pick out surgery as the only place where there is a significant fee variation. I think you need to look across the board. And in terms of the specifics you cite, there is indeed a substantial difference in the average charge in one sector of the country or in one State, or particularly in one segment in many States. And rather than approaching it from an overall direct fee reduction, if fees or if charges or allowable reimbursement must be readjusted, I think it is far preferable to approach it from the top than from the average, and would encourage you to look in that direction.

[The prepared written statement of Dr. Spivey follows:]

AMERICAN ACADEMY OF OPHTHALMOLOGY

TESTIMONY BEFORE THE
SENATE COMMITTEE ON FINANCE
July 9, 1987

My name is Bruce E. Spivey, MD. I am an ophthalmologist in practice in San Francisco, and Executive Vice President of the American Academy of Ophthalmology. I am speaking on behalf of the Academy, whose membership represents more than 15,000 or 93% of the ophthalmologists in the U.S.

Our testimony will emphasize these points: (1) that cataract surgery is a delicate, highly successful procedure that should not be penalized for its success; (2) that cataract surgery has experienced more reimbursement reductions over the last four years than any other procedure, and therefore, should not be included in this year's budget cuts; (3) that the impact of the 1986 enacted 12% prevailing cut and special cap on actual charges for cataract surgery has not been studied, and hence, no further cuts should be made until Congress can be assured that patient care, quality, access, and patterns of practice have not been negatively affected by the existing reductions; and (4) that HHS may be sending signals to providers that Medicare is more concerned with quantity not quality of care, especially in terms of the unbundling of cataract post-operative care.

We wish to stress that we appreciate the opportunity to be here today, and to continue our sincere interest in working with you and your staff to achieve our mutual long term goal. We strongly believe that the worthy goal of designing a more rational, equitable physician payment system, however, will not be met through the selective and divisive reductions in certain surgical procedures, especially the continual barrage aimed at cataract surgery reimbursement.

We commend this Committee for resisting policy last year that would have singled out cataract surgery for specific cuts. We urge you to maintain your commitment to rational policy development again this year.

Cataract surgery is a very successful procedure that is often misunderstood. It is extremely complex surgery, performed under a powerful microscope on an area of the body smaller than my thumb, with sutures that are invisible to the unaided eye.

Unlike the CAT scan, where technology replaces exploratory surgery, or lasers, where the technology permits surgery without a blade, the technology associated with cataract surgery places great demands on the surgeon's skills. The surgeon must still cut into the delicate tissues of the eye with a knife--precisely--or lose the eye. Then, using tiny forceps, the surgeon places an intraocular lens--measured by ultrasound to fit the unique shape of the patient's eye -- through a tiny slit, into just the right location, in the same small, fragile pocket where the clouded natural lens was carefully removed. While expensive new technology is an integral part of modern cataract surgery, it has made the "job" harder, not easier for the surgeon.

The advances in the technical skills of the surgeon, quality of the knife blades, the microscope, the sutures, and the intraocular lens implants have greatly improved the success of cataract surgery, reduced the complication rates, and greatly enhanced the patient's visual outcome. These results, coupled with the use of local anesthesia which permits one-day surgery, have greatly increased the public's demand for this operation.

It is largely patient demand which has resulted in the high volume of cataract surgery. Patients demand this surgery because they want to lead more active lives, to be more self-sufficient. The development of cataracts is all too often an inevitable result of the human aging process. Older Americans do not wish to sacrifice their independence or quality of life to the encroaching blindness of cataracts, especially given the 98% success rate of modern cataract surgery.

Despite the progress in cataract surgery, in its quality and success, it has come under continual scrutiny from Congress, largely because of the volume of cases, over 1 million surgeries performed yearly. As a result, cataract surgery has shouldered more than its fair share of Part B cuts over the last four years. These reductions include:

- A 12% reduction in the surgeons fee.
- A cap on actual charges, only 25% over the prevailing fee, or the MAAC calculation, whichever is lower. This is the only Medicare procedure subject to a specific roll-back of the physicians actual charges. The special cap on cataract fees provides a permanent mechanism to hold down the surgeon's actual charges, reduce the beneficiary's out-of-pocket expense, and strictly limit the amount Medicare will pay for the foreseeable future.
- The use of an assistant surgeon has been nearly eliminated in most areas.
- The payment to the anesthesiologist for monitored anesthesia services only during cataract surgery has been cut significantly.
- Peer Review Organizations have moved cataract surgery to the outpatient setting. Today, it is virtually impossible to admit a cataract patient even for an overnight stay, no matter how frail the patient or what social factors are present.
- Hospital outpatient reimbursement and ambulatory surgery center payments have been reformed for program savings.
- This fall, when the Peer Review Organizations implement their second surgical opinion program, it is likely that no cataract surgery will be permitted under Medicare unless it has expressed pre-approval.

Due to these changes, cataract surgery, as a package, is now significantly less expensive to the Medicare program, and to the beneficiary.

Further, these policies have altered cataract surgery in ways that might not become apparent for some time. We respectfully urge you to refrain from any further reductions in cataract surgery reimbursement until proper studies can show us what impact these changes have had on quality of care, patient access and physician practice patterns.

We believe it is unfair to contemplate any further reductions in cataract surgery fees in 1988. It is unfair because we were the "test case" in last year's inherent reasonableness experiment. It is unfair because of the inequities of a further straight percentage across-the-board cut. It is unreasonable because it perpetuates the many other inequities and inconsistencies of the usual-customary-prevailing fee system inherent in the national Medicare system.

We have further concerns with the method of choosing the "overpriced" procedures. The Mitchell-Stason study, which has been cited as a reference, selected the highest volume Medicare procedures in four states, in 1984. This was BEFORE any of the above-noted changes in cataract surgery were enacted. We take issue with the data and methodology used in their study:

(1) Higher volume tends to reflect higher success; by singling out these procedures, you may penalize success, and attack the procedures which the patients demand.

(2) The data available (1984) is out-of-date for cataract surgery, and inadequate; only high volume procedures were chosen in order to perform statistical manipulations, and the statistics will be subject to large margins of error. Even Dr. William Hsiao, who constructed the 1985 relative value scale upon which Mitchell and Stason base their study, has indicated that the 1985 RVS needed significant refinement; that individual values could be subject to as much as a 25% error rate.

(3) Modern medical practice, technique and supplies change rapidly, enough so that 1984 data may not accurately reflect 1988's medical care.

We are all aware of the difficulties in collecting and analyzing national Medicare data. Because of this, the actual impact of the recommended across-the-board percentage cuts in the selected procedures is difficult to assess, especially in terms of the greater likelihood that rural areas and physicians who have kept their fees at moderate levels would be hit hardest.

May we respectfully remind you, that for cataract surgery, the Administration's proposal would result in a total reduction of 25 percent over two years. Such a large cut clearly raises larger risks and uncertainties for the Medicare program. Just last year, Congress declared that such a significant reduction was NOT acceptable, and therefore enacted the 10% cut.

While we vehemently object to any further reductions in cataract surgery reimbursement, it is possible that program savings could be achieved by Congressional direction to HHS to maintain the integrity of the global surgical fee. Currently, HHS allows post-operative care for cataract surgery alone to

be unbundled, and provided separately by non-physicians. Not only is this fragmentation costly to the Medicare program, it is unethical. Natural referral patterns between generalists and surgical specialists or surgeons and allied health professionals should be maintained. HCFA should be directed to pursue reasonable definitions of services which may include bundling. In the case of cataract surgery the unbundling which presently is allowed to exist not only endorses patient abandonment but creates an environment where certain surgeons are indirectly rewarded for abandoning patients. This has institutionalized fee splitting.

In closing, we support the American Medical Association's position that physicians have been subjected to years of fee freezes, MAACs and other burdensome program changes. This constant barrage should stop, until a rational, equitable reform can be crafted. We also support the efforts of the American College of Surgeons in exploring long term, systemwide adjustments aimed at equitable solutions to some of the Medicare payment problems.

We recommend that substantive policy changes not be proposed without further study. And finally, we believe that cataract surgery has already shouldered its fair share of federal budget cuts and should NOT be part of any new reduction package.

Thank you for this opportunity to voice our comments. We look forward to working with you and your staff.

Senator CHAFEE. I want to thank each of you for taking the trouble of coming here. You have come from some distance, each of you, and we are grateful for that.

Dr. Jones and Dr. Connally both talked about the cognitive services and the failure to be reimbursed properly and the unfortunate side effects in that. And I was interested in your comments, Dr. Jones, about the inability to give the proper preventive advice—preventive medical advice—as a result of the failure to adequately reimburse for cognitive services. Could you amplify on that a little more? In other words, you must find it in your own situation. You have got to meet your overhead. You have got a fixed overhead—rent, insurance—and I don't know what the standard is.

When I was practicing law, they used to think your overhead should not be more than 30, 33 percent of your gross. I don't know what you figure it is, but discuss that a little bit more, how it impacts on you, the failure to be adequately reimbursed.

Dr. JONES. Thank you very much, Senator Chafee.

It really boils down to a matter of access and it has been addressed here several times already. Though family physicians practice in a great variety of geographic areas, a large number of our Academy members practice in rural areas. It may be that there are only one or two doctors providing care to the Medicare population in a given town or county, or what have you.

If a doctor finds himself providing those services that are already barely profitable or not profitable at all, reduced to the point that he simply cannot afford to see those patients, then not only is care—acute care—going to go by the wayside, so there will be no access to care, but, more importantly, we believe that he will not be able to see patients on a regularly scheduled basis and institute some preventive and maintenance care if you will, that might prevent much more costly care down the road, such as controlling diabetes, controlling high blood pressure, and those chronic diseases that, unfortunately, beset our older citizens.

Senator CHAFEE. Let me ask each of you; I would be interested in the panel's reaction. I presume that when you are charging your Medicare patients that you, if somebody is wealthy, you charge more, presumably, than you would for somebody who is not. Is that true or isn't it? How do you work this?

Dr. JONES. No, sir, that certainly is not true. As a matter of fact, it is my understanding that that is against the law.

Dr. CONNALLY. They cannot do that.

Senator CHAFEE. You can't do that at all. So you charge them all the same.

Dr. JONES. Yes.

Dr. CONNALLY. Senator, I have a patient who is a billionaire.

Senator CHAFEE. A billionaire?

Dr. CONNALLY. A billionaire, with a "B", if you can believe Fortune Magazine.

Senator CHAFEE. How many have you got?

Dr. CONNALLY. Just one. [Laughter.]

She has Medicare, and I charge her the same thing as I do some very impoverished ladies who live on Connecticut Avenue and who are living on a very small government retirement. And, legally, you have to do that under Medicare. Now the one difference is that

we do have the right to accept assignment on some patients and not on others. So that is one of the ways that we make a difference.

Senator CHAFEE. Yes. But that is if you are a participating physician.

Dr. CONNALLY. No. If you are a participator, you have to accept assignment on everybody. If you are a non-participator, then you can accept assignment on some patients and not on the others.

Dr. JONES. Case by case.

Dr. CONNALLY. Case by case.

Senator CHAFEE. Good. Go ahead. I am interested in your billionaire. [Laughter.]

Dr. CONNALLY. Well we are stuck. We cannot increase our fees on people who are very wealthy. Now we have the MAAC, which says how much we can charge, and you have to charge that and only that. So in a way, you know, I guess about six months ago I went to a dual fee schedule. I was very sad to do it. I have a large Medicare practice and had to start charging my non-Medicare patients more than I could the Medicare patients. We had been under the freeze for almost three years then.

So, in a sense, we have a dual system of charges, but it is not wealthy versus poor. It is non-Medicare versus Medicare. It's what we are doing right now and that has already happened.

We do differentiate within the Medicare population, those of us who are not participators, who accept assignment on some and not others. We make our differentiation and protect our poor patients by accepting assignment. Indeed, on a few of them I do something that is illegal. I don't even go after the 20 percent copayment that they have to have on a very poor patient. But we cannot change that.

Senator CHAFEE. Now, Dr. Reinhardt had some comments—and, Dr. Reinhardt, do you want to come up—you had some comments on the nine procedures that were being targeted. I think that was particularly in connection with Dr. Ebert's testimony. Why don't you go ahead.

Dr. REINHARDT. If I may ask Dr. Hammons to come up too because he is the one who actually worked on this methodology. Would you like me to explain?

Senator CHAFEE. Go ahead.

Dr. REINHARDT. Why don't you explain how that was done.

Dr. HAMMONS. The question that I was asked earlier and would like to address again is this. Given that there are variations in bundling in different locations, does that mean if you do implement across-the-board reductions—for example, 10 percent in all areas—in prevailing charges for these selected procedures, is that unfair? Does that unfairly hit some physicians or some areas more than others? I believe that is the question. Further, does it affect the analysis generally? Let me address both of those.

It is clear that bundling variation does exist and is significant. One example is the data cited from Jan Mitchell's study. And, in fact, that is one of the two reasons we find it difficult to suggest a policy to redress geographic variations generally, as has been advocated a little earlier.

Now to get to the two questions. Does it affect the analysis, the integrity of the analysis designed to select which procedures are

most likely to be overvalued? No, it does not. It does not because we did the analysis in terms of relative valves within each pair. The only way it could is a real long shot, and that is if bundling practices were significantly different for different procedures within a single pair. There is no reason to believe they are.

So let me reiterate. No, the analysis, I think, is not affected by it.

Now does it introduce unfairness if it were implemented the same in various locations? There we are back to the geographic question. If you could determine which areas had higher—which areas were more higher than other areas, if you will, then you would like to cut those areas more. But as we discussed earlier with geographic differences, generally, we do not have the data to do that. Okay? So it neither improves or makes worse the current differences geographically. And that is true whether those geographic differences are based on coding—that is, bundling differences—or cost-of-practice differences.

I would like to make one other small point, and that is, when we did this analysis we tried very hard to be cautious and conservative. That is to work with smaller cuts than the data suggest, just because any factors that might make it less robust than are unlikely to lead to any harm.

If I haven't addressed the question, I would be pleased to continue trying.

Senator CHAFEE. Go ahead, Doctor. Do you have some comment on that?

Dr. EBERT. Well I think it is rather presumptous to assume that the bundling practices within any single carrier are totally the same, because the bundles are totally different for almost every procedure when we check through and you can see what is done with various carriers. So I think there are great differentials in that.

But I think more important than that is that if you imposed a certain percent cut across-the-board on any procedure, you affect the physicians who are already charging what one might like to say reasonable charges. In other words, the person in the rural area who is making a minimal charge is affected 10 or 15 percent just as much as a person who is overcharging.

Now the answer to that is, if you are in an area that you can vary your fees, you overcharge. And, consequently, what we made the suggestion was, why not pick a mean charge, and assume that the people below that are complying with the intent of the practice of medicine, and that someplace above that line one would have to decide how much budget savings they would incur. This would have more effect on those that are overcharging for a specific procedure.

I think trying to take RVS codes, one from Canada and two from several other private carriers, and saying that the bundling is the same within it, that they represent the same type of services, that they imply the same type of medical malpractice insurance problems with it, I think, is rather thin. And then to, out of that, come up with nine procedures, and say why take all the savings from nine, we are saying, why not spread it over a larger variety? We know that there is probably 255 or 256 codes that make up approximately 80 percent of Medicare's cost. And whether you exclude cer-

tain procedures or office visits from this, this is certainly discretionary. But it would still seem more logical to us to say pay one standard deviation above, or whatever the mean, whatever number was necessary to achieve the budget savings that you decide.

Senator CHAFEE. Well that seems to make sense. Dr. Reinhardt, what do you say to that?

Dr. REINHARDT. Well it is, of course, a vastly different approach. If you did this on a State by State basis, which, I believe, the College of Surgeons has recommended, then some States that are already low, some physicians there might even be cut further. So I presume when you talk about standard deviations you must be talking about something national.

Dr. EBERT. I cannot understand why you would say some States would be hurt more when you are only dealing with the higher level of payment within. We know there is fee variations within every State. We also know that it would be rather disruptive, we believe, to take a national average and then try to compare this from a State average. And why not take it on a piecemeal basis? Why not go State by State to begin with? The geographic variation is still present, we admit, but you are only addressing the higher charges within a specific State.

Dr. REINHARDT. I suppose what one has in mind is that in some States physician fees would be cut, although they are already lower than fees would be in other States that would not be cut. And you would have testimony coming before you how inequitable that is.

I think sometimes it pays to step back from the whole problem a little bit and ask, what is actually being attempted to do here?

You can take the taxpayer's point of view and ask, how much money has the taxpayer turned over to health care providers under Part B in the last year? You will find if you look from 1980 to 1985 that that cost more than doubled. I believe I am quite correct on that.

We always talk about budget cuts. It is cuts from some imaginery line. But as a matter of fact, what we really ought to focus on is how much has actually been paid under Part B, and that has more than doubled. And so the taxpayer could take the view that we have been actually fairly generous on that account because GNP in that period went up, I believe, 38 percent, but Part B doubled.

Now the question is, how is that amount of money to be shared among the 500,000 American physicians that are out there? And the notion is that perhaps some specialists who do certain procedures more frequently have received much more of that than certain specialists that perform more primary care procedures. And none of the approaches that one might pick to redress that balance to pay rural physicians more or to pay certain primary care physicians more can be done unless you take it away from somewhere else within that Part, unless you want to go to the taxpayer and say, pay even more than what is paid.

And it seems to me what we are looking for here is a method that is perfect, and there will be none. I do not think this method that was proposed is going to be any more perfect than the method that was recommended by the Commission. The Commission does not argue that this is fault-free, but my sense would be it is less

faulty than going by a State by State method. But it is a pipe dream to assume that we can do this without being inequitable to someone.

Senator CHAFEE. Well I will give you one last shot, Doctor, if you want it. This could go on back and forth for quite a while.

Dr. EBERT. I just would only comment that if there are certain areas that are procedures—office visits, rural physicians, or whatever—they certainly could be carved out of the package. And I don't have any objection to that. Where our objection is that this is a rather arbitrary selection of a small number of procedures. And the overpricing concept has somehow been present and recommended.

Why not say that if procedures are overpriced versus nonprocedural physicians, why not take a wider breadth of the procedures and do 256 of them instead of nine?

Senator CHAFEE. All right. We might be back in touch with both of you on this.

Thank you very much for coming. All of you have been very helpful and we appreciate it. Thank you. That concludes the hearing.

[Whereupon, at 12:25 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

AMERICAN COLLEGE OF GASTROENTEROLOGY
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Mr. Chairman and Members of the Committee, I am Dr. Edwin Cohn, a practicing gastroenterologist, and Chairman of the National Affairs Committee of the American College of Gastroenterology (ACG). ACG represents approximately 2,200 specialists throughout the country.

Of primary importance to our organization is providing the best care available to our patients. A great percentage of our patients are elderly individuals who are beneficiaries of the Medicare program.

The most significant point I wish to make is that we in health care, and health policy should constantly remind ourselves that beneficiaries of the Medicare program deserve to be extended every health care opportunity that is available to insure their good health and longevity. So, as we deliberate options for budget reconciliation through savings in the Medicare program, it is vital to remember that this is not just a numbers game. Medicare policy translates into health care policy. Significant cost cutting in the Medicare program has every reason to translate into reduced quality of care for Medicare beneficiaries. There is no justification anywhere to permit Medicare to become a second class benefit to our nations aged population. ACG certainly does not think of elderly Americans as second class citizens.

The American College of Gastroenterology does not endorse any cuts in the Medicare program. In recent years, Congress and the Health Care Financing Administration have made significant reductions already through changes in policy and trimming of payments. Yet we recognize the inevitability of budget

reconciliation will yield some recommendations from Congress in the form of Medicare cuts.

The Physician Payment Review Commission outlined several options for our comments. During a hearing in May, the American College of Gastroenterology responded to these options. The second option proposes an "inherent reasonableness" plan that would establish a uniform percentage reduction for a number of procedures regarded as outliers. Diagnostic colonoscopy is listed as one of the outliers. ACG questions the criteria used to determine diagnostic colonoscopy as an outlier, subject to reduction in payment. As well we find it difficult to find the common denominator that singles out a number of the procedures listed, unless volume of procedures is a consideration.

Diagnostic colonoscopy is utilized by specialists as a tool for detection of serious gastrointestinal disease and for many precursors to serious digestive aliments. Technology in recent years has improved this procedure to a point where an endoscopic specialist can more readily observe signs of disease at an early stage, or detect percursor signals such as polyps in the colon. Because of this advanced technology, as well, the need to perform more costly exploratory surgery is diminished significantly, thus producing a net savings to the Medicare program. Utilization of this enhanced diagnostic and therapeutic capability has increased recently, but at a demonstratable savings, and as an improved health care resource for our elderly patients. The best method of dealing with gastrointestinal disease is through early screening and detection.

So, while utilization of this pr·edure may be up, the American College of Gastroenterology .ieves a major component of this increase is attributable to improved patient care. Peer review mechanisms are in place throughout the Medicare system to

prevent over-utilization of a procedure, or inappropriate use of a procedure. Specialty societies in endoscopy have developed standards for the appropriate use of endoscopy, and when followed, insure that unnecessary procedures do not occur. Singling out diagnostic colonoscopy arbitrarily because utilization has increased does not make sense. Further, assigning it as an "outlier" is confusing because it does not appear that there is sufficient data to support this catch all term. The Health Care Financing Administration is currently conducting an inherent reasonableness analysis under a specific charge from Congress (and apparently has preliminarily stated that colonoscopy was not over-reimbursed). It would seem inconsistent for Congress to suggest a drop in payment while HCFA is still studying the question. We respectfully request that you reject this option and save judgement on specific procedures until more is known to substantiate these unjust, arbitrary outlier designations.

If in fact it is necessary to recommend cuts, the ACG urges Congress to deal with costs savings through improvement in various administrative items. For example, Medicare and insurance fraud are estimated at $1 million per day. A significant savings could be achieved through elimination of these revenue draining fraud cases.

Certainly while Congress, PhysPRC and HCFA is gathering information and data to best recommend physician pay reform, the least prudent choice would be to single out specific procedures and make a blanket cut. The American College of Gastroenterology does not endorse the idea of an adjustment in the Medicare Economic Index, or an overall percentage freeze in fees for service. Nor does ACG endorse proposals that would reduce payments for new physicians. However, given the current budget stituation, these may be the least painful approaches to a

short-term savings while PhysPRC and HCFA consider well-thought out, viable options.

The American College of Gastroenterology recognizes the tough choices that face you in the coming months. If, in any way we can assist you in carrying out your mission, we offer our expertise.

Thank you for the opportunity to present our views.

STATEMENT

of the

AMERICAN COLLEGE OF PHYSICIANS

Submitted to the

COMMITTEE ON FINANCE

UNITED STATES SENATE

July 9, 1987

The American College of Physicians (ACP) is pleased to have this opportunity to submit testimony outlining our priorities concerning Fiscal Year 1988 budget reconciliation issues related to physician payment under the Medicare program and to comment on issues raised by the Physician Payment Review Commission.

The College represents over 65,000 doctors of internal medicine, subspecialists, and physicians-in-training. Our membership includes private practitioners delivering primary health care; medical specialists in such fields as gastroenterology, endocrinology, oncology, and cardiology; medical educators; and researchers. Since its inception in 1915, the College has sought to uphold high standards in medical education, medical practice, and medical research. As payment policies have increasingly affected each of these areas, the College has become extensively involved in issues raised by physician payment policy.

Overview

For several years the American College of Physicians has strongly advocated that short-term budget reductions should be consonant with long-term objectives for reform of the physician payment system. We welcomed Congressional establishment of the Physician Payment Review Commission as an effort to bring careful deliberation and reasoned analysis to an important policy area--namely, how physicians are paid for the services they deliver.

Our recommendations have continued to emphasize the need to achieve both short-term savings and interim reform of the system through policies that:

1) reduce payments for those procedures that are overpriced;

2) raise payments for those essential and necessary services that are underpriced; and

3) eliminate payments for those procedures that are outmoded, ineffective or unnecessary.

It is our view that although extensive research efforts are needed to achieve definitive long-term Medicare payment reform, some steps can be taken promptly to revise the current physician payment system, as we await essential results of ongoing research studies. Such

modifications can provide needed budgetary savings and still be consonant with the goals of overall reform. Accordingly, the College has been pleased with the thoughtful approach reflected in the March 1987 report of the Physician Payment Review Commission. In that report, the Commission set forth an agenda for long-term physician payment reform that we hope will lead to needed improvements in the current payment system and will result in correction of payment inequities that are inherent in the current payment system.

Selected Reductions in Overpriced Services

An option for short-term budget savings proposed by the Physician Payment Review Commission is that of selective reductions in medical and surgical procedures for which current Medicare payments are excessive. The Commission showed that Medicare payments for some medical and surgical procedures are artificially high, compared to payments made under other reimbursement schemes. At the same time, Medicare payments for certain services are well below what other payers consider to be reasonable levels. These disparities have arisen in part because the payment methodology based on customary, reasonable and prevailing charges has tended to lock into place the relative pricing patterns that were in existence at the inception of the Medicare program, paying highly for technological and procedural services and underpaying (or not covering) non-procedural services such as physical examinations, patient history taking, diagnostic evaluations, and patient counseling and education.

Further disparities have occurred because Medicare has lacked the ability to adjust prices in accordance with changes in availability and costs of services. Thus, when a new, highly sophisticated technological procedure is developed, charges may initially be extremely high, reflecting developmental costs and availability from only a relatively few physicians and surgeons possessing requisite skills and training. As relevant medical and scientific knowledge is disseminated, medical skills advance, the procedure becomes more commonplace, and efficiencies in utilization are achieved, price reductions should occur. However, the current payment system, which reflects historical prices, and the medical marketplace, which is relatively insensitive to competitive forces, tend to perpetuate payments for procedural services at the initial excessively high levels.

One method to correct for these market distortions and to achieve short-term budget savings is to adjust Medicare payments on the basis of inherent reasonableness. We believe that limiting payments for those procedures that have become overpriced is a more preferable means of obtaining budget savings than imposition of arbitrary, across-the-board reductions. Furthermore, we believe it is an appropriate goal of Medicare to establish a process for reducing excessive payments for specific Medicare services. Consequently, the College has been supportive of recent regulatory efforts to better define "inherent reasonableness" and to adjust Medicare payments accordingly.

The College has also been supportive of the Physician Payment Review Commission in its efforts to develop a relative value system for Medicare and in its efforts to identify medical and surgical procedures that are overpriced. The Commission has now developed a methodology for comparing payments under Medicare with those under systems that are based on objective determinations of relative values. While these findings are preliminary and only apply to a limited number of procedures, we believe that this is an important interim step in developing a fairer and more objectively determined payment system. We would reiterate our support for using this approach to identify budget savings for the coming fiscal year.

Adjustments for Underpriced Services

In recent testimony before the Physician Payment Review Commission, we expressed our opposition to contemplated across-the-board reductions in the Medicare Economic Index (MEI) update that would apply equally to underpaid services as well as to those that are now overpaid. We urged--and the Commission endorsed this recommendation--that undervalued primary care services be exempt from any cutback in the MEI update.

Congress should set Medicare policy so that payment rules are consistent with steps considered necessary to improve health care for the nation's elderly. The primary care physician plays a critical role in caring for Medicare beneficiaries, as well as in serving as an "entry point" into the wider health care system. Medicare

reimbursement rules, however, have placed an inadequate value on primary care. The Physician Payment Review Commission recognized the underpricing of primary care in its testimony of June 15, 1987, when it expressed concern "that physicians are paid less well for primary care services than for other services, and that this distortion limits beneficiary access to these crucial services and is unfair to those physicians providing such services."

Congress can take a first step towards redressing this imbalance by accepting the recommendation of the Commission that prevailing charges for primary care services (office visits, home visits, nursing home visits) be updated by the full amount of the MEI. If meeting budget targets requires some savings in the overall MEI update, at least this approach will moderate the inequities of an across-the-board cutback. Estimates are that this adjustment would reduce savings by only $30-35 million from an across-the-board MEI freeze, which would otherwise save approximately $230 million.

In addition to encouraging access to primary care services in this manner, Congress should fashion Medicare payments to achieve other goals it considers desirable. A portion of savings could be used to take initial steps towards improved access and more complete coverage. For example, reimbursement could be increased for services provided in an underserved area, as proposed by the Physician Payment Review Commission.

A second area that demands attention is Medicare coverage for preventive health services. We suggest that the Congress begin to consider improving coverage for preventive health measures by first examining those areas where the recommendations of the Public Health Service are inconsistent with the coverage policy of Medicare. For example, the Center for Disease Control endorses influenza vaccination and mammography as effective preventive care, but Medicare does not provide reimbursement for these services. Services such as geriatric assessments and patient counselling and education are highly cost-effective and hold the promise of paying for themselves through reduced acute care expenditures, but again Medicare does not provide coverage for its beneficiaries.

The College believes that Medicare as well as other purchasers of health care services should provide adequate and equitable payment for appropriately rendered services. The College believes that it is extremely important, especially in these times of budgetary deficits and economic constraints, to assure that appropriate health care services of good quality are provided safely and effectively and to focus cost-reduction efforts on services that are overpriced, unnecessary, ineffective or inappropriate.

The College's overall approach to payment system reform has been guided by several principles that we believe are needed for a clinically-effective reimbursement system:

- First, the goal of the payment system should be to pay appropriately for effective services.

- Second, it should not perpetuate incentives for excessive, inappropriate, or ineffective care.

- Third, it should be based, to the extent possible, on objective, quantifiable data, rather than on historical or normative charges, opinions, or anecdotes.

- Fourth, it should be flexible enough to foster effective innovation and to be modified in the face of valid changes in medical practice.

- Fifth, it should take the patient into account.

For these reasons, the College believes that long-term reform of the service-based reimbursement system are needed. We are hopeful that work by the Physician Payment Review Commission on developing relative value scales will lead to a more equitable payment system. We are also encouraged that modifications based on resource use, that take into account the effectiveness of the service and the outcome of the patient, are being considered.

For the short-term, if choices have to be made to achieve budgetary target savings, we prefer that the savings be achieved by limiting payments that are determined to be inherently unreasonable. We believe

that this is fully consistent with short-term budget needs and the need for long-term Medicare payment reform. Secondly, we believe that a stage has been reached where some relief is needed for certain clearly underpriced services and services in certain settings. Relief is needed now as an interim step, as we await long-term reform of the payment system. Lastly, we oppose across-the-board reductions in Medicare adjustments to allowable prevailing charges, except to the extent that savings from such reductions are used to correct some of the historical inequities that have led to underpayments for primary care services.

In closing, we would note that the American College of Physicians has for many years led the way in developing sound data to eliminate unneeded and inappropriate medical services. The activities of our Clinical Efficacy Assessment Project in determining the medical necessity and clinical efficacy of various medical tests and treatments are unprecedented among medical organizations and have helped to set the standard for technology assessment. Through our medical education activities we seek to continually advance the profession's understanding of what is and is not known about the usefulness of various clinical approaches.

Our recent, widely publicized work with the Blue Cross and Blue Shield Association in developing guidelines for the use of common diagnostic tests was one more effort in this long history. The Blue Cross and Blue Shield Association has indicated that it believes implementation of the guidelines will result in significant patient care savings and

improved quality of care. But at the same time that the College works towards enhancing quality and cost-effectiveness of care by applying rigorous scientific standards that potentially may result in payment denials for some services, we must also argue forcefully for some redress for those services that are very much needed and which therefore should be appropriately reimbursed.

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ECONOMIC POINTS TO BE CONSIDERED IN REGARDS TO AMERICAN HEALTH FINANCE AND INSURANCE, PARTICULARLY THE MEDICARE AND MEDICAID PROGRAMS.

"Today we spend apprximately $1892/year for health care for every man, woman, and child. We spend two to three times on average that for the retired. A child born in 1985 can expect, at a minimum, a total health bill of $134.000 in his/her lifetime. Since 1965 in avoiding National Health Insurance we have had a doubling of of 'real' national health expenditures. At what point are you going to 'throw in the towel' and get out of health care provision?"

Questioner from Audience to Business Panel, Secretary's Conference on Retiree Health, June 26, 1987

In 1965, after twenty years of debate, Medicare Parts A & B (dealing with health insurance for the disabled and over 65) and Medicaid (dealing with health insurance for the impoverished) was established for the nation at the same time. A review of U. S. health expenditures since that time with comparisons to other nations' health expenditures should be reviewed. Average yearly health expenditure growth for the U. S. since 1960 has been .22% of U. S. Gross - National Produce (GNP) annually or 2.2% per decade. In the developed world (OECD) the growth has been .14% of their average weighted GNP annually, or 1.4% per decade. U. S. growth has been approximately 157% of the average for the other developed nations of the world. In addition to growing faster, U.S. health outlay was higher to begin with, being 129% of the OECD average at the beginning of the baseline comparison, 1960. Experts agree that U.S, health care has grown more rapidly and from a higher base than any other developed economy in the world. At present the expenditure is approximately $458 billion (1985), or something like $1892 per year for every man woman and child in the nation. What has accounted for this economic event?

The table below gives some indication.

SELECTED INTERNATIONAL COMPARISONS:
HEALTH EXPENDITURES/GROSS NATIONAL PRODUCT

	U. S.	OECD	CANADA	U. K.
1960	5.3%	4.1%	5.5%	3.9%
1965	6.1%	4.7%	6.1%	4.2%
1970	7.6%	5.6%	7.2%	4.5%
1975	8.6%	6.7%	7.4%	5.5%
1980	9.5%	6.7%	7.4%	5.5%
1985	10.9%	7.6%	8.6%	6.2%
RATIOS				
1985/1960	104%	85.3%	56.4%	36.2%
1985/1965	77%	62%	41%	48%

(OECD represents GNP weighted average of 21 developed economies)

FOUR ESTIMATES OF U. S. HEALTH EXPENDITURES
THRU 2035 (percent GNP)

	MIN	HISTORIC MAX		AVERAGE (MIN-MAX-HIST)
1995	11.9	13.0	13.2	12.7
2005	13.0	15.2	15.5	14.6
2015	14.1	17.4	20.0	17.2
2025	15.2	19.6	24.7	19.8
2035	16.3	21.8	30.4	22.8
Delta (GNP)	1.1/dec	2.2/dec	3.9/dec	2.4/dec

The question presented the American health economist and legislator is: What is the expectation for health expenditure growth in the U. S. economy for the next several decades under different legislative and economic scenarios? Arithmetically it could be concluded from trend line analysis that, absent any major policy change, the growth of health care expenditures as a percentage of GNP would be 2.2% per decade. In other words, the period 1985 - 1995 would go from 10.8% GNP to 13.0% GNP; THE period 1995 - 2005 would go from 13.0% GNP to 15.2% and so on .

MINIMAL INCREASE POSSLBE/LIKELY

I would like to address the concept of the minimal increase that can be actuarilly forecast for health expenditures, assuming the present pluralistic health care system continues in form and style substantially as it exists today. At least five major health factors exist today to raise the proportion of national product spent on health care; there is one major unknow to be considered, and there are three economic/ social factors that will drive government policy and limit governmental options in all areas of expenditure . Factors that must be considered individually are: (1) an increased supply of physicians graduating from medical schools, raising the total number of practitioners to a projected 630,000 in 2035; (2) the ageing of the population, independent of the increase in the numbers of aged; (3) an increased number of aged beginning in 2011 due to the birth of 74 million "baby boomers" between 1946 and 1965; (4) technological improvements in the diagnosis, management and administration of health care and services to include the increase and diffusion of all levels of technology; and (5) the normal growth of population due to immigration, births in excess of deaths, etc.

An unknown factor of significant proportions in 1987 is the appearance of the Acquired Immunodeficiency Syndrome (AIDS) which is currently expected to affect 1.5 million Americans by 1991 and cost approximately $75,000- 100,000 per case/year according to the recent Institute of Medicine Report.

Three economic factors that limit local, state and national government options is the large unfunded pension liability particularly before state and local employees, and Federal Civil Servants and retired military. Although previously addressed, social security funds are by no means certain for the retirees of the year 2011 and beyond. Second, because of large & continuing trade deficits it appears that the U. S. will have a substantial foreign debt to service throughout the early 1990's and beyond. Finally, debt service on the $2.5 - 4.0 trillion national debt will continue to be a constraint on other governmental functions depending somewhat on interest rates and the societal propensities to save and to be taxed. Not included in this

assessment are such factors as the increased participation and specialization of other health professionals; unexpected breakthroughs in the management or treatment of disease groups; or the possibility of a major war and its consequences.

PHYSICIAN SUPPLY: PROJECTIONS

The first of these factors is the supply of physicians. In Canada, sixteen (16) medical schools have an enrollment of 7350 with approximately 1837 students being graduated annually. In the U. S. 127 medical schools have 66,604 students with 16,661 students graduating annually. This is approximately an 89% increase over twenty years in Canada, and a 102% increase in the U. S.. Each medical school has larger classes graduating and there are forty plus new schools since 1965. It is possible to imagine a small future decrease in class size at the 143 school in the U. S. and Canada, and perhaps a handful of marginal schools might close because of location or absence of funds for rennovation and rehabilitation of physical plant. However, students of public policy, human nature and academic medicine would be skeptical about any wholesale reduction in programs or in any resulting decrease in number of medical school graduates. Put another way, the class of 1946 is retiring from the active practice shortly, and they are being replaced by the class of 1986. Since the class of 1986 is substantially larger than the class of 1946, what will be the economic impact of their entry over the next forty to fifty years? When this question is addressed, the cumulative impact of the classes entering since 1966 and those classes expected to enter after 1986 should be analyzed for economic impact by economists, actuaries and statisticians.

The organized medical profession today consists of 460,000 active practitioners in more than 200,000 predominantly small entities, each generally behaving as a small business. There are 128,000 primary care practitioners, alone. This group of individuals and small businesses are represented very effectively by one of the strongest trade group/professional unions known on the American political scene, the American Medical Association (AMA) and its state, county and affiliated bodies. The market has exterted only minimal force on the organization and remuneration of physicians, this is not expected to change significantly. Physicians are substantially able to generate and control their own demand.

It is my rough calculation that the increase of active physicians from 460,000 in 1985 to 635,000 in 2035 will result in a yearly increase of one billion dollars in health expenditures for each two thousand physicians added to the system. This is an increase that is linear and begins at $1.75 billion in 1985 and ends at $88 billion in 2035. The cumulative addition would be approximately $2.23 trillion to the health care budget over fifty years. It is vital to remember that physicians, in addition to being paid on average $113,000 per year, order referrals, services, tests, procedures and hospitalization. It is a rough estimate that a physician accounts for approximately $500,000 annually in total health services ordered on behalf of clients and beneficiaries. Epidemiologists, manpower and health economists, and health actuaries should examine this concept in detail and depth to develop sensible and realistic figures. One sobering factor that must be weighed is that there has been a substantial increase in the numbers of practicing physicians in the U. S. since 1965, and physicians income has risen regularly in both absolute and in real terms except for a brief period in 1974 and 1980. The ration of physicians to population has increased constantly since World War II.

The second factor causing an increase in American health expenditures is the aging of the population. There are more very old, those aged 75+, than any previous time. It is expected that in absolute numbers thoe over 85 will increase by several hundred percent in the coming decades. We will have more than a million over 85 and more than a hundred thousand older than 100. The aged are predominately female and have been, are, and probably will be in the lower rungs of the economic ladder. Although the absolute numbers of the very old will not be a large percentage of the total population, the absolute increase will have an economic impact on health services costs and distribution.

It is more expensive to treat a long term degenerative disease than it is to treat an acute myocardial infarct. It is more expensive to successfully treat cancer and then five years later to treat a reoccurence. It is strange, but total lifetime health expenditures are higher for fit, healthy people. Previuously nothing was really done for "galloping consumption" and the afflicted died rather inexpensively.

The management of neo-nates is similar. Three to seven percent of births have significant medical problems. Today it is possible to save babies delivered at less than 1000 grams but at a cost than can run to hundreds of thousands of dollars in care, and care that is often not covered by insurance. Throughout the the health system simple and relatively inexpensive deaths have been replaced through heroic intervention with extensions of life and expiration much later, but at much greater total lifetime health costs. Further, as the aged live longer, the variety of complications and co-morbidities managed or palliated becomes more extensive and more expensive.

No mention has been made to such heroic efforts as organ transplants and mechanical replacements. The issues raised by the End Stage Renal Disease (ESRD) program is but the first chapter of increased costs due to the diffusion of an experimental set of technologies based on chemical management and transplantation. The cost per year of the program is in excess of one billion for approximately 80,000 beneficieries, and the cost per year of life is in excess of $50,000 per beneficiary year. A national AIDS entitlement program will likely follow, costing billions annually.

The third factor to be considered, especially in planning for health care expenditures after the year 2011, is the 74 million Americans that will reach retirement age for two decades until 2031. This is the largest cohort born in 20 years in American experience. This group has moved through the schools, colleges and workforce with an outline that is compared to "the pig moving through the python". Its outline is evident to any that look. The major problem is that there is not a concommitant number of offspring expected in the economy to support the "baby boomer" health and retirment costs. In the 1930's 9 workers supported each retiree; in the 1950's, 6; and in the 1970's, 5. In the next centgrury the ration will go to two and a half or three to one.

Any adjustment to the health system today should address the husbanding for resources to provide for the health and retirement expenditures of this unusually large group. Perhaps special Medicare, Medicaid, Social Security and General Pension funds or programs should be encouraged thorough legislative enactments. It is possible that intergenerational tensions will peak when the "baby boomers" use a very large share of the national product for health and pension benefits and there are not sufficient resources in the American economy to meet the needs and wants of the balance of the population. A worst case scenario taking account health, retirement, debt service, international debt

service is truly cataclysmic. In this problem it is important to remember that one Congress of the United States cannot bind a succeeding Congress, and thus the "baby boomers" are currently anxious, and the real prospect of a renunciation of present health and pension programs exists.

It could be argued that it is the current high earning and production efforts of the "baby boomers" that allow for generous treatment of those now retired or disabled. It need not be a problem that is faced only in 2011 and thereafter. It is a problem that could be addressed immediately and certainly when the Medicare program is restructured in the mid to late 1990's. It could be argued that the "baby boomers" is going to pay the health and retirement benefits of this decade and the next, but that shortly after 2011 the succeeding workers in society will substantially modify, reduce, or renounce their "social contract" obligations to this cohort.

It is possible to construct a scenario where this is the only viable alternative for the society. It is difficult in a capitalistic society that is democratic and pluralistic to plan rationally for the impact that such a segment of the population will surely bring. It is not difficult to imagine the relative unavailability of nursing home beds, home care services, hospital space, hospice beds, and price escalation that such situations engender in a capitalistic society. One might send children to school on a split double daily shift with fifty students per teacher, but double shifting as nursing home is a different matter. It is possible for the health analyst and policy maker to imagine aged poverty, and health care neglect on a scale never before experienced in America. It is an obligation of all health policy makers: legislators, administrators, insurors, beneficiaries, providers and economists and actuaries to prepare for the arrival of this large population cohort. A necessary adjustment must be a slowing of health expenditure now, rather than a severe breakdown on health budgets later. Let us also start examinations of specific disease management in other cultures, particularly Japan, Canada and to a lesser extent Western European Nations.

The fourth factor concerning technological improvements such as artificial joints and joint procedures, computer assisted tomography, magnetic resonance imaging, positron emission tomography, lythotripsy, etc., etc., etc. will have their own impact on the increase in health expenditures. Each technology is expected to have its own incremental addition or subtraction from the total cost of health care. It appears that the diffusion of small technological changes such as exemplified in the past by the use of unit dose pharmecuticals and disposable operating room supplies and linens may have as large an impact as do the "major" developments noted in the medical press. Knowledgible analysts indicate that their best guess on cost impact of technology has been between 20 - 30% of the increase in medical costs since 1965.

Rather than attempt to tabulate the costs associated with each technological change, it would be wiser and more practical to focus on the fact that these devices, medicines, and supplies are produced by forprofit corporate entities whose fiduciary duty to stockholders is to maximize long term stock value. It is also wise to acknowledge that these large and mid-sized corporations are familiar with the political leverage points in any government, and especially intimately familiar with the Washington lobbying process. As entities with fiduciary duties to stockholders, it must be expected that they will aggressively promote the sale of their products and services throughout the U.S. health economy, and throughout the world health economy as well.

When technology is considered, two claims should be investigated.

One is that between one quarter and one third of all American diagnostic and therapeutic procedures have no value. Second, it has been acknowledged that thirty percent of the health care dollar now spent in the last year of life often "exquisitely measures death". This policy might be moderated by governmental policy fostering changes in societal expectations, and with an amelioration of malpractice and defensive medicine problems. To expect wholesale change in long term history and experience flies in the face of reality. The multinationals in health care will continue to encourage demand, and will continue to maximize profit from the technologies, services and products developed.

Health insurors and investor owned inpatient, outpatient and ambulatory facilities impacts on costs of health services over the next several decades is unclear. Perhaps the most clearly defined problem is that corporations owned by stockholders and investors have a fiduciary duty to their owners to maximize long term profit, and that they are less likely to cost shift from one group of health beneficiaries to another, and they are likely to have a long term strategy for profit optimization. It is possible that the for "profit health" sector is more efficient and better in the utilization of health resources than the non-profit voluntary systems. It is also possible to imagine segements of the for profit sector "skimming" to maximize profit from various affluent segments of the health economy that previously subsidized the less profitable. No one really knows how forprofit and non-profit sectors of the health economy compare.

It is plain, however, that in most sectors of the health economy the beneficiaries choices are constrained either by geography, experience, policy or nature. Physicians have admitting priveleges at a limited number of facilities, usually three or fewer. Patients are limited by geographic location to hospitals and clinics in that region and that usually means a handful of primary care facilities, one public institution, and a tertiary medical center within 200 miles.

As for health insurance, it is wise to remember, as a founder of the social security system told me years ago, "Insurance companies are in business to collect money and invest it, not to pay claims." If Blue Cross and Blue Shield Associations were to completely lose their anti-trust immunity, some incremental gains in system costs would be passed to the beneficiaries. The existence of 400 health insurors, 50 state medicaid programs, and a multitude of fiscal intermediaries, peer review organizations, plus a dozen or so governmental health programs does not make for administrative efficiency. Experts have calculated that at least $29 billion have been spent annually on health care administrative costs that might have been avoided by a more streamlined and compact administrative system.

The final factors causing increases in economy-wide health care expenditures beyond the present 10.9 of GNP or $458 billion (1985) dollars can be related to: (1) natural increase in population due to net immigration and normal birth/death rations (2) legalization of up to seven (7) million illegal immigrants already within the U. S. and (3) high medical costs for care of high risk children in various minority groups. An illegitimacy rate of 50+% for Black and 40+% for Hispanic Americans goes beyond the immediate costs of neo-natology units, but to higher health expenditures throughout the life of the mother and the child/children born under such circumstances. These children traditionally use more health care services than do other more traditional arrangements where fewer birth, psychological, and physiological complications are encountered. (4) AIDS has been mentioned, and it is unclear whether this will be a problem that costs four - five billion dollars pey year for a number of years, or whether it is a major epidemic that could cost hundreds of billions for treatment, education, and research. Present ranges

indicate that New York City alone expects to devote a billion dollars per year to the issue, and the Institute of Medicine projects that by 1991 the annual cost will be in the $8 - 16 billion annual range for health, alone. No one expects the health sector to grow less rapidly than the real growth of national product.

Three non-health economic factors must be examined because they limit local, state and federal government's range of options and ability to respond to increased demands for health resources. (1) Pension liabilities in local, state, and Federal Government for military and civil service retirees and current employees are currently largely unfunded. The recent problems of the Pension Benefit Guaranty System highlight how badly the private sector is prepared to handle the pension rights of it's retirees. Steel industry claims alone are approximately 300 percent of the yearly fund revenues. It is obvious to all that have examined the pension problem that huge unfunded liabilities will have to be met or defaulted on by business, local, state and federal government. This problem tends to coincide with the health care shortfalls. (2) International debt obligations in the range of $500 billion to $2 trillion will need to be serviced because of trade problems with the rest of the world. The experts concur in the belief that the yearly current accounts deficit in excess of $150 billion in 1986 will not quickly recede, much less reverse itself. This debt must be serviced at the international market lending rate and this outflow further reduces economy wide options for other resource allocations, as well as a further drain on savings. (3) A national debt at $2.3 trillion dollars currently requires in excess of $125 billion annually to service interest charges, alone. No one can see the debt being realistically reduced, and one can expect the $3 trillion mark being passed by 1995 or during the next economic downturn, whichever comes earlier. (4) Finally, no one expects the proportion of GNP devoted to national defense to significantly decline from the 6 - 8% of GNP , nor does anyone have realistic expectations for reduction in national education, housing, agriculture, airport, and smaller regulatory and infrastructure programs.

The real concern is not the next decade, which will have its own problems, but rather the decades beyond 2011 when the confluence of the factors discussed here are realized. All these would be manageable were there normal populations in the workforce to provide the foundation funding, but this appears impossible at this time.

The supporting workforce is already largely present and their numbers do not appear sufficient to support an increasingly larger portion of gross national product devoted to health, pensions, national defense, international debt service and governmental debt service as well as the basic governmental and infrastructure programs.

If a worse case scenario is considered, it is possible to project in excess of 17% of national product being devoted to health by the year 2005. Even a best case scenario, where the historic rate of health care cost increases was half its historical twenty year rate, one would expect that the proportion of national product devoted to health would increase by 1.1% of national product per decade. This would bring the 2005 best case of 13.0% Translated into real numbers, best case, this means in 1996 $504 billion would be expended on health in 1985 dollars, and in 2005 approximately $550 billion 1985 dollars would be spent annually. If one extrapolates the dollars spent today on federal health programs, assuming no major programatic changes, this would mean that Medicare A would receive approximatley 16% of that increase; Medicare B, approximately 8.5% of the increase; and Medicaid approximately 7.9% of the increase.

In total the Federal share of the health dollar has been about 29% of total health expenditures, the states represent approximately 12%, and the total Federal and State share is about 41% of the health care dollar. Sometime, a calculation of tax expenditures, employer administrative expense for Federal health program, and insurance loading costs associated should be tabulated.

POLICY DECISIONS: PRESENT TO 2000

The decisions between today and the expected depletion of the Medicare trust funds are: (1) Do we want to continue the present pluralistic health system or do we want to adopt/accept another model? (2) Do we want to patch and "retread" the present system with mandatory employer insurance coverages? voucher systems? rates with extensive regulations, severity, and exceptions? extensive peer review and quality control programs? state insurance pools for the "presently unisurable"? all of the above? etc. etc. ect..

Preliminary calculations show that health expenditures in excess of 15% national product are not sustainable for long periods for the American economy in the situation that it presently finds itself. Health expenditures, particularly for the elderly, must be considered "consumption" as opposed to "investment". It is clear that the combination of 15% spent on health; 6 - 8% spent on national defense programs; debt service on three trillion dollar national debt; and foreign interest service on accumulations of international debt must put the economy at a disadvantage with other industrial nations and with some advanced developing economies. Of the four or five categories listed above, the only ones really susceptible to reduction by policy changes are health and defense, and if health and defense were to be reduced proportionately, health would need to take two-thirds of the proportionate reduction.

Put another way, it cannot escape the economist that U. S. health costs, as in automobile manufacturing, are higher on a comparative basis than the total hourly costs in countries such as Mexico, Korea, and Taiwan. In Mexico and Korea, hourly wages in 1985 were as low as $.72/hour in Mexico, and $1.90/hour in Korea.

The Canadian example offers some advantages for a U. S. comparison because of cultural and language similarities. Appendix A shows the selected statistics for comparison. Also it is not quite as "socialistic" as many European health systems. The adoption of a Canadian system results in two major items for health cost savings. The first is the reduction of financial and budget associated paper flows between providers, beneficiaries and the intermediaries and the payor, savings from which are estimated to be at least $29 billion per year. The U. S. network of Blue Cross and Blue Shield Associations; Fiscal Intermediaries of the Governmental programs; 50 state Medicaid Programs; Indian, Military, and other government health programs; 400 plus health insurance companies; plus an assortment of Health Maintenance Organizations, Preferred Provider Organizations, etc. is an "boulibasse". Further, the U. S. preoccupation with malpractice and "defensive medicine" is estimated to cost more than 15% of the total expended, and one has heard estimates as high as 50% of hospital costs being tied to "defensive medicine".

The problem with adopting a "Canadian" style system is that the insurance companies and many others make money from the present system, with the excess costs being passed on to the payors: be they the employer, the government, the taxpayer, the

beneficiary, or the indemnity insuror. Vested interests also benefit from the continuation of the present tort/malpractice arrangements. Reasonable analysis would show that if we, tomorrow, were willing and did adopt a "Canadian" style national health insurance system with one government insuror and one set of policies and procedures, we would have hundreds of thousands of mid and lowerlevel administrative workers with no real function located throughout the health system -- in doctors offices, in hospitals & clinics; at insurance offices and in insurance companies, at data processors, and in government. No one knows what the bulk of these claims and information transfer personnel contribute to health care of the beneficiary, but one does know that $29 billion annually probably pays for something like a million workers. A million workers who could productively be used elsewhere, though retraining and dislocation program costs would be substantial.

PROSPECTIVE PAYMENT -- DIAGNOSIS RELATED GROUPS

This recent effort, that of prospective pricing in Medicare Part A and some state Medicaid and nursing home, and a handful of "all payor" hospital programs, has a mixed history . After an initial "notch" of reduction and rationalization of the health service process. The rate of increase in health care costs charged to the government appears to continue at a rate substantially higher than the comsumer price index, or even the more generous medical economic index. No severity of illness index has been installed across the nation to discriminate between levels of complexity and intensity of resource use.

The Peer Review Program (PRO) established almost simultaneoulsy has been lagging due to a variety of regulatory, budgetary, and political complications. It does not appear that the political will to do the deep and complete analysis that would be required for a true "product line management" system; to develop, implement, and enforce Peer Review Standards of a National PRO progam that would eliminate or reduce much of the malpractice potential.

It appears that the inclusion of hospital based physicians in radiology, anesthesiology, and pathology in the PPS/DRG system is years away, if ever, and that the regional and geographic variations of medical practice and cost are very difficult problems for a capitilistic political system to address.

It appears that the medical communities major players: the Medical, Nursing, Hospital, Medical Education, Equipment Suppliers, and Insurors insist on the application of constituency power to block or slow changes to a more efficient system. If the major players insist on a perpetuation of the present system , a rate of health care costs increases that is half of the historic rate of increase for the past twenty years is not achievable.

PEER REVIEW, UTILIZATION REVIEW AND QUALITY ISSUES.

Peer Review issues are intimately tied to health care economic, policy and philosophy issues: (1) product line protocols will eventually be defined on state, regional, national and eventually international levels, at least among the advanced developed nations. (2) the division between "art" and "science" in medicine will be more clearly delineated, with the result that the missing "theory of medicine" will become more and more systemically defined. (3) peer review must be available to counterbalance the

tendency of a prospective payment system to discharge earlier and treat less aggressively. (4) Finally, the functions of reduction of variations in medical practice and incidence of questionable medical actions are natural roles of this process. Peer review can be expected to increase in budget terms as more and more payers of different stripe and persuasion undertake the examination of the details of medical management. Currently, the PRO budget for Medicare A is approximately $154 million per year, with approvals suggested for an increase of $67 million in the OMB mill, with another $33 million on request. Peer Review requirements mandated by Congressional action signed into law in the various budget reconciliation acts have substantially increased the scope of work in the 53 contracts initially negotiated in 1984 & 85.

An issue that must be focused on is the involvement with, and participation in, the peer review process by the American Medical Association. A second major issue that has not been addressed is the combination of financial data with the medical data, and the development of "longitudinal" analysis of health care on some statistically sound basis. Confidentiality is an issue that keeps coming up. The release of data and its impact on institutions and the privacy rights of individual patients is a concern and a problem for management of health care. It can and has been used as a "straw man" to block progress, analysis, and development of health policy.

QUICKER & SICKER

The quality issue of "quicker and sicker" will be with the system as long as efforts are made to control cost. For twenty years cost reimbursement made for medical and administrative health practices that did not measure benefit in relation to resources employed. Once you begin measuring resources employed and weighing against benefit received, it is inevitable that those individuals receiving fewer services or services in a different setting will complain. For example, if the average acute care length of stay drops from eleven days to seven, what would one expect in either nursing home, home health serice, or visiting nurse service than clients that are not marginally as well, ceteris paribus. It does seem to make sense to shift care to a site where daily cost is lower, rather than the acute care setting where average medicare costs per day exceed $500 nationwide, and $800 in many localities and institutions.

Quality control issues have a potential for better management at individual institutions. The more clearly an institution is aware of its patient mix including the severity of their illness, the better it can plan for long term management of the institution. Put another way, quality control and utilization review internally are part of a product line management system that have historically yielded a return to management from the investment. The gains are not only internal, but also in customer assurance. It would be wise for many providers to move ahead with quality and utilization programs in advance of government mandates just because it is good management, and will assist in problem identification, resolution, managment control, and beneficiary and third party payor confidence. One wonders what an apporpriate level for this activiy might be, but is is certainly larger than the $130 to $250 million currently allocated for such activities by HCFA from the Medicare insurance funds. Experts indicate that 3 - 5% of gross revenue is not uncommon in industry for such purposes. This figure would translate to $13 billion annually in health care. Another problem that has not been addressed is the hidden cost and the difficulty of adequately measuring the resources of all the players in the peer review, quality and utilization review efforts at the different levels. It is safe to say the amounts formally earmarked for such program

are much less than the total resources expended. Efforts to identify total costs of quality and product line management need to begin.

CONCLUDING POINTS: RARELY CONSIDERED

I would like to conclude this paper with three simple items for consideration that are rarely mentioned, though each of us intuitively knows their importance and significance in policy formulation: (1) the distribution of physicians, nurses, and hospitals by congressional district; (2) the implied requirements on a physician and practice to support an average physician income of $113,000 annually, (3) some practical ideas that must be considered in the national debate to modify and restructure American Health Care.

DISTRIBUTION ISSUES: CONGRESSIONAL DISTRICT

If physicians, hospitals and nurses were distributed uniformly across 435 Congressional Districts (and they are not even remotely evenly distributed) the following would be true: aproximately $1.053 billion would be spent for health care in each Congressional District annually for each districts approximately 525,000 inhabitants. This is: $484 million for hospitals; $232 million for physicians services; $94 million for nursing homes; $84 million for drugs; $73 million for dentists; and about $94 million for miscellaneous NEC than health insurance, education and "tax expenditures". These constituents are served by eleven acute care hospitals and approximately four specialty or government hospitals. Each district has approximately 1,225 physicians, 3218 registerred nurses, 1300 practical or vocational nurses and an assortment of pharmacists, administrators, therapists, and other allied health personnel. There are 3198 counties or independent cities in the U. S., which makes for an average of approximately seven per Congressional District. The average hospital in this hypothetical district has between approximately 100 beds, with 174 physicians on staff due to duplicate staff priveleges. There are 127 medical centers that serve as tertiary care centers across the nation, and these must be described as medical and economic behemoths. Associated with these medical centers are approximately 450 Council of Teaching Hospital Institutions. The important economic and policy point to consider is that the smaller hospitals make up more than 50% of the total number of facilities, but they take account of only 14% of the patient days/revenue. The corollary is true for the medical centers and Council of Teaching Hospital Facilities. They make up about 10% of the institutions but have a much larger proportionate share of both dollar and patient days. The group of facilities represented by the American Association of Medical Colleges are truly the giants of American Medicine. Further, since their staff is often faculty, resident, and highly selected attending physicians, they do not have the problems of physician management that are sometimes associated with the smaller suburban and rural facilities. These institutions also account for the lions share of medical research funds; funds that total $4 - 10 billion annually from Federal, State, philanthropic and foundation sources.

Each constituent has the choice of between one and three hospitals for immediate acute care, and virtually all, by virtue of interstate highway or air medical service, have access to secondary and tertiary care referral centers. Most physicians have admitting priveleges and staff obligations at between one

and six or seven institutions. I suspect, though studies have not been published, that the average physican in private practice has priveleges at two or three institutions in a limited geographic area. Those with more than three staff appointments would be rare. Other than the non-profit voluntary, or the investor owned facilities, each constituent has access on some basis to a public or county hospital. There are approximately 900 county hospitals with 75 of them located in large cities, and the balance in small towns or rural areas. Beneficiaries are restricted in their choice of hospital to (1) those where their physician has admitting and staff priveleges (2) those in their geographic or service areas and (3) to a smaller number of public hospitals and to referral centers. The average physican in private practice has staff priveleges at one or two small hospitals to which he owes primary allegiance. Perhaps he also is allowed to admit to a public hospital,often a hospital of last resort though their staff is often salaried. He is not likely to have a clinical appointment at a tertiary care or teaching hospital.

The point of this discussion is to point out that medicine has some of the qualities associated with a public utility with restraints for the beneficiary on the basis of geography and bureaucratic privelege. A patient cannot go to any physician seeking treatment at any facility. A patient usually goes to the physician that has been treating him/her, and then is referred to the hospital where that physician has priveleges. A beneficiary can make alternative choices, but often at great expense, without guidance, and often requiring the acceptance of a new physician, outside the area of his/her domicile.

PHYSICIAN CHARACTERISTICS

Another factor should be considered when taking into account the relation of beneficiary - physician - hospital - third party payor. Physicians are very talented. Their earnings are in the top percentile; they are in the top social stratum of their society and have always been. They were academically excellent in secondary school, and in college. They have been trained for four years in medical school, and in a residency of three or more years. They see hundreds of sick monthly and thousands in a career, and are rarely at a disadvantage with their clients. The hospital depends on physicians to admit patients, and key players in several hospital departments are often physicians. Physicians network with each other very well.

Insuror's pay claims on the basis of experience, and they are not inclined to "haggle" if the increased cost can be passed to the beneficiarey, government, the employer, or to the insurance purchasor. Altogether it is a system that favors the physician, the institution, the insuror, and does not take into account the wishes of the patient. The patient is generally inarticulate. When the beneficiary has input, it is often transmitted through his physician, and occassionally the hospital.

The dominant player in state and national health policy debates about American Medicine is and has been the physician for at least fifty years. When we look to modification of health policy, it is to the physician that these modifications must primarily be addressed and whose favorable response is critical in any reform. There are exceptions, there are methods by which this is occasionally overcome, but for the average person, in the average place, with the average disease, the physician manages and directs the employment of resources. Why is this? What underlying economic, political, and social realities cause the physicians to be the drivers of the health system?

FACTORS: PHYSICIAN POLICY DOMINANCE

Several important facts follow from the organization of medicine. By "organization" we mean those choices made through time that formed the policy and economic structure within which the medical professions practice. Ours is a pluralistic, free enterprise, mixed capitalistic-socialistic economy governed by a tri-partitate Federal national government in concert with smaller units of government. Much medical and insurance regulation comes from the 50 state governments, and the three big Federal Insurance programs. Remember that 22 cents from each health care dollar goes to physicians. That number itself totals approximately $101 billion in 1985. This is not profit, this is not income, but rather approximately gross physician receipts. Average physician income was calculated to be $113,000 in 1985. This $101 should be compared to $211 billion for hospital, $41 billion for nursing home $ 36 billion for drugs; $32 billion for dentists; and $36 billion for other personnel services & supplies. Omitted from this calculation are funds spent for health insurance administrative expenses; investment in medical education; and costs associated with employer & government insurance administration as well as "tax expenditures" due to the deductibility of employer paid premiums, and other medical tax deductions.

In most settings the physician directly or indirectly dominates the encounter. Physicians are organized in more than 200,000 small businesses, 128,000 in primary care alone. No guarantees are given that any patient or referral will be given today, tomorrow, next week or next year. Physicians depend on each other and the hospital to care for the client beneficiary. The very organization of the network of small businesses insures that changes to a "status quo" that has provided for its members an assured high income is not likely to be undertaken quickly, easily,or without expression and examination of real and imagined problems with a potential for anxiety. It is no surprise, after fifty years of experience, in the present economic situation, to find physicians resisting movements to change and rationalize the practice of medicine. Much physician behavior recalls the "Luddites and the looms" of 18th Century England.

Physicians can't even agree among themselves what appropriate levels of compensation should be between and among their specialty groups, between academics and practices, between practice based and hospital based, between urban and rural, and between "cognitive" and "procedurally" oriented specialties. Couple this with the already experienced expansion in the number of physicians, plus the expectations of 630,000 practicing physicians in the forseeable future and one sees the root of professional intransigence absent any threat of increased Federal presence in medical economic issues. Faced with proposals of major changes on Federal payment programs, the fears and intransigence escalate. Forgotten is the fact that Medicaid and Medicare Part B substantially increased payment to physicians, providing payment for services previously provided without compensation. Twenty percent of gross practice revenue, or something like $35,000 annually, comes from Medicare and Medicaid physician payments. Medicare B payments alone total 24 billion in 1986 and that does not include deductibles, co-payments, and balance billings allowed. The total of $24 billion divided by 460,000 active physicians, yields $52,173 per physician. Someone gets the money!

PRACTICE ECONOMICS: TO SUPPORT 113,000 INCOME

ASSUMPTIONS:

50% NET OFFICE OVERHEAD; 2080 TOTAL SCHEDULED PRACTICE WORK WEEK HOURS; 160 HOURS ANNUAL LEAVE; 88 HOURS NATIONAL HOLIDAY TIME; 96 HOURS AVERAGE SICK LEAVE; ATTENDANCE AT FOUR CONTINUING MEDICAL EDUCATION MEETINGS; BAD DEBTS 15% GROSS BILLING; AND 7% DONATED CHARITY CARE; 40 HOURS ANNUALLY IN HOSPITAL AND PRACTICE STAFF ACTIVITY & MEETINGS.

AVERAGE SOLO PRACTICE PROJECTIONS

Total hours for practice	2080	
Annual leave/vacation		160
Holiday Time		88
Professional Meetings/CME		64
Average Sick Leave		96
Hospital staff & peer review		40
Sub Total	(448)	
Bad Debt (15%)		312
Charity care (7%)		145
	(457)	
Hours	2080	905
Regular revenue hours	1175	

Practice income 50% gross income 226,000
192.34 hour or $48. per quarter hour time increment.

The end result is that approximately 1632 hours of patient contact, with 1175 paid revenue hours, result in the necessity for a charge of $48 per 15 visit/time increment to support income of $113,000 year. for those that actually pay their bills. There is great variation on this theme, but it is not unrealistic, and is employed for exposition purposes only. No account is taken for weekend, after-hours work, procedural income, coverage, and group practice divisions. What is clear is that a physician probably must have a client base in the neighborhood of 1000 to 2000 patients to support 1600 hours of yearly practice experience. One must remember that on the day a practice opens, no patient is assured, and that economic viability is slowly built. Once built, of course, this client base offers both economic, practice and political stability to the practitioner and the profession. Physicians are sure only that people will be born; that they will be sick and injured, and they will ultimately expire. No patients are guaranteed.

POLITICAL PARTICIPATION: PRACTICE & POTENTIAL

Several important consequences flow from the organization of medicine. Most important, with an average income of $113,000 per year, it is possible for physicians and their families to be active in the State and Federal elective campaigns. Imagine the impact of two or three groups of several hundred physicians and their wives contributing $1000 each to the Congressional District primary and general election campaign. With 1225 physicians per district, on average, they can effectively fund a viable challenger in any Congressional District. Though they might not cause their candidate to be elected, or even to be nominated,

let me assure you that the potential of a "war chest" of several hundred thousand dollars certainly gets the attention of the party and of any incumbent. Ten or twenty such challenges around the nation would have measurable policy impacts. It has never been done, but it could be.

The Medical and Dental professions have not exploited this potential to date, but they could. However, their PAC, "In Kind", "soft money" and "independent expenditure"other efforts are not unnoticed. There are many state AMA-PACS and no collective data are readily available. Federal PAC data show that five of the top ten non-affiliated Political Committees are the AMA, the Texas, California, New York Associations and National Dental Group. The average AMA member contribution of $35 has accounted for an accumulation of several million dollars, and the ability to do independent expenditures for selected races to the extent of several hundred thousand dollars.

The potential for political influence in a Congressional district is through contact with the medical beneficiaries being treated. With exposure to between 1000 and 2000 people per year, the 1225 physicians in a given district have effective avenues for the dissemination of their political views not open to other groups. Further in this encounter, the physician's advice, belief and request has more credence and impact than other professional groups. Physicians spend their lives advising people, and learn the techniques of effective advice giving as a part of their professional training. Finally, physicians have been in a variety of leadership and organized committee groups.

They have been exposed to rigorous scientific and social training. They substantially control their own schedule and have a network of referral and professional contacts in any given geographic area. Were physicians to choose to do so, in a decade they could elect dozens of members to Congress, and shortly therafter it would be possible to take over health policy positions. It is the prospect of increased physician political involvement over the past fifty years that has allowed them their preeminent position in the setting of health policy. The prospect of direct, organized, orchestrated long term involvements by physicians in Congressional District Politics is enough to strike fear in the heart of the professional politician.

REFORM: PRINCIPLES & REQUIREMENTS

Some ideas that should be considered in reforming American health care system policy are:

(1) Grandfather economic rights. Assure the physician community that their collective income will not be smaller than it is today, and protect them with an inflation escalator, plus adjustments for population growth and real GNP growth.. This seems generous, but had it been applied since 1965, national health expenditure would have been substantialy lower annually, and the aggregate savings would be several hundred billion dollars for the federal treasury alone. These savings occur not from reduced physician income, but from reduced demand for hospitalization and use of all other medical services.

(2) Change the present system of first dollar coverages, deductibles and co-payments, to one where beneficiaries pay substantially all of his/her family routine and normal expenses up to some indexed annual and lifetime limit. Employ vouchers for the impoverished or elderly, and allow credit to individuals for the unused portion of the yearly credit on some sort of multiple year rolling average. Somewhere we must recognize that economi-

cally the aged are not better off in 1985 than in 1965 when the Medicare/Medicaid program was established. Then approximately 15-20% of aged income was committed to medical care, and in 1985 this proportion was again reached and exceeded. The benefit has been more extensive and intensive service, and perhaps an extension of life expectancy of 3 - 5 years. Many would make causually connect the growth of health expenditure as a proportion from 5.3% to 10.9% GNP as a direct consequence of the establishment of the Medicare/Medicaid Programs.

Perhaps the limit should be $1500 for an individual and $2500 for a family yearly, and 75,000 lifetime before Federal Catastrophic Health Program benefits are triggered. When such a program is constructed, it is possible to include inflation modifiers, rolling average concepts, and life-time expenditure accounts for both payment and benefits employed. If such a program were constructed and employed, the government programs would then pay when limits are reached. For the individuals truly unable to pay, the government could develop a voucher system to pay for services. Perhaps even children could be included in a voucher program, with lifetime accounting to allow for payment of medical services after a given age, such as 25, is attained.

The possibilities are limitless. It should be remembered that individuals could still buy any variety of insurance policies to insure against this first increment of yearly medical services, and lifetime and catastrophic risks. Sometime, it must be remembered and emphasized that if 242 million people spend $458 billion dollars annually for health care, that the $1892 spent annually comes from the society, all its members. The question that must be addressed by policy makers is who is to pay the funds, and who is to receive them, and finally, what can be done to decrease the absolute real level of expenditure.

Absent the ability to decrease the expenditure to minimize the rate of increase over the long term, the present health inflation will continue. The present system is characterized by being the worst of "socialized medicine" and capitalism. It is difficult to visualize a system where more health resources are used; where the rate of increase in payment for those services is faster; or where there is more paper generated in administrative processes. Not only has the proportion of the national pie used for health care doubled in twenty years, but the pie was already much larger than any other in the health care world.

One wonders when the cost spiral will cease, and what will bring its halt. Nothing appears on the economic or policy horizon presently other than the limit of the society to tax and the willingness of employers to pay and a comparison of health program expenditures compared against other programs such as Defense, Education, Housing, Agriculture, and Debt Service. Political realists know that the $1892 spent per person for health care in 1985 will not be reduced, the best that can be hoped for is to slow the rate of increase.

The policy questions for the next several decades will address the question: How is the $1892 and any real increase to be distributed between long term borrowing, employers, taxpayers, and beneficiaries. No one else is going to come forward and volunteer to shoulder the burden. The debate in U. S. health care has really been over who receives how much of the $1892 spent each year for each of us. That fight has little to do with health, and much to do with politics, economics and the exercise of power.

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • TWX 910-221-0300

The Honorable Henry A. Waxman
Chairman
Subcommittee on Health and the
Environment
Committee on Energy & Commerce
U.S. House of Representatives
2415 Rayburn House Office Bldg.
Washington, D.C. 20515

Dear Chairman Waxman:

On behalf of the undersigned organizations, we are writing to request your help in correcting some of the considerable problems and distortions created by Medicare's maximum allowable actual charge (MAAC) limits, mandated by the Omnibus Budget Reconciliation Act of 1986 (OBRA). Since the law was enacted, it has been increasingly apparent that this and other requirements in the law are causing unintended — but nevertheless extensive — inequities and distortions in Medicare's physician payment system. Consequently, the undersigned organizations strongly believe that the MAAC program should be repealed. In the interim, we recognize that some of the inequities in the program could be eliminated through minor modifications.

OBRA established a complex formula for determining how much physicians may charge medicare beneficiaries each year, based upon a comparison of the physician's charges and Medicare's prevailing charges. For a MAAC to be determined based on an individual physician's actual charges, the physician must have charged for services provided during April through June of 1984. In all instances where Medicare is not able to identify the physician's actual charge in April-June, 1984, the MAACs are established based on the 50th percentile of the customary charges of all other non-participating physicians in the locality for the 12-month period ending on June 30, 1986, rather than the individual physician's own established pattern of charges.

The purpose of the attached draft amendments is to make the following modifications to the MAAC program to correct some of the glaring inequities instituted by the program.

1. Base each physician's MAACs on his or her own current established customary charge profile (i.e. actual charges submitted from July 1, 1985 - June 30, 1986).

   This change will help correct many of the inequities caused by the law, without circumventing Congress' intent that MAACs for established physicians continue to be based on charges in effect during the fee freeze. For the most part, actual charges for services furnished from July 1, 1985 through June 30, 1986 were frozen by law at the charge levels in effect in April-June, 1984.

   - It will provide a more accurate MAAC— based on the physician's own established charge—for services that were not provided during the base period, such as newer services and services provided before and after the period from April-June 1984. This will eliminate the unjustified rollback experienced by many physicians for some of their charges and make program enforcement more realistic.

   - It will base the MAACs for physicians who entered practice from July 1, 1984-June 30, 1986 on their

own established customary charges, thus eliminating unfair rollbacks in their established fees.

- o It will correct many of the problems resulting from coding conversion. All carriers were required to convert to the new HCFA Common Procedure Coding System (HCPCS) by October, 1985. Consequently, there has been considerable trouble in matching up the old codes in use in April-June 1984 with the new HCPCS codes--a process often analogous to comparing apples to oranges. This is less likely to be a problem if the more current customary profile is used, since it includes actual charges for all or most of the new HCPCS codes. (Some coding problems may still persist, however, so the existing process that allows an opportunity for individual physicians to ask for a review of errors resulting from the conversion to the new codes should still be continued.)

- o It will simplify administration of the program by Medicare carriers. Instead of maintaining two profiles--the April-June 1984 base period charges and the current customary charges--for each physician, Medicare carriers would only need to maintain the current customary charge profile, which they already were required to calculate for the January 1, 1987 profile update. In addition, since that profile is more current, accurate, and inclusive than the April-June 1984 charges, carrier administration and expense will be eased.

2. Provide physicans with access to MAAC information in a timely fashion for making future participation decisions. In 1987, physicians were not provided with MAACs in time to make a decision on participation and the MAACs that eventually were provided often were inaccurate.

3. Make the proposed changes in the MAAC methodology retroactive to January 1, 1987, so that physicians are not penalized for the failure of carriers to provide accurate and timely information and for the use of a flawed methodology to determine MAACs.

We strongly urge you to support the attached draft legislative language to implement these changes to the MAAC program.

American Medical Association
American Association of Neurological Surgeons
American Academy of Ophthalmology
American College of Surgeons
American Society of Gastrointestinal Endoscopy
American Association of Clinical Urologists
Renal Physicians Association
American Academy of Family Physicians
College of American Pathologists
American Academy of Physical Medicine and Rehabilitation
American Society of Cataract and Refractive Surgery
American Academy of Otolaryngic Allergy
American College of Gastroenterology
American Society of Hematology
Association of Military Surgeons of the U.S.
American College of Nuclear Physicians
American Society of Internal Medicine
Congress of Neurological Surgeons
American Academy of Otolarygology - Head and Neck Surgery
American Group Practice Association
American Urological Association
American Society of Anesthesiologists
American Rheumatism Association
American Academy of Neurology
Medical Group Management Association
Joint Council on Allergy and Immunology
American Society of Ophthalmic Administrators
American College of Emergency Physicians
American Academy of Dermatology
American Society of Clinical Oncology
American Psychiatric Association
American Society of Clinical Pathologists

Written Statement
by
American Medical Peer Review Association

The American Medical Peer Review Association (AMPRA), is pleased to present written testimony regarding necessary improvements in the current statute authorizing the Utilization and Quality Control Peer Review Organization (PRO) program. AMPRA is the national association of physician directed medical review organizations, including the federally designated PROs. We appreciate this opportunity to present our views.

We have had several years of experience with the PRO program and AMPRA is prepared to recommend six changes needed to strengthen it. We believe these changes will help assure that the PROs remain strong guardians of quality for Medicare's beneficiaries, especially important at a time when the Congress must find ways to achieve $1.5 billion in Medicare savings for fiscal year 1988, and a total of $8.7 billion over the next three fiscal years. Continued tightening of Medicare's reimbursement of health care providers and practitioners may increase the possibility that beneficiaries will be exposed to inadequate care, hence the need for an effective peer review program.

Budgeting for PRO Review Activities

AMPRA'S FIRST RECOMMENDATION IS THAT THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) SHOULD BE REQUIRED TO SET FORTH ANNUALLY SEPARATE BUDGETS FOR EACH OF THE NEW CONGRESSIONALLY MANDATED PRO FUNCTIONS: health maintenance organization (HMO) reviews, skilled nursing facility (SNF) reviews, and home health agency (HHA) reviews. For inpatient reviews, AMPRA recommends that it is now time for Congress to establish an explicit funding level in the statute to protect against the Administration's unwillingness to set PRO budgets at appropriate levels.

The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) included amendments to the procedure for determining the annual level for funding

PRO activities in a number of specific settings. Section 1866(a) of the Medicare statute now states that, in addition to hospitals, all HMOs, SNFs and HHAs must maintain an agreement with the PRO in their state. The purpose of these agreements is to assure that PROs are reviewing the quality of care in these settings and responding in a timely manner to beneficiary complaints about quality.

The new statutory provisions direct the Secretary of HHS to cover the costs of this expanded review activity by transferring from the Medicare Trust Funds the amounts deemed sufficient by the Secretary. These provisions are similar to those in place for the funding of PRO review of inpatient hospital services, and we believe that the clear intent was that these amounts be in addition to those required for inpatient hospital review activities.

Unfortunately, in presenting its fiscal year 1988 budget to the Congress, the Administration failed to acknowledge the new statutory requirements, providing instead for a total funding amount based on the historic amount required for inpatient hospital reviews, adjusted only for inflation. AMPRA believes that HCFA should set forth budgets for each of the new Medicare-covered settings in which review is to be conducted. This would permit Congress and the public to review and comment on the judgements of the Secretary in preparing these individual budgets, and to determine whether these budgets are adequate to support the review efforts required by law in each of the settings. We believe that this was the intent of the OBRA 86 provisions, and we recommend that Congress require HCFA to provide explicit budgets for implementation of expanded PRO functions.

As an alternative to separate budgets for the different PRO review functions, Congress may want to consider and AMPRA could support the development of a single budget for the PRO program. This approach has the benefit of simplicity and permits greater flexibility in allocating

budgeted dollars to various review functions as the need arises. This funding level should be explicitly stated in law and be sufficient to support the entire scope of PRO review functions including: inpatient review, the second opinion program; ambulatory surgery review; quality denials; assistants at cataract surgery review; HMO/CMP review; SNF review; and home health agency review. Finally, this statutorily mandated funding level must also take into account the new requirement that hospitals be paid for all xeroxed copies of medical records requested by the PRO. AMPRA would be pleased to work with the Senate Finance Committee on developing a sufficient budget for the entire PRO program. Given the clear intent by Congress to expand the PRO program and the Administration's unwillingness to support these new activities, there can be no higher priority for the PRO program at this time.

PRO Contract Administration

AMPRA's SECOND RECOMMENDATION IS THAT HCFA BE REQUIRED TO COMPLETE PRO CONTRACT MODIFICATIONS, INCLUDING NECESSARY FINANCIAL ADJUSTMENTS, PRIOR TO REQUIRING PROS TO IMPLEMENT ADDITIONAL REVIEW ACTIVITIES.

PROs have been particularly concerned with the manner in which HCFA has implemented changes in the scope of work that result from either statutory or administrative requirements. In a number of cases, PROs have been required to perform significant, additional work in the absence of timely adjustments in their operating budgets. A good example of this was the new provision for review of the use of assistants at surgery for cataract procedures, where PROs were required to perform the additional duties far in advance of the necessary additional funding.

We urge the Congress to adopt an amendment to the PRO statute which would require that all necessary contract modifications, including the negotiation of additional dollars, are accomplished prior to the effective date for changes in the scope of work. Such a procedure would ensure that

PROs and providers have timely notice for necessary changes and that the financial resources to carry out new assignments are available. In our view, this procedure is in place under most other contracting arrangements, including federal contracts, and is a generally accepted means of conducting business. Present limited financing for peer review leaves little room for absorbing new work without the addition of funds to carry out new program initiatives.

PRO Contract Period

AMPRA ALSO RECOMMENDS THAT THE PRO LAW BE AMENDED TO EXTEND THE PRO CONTRACT PERIOD FROM TWO TO THREE YEARS.

Current law authorized HCFA to contract with a PRO for a period of two years. There is no discretion for a longer contract period, although contracts are subject to two year renewals under certain circumstances. There has now been a significant period of experience with the new PRO program and the time has come to provide for longer contract periods. A three year contract would have the following benefits:

- It would promote increased stability and continuity in the PRO's quality assurance activities under the Medicare program;
- It would provide for a contract period that is long enough to allow a fair and thorough evaluation of a PRO's performance; and
- It would reduce HCFA administrative costs inherent in contract renewals and renegotiations.

Stability and continuity are important to the PRO program because they foster strong PRO-beneficiary and PRO-provider relations essential to accomplishing the quality assurance mission of the program. The continual changing nature of the PRO scope of work during the last three years also

argues for a longer contract period to allow PRO physicians and staff to focus for an extended period of time on their quality assurance duties rather than on preparations for contract renewals.

It is important to note that HCFA has the ability to terminate a contract with a PRO at any time during the contract cycle for poor performance. Therefore, Congress should not be concerned that extending the PRO contract period to three years runs the risk of enfranchising a review organization over a long period of time.

Liability Protection for PROs

Our fourth recommendation is that the PRO STATUTE SHOULD BE AMENDED TO EXPLICITLY CLARIFY THAT PROTECTION AGAINST CRIMINAL OR CIVIL LIABILITY IS EXTENDED TO THE PRO CORPORATE ORGANIZATION AND THE STANDARD SHOULD BE REVISED FOR INVOKING THE LIABILITY PROTECTION TO GRANT IMMUNITY TO INDIVIDUALS AND PROS "ACTING IN GOOD FAITH".

Under the 1982 PRO law, the statutory language dealing with limitations on the liability of persons participating in the program applies to three circumstances. First, persons who supply information to a PRO cannot be held liable so long as the information is true to the best of their knowledge and is relevant to the conduct of review activities.

Second, individuals who are employed by or otherwise furnish professional services to a PRO may not be held liable for the performance of their duties so long as they exercise due care. And, third, providers and practitioners and others related to health care institutions under PRO review are protected from liability so long as they exercise due care and act in accordance with professionally accepted norms of care and treatment in carrying out their responsibilities.

Although the language of this section of the law implies that the PRO as an organization also enjoys the same immunity from liability, there is no

explicit reference to it. Thus, AMPRA recommends a revision to the section for this purpose. We believe this change is simply a clarification of existing law.

There is a second issue concerning the standard of behavior set forth in the law as a prerequisite to the limitation on liability. At present, the law requires that persons exercise due care in the conduct of their responsibilities. We believe this standard should be revised to require that persons perform their duties in good faith. AMPRA would like to remind the Committee that this is the same language contained in the recently enacted Health Care Quality Improvement Act of 1986. AMPRA believes PROs should be protected by the exact same legal standard. This standard implicitly recognizes that errors do occur, but so long as they are not intentional or committed with malice the statutory immunity should continue in force.

Quality of Care Research and Education Center

AMPRA ALSO RECOMMENDS THAT CONGRESS EARMARK A ONE PERCENT ADD-ON TO THE PRO BUDGET TO SUPPORT A PRIVATE SECTOR, QUALITY OF CARE RESEARCH AND EDUCATION CENTER.

During the last several years, PROs have been involved in a variety of quality assurance activities, requiring the use of complex methodologies, some of which are quite new and relatively untested. As review mandates for PROs are expanded, there is a greater need to further develop the art and science of quality review, including the generation of meaningful data and information on quality of care under the Medicare program. Unfortunately, little funding has been made available to support technical assistance for PROs or educational workshops for community physicians and PRO staff. This is in stark contrast to the active federal support given the Professional Standards Review Organization program.

A quality of care research and education center, funded through a one

percent PRO budget add-on (about $2 million in fiscal year 1988), could perform a number of critical tasks. For example, the center could 1) assemble a multi-disciplinary technical assistance team to help PROs improve their performance; 2) provide a much-needed independent forum to evaluate and validate the quality assurance methodologies currently in use; 3) support meaningful analysis of the data currently being generated by the PRO program; 4) devote resources to develop and pilot test innovative quality assurance techniques; 5) provide the resources necessary to build model continuing medical education programs for providers identified through the review process as requiring needed changes in behavior; and 6) take the lead in disseminating new information to physicians regarding practice pattern variations and the outcomes of medical interventions, and support additional research in this area.

In general, the center would foster a strong and effective nationwide network of PROs. A financial commitment is needed now to develop new review methodologies and to encourage PRO/provider educational activities to ensure PRO program success and to adequately monitor quality of care under the Medicare program.

Standards for Evaluating PRO Performance

Finally, AMPRA urges that the CONGRESS REQUIRE HCFA TO PUBLISH IN THE FEDERAL REGISTER THE CRITERIA AND STANDARDS BY WHICH PROS WILL BE EVALUATED with an opportunity for public comment prior to their use. Sections 1816(f) and 1842(b)(2) of the Social Security Act require the Secretary to publish annually in the Federal Register the criteria and standards which will be used in evaluating the performance of Medicare intermediaries and carriers, and to provide an opportunity for public comment prior to implementation. In the case of the PRO program, there are no similar requirements.

The absence of published evaluation criteria and standards has resulted in confusion on the part of PROs as to exactly how their performance would be judged in deciding whether to renew or to recompete their contracts. Published criteria would end this confusion and allow PROs, Medicare beneficiaries, health care providers, the Congress and others to know specifically how HCFA expects PROs to accomplish their utilization and quality review assignments.

In summary, AMPRA is recommending a number of improvements to the PRO program. We believe that, if enacted, these refinements will result in an even stronger quality assurance system to serve Medicare's 32 million beneficiaries. Thank you for the opportunity to comment.

Statement of The American Occupational Therapy Association, Inc. (AOTA) on Improvements to the Medicare Home Health Program

United States Senate
Committee on Finance
Hearing on Medicare Part A
July 9, 1987

The American Occupational Therapy Association, Inc. (AOTA) is pleased to submit this statement on improvements to the Medicare home care program in conjunction with the Committee's hearing on Medicare Part A. The Association, which was formed in 1917, represents over 45,000 members including occupational therapists, occupational therapy assistants, and students of occupational therapy.

The Association wishes to call the Committee's attention to S. 1076, the Medicare Home Health Services Improvement Act of 1987. This bill was introduced April 22, 1987 by Senator Bill Bradley and co-sponsored by several Senators, including many members of the Finance Committee.

We believe the provisions of this bill represent excellent and much needed remedies to the many problems encountered by beneficiaries and providers in the Medicare home health program. Of particular concern to us is the tremendous increase in claims denials in recent years, the reasons for which, when stated, are arbitrary and capricious. This unusual, and in our opinion unwarranted, surge in denials has seriously affected beneficiary access to rehabilitation services such as occupational therapy and jeopardized their ability to remain at home and avoid institutionalization. The provision of S. 1076 calling for reform of the claims denial process strikes us as encouraging and long overdue.

The Association also welcomes the provision of S. 1076 that would establish occupational therapy as the fourth qualifying service under the Medicare home health benefit. Occupational therapy personnel and the beneficiaries they serve are confused and frustrated by a Medicare policy that allows beneficiaries to receive medically necessary occupational therapy services at home only if they are in need of another service. Requiring a multitude of services when a person needs only one is neither logical nor cost effective and we are pleased that S. 1076 addresses this problem.

Occupational therapy is an important part of the home health care provided to many Medicare beneficiaries. It is especially necessary for individuals who are victims of strokes, heart attacks, diabetes, multiple sclerosis or spinal cord injury, who are disabled by severe arthritis, or who have suffered physical injury as a result of a fall or some other accident. Under the current Medicare law occupational therapy is a covered service only if the patient also requires nursing, physical therapy or speech pathology services. This legislative restriction on coverage for occupational therapy contradicts the mandates of quality health care and contributes to the unnecessary spiraling of health care costs.

Occupational therapy focuses on increasing the patient's functional level. The application of this service often plays a critical role in ensuring the patient's full recovery, the prevention of further disability, and a successful readjustment to the home and community environment. The occupational therapist will establish a treatment program designed to increase the patient's level of physical function. The therapist will also teach the patient, and those family members or others who will care for the patient, compensatory techniques which permit the patient to function more independently with feeding, dressing, and personal hygiene activities. The therapist will also make splints and self-help devices which either protect against joint deterioration, e.g. with an arthritic patient, or make the individual more independent, e.g. by providing stability of the wrist joint which will allow a person with severe wrist deterioration to use their remaining hand function. Finally, the therapist will recommend changes in the physical environment of the home to promote increased patient independence under the safest conditions possible.

In many instances only occupational therapy is required to meet the medical needs of beneficiaries covered under the Medicare home health benefit. Specific patient conditions where only occupational therapy might be needed include the following:

- The patient who has been ambulatory and functioning independently in her home calls her physician because she is no longer able to walk safely and has fallen several times. The physician determines that she has decreased knee and ankle motion bilaterally due to accelerated osteoarthritic changes. The physician orders a home health occupational therapist to design and fabricate night resting splints to increase knee and ankle motion and prevent further deformity. Without these splints, the joints will permanently lose range of motion, and the patient may never walk again. The physician's alternative to occupational therapy in the home is admitting the patient to a hospital or transporting her by ambulance to the occupational therapy outpatient department of the hospital.

- The diabetic wheelchair-bound patient with bilateral above-knee amputation, partial blindness, and decreased sensation in her hands due to diabetic neuropathy has been discharged from physical therapy soon after she was independent in wheelchair transfer techniques. She needs the continued services of an occupational therapist to teach her an acute awareness of her sensory deficits and compensatory techniques to overcome her partial blindness and poor hand sensation. Without the occupational therapy program, complications such as accidental burns in the kitchen and decubiti can easily occur.

- The homebound patient with chronic lung disease and subsequent weakness, decreased endurance, and a continuous need for oxygen has difficulty performing daily functional activities. She is unable to pace her activities with her limited breathing capacity, and her physician has ordered occupational therapy to see if an energy conservation program will allow the patient to perform the necessary daily activities to remain at home and avoid nursing home placement.

- The patient with a long history of multiple sclerosis is experiencing increased difficulty with coordination due to spasticity and is no longer able to feed herself. She needs an occupational therapist to decide whether adaptive equipment would allow her to regain independence. Only the occupational therapist is skilled in assessing and providing this type of equipment, and no other service is necessary.

In all of these instances occupational therapy would be provided in accord with existing Medicare coverage criteria as specified in the intermediary manual for home health agencies. These criteria require that occupational therapy be prescribed by a physician, be performed by a qualified occupational therapist or assistant, and be reasonable and necessary for the treatment of the individual's illness or injury. Occupational therapy is considered reasonable and necessary when "an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time."

Cost considerations must be an essential part of every proposal to revise the Medicare benefit system. With regard to the occupational therapy home health amendment, all cost expenditures must be assessed in the light of potential cost savings. The current Medicare restriction on home health coverage for occupational therapy occasions a variety of unnecessary costs. The present law now contains incentives for placing people in the more expensive hospital or nursing home setting where treatment can be provided on a covered basis. In those instances where the treatment terminates

prematurely because the coverage ends, the possibility of recurring disability with its accompanying need for a return to more costly institutional care is increased. Under existing law unnecessary home health costs can be incurred because additional prerequisite services may be ordered so coverage for necessary occupational therapy treatment will be available. The proposed amendment would correct these systemic problems and in the process provide savings to offset the initial costs necessary to make this service more available. With respect to this initial cost, the Association maintains it would be minimal since it would not affect a very large number of beneficiaries. However, for those beneficiaries who would be affected, their need is critical.

We hope that all of the provisions of S. 1076 will be approved by Congress this year. We believe it is a balanced and reasonable package of home care improvements which will significantly strengthen the program. We appreciate the fact that enactment of these amendments will depend largely on their impact on the Federal budget. However, we are hopeful room can be found, possibly in reconciliation legislation, for these important amendments. If Association members or staff can be of any assistance to the Committee on this or other matters, we will be happy to do so.

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UNITED STATES SENATE
COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH

STATEMENT
OF THE
AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY
JULY 9, 1987

The American Society of Cataract and Refractive Surgery submits these views to the Subcommittee on Health in connection with its efforts to effect budget reconciliation for Fiscal Year 1988 through reductions in Medicare payments for physicians' services. The Cataract Society understands and respects the need for our federal government to act responsibly with respect to reduction of overall budget deficits. It recognizes, too, that even such crucial programs as those providing medical reimbursement for the aged must be closely scrutinized for possible contributions to budget reductions.

The Cataract Society wishes to offer its views and recommendations with respect to (1) the general approach of the Congress on reducing Medicare payments for physicians' services and (2) some specific proposals to achieve reductions in Medicare reimbursement for cataract surgery as alternatives to direct physician payment cuts.

First, the general approach.

Among the options available to the Congress in reducing Medicare payments for physicians' services, two general approaches stand out as possibilities.

First, some broad, across-the-board reductions can be made with respect to all payments under the Medicare Part B program for physicians' services. This could be done by a simple percentage reduction in prevailing charges nationwide for all Medicare Part B physician reimbursement. The Physician Payment Review Commission has considered an alternative whereby there would be a reduction in the updating of prevailing charges by the Medicare Economic Index.[1/] A variation of this broad, across-the-board-approach might be to identify large categories of physicians by experience, nature of practice, or other features (office-based vs. surgical, "cognitive" vs. "hands-on", experienced vs. newer physician, etc.). The PPRC also has considered one form of this -- reduction in reimbursement for Medicare-defined "new physicians."[2/]

The second option available to Congress as a general approach would be to focus on Medicare physician reimbursement for a few frequently-performed services or procedures for which current reimbursement is thought to be excessive. Prevailing charges would be reduced nationwide for those services or procedures exclusively. This is the so-called "inherent reasonableness" approach. It was first proposed as a way to adjust Medicare rates nationwide by the Health Care Financing Administration in 1986.[3/] It was

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1/ Letter of May 14, 1987 to several medical organizations including ASCRS from Paul B. Ginsburg, Ph.D., Executive Director of the PPRC.

2/ Id.

3/ Proposed regulation, 51 Fed. Reg. 5726 (Feb. 18, 1986); final regulation, 51 Fed. Reg. 28710 (Aug. 11, 1986).

endorsed for use by HCFA in budget reconciliation legislation last year, although according to carefully described criteria and using specific comparisons.[4] Again, the PPRC has considered reduction in prevailing charges for some Medicare-reimbursed procedures based upon "inherent reasonableness."[5]

In reaching its Medicare budget reconciliation reductions in physician payments for FY 1988, the Cataract Society urges Congress to the avoid utilization of the second option, the "inherent reasonableness" approach, because it would be redundant and excessive if applied to cataract surgery, and, overall, the results would be unsubstantiated, arbitrary and unfair. The Cataract Society urges Congress instead to utilize whatever form of the first option that it finds would most broadly and uniformly spread any necessary budget reductions throughout the Medicare physician reimbursement program.

The Cataract Society has additional specific recommendations for other possible approaches to meeting Congressional budget targets.

ASCRS

The Cataract Society is a national scientific and educational professional society of some 4,500 ophthalmologists (physician eye specialists) who perform cataract surgery. The organization was formed in 1974 as the American Intra-Ocular Implant Society.

Its primary endeavors are the presentation of scientific symposia and the publication of a peer-reviewed journal on cataract surgery, intraocular lens implantation, and other aspects of anterior segment eye surgery. The Cataract Society believes that its membership includes the vast majority of all United States ophthalmologists who regularly perform cataract/IOL surgery.

Cataract is the condition of the eye, usually occurring because of the normal human aging process, in which the eye's natural crystalline lens becomes clouded and impairs vision. In cataract surgery, the ophthalmologist removes the opacified portion of the lens and, usually, replaces it with a permanently-implanted clear plastic intraocular lens.

In 1987, it is estimated that between 1.25 and 1.5 million patients will have cataract surgery performed. The average age of a cataract patient is estimated to be 70 years; thus, the overwhelming majority are eligible for reimbursement of their expenses under the Medicare program. The annual Medicare outlays for physicians' services for cataract/IOL surgery are estimated to be about $1 billion. Among all of the specialities and subspecialities of medicine, cataract surgery is likely the most immediately and most universally affected by budget cuts in Medicare payments for physicians' services.

THE CATARACT SOCIETY OPPOSES THE "INHERENT REASONABLENESS" OPTION

The Cataract Society strongly urges Congress that it not attempt to meet budget targets for Medicare physician

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4/ Omnibus Budget Reconciliation Act, P.L. 99-509 at § 9333 (1986).

5/ Id. n. 1.

payments in FY 1988 through an "inherent reasonableness" approach.

That approach would be redundant for ophthalmologists who perform cataract surgery, because Congress has already specifically reduced prevailing charges for cataract surgery in FY 1987 and FY 1988. In addition, Congress has itself established appropriate criteria for evaluation of Medicare physician reimbursement based upon "inherent reasonableness". Those criteria should be addressed by an appropriate administrative agency based upon the requisite notice and comment rulemaking procedure, not in the necessarily rushed Congressional budget process. Finally, reference points previously identified by the HCFA or the PPRC in these "inherent reasonableness" approaches have been extremely unreliable indicators of the relative value of physicians' services; reliance upon them by Congress would result in payment reductions that would be unsubstantiated, arbitrary and unfair.

1. Congress Has Already Reduced Cataract Surgery Reimbursement

Last year the Health Care Financing Administration proposed and finalized a controversial regulation by which it assumed authority to modify Medicare reimbursement nationwide for particular procedures when the reimbursement was not "inherently reasonable". Many doubted that HCFA had authority to do this on a nationwide basis.[6/] The first procedure that HCFA proposed to address under "inherent reasonableness" authority was cataract surgery. The agency conducted a study of the 30 hospitals in the United States at which cataract surgery was most frequently performed; it determined that cataract surgery with the implantation of an intraocular lens took about the same amount of time at those hospitals as cataract surgery without an IOL. HCFA proposed that prevailing charges for cataract/IOL surgery be reduced in steps nationwide to 10% above prevailing charges for cataract surgery alone.[7/]

Among many challengers opposing the HCFA proposal, the Cataract Society filed extensive comments that exposed serious flaws in the agency's methodology. A supplementary report to the Cataract Society by the highly regarded health care reimbursement firm of Lewin and Associates discussed the gaps and weaknesses in the surgical time study as well as in several published reports that had been cited by the agency. Ultimately, however, Congress itself preempted finalization of the HCFA proposal on cataract surgery.

In its Omnibus Budget Reconciliation Act,[8/] Congress ended the controversy over HCFA authority to make nationwide modifications in Medicare physician payments using the "inherent reasonableness" approach. It specifically granted[9/] that authority and made it subject to a list of criteria.[9/] In OBRA Congress also addressed cataract surgery physician reimbursement.[10/] Congress reduced Medicare prevailing charges for cataract surgery in FY 1987

6/ See comments submitted in response to the proposed regulation identified in n. 3.

7/ See 51 Fed. Reg. 29321 (Aug. 15, 1986).

8/ Id. n. 4.

9/ Id.

10/ See id. at § 9334(a).

by 10%. It reduced prevailing charges for cataract surgery in FY 1988 by an additional 2%. No other medical or surgical procedures were singled out by Congress for reductions in Medicare payments to physicians.[11]

If Congress were to subject several procedures, including cataract surgery, to physician payment reductions on the basis of "inherent reasonableness" for FY 1988, cataract surgery reimbursement would be subject to singularly redundant and excessive additional reductions.

Congress should exclude and exempt cataract surgery if it proceeds with any other Medicare physician payment reductions based upon "inherent reasonableness".

2. The HCFA and PPRC "Inherent Reasonableness" Approaches Have Been Seriously Flawed

In OBRA, Congress laid out in detail a strategy for Medicare physician payment policy. An important element of that strategy, to achieve short-term reform, is the specification of a process for HCFA as an administrative agency to implement "inherent reasonableness" review of physician reimbursement. Congress has appropriately encouraged HCFA to reduce physician fees for overpriced services. But it has also mandated a system for identifying overpriced procedures and for determining the extent to which those procedures are overpriced. Congress listed six circumstances in which nationwide Medicare rate adjustments would be appropriate and four methods of comparison as the bases for the adjustments to be used by HCFA in "inherent reasonableness" determinations.[12]

Congress has also already effectively made its own "inherent reasonableness" determination with respect to cataract surgery. It is therefore unnecessary and inappropriate to again address cataract surgery physician reimbursement at least until the changes effected by Congress can be evaluated.

Any "inherent reasonableness" determinations by Congress would presumably rely upon preliminary relative value scale work identified and discussed by both HCFA and PPRC in its previous considerations of "inherent

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11/ In addition to cuts in Medicare reimbursement for ophthalmologists who perform cataract surgery, Congress also ratified HCFA's reduction in payments for anesthesia services in connection with cataract surgery. Id. at §9334(b).

12/ See id. n.5. In summary, the six circumstances in which an adjustment in Medicare payment for a procedure may be appropriate are where: previously charges are significantly different from those in comparable localities; Medicare is the sole or primary source of payment; the marketplace is not truly competitive; there have been increases not explained by inflation or technology; the charges do not reflect technology; there is increased facility with the technology or reduced costs; or the charges are substantially different than those of other payers. The four methods of comparison are: between charges and resource costs for related procedures; between charges and resource costs for a procedure over a period of time; between charges for a procedure in different geographic areas; or between charges paid by Medicare and by other payers. There must be substantial economic justification for a nationwide Medicare payment; there must be proposed and final notices by HCFA.

reasonableness" approaches to Medicare physician reimbursement reductions. Two works in particular have been repeatedly cited as appropriate bases for the "inherent reasonableness" approach.

Work by Professor Hsiao on a "resource-based relative value scale"[13/] has been cited by both HCFA and PPRC. Likewise the Mitchell-Stason report[14/] on Medicare relative values has been used as a basis for comparison of physician fees by HCFA and PPRC.

The Cataract Society addressed the most recent Hsiao work and the Mitchell-Stason Study very extensively on its own, and through submission of a supplemental report by the firm of Lewin and Associates, in response to the HCFA proposal last year on cataract surgery physician reimbursement reductions. An abstract of the Cataract Society's pertinent comments, and the entire Lewin and Associates submission, appear as Attachment 1 to this Statement.

Greatly summarized, a number of serious flaws in the Hsiao and Mitchell-Stason studies were noted. With respect to the Hsiao work:

- It is not meant to be used to judge compensation. The second Hsiao work makes no attempt to evaluate how physicians should be paid for services; it only addresses the value of medical procedures in relation to one another; it does not support the conclusion that any one or a few procedures are overpriced, as Dr. Hsiao has himself acknowledges in the work.

- It makes arbitrary assessments of complexity. As a primarily time-based study, the Hsiao work has been severely criticized in a report under contract to HCFA as unreliable for the proper measurement of compensation for medical services; physicians' time is not combined in fixed proportion with other resources; measuring relative physicians' time alone is a poor indication of costs; adjustments to time to reflect complexity of procedures must of necessity be arbitrary ones.

- It is sensitive to weighting. Dr. Hsiao gives equal weight to "time-on-task" and "complexity", or risk, skill and judgment; even minor changes to the weighting of these factors produces radically different results under Hsiao's methodology, as demonstrated by the Lewin and Associates analysis.

With respect to the Mitchell-Stason Study:

- It is based on Hsiao's work. Having adopted the Hsiao methodology, the Mitchell-Stason Study necessarily transfers, or even amplifies, the concerns expressed above.

- It depends upon arbitrary index procedures. The Study adopts particular procedures as precisely priced and measures others against those index

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13/ Hsiao, Braun, et al., "Final Report: Resource Based Relative Values of Selected Medical and Surgical Procedures in Massachusetts" (Dec. 1985).

14/ Center for Health Economics Research, "What Should Medicare Pay for Surgical Procedures?" (June, 1986).

procedures; the authors acknowledge this problem and suggest further work on it.

3. ASCRS Recommendations for a Relative Value Scale

Preliminary work on primarily time-based relative value scales, such as the work of Hsiao and Mitchell-Stason, is not suitable for Congress to use to base short-range determinations on Medicare physician reimbursement for some procedures in an "inherent reasonableness" approach. Among other infirmities, that preliminary RVS work relies excessively on time measurements, arbitrarily weights time and complexity, and very poorly measures complexity. Any "inherent reasonableness" determinations based upon that work will inevitably be unsubstantiated, arbitrary and unfair.

Congress has offered to HCFA its own "inherent reasonableness" criteria for use in these short-range determinations which Congress should allow to be followed.[15/]

Having questioned the relative value scale work to date as a proper basis for "inherent reasonableness" determinations, however, the Cataract Society would be remiss if it did not offer recommendations to Congress for the future direction of work on relative value scales.

Congress has ordered the Department of Health and Human Services to develop a relative value scale for physicians' services and to report to Congress on it by July 1, 1989.[16/] Two members of the Cataract Society's Scientific Advisory Board are among the four members of a panel of ophthalmologists responsible for providing expert assistance in the Harvard/AMA relative value scale project pursuant to the HHS obligation imposed by Congress.

The development of a relative value scale for physicians' services reimbursed by Medicare, mandated by Congress to be performed by HHS, is admittedly a long-range effort rather than a short-range one. It is therefore not directly germane to the present mission of Congress on short-range methodologies to meet FY 1988 budget targets. Nevertheless these recommendations on RVS development are offered to Congress by the Cataract Society.

First, preliminary work to date on a "resource-based relative value scale" has focused too much on the time it takes to perform physicians' services. Time is measurable; it is not surprising that scientific researchers favor time measurement when attempting to compare the value of physicians' services. However, physicians do not perceive their own work, are not perceived by patients, are not now reimbursed, and should not in the future be reimbursed, as only "hourly fee" professionals. Time-on-task measurement of physicians' services is a trap for the unwary. Cataract surgery, for example, has been popularly characterized as a "routine" procedure that takes perhaps one-half hour to perform. In fact, of course, the characterization is inadequate. Cataract surgery time varies considerably depending upon patient condition and surgeon methodology.[17/]

15/ See id. n. 9.

16/ P.L. 99-272, §9305(b) (1986).

17/ The HCFA time study of cataract surgery last year was severly criticized because no methodology was published,

(Footnote Continued)

Moreover, Medicare reimbursement for cataract surgery is on a "global fee" basis -- it covers extensive preoperative, operative and postoperative services that often involve a considerable commitment of a physician's time and attention to patient care. Finally, the cognitive function of the surgeon in today's highly complex cataract procedure is enormous. In short, the Cataract Society recommends that Congress consider how some now frequently-publicized studies, such as that of Dr. Hsiao, can inaccurately reflect actual physician time reimbursed by Medicare and, even more important, that time-on-task should not be given undue weight in evaluating the relative value of physicians' services.

Second, more scientific analyses must be conducted as to the complexity of medical services. The Hsiao and Mitchell-Stason work makes assumptions regarding complexity that the researchers admit are arbitrary ones.[18/] Both rely on interviews with a small number of physicians as a gauge of the complexity of cataract surgery, for example. It is likely that no physician can assess the complexity of a medical procedure, whether within that physician's specialty or not, without significant bias. Other methods beyond consultations with physicians must be found to help determine the relative complexity of medical procedures for purposes of developing a relative value scale.

Third, whether as a function of the study of medical procedure complexity or otherwise, the Cataract Society recommends consideration of several factors that it regards as "orphans" in the relative value scale work to date:

- Patient risk. Some methodology should be developed to assess the relative perceptions of patients in subjecting themselves to medical procedures performed by physicians. With respect to cataract surgery, patients are nearly always the elderly who have gradually lost full functional vision and greatly fear blindness. They subject themselves to an elective procedure that has as one of its risks, although thankfully a remote one, the risk of blindness. Many patients regard the risk of blindness as greater than the risk of death. Patient risk is an important factor in determining the "value" of a medical procedure.

- Patient benefit. Another crucial measurement of the relative "value" of physicians' services in connection with various medical procedures is the perception of patients regarding the benefit to be achieved. The main reason that cataract surgery has proliferated, in addition to a vastly improved medical procedure and to the fact of an increasing old age population, is the enormous efficacy of the procedure. Patients often regard themselves as functionally "reborn" following successful cataract surgery. Their quality of life is almost always improved dramatically. The Cataract Society has recently arranged to fund a study at Johns Hopkins University School of Hygiene and Public Health regarding the patient benefits of

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(Footnote Continued)
there were apparently no standards used for time measurement and HCFA studied only the 30 highest volume, and presumably most efficient, cataract surgical facilities. See Attachment 1.

18/ See Attachment 1.

cataract surgery. This factor cannot be disregarded in an attempt to relate the value of one medical procedure to another.

- Technical Sophistication. Preliminary relative value scale work has failed to adequately address elements of technical sophistication of medical procedures reviewed, but has instead relied only upon comments of a non-representative population of inevitably biased physicians. The technical sophistication of cataract surgery today, for example, is truly awesome. A listing of operation techniques of an uncomplicated cataract surgery procedure is included as Attachment 2 to this Statement. Cataract surgery demands that each of many intricate microsurgical steps must be performed with absolute precision to achieve a successful functional vision result for the patient. Clearly some methodology beyond seeking comments from physicians should be developed to measure the complexity of medical procedures for an RVS.

- Research. The extent to which the performance of a medical procedure includes a "by-product" of research should also be measured. In cataract surgery, for example, virtually all of the major revolutionary technical changes in the last 50 years have been developed in the course of clinical practice, rather than through traditional academic research. This is true with respect to intraocular lens implantation itself, the phakoemulsification procedure for extracapsular cataract extraction, development of modern IOL designs, the YAG laser surgery technique for posterior capsultomy, etc. A recent survey commissioned by the Cataract Society and conducted by Bonner & Associates demonstrates that fully a third of clinical practitioners in cataract surgery are conducting or planning research.[19] What value one places upon cataract surgery should reflect the research component.

- Education. An important "resource" to be considered in comparing the value of medical procedures is the extent of continuing education that is required. Cataract surgery has evolved so consistently and extensively that cataract surgeons must commonly attend several scientific symposia each year to stay abreast of clinical research. A recent study revealed that cataract surgeons spend at least five hours per week doing professional reading or viewing professional video tapes.[20] The requirements of education to successfully perform one medical procedure versus another is an important element of "relative value."

The Cataract Society is aware that a relative value scale can never measure one physician service against another accurately and completely. However, a useful measurement system can be approached. The preliminary work

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19/ "Report of Survey of ASCRS Members," Bonner & Associates, Washington, DC, Apr., 1987, p. 2. (available from the Cataract Society).

20/ Id. p. 3.

in this area is just that, preliminary. It should not be relied upon by Congress as adequate to make short-range "inherent reasonableness" determinations. In the longer range it should be modified to increase its accuracy and therefore its utility.

OTHER SHORT-RANGE OPTIONS FOR MEETING BUDGET TARGETS

It would be myopic for the Cataract Society to argue that there must be no changes in cataract surgery reimbursement by Medicare. Criticism of that reimbursement prior to the OBRA changes by Congress last year, although refuted by the Cataract Society, came from many quarters. It is too early to evaluate the OBRA changes; they have not yet even been fully implemented. But no doubt further changes can be made in Medicare cataract surgery reimbursement to increase efficiency and fairness. The Cataract Society believes strongly that the option of focusing on a few procedures, for adjustment arbitrarily using an "inherent reasonableness" approach, is ill-advised. It is redundant because cataract surgery is already subject to Congressional reductions. And it is improper because any "inherent reasonableness" approach should be conducted by an administrative agency according to due process and avoiding inadequate, irrelevant or unscientific bases. Nevertheless, the Cataract Society does have suggestions for assisting in meeting Congressional budget targets on a short-range basis with respect to Medicare reimbursement for physicians' services in performing cataract surgery, assuming there are no further so-called "inherent reasonableness" changes implemented by Congress.

First, Medicare reimbursement for intraocular lenses themselves when purchased by ophthalmologists is often inappropriately high. HCFA recognized this problem and has repeatedly suggested that Medicare carriers conduct their own individual "inherent reasonableness" reviews.[21/] So far many carriers have apparently either not conducted the reviews or have not reduced IOL reimbursement as a result. Medicare carriers in many states, such as Florida and Texas for example, continue to reimburse for ophthalmologist-purchased IOLs at the rate of $300-$400.[22/] And yet many IOL models can be purchased from manufacturers at considerably lower amounts. The subject is explained fully in a communication recently sent to all Cataract Society members which is included with this Statement as Attachment 3. Congress should consider declaring that Medicare reimbursement for an intraocular lens purchased by the ophthalmologist should be in an amount no higher than the acquisition cost plus a nominal handling charge, with the IOL reimbursement subject to a maximum amount determined by the Medicare carrier under "inherent reasonableness" methodology.

Second, much has been said about the possibility of "bundling" physicians' services that are now individually reimbursed into larger packages. In fact, the cataract surgery physician's fee has been bundled since the inception of the Medicare program. Medicare now reimburses a "global fee" for most preoperative, operative and postoperative

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21/ Medicare Carriers Manual, Transmittal No. 1129, Oct., 1985, §5246; Transmittal No. B-86-1, Jan., 1986; Transmittal No. 1180, Mar., 1987, § 5246.1.

22/ See "Cataract IOL Surgery Reimbursement under Medicare; Present Methodologies and Payments with Impending Changes," Health Coverage Strategies, Inc., Edina, MN, Oct., 1986.

services of the ophthalmologist in connection with cataract surgery. However, there do remain some procedures performed in connection with cataract surgery and not universally included or bundled by Medicare carriers into the cataract surgery global fee which might be appropriate for further bundling. Study would be necessary to identify procedures that are frequently performed in connection with cataract/IOL surgery but that are not now bundled by carriers.

Third is the subject of geographic disparity in cataract surgery reimbursement. Medicare prevailing charges for typical cataract/IOL surgery in FY 1985 varied by geographic region from $1,166 to $2,500, a difference of 114%.[23/] While practice costs and practice patterns may justify a reasonable disparity among geographic locales in physician global fee reimbursement for cataract surgery, the present enormous disparity is simply not warranted. If it can be effected administratively without undue bureaucracy, the Cataract Society favors a change whereby carriers would be required to "average out" cataract surgery reimbursement amounts by state or region, subject to some allowances for areas that have unusually high or low basic costs of practice. It might seem that savings to the Medicare program would not result by simply averaging reimbursement amounts by state or region. In fact, however, savings could result from averaging because higher reimbursement amounts for cataract surgery seem to occur in areas with higher populations of elderly and therefore higher incidence of cataract surgery.[24/] Further study, of course, would be necessary to determine this.

Fourth, savings can be effected in Medicare reimbursement for physicians' services in performing cataract surgery through improvements in enforcement of existing Medicare "fraud and abuse" laws. The Cataract Society believes that deliberate fraud and abuse in Medicare reimbursement for cataract surgery is uncommon, but it does occur. The Cataract Society has issued dozens of communications to members on avoiding prohibited payments such as inducements for IOL purchases, referral fees to other professionals, etc.[25/] By its educational efforts in this area, the Cataract Society has become, in effect, the primary "enforcement" agency, as acknowledged informally by HCFA. But instances of fraud and abuse, however abhorrent, no doubt continue to exist.[26/] There has been inadequate official enforcement by the federal government of Medicare fraud and abuse laws. With respect to fraud and abuse through kickbacks, bonuses or rebates such as in connection with the purchase of intraocular lenses, there has been virtually no enforcement by Medicare. Neither HCFA nor the Attorney General will assist in educational efforts such as those of the Cataract Society even by advising as to the scope and applicability of the fraud and abuse laws to

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23/ See Table 4 of Lewin and Associates' comments in Attachment 1.

24/ See id. Reimbursement rates in "Sunbelt" states of California, Nevada, New Mexico, Arizona, and Texas were all above the national average.

25/ See for example, Attachment 3.

26/ See report on "Cataract Surgery: Fraud, Waste and Abuse," Select Committee on Aging, Subcommittee on Health and Long-Term Care, U.S. House of Representations, July 19, 1985.

specific factual situations in cataract surgery.[27/] Congress should consider a program of increased enforcement of these laws.

CONCLUSION

In conclusion, the American Society of Cataract and Refractive Surgery respectfully submits to this Subcommittee that, in meeting Fiscal Year 1988 budget targets through changes in Medicare reimbursement for physicians' services, any "inherent reasonableness" option be avoided. Application of an "inherent reasonableness" approach to cataract surgery would be redundant, because Congress has already reduced cataract surgery reimbursement by Medicare in FY 1987 and FY 1988. There has not yet been sufficient time to evaluate the results of those reductions. Moreover, in general, an "inherent reasonableness" approach is best performed by an administrative agency such as HCFA utilizing due process and avoiding reliance upon inadequate, irrelevant or flawed data. For Congress to utilize an "inherent reasonableness" approach would necessarily result in Medicare reimbursement changes for physicians that are unsubstantiated, arbitrary or unfair. The Cataract Society recommends finally that its recommendations be considered with respect to long-term development of a relative value scale and with respect to short-term modifications in Medicare physician reimbursement for cataract surgery, as alternatives to further reductions in physician reimbursement for cataract surgery.

27/ Cong. Claude Pepper requested interpretations by letter to the Attorney General of December 18, 1985; the response was not helpful. The Cataract Society has itself unsuccessfully sought interpretations from HCFA, from the HCFA Office of Inspector General and from the Department of Justice.

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

July 22, 1987

The American Speech-Language-Hearing Association (ASHA) is pleased to have this opportunity to provide recommendations regarding federal Medicare budget issues as they affect the provision of services to Americans with communication and related disorders. Many of ASHA's 52,000 members deliver evaluation and rehabilitation services to Medicare beneficiaries. Consequently, we are acutely aware of the difficulties of older Americans who have communication disorders. ASHA, along with other national associations concerned with adequate service provision of rehabilitation services, has been advocating for controlling the potential catastrophic costs for certain illnesses and correcting deficiencies that exist in current Medicare coverage. We believe that Congress should not concern itself solely with catastrophic costs but should look more closely at established ways to prevent those catastrophic costs from occurring.

Overview

Our testimony describes the current shortcomings of the Medicare program as it relates to coverage of services to individuals with communication and related disorders. ASHA is concerned with the lack of coverage under the Medicare program for private practice professionals, hearing aids, assistive listening devices, rehabilitation services provided by audiologists, augmentative communication devices, and the two-year waiting period for disabled Americans who require services covered by the Medicare program. We also are providing specific recommendations to improve access to services that permit continuation of independent living or rehabilitate a person so that they may again live an independent life. Services provided by speech-language pathologists and audiologists are essential to eliminating the need for lorg-term care. We believe that communication - not solely mobility - is a crucial determinant of the need for institutionalization.

The availability of speech-language pathology and audiology services and devices to assist in communication remain out of reach for many Americans. Despite overall improvement in the economic status through Social Security payments, approximately 13% of the elderly have incomes below the poverty level. Additionally, more elderly Americans remained close to the poverty level than did members of any other age group. In 1984, for example, almost 30% of the elderly were in households with incomes below 1.5 times the poverty level or less than $10,000 (GAO, 1986).

Speech-language pathology and audiology services are Medicare benefits in many settings. Individuals who are Medicare beneficiaries may receive evaluation and treatment in inpatient and outpatient hospital settings, skilled nursing facilities (SNFs), rehabilitation agencies, comprehensive outpatient rehabilitation facilities (CORFs), home health agencies, and hospices. The most recent improvements in coverage have been the dramatic growth in rehabilitation agencies and the recent additions of the CORF and the hospice benefits. However, these new coverage sites have not included audiology services, either diagnostic or rehabilitative. ASHA does view the incentive for health maintenance organizations participating in Medicare risk contracting to include hearing aids as a positive incentive because benefits have been expanded.

Such modest expansions still lag far behind the needs of the older American. For example, many nursing homes do not provide, or provide only a minimal amount of services to persons with speech, language and hearing impairments (Mueller and Peters, 1981).

For those Americans who qualify for Medicaid, many states have found speech-language pathology and audiology services important. Services for

individuals with speech, language, or hearing disorders is an optional benefit under Title XIX. Nevertheless, many states include the benefit in various ways. According to an ASHA survey completed in 1983 (Downey, White and Karr, 1984), speech-language pathology services were covered by all states but 4 for hospital inpatients, all but 6 for hospital outpatients. Thirty-five states covered speech-language pathology services in skilled nursing facilities and through home health agencies. Most states (35) used speech and hearing clinic services as a benefit while 22 extended the benefit to independent speech-language pathology practitioners. Audiology coverage by the states was similar for hospital services but somewhat less for other settings. Skilled nursing facility coverage existed in 29, home health agency coverage in 24, speech and hearing clinic coverage in 29, and independent audiology practitioner coverage in 23.

Medicaid coverage of hearing aids was extended to children in all states because of the Early and Periodic Screening, Diagnosis and Treatment program required by federal law. The ASHA survey also found that hearing aid benefits for adults was present in a majority of the states (27). Therefore, elderly Americans who qualify for Medicaid, i.e., are poor, can receive rehabilitation services through programs in some states.

Hearing Loss

According to reports from the National Center for Health Statistics, hearing impairment ranks among the five most prevalent chronic conditions affecting the physical health of older persons. The prevalence of hearing impairment in the United States has been estimated to be 8% of the civilian non-institutionalized population or 21.1 million Americans, 1% of whom are deaf. For those over 65, the prevalence rate is 31.1%. Demographers have estimated that as a direct result of aging, hearing impairment will in crease approximately 102% as the U.S. population increases 36%. In 1980, the over-65 group with hearing loss constituted 43% of the total U.S. hearing impaired population. This percentage is projected to increase to 59% by the year 2050.

More recent data (Ries, 1985) are descriptive of hearing loss as it relates to aging. The findings were only for the non-institutionalized civilian population based on their responses to an interview. As such, careful interpretation of how these figures translate for those in residential facilities or who have military benefits must be taken into account, obviously an important consideration when the "older of the old" are the fastest growing segment of the aging group.

Tables I and II reveal prevalence of hearing impairment by age. Of the 21,190,000, a total of 8,229,00 or 31.13% are 65 or older; 4,208,000 or 25.84% are between 65-75 and 4,021,000 or 39.64% are over 75 years. Note that tinnitus (ringing in the ears), which may or may not be accompanied by hearing impairment, is reported by 2,213,000 of those over 65.

It is easy to see that one of the most pervasive health problems for America's older citizens is hearing loss. However, the Medicare program just barely covers needed evaluation and rehabilitation services for the hearing impaired and will not reimburse for any service remotely related to the most important assistive device available to the hearing impaired - the hearing aid. Approximately 16 million people in the United States have hearing loss and, of this number, more than 10 million of these people are 65 years of age and older. These 10 million persons represent approximately 31 percent of the non-institutionalized elderly population (National Health Interview Survey [NHIS], 1984). Hearing loss now has become the third most prevalent chronic condition among the non-institutionalized elderly population (National Center for Health Statistics [NCHS], 1984).

The Office of Technology Assessment succinctly divided the impact of hearing loss into two categories: the clinical impact and the psychosocial impact. The clinical impact of hearing loss in the elderly is the better known of the two areas of concern: the inability to hear speech and environ-

mental sounds, the inability to tune out background noise, and the inability to hear high frequency sounds. The psychosocial impact is the result of the interference of hearing loss on communication. As the OTA Report indicated, "Communication plays an essential role in maintaining relationships and the quality of life, and hearing loss deprives not only the individual, but also family and friends, of easy communication" (OTA, 1986, p. 18). Not only are family relationships severely strained but hearing impairment limits access to information that is normally available through personal communication, television, radio, and telephone. Other consequences of hearing loss, especially when coupled with aging, are severe: coping with loss of income and decreased sense of usefulness associated with retirement; loss of relationships due to the death of a spouse, siblings, and friends or due to a physical move; and diminished health, energy and mobility. According to Becker, et. al. (1984), most elderly people can cope with these losses but hearing impairment interferes with the coping process by hindering the person's ability to become involved in new activities, form new relationships, and arrange for needed services.

For some people, hearing loss can lead to withdrawal, social isolation, and depression caused by lack of interpersonal relationships. Other severe problems reported are: paranoid symptoms (Zimbardo and Anderson, 1981), dementia (Herbst and Humphrey, 1980), and the appearance of confusion (Thomas, et. al., 1983). All of these problems are typical of reasons for a family's contemplating admission to a nursing home. In combination, they would accelerate that thinking. According to the OTA report (1986):

> Nursing home residents are very likely to have hearing impairments that can be particularly devastating for several reasons. The move to a nursing home requires adjustment to a new environment, new people, and new daily routines. Hearing impairment interferes with the individual's ability to develop relationships with staff and other patients and to fully understand the daily schedule. One regular visitor to a nursing home reports a comment that is heard all too often with regard to hearing impaired residents, 'Don't bother talking to her, she can't hear you.'
> (Office of Technology Assessment, 1986)

And yet, Medicare will not help these older Americans. Medicare's avoidance of the problems of hearing loss in older people will not stop the changes in our society. Demographers predict that there will be an increase in hearing loss for Americans 65 years and older from 28.6 million in 1985 to 39.2 million by 2010 and 64.6 million by 2030 (Punch, 1983).

Devices

Hearing Aids

The use of hearing aids is well known in our society of high technology. Hearing aids are becoming smaller in size and more accepted by older Americans. Today there are five different types of hearing aids: in-the-canal (made popular by its small size and worn by President Reagan), in-the-ear (somewhat more larger), behind-the-ear, eyeglass, and body worn. A dramatic change has taken place in the past few years in the types of hearing aids sold. According to Cranmer (1985, 1987) the following proportions reflect hearing aids sold in 1983 versus 1986:

	1983	1986
in-the-canal	not available	24.15%
in-the-ear	51.20%	49.61%
behind-the-ear	44.45%	24.29%
eyeglass and body (combined)	4.35%	1.95%

The smaller hearing aids are capturing most of the hearing aid market not only because of their size but because of the ability to maintain quality of sound with miniaturization of electronics.

Recent surveys also indicate that older Americans are the major users of hearing aids. Cranmer (1985) reported that 64.27% of hearing aid dealers clients were over 65 while 52.69% of the hearing aids dispensed by audiologists were to patients over 65. The Market Facts survey conducted for the Federal Trade Commission found the following proportions of hearing aid purchasers: ages 2 to 39 - 8%, ages 40 to 49 - 3%, ages 50 to 59 - 11%, ages 60 to 69 - 31%, ages 70 to 79 - 30 %, ages 80 to 89 - 14%, and ages 90 to 99 - 3%. Interestingly, 47% of those surveyed by Market Facts (1985) were very satisfied with the use of the hearing aid and another 37% were somewhat satisfied with the hearing aid.

There are three service providers of hearing services: audiologists, physicians and hearing aid dealers. Audiologists hold master's or doctoral degrees and provide and coordinate services to the hearing impaired which include detection of the problem and management of any existing communication handicaps. The are over 7200 audiologists of which about 40% of which dispense hearing aids. Physicians, especially otolaryngo logists, can diagnosis and treat medical conditions of the ear and some are involved with hearing aid delivery.Hearing aid dealers are not required to complete any university training but may have completed a home study course and supervised practical experience. Of the three providers of services, only physicians and audiologists can participate in the Medicare program at the present time.

Older Americans who have difficulty affording hearing aids find no relief from the Medicare programs. The current average price of a hearing aid, $513.01 (Cranmer, 1987), is expensive in light of a fixed income. As the Office of Technology Assessment (OTA) of the Congress of the United States wrote:

> "Third-party payment, including Medicare and Medicaid, is available for medical and surgical treatment but usually not available for hearing aids, assistive listening devices, and some aural rehabilitation services. Thus, these reimbursement programs fail to fund the treatments that are most effective for elderly people."
>
> (Office of Technology Assessment, 1986)

OHTA's statement becomes more remarkable in light of Medicare coverage of cochlear implants; a decision that occurred following publication of the OHTA Background Paper. If a Medicare beneficiary is eligible for surgery to implant electrodes in the ear in order to permit the electrical stimulation of the auditory nerve, the Medicare program will pay for the surgery and the device that transduces the signal. Conversely, if another Medicare beneficiary had usable residual hearing and would profit from hearing aid wear, the Medicare program would deny coverage of any hearing aid related expense. Ironically, a hearing aid and associated aural rehabilitation services would cost the Medicare program substantially less than a cochlear implant now covered under diagnosis related group (DRG) 49, Major Head and Neck Procedures. ASHA believes that coverage of hearing aids and related services must be covered by Medicare if return to good health is a priority for the Medicare program.

Assistive Listening Devices

Hearing aids are not the only solution to rehabilitation of Americans with hearing loss. Assistive listening devices are similar to hearing aids in that they amplify sound but differ because they transmit sound directly from the source to the listener, e.g., the device can send the voice of a lecturer to the individual in the audience. Other assistive listening devices work similar to a hearing aid but are not fitted to a specific individual, that is, anybody with a hearing impairment may use this device on a temporary basis. An example of this type of device would be a hand-held

amplifier that could be used to facilitate communication between a person with a hearing loss during someone's visit to their home.

Augmentative Communication Devices

Another major shortcoming of the Medicare program is a lack of coverage for augmentative communication devices. As the Office of Technology Assessment, in their report, Technology and Aging in America (1985), indicated, assistive devices for speech may range from a manual communication board on which the individual points to a symbol or what he or she wants to say to a complex electronic communication board with memory and print-out capability. The augmentative communication device may be one in which the individual uses a switch to activate a cursor on the board to indicate words or messages.

In the United States, it has been estimated that as many as 1.5 million persons have expressive communication disorders that could benefit from an augmentative communication device or aid (Bureau of Education for the Handicapped, 1975). These speech and/or language disorders primarily affect the expression of thoughts, ideas, and feelings and prevent independent communication. Although ASHA does not know how many older Americans are represented in this number, a large proportion is assumed to exist because the need for communication devices includes individuals with Parkinson's Disease, head and neck cancer, stroke, amyotrophic lateral sclerosis (ALS), other progressive neurological diseases, spinal cord injuries and traumatic head injuries. The common goal is to improve the daily lives and opportunities of individuals with severe expressive communication disorders but Medicare has built a barrier in meeting the communication needs of these individuals. These people are usually eligible to receive speech-language pathology services but without financial support for needed assistive devices. Medicare considers communication devices (e.g., Communic-Aid) as "convenience items" (Medicare Coverage Issues Manual, HCFA-Pub. 6, Section 60-9). Consequently, families, community organizations, charities, and some private insurance companies and state Medicaid programs assume part of the responsibility for providing nonfunctional speaking people with these needed devices. Unfortunately, the grim reality is that many such individuals who receive Medicare benefits go without these devices and so remain communicatively dependent and need high cost daily personal care.

Ironically, these devices are viewed in a similar fashion as are hearing aids by the Medicare program, i.e., the program will pay for surgically related devices but not devices required because of disease or disability alone. Guidelines sent by the Health Care Financing Administration to fiscal intermediaries deny coverage for augmentative communication devices while paying for artificial larynges. The Medicare rational in this instance is that the body organ (the larynx) is still present in the person who requires an augmentative communication device while the laryngectomized patient has literally lost his or her voice because of surgery. Even though the individual no longer has the neurological ability to use his or her voice, the body organ remains intact thus causing a Medicare denial of payment for an augmentative communication device.

Even the devices that are the highest in cost, although proportionally small in number, have been viewed as important. Paul Rettig, Vice President for Health Care Policy of the Health Insurance Manufacturers Association, wrote that "some very high cost technologies, such as computerized communication aids, may be found useful and cost-effective in individual cases" (Business and Health, April, 1987, p. 64).

Aural Rehabilitation

Aural rehabilitation is a concern to both speech-language pathologists and audiologists who treat Medicare patients in certified skilled nursing facilities. Clients in nursing homes may be in the most acute need for aural rehabilitation services but Medicare vagaries may prohibit the receipt of such

valuable assistance. The counseling, speechreading (also known as lip reading), hearing aid orientation, and auditory training are much needed by our older fellow citizens. Hearing loss among nursing home residents has been reported to range from 48-82% of the elderly in long term care facilities according to prevalence studies. Mueller and Peters (1981) reported that nursing home administrators estimated 33% of SNF residents had hearing problems.

The use of both a hearing aid and an assistive listening device can only be effective in conjunction with an aural rehabilitation program. Unfortunately, neither the statute nor the regulations address aural rehabilitation and, consequently, contradictions occur in Medicare coverage for aural rehabilitation. One fiscal intermediary, Blue Cross and Blue Shield of Missouri wrote, "Generally, aural rehabilitation for presbycusis (hearing loss due to aging) would not meet Medicare criteria as reasonable and necessary" (Medicare Bulletin #788, 1984). This interpretation is in direct opposition to a Medicare Region III (Philadelphia) letter that stated "If a patient exhibits a severe hearing loss, regardless of the cause (e.g., 'the aging process') and the speechreading services are 'reasonable and necessary' in order for the patient to function adequately and safely in a day-to-day basis, speechreading services may be covered" (Health Care Financing Administration, Region III, 1982)

Independent Practice

Similarly, access of beneficiaries to speech-language pathology and audiology services is a major concern for ASHA. Currently, independent practitioners of physical therapy and occupational therapy are eligible for direct Medicare reimbursement but the independently practicing speech-language pathologist is not and the audiologist only has coverage for diagnostic services. Like physical therapists and occupational therapists, speech-language pathologists are eligible to provide services in all Part A and Part B settings. The restriction against independent practice coverage for the speech-language pathologist and audiologist denies access to Medicare beneficiaries who may not have a hospital, comprehensive outpatient rehabilitation facility, or rehabilitation agency within a reasonable distance and restricts physicians in the choice of referrals. These people will more than likely have a speech-language pathologist nearby who will be able to provide evaluation and treatment services if Medicare coverage was available.

Professional licensure is required for speech-language pathologists in 36 states and licensure for audiologists is mandatory in 37 states. Medicare and other federal and state programs such as Medicaid and Vocational Rehabilitation require the ASHA Certificate of Clinical Competence for those professionals participating in service delivery. Therefore, adequate protection is afforded the Medicare beneficiary with coverage extended to the independedent practitioner.

Naturally, the population that lives in rural America and in other underserved areas of the country will be the primary benefactor of such a change in Medicare statute. People who have had strokes and, consequently, lost the ability to speak well and become dependent on others will be afforded the opportunity to regain independence. The same would be true for Americans with hearing impairment and other communication disorders such as that resulting from laryngectomy and traumatic head injuries.

Two Year Waiting Period

ASHA believes that the time has come to eliminate the two-year waiting period for disabled Americans to become eligible for Medicare benefits. This waiting period creates an artificial delay before receipt and coverage of important rehabilitation services. Precious time is lost for the person to receive benefits that can improve independence.

RECOMMENDATIONS

The American Speech-Language-Hearing Association has developed a proposal that will eliminate the current failing of the Medicare system as it relates to communication disorders. Our concept for a reorganization of the speech-language pathology outpatient benefit has been directed toward a quality assurance program as well as cost containment methodology. We believe that older Americans who have disability or impairment that results in isolation because of an inability to communicate or communicate well will be served by this plan. We have examined Medicare Part C proposals and believe that our proposal includes the merits of that legislation but additionally addresses augmentative communication device coverage, better accessibility to care, and clarifies vagaries in current Medicare coverage of audiology services.

1. Remove speech-language pathology from the current location [42 U.S.C. Sec. 1395x, Sec. 1861 (p) of Title XVIII of the Social Security Act] in the Outpatient Physical Therapy Services section and create a new Communication Disorders Services section.

2. Delete the exclusion of hearing aids and examinations therefore [42 U.S.C. Sec. 1395y, Sec. 1862 (A)(7) of Title XVIII of the Social Security Act] in the current law.

3. The new Communication Disorders Services section should provide that:

   A. Beneficiaries are eligible for necessary speech-language pathology, audiology and related disorders services and devices.

   B. Speech-language pathology and audiology services are available from current Medicare providers and from ASHA certified, and, where appropriate, licensed independent practitioners.

   C. Beneficiaries are eligible for hearing aid evaluations and hearing aids (one hearing aid every three years) if the hearing aid meets standards established by the United States Veteran's Administration and other appropriate standards (e.g., the United States Food and Drug Administration standards for hearing aids) and other augmentative communication devices when recommended by a licensed or certified speech-language pathologist or audiologist.

      1. Beneficiaries would be required to make a copayment of $150 (with payment level indexed to the cost of living) for any device and the Medicare program will reimburse up to $400 (indexed to cost of living) for a hearing aid or $600 (indexed to cost of living) for an augmentative communication device. Beneficiaries must be provided with a trial period of not less than 30 days. The Secretary is authorized to remove a provider from this benefit if the provider has a rate of return which significantly exceeds the national average and the provider has been afforded a hearing. If the beneficiary returns the device because of an inappropriate fitting, the copayment is to be returned to the beneficiary.

      2. Providers eligible to render this benefit include: prospective payment exempt rehabilitation hospitals, prospective payment exempt rehabilitation units of hospitals,

hospitals and hospital units accredited by the Joint COmmission on the Accreditation of Hospitals as providing comprehensive rehabilitation programs, facilities accredited by the Commission on Accreditation of Rehabilitation Facilities, speech-language pathology and audiology providers accredited by the Professional Services Board of the American Speech-Language-Hearing Association, comprehensive outpatient rehabilitation facilities, public health agencies, clinics which provide outpatient speech-language pathology services, rehabilitation agencies, and independently practicing speech-language pathologists and audiologists. The provider of hearing aid related services, in order to be eligible, must provide the following on-site:

a. audiological evaluations

b. audiometric facilities and equipment that conform to standards of the American National Standards Institute

c. aural rehabilitation and counseling

D. For the purposes of this benefit, "necessary speech, language and hearing services and devices" is defined to mean those services and devices necessary to either restore, maximize or maintain the functional communication abilities and related abilities of the beneficiary as determined by a licensed or certified speech-language pathologist, audiologist or physician.

The American Speech-Language-Hearing Association will endeavor to make certain that the benefit described above is developed in such a way to assure maximum independence for older Americans at a level that will promote independence of life and mitigate against the need for long term care.

Statement of the American Urological Association
to the
Committee on Finance
United States Senate
July 13, 1987

The American Urological Association is pleased to submit the following statement to the Committee on Finance for its consideration as it examines budget reconciliation issues relating to physician payment under Medicare. AUA's membership of 6380 represents the majority of physicians specializing in urology.

The American Urological Association is very concerned that the nation's budget deficit continues to force the Administration and Congress to seek funding reductions in the Medicare program. We believe that the many program changes and spending cuts that have been made in recent years tend to undermine the confidence that patients, physicians, and institutions have in the Medicare system. We realize that Congress is faced with many difficult choices in dealing with the budget deficit; however, we caution you not to choose deficit reduction measures that could jeopardize the future of the Medicare program for its beneficiaries.

Recognizing the responsibilities you have, AUA believes it is imperative that physicians discuss with you the various deficit reduction proposals affecting Medicare in order to seek those that will cause the least disruption to the delivery of medical services. Our comments will focus on three areas of possible savings. The first is the selective reduction in payment of certain surgical and medical procedures for which current levels of payment are alleged to be excessive. The second is an across-the-board adjustment to the Medicare Economic Index. The third relates to geographic variations in payment for services.

The House Ways and Means Health Subcommittee has, as part of its reconciliation package, agreed to reduce the Medicare prevailing rate for nine procedures by 15 percent below 1987 levels. This is effectively a 15 percent cut in payment. Limits on balance billing would be applied. One of the procedures targeted for payment reduction is prostate surgery. We are extremely concerned by this entire approach to budget savings and especially by the inclusion of prostate surgery. We believe there is a fundamental misunderstanding of the procedure. Therefore, before we turn to discussing the specific budget proposals, we think it is important to offer you some insight into prostate surgery, especially the transurethral resection of the prostate (TURP), which is the more commonly performed prostate procedure. It is the volume of procedures performed and the total of the program costs that have drawn the government's attention to this procedure. AUA thinks that an understanding of the procedure is essential before you look at the reasonableness of its reimbursement.

All men have a prostate gland, and as men age, most of them experience benign growth in that gland. What causes this enlargement is not clearly understood. However, it does occur quite commonly, and the longer a man lives, the more likely he is to experience problems associated with that growth.

Because men live longer today, prostate problems are becoming as common as gray hair and balding. As the prostate enlarges, it spreads, tightens around the urethra like a clamp around a garden hose, and interrupts urine flow. Surgical intervention, a prostatectomy, relieves this problem. There is no medical alternative. If treatment is delayed too long, or if the condition is not treated, it can cause bladder damage and kidney failure. Prevention of these conditions is an important aspect of this surgery. Treating kidney failure is far more difficult and expensive than performing prostate surgery. Timely surgical intervention prevents these complications from developing. The TURP is, in the best sense, preventive medicine in that it is curative of the problem and will, if done on a timely basis, avoid complications to the bladder and the kidneys.

Once the process of enlargement begins, the issue is not what to do but when to do it. Remember, for most men who live long enough, the enlargement will cause pain, discomfort, and other problems that can only be relieved by surgery. The question for the surgeon is when is the most appropriate time to perform the surgery. The timing will vary somewhat from patient to patient, but in general, urologists agree that certain indications always require immediate surgical intervention. These include urinary retention, when the blockage has become so severe that the patient can no longer urinate and will die if surgery is not performed. The second indication dictating surgery would be frequent bleeding or infection. When these sorts of indicators show up, surgery must be performed and quickly. These are the kinds of emergency situations that urologists hope to avoid by performing the TURP early.

The other, more common, indications for surgery are the presence of symptoms of urinary disruption. This generally means that the patient is experiencing discomfort in urination, frequent urination, or other alterations of normal urinary function. The decision to operate depends upon the severity of this disruptive pattern. For some men, it may occur early in the growth of the prostate with obstruction resulting from a relatively small gland; other men may not experience these symptoms until the gland has gotten quite large. The degree of disruption to life caused by these symptoms is very important in determining when surgery will be performed, and each man will differ in his ability to tolerate them.

Thus, we see that the volume of prostate procedures results from an aging male population and the almost inevitable prostatic enlargement that accompanies long life.

The American Urological Association has published standards for various urologic procedures, including prostate surgery, and the indications for performance of these procedures. We think that adherence to these standards and effective utilization review in the hospital are ways to keep the volume at appropriate levels. Congress has already directed the PROs to have mandatory preadmission review and possible second opinions for a number of high-volume procedures. We understand that prostate surgery will be one of the procedures on that list. Thus, utilization review will be broadly applied, and inappropriate procedures should be eliminated. AUA sees this a positive development that can benefit both patient and surgeon.

A distinction should be made between the transurethral resection of the prostate (TURP) and the suprapubic or open prostatectomy. The choice of procedure by the surgeon is based largely on the gland size. A larger gland, perhaps 65 grams or over, is going to be removed by many surgeons using the open procedure. This is a function of the time it takes most surgeons to perform a TURP on a gland of that size. Physician and patient fatigue becomes a very critical factor in those circumstances. For the large gland, the open procedure is much quicker for the surgeon and less fatiguing for all parties. Nonetheless, the open procedure is substantially more expensive in its overall cost because the length of hospital stay for the patient who has had the open procedure is, on the average, twice as long as that of the TURP patient. Both procedures are considered major surgery. The open procedure is also harder on the patient since it requires a major incision which causes substantial discomfort. The TURP does not require an incision, and patients much prefer this procedure. They can be discharged sooner but must be cautious in their activities for several weeks. All of this argues for early intervention so that the TURP can be performed safely, and the patient can then get out of the hospital in three or four days rather than eight or nine.

AUA believes that most urologists are making an effort to intervene surgically at a time when the TURP can be performed effectively, thus sparing the patient the rigors of open surgery and the cost of a long hospital stay. Given the lower costs overall of the TURP to the government, it would seem that the reimbursement system should be structured to encourage the earliest appropriate intervention on behalf of the patient so that the TURP can be performed.

TURP is clearly the preferable procedure and has been so for many years. First introduced in the 1920s, TURP gained wide acceptance among urologists many years ago. The procedure is largely unchanged since then. Equipment improvements have occurred, most notably in the optics, but there have been no dramatic breakthroughs in technology. The surgical skills needed have remained unchanged.

Done properly, a TURP looks like a very smooth procedure. In the hands of a skilled urologist, it should be so, since he has had extensive training in it. Despite the apparent ease of its performance, educators in urology generally agree that the TURP is a difficult procedure to teach and probably the most difficult urologic procedure to learn. This is because it is a one-on-one procedure in a closed environment. Open procedures such as the open prostatectomy or a cholecystectomy are easier to teach because the physician in training can readily observe and participate in the operation. This is not possible in the TURP, so training is more difficult.

A study performed for HCFA by Drs. Stason and Mitchell has compared a TURP to a cholecystectomy in terms of relative difficulty and has determined that the TURP is less difficult. AUA believes this is incorrect and reflects a lack of understanding of the TURP. One way of comparing the relative complexities is to look at when in the course of physician training a person learns to perform a specific procedure. A general surgical resident will perform a cholecystectomy in the first or second year of training after medical school. In fact, many residents in general surgery could in their second year perform a cholecystectomy competently and with minimal supervision. On the other hand, the urological resident will usually not perform a TURP until well into the fourth or fifth year of training. We regard it as a difficult operation to do and require that the urologist in training have developed substantial skills in many areas before attempting to do it.

Even though the procedure appears relatively simple, even to other physicians who do not perform it, it is not. It is major surgery with all of the attendant risks to the patient if not done right. In fact, patients often need to be reminded that they have had major surgery and that recovery takes several weeks. The President's experience with his recent prostate surgery is instructive. Despite reports in the news media that the President was undergoing a relatively "simple procedure", his recovery of about six weeks was consistent with what should be expected. That recovery time is consistent with other types of major surgery.

We will now turn to the particular budget reconciliation items under consideration. One approach being considered involves selective reductions in payment for certain medical or surgical procedures for which current payment levels appear to be excessive. This is the one agreed to by the Ways and Means Health Subcommittee. AUA has a number of concerns about this approach.

Last year in the Omnibus Budget Reconciliation Act, Congress directed the Health Care Financing Administration to conduct "inherent reasonableness" analyses of high-volume, high-cost procedures. The purpose was to examine the appropriateness of payments and to make changes as needed. Prostate surgery is on that list. Since that work is still ongoing, we wonder why it is necessary to rush forward on another track and try to undertake a similar kind of effort, but without the study and analysis that HCFA is doing. AUA believes Congress should stick with the procedure developed last year. It allows for consideration of a variety of important issues, such as beneficiary impact, and permits participation and negotiation by physician groups. The proposal before the Ways and Means Committee does not.

The proposal to reduce payments for certain surgical and medical procedures is based largely on a preliminary feasibility study performed by Drs. Mitchell and Stason under contract with HCFA and subsequent recommendations of the Physician Payment Review Commission. For the first

time, an attempt was made to look at the relative values of certain surgical and diagnostic procedures to see if some of the procedures were overpaid compared to others. Clearly, this work raises some intriguing questions about physician charges and payments; however, the authors clearly noted the preliminary and tentative nature of their study. We do not view that single study as sufficiently convincing evidence for Congress that would allow intelligent and equitable judgments to be made about the relative worth of physician procedures in general or about the few that they specifically identify. AUA thinks it would be extremely ill-advised to proceed at this time on this course.

We believe the wiser decision would be for the Physician Payment Review Commission to continue to look at this avenue of approach and to make further recommendations after more careful examination and debate. If this were a new medical procedure, physicians would be reluctant to embrace it until there had been an opportunity for replication of the studies and adequate peer review. If it were a new drug, the government would mandate this cautious type of approach. The study of Drs. Mitchell and Stason has yet to be subjected to the kinds of review, comment, and criticism that is appropriate for a work of this magnitude. Until the many questions already raised about this study are answered, Congress should not use this work as a basis to proceed with cuts in payment for selected procedures.

A troubling point for AUA is the allegation by PPRC that the relative value scales used for comparison with Medicare "undervalue" TURP compared to Medicare. Presumably, payment based on these relative value guides would be less than Medicare payment. Yet an informal survey of urologists in nine states indicates that private payors <u>always</u> pay more for a TURP than does Medicare. It would appear from this limited data that Medicare "undervalues" the TURP, not the private sector.

In addition to the overall problems with this study, the authors express a real misunderstanding about urologic surgery. Drs. Mitchell and Stason refer to open prostatectomy as more complex than TURP. This is absolutely wrong. The TURP is much more difficult. Problems like this must be resolved before Congress acts on the basis of their work.

There is no question that there are many issues in physician payment that need to be addressed. For example, are procedures more highly valued than the so called cognitive services? That is difficult to answer, but certainly it is appropriate to look at payment levels and try to reach some conclusions. The HCFA-Harvard study of relative value scales is attempting to do this. An examination of prices should look at the risks assumed by the physicians, the stress of doing the procedures, and the benefit to the patient.

One area that we are very concerned about is geographic variation in payments. AUA recognizes that there are legitimate differences in the cost of doing business which need to be reflected in fees. However, we do not think that all the variation in fees can be accounted for on the basis of differences in costs of living. More work needs to be done in this area.

We are also aware that the incidence of procedures tends to vary around the country and we are not at all certain about the rationale for that. However, rather than assuming one answer or another, we would be most interested in working with Congress, HCFA or the Physician Payment Review Commission to see if we can't answer these questions and decide what steps should be taken.

AUA has commissioned two studies to be done relative to TURP so we can get a better handle on what is happening. The first is a major scientific study which will look at the performance of TURP in a variety of settings and deal with the medical issues surrounding it. The second is a survey of all urologists which will look at some of the practice and socioeconomic issues surrounding TURP. We hope that through these two studies, AUA will gain information which will be valuable not only to us but also to policy

makers. We would be pleased to share the results of this work with the Members of this Subcommittee when the studies are completed.

AUA recognizes the compelling need to achieve budget savings for FY 1988; however, we hope that Congress will not make a decision today that will cause an erosion in patient access to services some time in the future. We are concerned that older experienced urologic surgeons, at the peak of their career, may decide that the pressures and costs of doing business are too troublesome to continue in practice. These physicians may well decide to retire early, which means that the patient no longer will have available to him the wide range of skill that now exists. It means that many Medicare patients would have their prostate surgery by the easier, open prostate procedure, requiring many more days of hospital expenses.

We think a clear example of this problem exists in obstetrical care in many states where the incredible growth of professional liability insurance premiums has made the practice of obstetrics either unattractive or impossible. As these obstetricians retire or stop delivering babies, expectant mothers find that their access to care is significantly reduced. In many states, pregnant women now have large distances to travel for their prenatal care. Such a situation is obviously not desirable and we would be disturbed if decisions about payment for Medicare patients lead to similar results. As an example of what happens when cost cutting continues unabated, one only need look at the Medicaid program in many parts of the country. In many states, Medicaid payment is so low, it is often not worth the cost of processing the paper for payment. It would certainly be unfortunate if Congress took actions that had the same corroding effect on the Medicare program.

Two other observations are important. First, the TURP is probably the most common surgical procedure performed by urologists. For many, it is the bulk of their surgical practice. A major reduction in payment for TURP would be a severe financial blow.

Second, a cut targeted on TURP payments would punish urologists whose fees have been reasonable far more severely than those few urologists whose charges have been outlandish. Across-the-board cuts of this magnitude are unfair in the extreme, especially when they are not based on credible evidence that payment levels are improper.

The AUA believes that the time is not right for Congress to proceed with still another version of the "inherent reasonableness" analysis. HCFA is already working on this process at Congress' direction. Additionally, work is ongoing at Harvard on relative value scales and we urge that you wait until that work is in and adequately reviewed before you make any decision to fundamentally alter payment levels or mechanisms. We certainly have concerns about the way that program at Harvard will come out, but we think it is preferable to work within that framework rather than to simply make arbitrary decisions about payments for selected procedures.

AUA recognizes that program savings must be found in order to meet the budget targets. We have a specific suggestion for how the Congress may be able to provide savings without significant program disruption. AUA believes that some savings can be found from adjustment to the Medicare Economic Index. We are not enthusiastic about another freeze and we recognize that other medical organizations do not share our view. However, we believe that it spreads the misery and does not unduly burden any one specialty or any one procedure. You may wish to recommend that certain physicians who would be especially disadvantaged by a further freeze get some special consideration. In any event, we feel that adjustments to the Medicare Economic Index are an appropriate source of savings. Both customary charges and prevailing charges could be held at current levels.

As noted earlier, we are also concerned about the geographic variations in payment. We think that this is an area which the Committee could look at and perhaps find some initial savings this year and other savings in future years as the methodology for reviewing these problems becomes more secure. Such a system could measure the prevailing charges for a number of procedures against the national average. Payments higher than the national average could be reduced slightly in order to achieve savings and reduce geographic differences.

In conclusion, the American Urological Association is deeply concerned that the Medicare program continues to be a target for budget deficit reduction. We are very concerned about the future of the accessibility and quality of services for patients under the program. Second, we are persuaded that the proposal to cut selected procedures should not be adopted at this time. Much more work is needed. Third, we believe that short-term budget savings under Medicare can be found in proposals to adjust the Medicare Economic Index to hold customary and prevailing charge levels constant. Finally, geographic variation is a problem which is deserving of your attention and which may offer some savings to the Committee.

Mr. Chairman and Members of the Committee, the Association of Professional Sleep Societies is pleased to present our views concerning physician payment under the Medicare Program. As you well-know, our population's age distribution is shifting towards the elderly. Each year, a greater proportion of our medical practices are comprised of Medicare patients. The elderly have more diseases as a group and are individually more likely to have multiple diseases. New technologies can diagnose and treat those elderly at risk for medical catastrophes before death or disability claim their tolls in quality of life and Medicare expenditures. The control of high blood pressure is just one example. During your Committee's consideration of options for cuts in the Medicare program to achieve reconciliation targets, I believe it is vital that you remember that Medicare is designed and intended to provide top care to our nation's elderly. Every technological and scientific advance that is available to the medical community should be utilized to insure good health and longevity for our aged citizens. Too ofen decision-makers look at the Medicare program as a numbers issue. But those numbers translate into health care coverge and Medicare policy.

My specific message to you today is that many diseases, particularly those of the heart and lungs, change for the worse on a nightly basis during sleep. In people over 65 years of age, most disease-related deaths and disease-related medical catastrophes (such as heart attack and stroke) occur during the hours of sleep. Any reimbursement proposals for physicians, such as prospective plans based on Diagnostic Related Groups, or specific cuts in allegedly over-utilized procedures must recognize the 24-hour nature of disease and accordingly provide for responsible care. Current and proposed Medicare guidelines and payment policies force the health care system into short-sighted treatments because patients cannot afford the necessary tests for sleep related abnormalities. A further ratcheting down

of these policies in the name of cost containment would present additional likeliness of catastrophe.

internal medicine who have studied for additional accreditation in diagnosing and treating sleep disorders. The emphasis on internal medicine and specialized training stems from the fact that most frequent sleep disorders are associated with life-threatening cardio-pulmonary problems during the night, such as sleep apnea, asthma, heart disease and chronic obstructive pulmonary disease.

Our ability to differentially diagnose patients with sleep complaints has progressed rapidly in the past ten years. We now have well-accepted guidelines and rationales for treating sleep disorders with surgery, mechanical devices, medication or some combination of these approaches. There is broad consensus as to the life-threatening nature of cardio-pulmonary abnormalities in sleep and risks of falling asleep while driving a vehicle or operating dangerous machinery. Furthermore, recent studies indicate that over 90% of the patients evaluated by sleep disorders centers are significantly improved by recommended treatments. The great impediment that we face as clinicians is that the elderly are reluctant to seek out our expertise because Medicare already pays so little for the costs associated with testing. This fact has recently been supported by reports from members of the Association of Professional Sleep Societies. I will describe two types of life-threatening, yet treatable, medical conditions. For both, current Medicare policy effectively prevents treatment due to inadequate reimbursement.

Inappropriate use and overuse of sleeping pills is particularly common in elderly, Medicare patients. Many patients began such treatments years before modern knowledge was available. Most of the prescriptions for sleeping pills are written for this category of patients. Research indicates that cardio-pulmonary disorders, also common in the elderly, are exacerbated by sleep and account for the disproportionate number of medical catastrophes that occur during the night. Sleeping

pills enhance the depression of respiration and cardiac function that normally accompanies sleep. Inappropriate use of sleeping pills in the elderly may also contribute to confusion and locomotor problems and thus potentiate accidents and falls. This vicious cycle can now be broken with rational approaches to problems of sleep in the elderly.

Second is the major problem surrounding people who cannot stay awake to function. Such patients often take prescribed stimulants, to help them stay awake while driving a vehicle or during activities that require sustained alertness. The United States Senate, in report #99-152 accompanying the fiscal year 1986 Appropriations Bill for the Department of Transportation, has recognized the potential impact these disorders have on highway safety. Stimulants, such as amphetamines, are proper treatment for only 10% of the people who have prescriptions for stimulants. For example, the most common cause of an inability to stay awake in the day is the disorder of sleep apnea which is characterized by symptoms of loud irregular snoring and high blood pressure. Stimulants are medically inappropriate for such patients. Now we know how to correctly diagnose conditions of excessive somnolence and provide appropriate treatment for the millions of Americans with these symptoms, but in many cases Medicare policy prevents this important diagnosis.

We ask that this Subcommittee carefully review reimbursement practices for Medicare patients and suggest that revisions to the Medicare Guidelines be made which are in line with present knowledge and standards of practice. As a further policy recommendation, we do not believe it is advisable to increase Part B preminums or raise deductibles, unless a comprehensive benefit is added, such as the pending proposal that would establish catastrophic health care coverage. Right now, access and affordability are major obstacles to many elderly persons seeking health care.

Thank you for the opportunity to present our views.

College of American Pathologists

The College of American Pathologists, a national medical specialty society representing more than 10,000 pathologists who practice medicine in community and teaching hospitals and in independent laboratory settings, is pleased to present it's views on the proposal to include pathology services in a DRG payment system. The College believes that changes in the Part B system for physician services require careful analysis because of the potential adverse impact on quality, availability, and cost of physician services to beneficiaries. The current reimbursement system has, so far, assured Medicare beneficiary access to high quality medical care. It should not be abandoned in favor of other forms of payment which have not been adequately investigated. While there are problems with the current system, we believe that precipitous change is not warranted.

Pathology Services to Patients

Our concerns will be better understood if we first describe what a pathologist does and then describe how pathology services are currently paid under Medicare. Pathology is generally divided into two major categories: clinical pathology and anatomic pathology. The pathologist specializes in diagnosing diseases found in all areas of the body. Through examination of body tissues, fluids, or other specimens removed from the body, the pathologist determines whether disease exists, the nature of the disease, and what changes the disease has produced in the patient. The pathologist reports his or her findings to the patient's personal physician and assists that physician in determining the correct diagnosis and best course of treatment.

Often from the patient's perspective, the pathologist's work is not visible. Such is the case for a surgical patient who is on the operating table and anesthetized when the pathologist examines patient tissue and identifies whether or not disease is present. Similarly, the patient may be unaware that it is the pathologist who consults with the attending physician to determine the implications of unexpected laboratory test results or that it is the pathologist who investigates a transfusion reaction or performs a difficult blood crossmatch.

Pathologists practice medicine to find answers to bring together, on a daily basis, the scientific medical knowledge about disease and the patient's presentation of the disease. In this role, the pathologist most often will communicate his findings to the patient's personal physician. However, the pathologist's primary responsibility is to the patient -- to ensure to the degree possible that disease is accurately diagnosed.

The Current Medicare Payment System

Medicare regulations divide pathology services into two categories: physician services to an individual patient (e.g., surgical pathology, cytopathology, hematology, blood banking services) which are paid on a fee-for-service basis under Part B; and services which benefit all patients (e.g., quality control, infection control, technology evaluation and implementation, morbidity and mortality analysis, and laboratory administration) which are paid under Part A through the hospital DRG rate. Significant amounts of the pathologist's time and effort are involved in the provision of care to individual patients and are therefore billed on a fee-for-service basis to Part B. Therefore, proposals for change in the method of paying for Part B physician services are critically important to our members and the beneficiaries they serve.

The provider-based physician regulation which implemented Section 108 of TEFRA redefined Part A and Part B pathology services and eliminated hospital combined billing for physician Part B services. The regulation requires that Part B services be separately identified and billed to Part B. Today, like other physicians, most of our members are not paid by the hospital for Part B services; instead they directly bill on a fee-for-service basis for services to Medicare beneficiaries as well as to other patients.

Conversely, pathologists are precluded from billing the Medicare program or Medicare patients for significant portions of their clinical pathology services, even though the services are expected to be provided. This arbitrary redefinition of some pathology services to patients as Part A services resulted in disruption in coding and reimbursement for all pathology services. Our members and their Medicare carriers are still attempting to resolve these problems equitably.

No other specialty was affected by TEFRA so profoundly as pathology.

TEFRA regulatory changes in conjunction with the 1984-86 physician fee freeze had a severe impact on pathology. Many pathologists received Part B payments based on prior combined-billing arrangements that did not reflect historical charging practices of pathologists or the resource costs associated with the service. Payment for Part B services was frozen at levels which were often below what any objective analysis would deem reasonable. These problems significantly distorted the Part B database for pathology services.

Pathology services which are of general benefit to all hospital patients (e.g., quality control) are paid under Part A to the hospital in the hospital DRG rate. The financial incentives of the hospital prospective payment system have resulted in significant hospital pressures to reduce Part A payments to pathologists. Because Medicare rules do not require the hospital to make Part A payments to pathologists, some hospitals have refused to pay the pathologist for Part A services, even though the DRG rate includes payment for the service.

DRG-Based Payment for RAPs

The problems we have outlined above illustrate the inequities and arbitrary nature of the current system. The College believes a DRG-based payment system will not correct the inequities of the current system. Instead, it will exacerbate current problems and create new problems.

Pathologists recognize that payment for physician services will be reevaluated and considered in the context of limited fiscal resources available to the federal government. The College supports Physician Payment Review Commission efforts to advise Congress on a reasoned public policy for payment of physicians services and appreciates the difficulty of the task at hand.

Physician payment changes that single out radiologists, anesthesiologists, and pathologists for special treatment are not, in our opinion, justified. Pathology services should be considered as part of the comprehensive reform of physician payment that is under way. Piecemeal radical change for only pathology services and other selected specialties would be unnecessarily disruptive and could adversely affect patient care.

The Administration's FY 1988 budget proposes the use of MD-DRGs to pay for the services of radiologists, anesthesiologists, and pathologists (RAPs) to Medicare inpatients. The proposal is known as MD-DRGs for RAPs.

The MD-DRG proposal is an abrupt change in payment methods. The new system would include the services of pathologists and other selected specialties under a DRG payment system. Medicare would pay an average predetermined amount for RAP services for each Medicare hospital discharge according to the patient's hospital DRG.

Several options for implementation of RAP-DRGS have been discussed by Administration officials. Two basic options have been described:

1. Pay the MD-DRG amount to the hospital in the hospital Part A DRG rate with assignment mandatory.

2. Pay the MD-DRG amount to a medical staff entity comprised of radiologists, anesthesiologists and pathologists (RAP, Inc.) Assignment would not be mandatory, but there would be limitations on balance billing.

Each of these options has significant potential for adversely affecting the provision of pathology services and the quality of care available to beneficiaries. No one has demonstrated that any MD-DRG payment option is administratively feasible or equitable. Proponents claim that DRG payment would create incentives for greater efficiency. We believe a DRG system is more likely to lead to reductions in needed services and would compromise the individual physician's ability to provide quality care. We are opposed to DRG payment; none of the options for implementation is appropriate.

Reasons for Opposition to DRGs

The use of Diagnosis Related Groups (DRGs) as the basis of payment for all physician services has raised serious questions concerning the feasibility of this approach. We believe that DRGs are also inappropriate for pathology services. The reasons for our opposition are presented below and then followed by College recommendations for development of a rational system for paying for pathology Part B services.

1. Financial Incentives. Any MD-DRG payment system will introduce inappropriate financial incentives into the provision of direct patient care services to patients. Fee-for-service for physician services provided to hospital inpatients is an important countervailing force to the incentives now in place under the hospital DRG system. There is already much concern that the DRG prospective payment system for hospital services has great potential for suboptimal care. It is a mistake to extend the DRG system to the direct patient care activities of hospital-based physicians.

   If the hospital were paid the DRG amount, hospital-based physicians and attending physicians would be under pressure from the hospital to reduce Part B services to Medicare inpatients. Hospitals could earn a profit or lose money on Part B services. Hospital efforts to deal with these new incentives in the arena of physician direct patient care activities holds great potential for reducing quality. Hospital economic incentives should not be allowed to determine when, whether, or to what extent pathology services are provided to individual Medicare patients.

   If RAP, Inc., were paid the MD-DRG amount additional concerns become apparent. The financial incentive to reduce services would shift from the hospital to an entirely new artificial entity created solely to receive the DRG payment. There is no practical experience as a guide to assess probable impact of this arrangement, because group practice of RAPs is not consistent with medical practice patterns. The three involved specialties would presumably negotiate payment among themselves, but without the ability to control utilization of their services. We see no benefit to a system which forces physicians to trade off patient care resources among specialties.

2. Part B Data for Pathology Services. In the past few years, Medicare requirements for billing and reporting pathology services have undergone substantial and repeated changes. These changes have been implemented during the period when other general Part B program changes have occurred, such as Medicare carrier conversion to a common procedural coding system, imposition of a freeze on physicians' actual charges, and inclusion of some pathologists' services in the hospital DRG payment.

   The result is a Medicare Part B database for pathology services which is in a transitional phase and is inherently inaccurate. This data should not be used as the basis for yet another, and more radical, change in Medicare reimbursement policy for pathology services, such as an MD-DRG.

   The MD-DRG payment amount would likely be based on FY1984 or 1985 Part B allowed amounts. HCFA has publicly acknowledged that FY1984 data for pathology services are incomplete and inaccurate because of TEFRA

billing changes and the recent conversion to a new physician coding system (HCPCS). FY1985 and 1986 data will not be much better because the billing system will not reflect all of these changes. There is continuing variation in Medicare carrier implementation of HCFA instructions regarding reimbursement for pathology Part B services.

The physician fee freeze has compounded the problem of inaccurate and incomplete Part B data. Medicare Part B customary charges for pathology services prior to May 1, 1986, were often developed based on combined billing arrangements that predated the implementation of TEFRA. These compensation-related customary charges (CCRCs) limited Medicare payment to unreasonably low amounts because they were not based on historical charging practices of pathologists or on procedural resource costs. For example, one California pathologist's reimbursement for a complex diagnostic problem in surgical pathology was limited to his CRCC of $6.00. He received as little as 90 cents for the less difficult cases. In Connecticut, one CRCC for consultation during surgery was $2.70. Less difficult cases requiring gross and microscopic examination of tissue were reimbursed $1.90. Pathologists' low CRCCs were frozen from July 1, 1984, until May 1, 1986, when Congress eliminated the use of CRCCs in determining customary charges for pathologists who direct bill Medicare.

CRCC and non-CRCC charges continue to be combined to produce Medicare prevailing charges for pathology services. This results in prevailing charges which do not reflect actual charges of pathologists in many instances.

Medicare prevailing charge screens for pathology services are also affected by the lack of accurate historical charge data for pathology services. Many carriers used "gap filling" techniques to establish pathology prevailings during 1983 through 1986. In the normal course of events, gap filling applies to only a small number of the total services an individual physician provides over a very limited period of time. In the case of pathologists, gap filling was used by some carriers to establish prevailings for most of the services pathologists performed. Moreover, the physician fee freeze kept the "gap filled" prevailings in place until May 1, 1986.

3. The DRG as a Basis for Payment. To our knowledge, no definitive studies exist that demonstrate the DRG would be adequate for predicting expected pathology resource requirements. Given the Part B data problems I have described, it is unlikely that a study using historical Part B data could be relied upon to determine the feasibility of using the DRG as the unit of payment for pathology services.

The DRG averaging concept is unworkable when applied to pathology services. Pathology services provided to patients within a DRG are substantially dissimilar. Patients classified within the same DRG will require different pathology patient care services, depending on the stage of diagnosis and the treatment plan. Pathology services are provided to patients in association with surgical and other services which are not initiated by the pathologist. Therefore, the pathologist has little opportunity to shift resources between patients in order to adjust to a DRG averaging concept. The payment of an average DRG amount is likely to result in arbitrary underpayments and overpayments to individual pathologists.

4. RAP-DRG Budget Savings. Medicare Part B payment for inpatient RAP services is only 10% of total physician payments. Medicare Part B approved amounts for pathology services are less than 1% of total Medicare-approved amounts for physician services, according to a 1986 Congressional Budget Office report on physician reimbursement. In our opinion, the potential for budget savings is minimal.

We know of no studies which indicate that pathology Part B services are inappropriately ordered or over-utilized. Pathology services are

provided in association with surgical services or diagnostic procedures which are not initiated by the pathologist. Therefore, MD-DRGs for pathologists have no realistic potential for encouraging more effective utilization of pathology services.

5. Pathologists and Medicare Assignment. It has been suggested that DRG payment for hospital-based physician services could be implemented with mandatory assignment or with limits on balance billing.

Many pathologists are Medicare participating physicians and accept assignment for all Medicare services. A recent study funded by the Health Care Financing Administration (HCFA) shows that our specialty has a very high participation rate - approximately 50 percent of pathologists have signed participating physician agreements. Many pathologists who have not signed participation agreements do accept assignment for Medicare services. According to the HCFA-funded study, 17% of nonparticipating pathologists accept Medicare assignment on 100% of their cases. An additional 41% of nonparticipating pathologists accept assignment on some of their Medicare claims. Thus the assignment rate for pathology services is much higher than the participation rate. When more recent data on assignment rates by physician specialty are available, we believe they will continue to show that pathologist assignment rates are high.

Pathologists and Exclusive Contracts

The College is aware that some view the use by hospitals of exclusive contracts for physician services as potentially conducive to excessive fee levels. The experience of pathologists is that hospital administrations may prefer exclusive contractual arrangements in order to facilitate efficient and predictable delivery of pathology services to patients. Hospital administrations do exert considerable influence on pathologists to keep their fees low in order to limit beneficiary out-of-pocket costs. Information received from College members indicates that hospital administrators exert this influence whether or not a clause in the contract addresses this issue. It is in the best interest of the hospital and pathologist that fees are competitive; an exclusive contract may be an appropriate method of attaining this result. In addition, attending physician staff are concerned that fees of referral physicians are not excessive and informally exert their influence on pathologists.

Pathologists are afforded little protection by the exclusive contract. Most pathology contracts contain a provision for termination with 30 to 120 days' notice. Thus, the contract is effectively a 30-to-120 day contract. Any pathology group could be replaced quickly should the hospital perceive that to be in the patients' best interest. While a contract is in effect, pathology departments have provisions for honoring medical staff or patient requests for use of another pathologist. These requests are handled without disruption to the ongoing operation of the pathology department.

For pathology services the exclusive contract is often used as a means of assuring adequacy and continuity in the provision of laboratory services. We know of no study results or other evidence that exclusive contractual arrangements produce excessive pathology fees. It is not necessary to mandate assignment or establish arbitrary limits on pathologists charges in order to protect Medicare beneficiaries, to reduce excessive pathology fees, or to foster competition for pathology services.

6. Quality and Access. Some proponents of MD-DRGs for provider-based physicians claim that beneficiary access to quality services would not be adversely affected. We strongly disagree with that premise.

The financial incentive of an MD-DRG payment system is to reduce services because the payment amount would remain the same regardless of

the services actually provided. If the hospital is paid, the hospital would be imposed into the physician's medical decision-making process concerning the diagnosis and treatment of individual patients. It is our opinion that hospital-physician relationships would be disrupted. If RAP, Inc., were paid, physician relationships with one another would be disrupted. Disruption of these relationships should be of concern to federal policymakers because it will affect the ability of all physicians to provide high quality care. MD-DRGs would impose costly administrative burdens on the payment system with no assurances that quality would not be harmed. No studies exist which demonstrate the impact on quality and access of an MD-DRG payment system for pathology services.

7. Future Delivery of Pathology Services. Of particular concern to the College is the effect of radical change on the future supply of pathologists. Data from the National Residency Matching Program for 1986 show declining interest in pathology by medical school graduates. The percentage of pathology residency positions filled has declined from 67% in 1983 to 58% in 1986. In contrast, 86% of all physician residency training positions were filled in 1986. In 1983, 326 pathology residency positions were filled. Only 276 positions were filled in 1986.

   This decline began and continued during the disruption caused by TEFRA and the implementation of hospital DRGs in 1983. Pathology residents tell us that the MD-DRG proposal introduces additional uncertainties about the future of pathology that reduce the attractiveness of pathology as a medical specialty.

   A period of stability is now required to allow our specialty to adjust. MD-DRGs for RAPs would mean further disruption and would raise serious questions about the available supply of pathologists for the future.

Alternative Recommendations for Physician Payment Reform

The College recognizes that the Medicare payment system will be changed and supports appropriate efforts to improve Medicare payment methodology for physician services. We have described problems with current Medicare data on pathology services that make the data unsuitable as a basis for construction of MD-DRGs or any other radical change in payment methodology. The College is not calling for continuation of the current system, however. Instead, the College recommends the following approach to Medicare reform of payment for physician Part B services:

1. **Allow Medicare reimbursement policy changes made by Congress and the Department of Health and Human Services over the last 5 years, which have greatly affected pathology services, to be fully implemented and their effects known.**

   Only when pathologists and Medicare carriers have adjusted to recent changes will the Medicare database on pathology services move from a transitional to a stable mode. In the interests of equity and accuracy, this stabilization period should be allowed to occur.

2. **Consider the results of the Harvard University Relative Value Study.**

   Only last year, Congress directed the Secretary of HHS to develop an RVS and submit recommendations for its application. Pathologists and 29 other specialties are involved in this effort to establish a system of relative values among physician services. Results of the Harvard study may be useful in identifying the nature and magnitude of current inequities in the Medicare fee-for-service system.

3. **Reform the fee-for-service system across all specialties rather than considering drastic change in the current methodology for only selected specialties. Effective reform must consider the interrelationships of all physician services.**

The present system has afforded Medicare beneficiaries access to very high quality medical care because, with all of its problems, the fee-for-service system does provide strong physician incentives for excellence in diagnosis and treatment. Changing that system of incentives is an undertaking that has the potential for unintended adverse impact on Medicare beneficiaries. Changing the system precipitously and without first establishing an adequate and equitable database is even more risky.

It is totally inappropriate to establish negative incentives for diagnosis and treatment among a subset of specialist physicians whose services affect the ability of other physicians to provide high quality medical care.

The Physician Payment Review Commission has endorsed the concept of a Medicare fee schedule for physician services and said that recommendations for how a fee schedule would be implemented will be forthcoming. The Commission has also opposed the use of DRGs to pay for RAP services. A fee schedule for pathology services, paid directly to the pathologist and developed with appropriate data, could be an equitable approach to payment reform. The College strongly recommends that existing Part B data on pathology services not be used for development of a fee schedule for pathology services - it is incomplete and inaccurate.

Since 1982 Medicare requirements for billing and reporting pathology services have undergone substantial and repeated changes. These changes have been implemented during the period that other general Part B program changes have occurred, including Medicare carrier conversion to a common procedural coding system, imposition of a freeze on physicians' charges, and bundling of previously Part B physician services into the hospital Part A DRG payment.

The result is a Medicare Part B database for pathology services which is in a transitional phase and is inherently inaccurate. At this point there is no data in the Part B system which could appropriately be used as a basis for a fee schedule for pathology services.

- Customary charge data on pathology services reflects low compensation-related customary charges (CRCCs). CRCCs do not reflect historical charging practices of pathologists or procedural resource costs. Congress acknowledged this inequity and granted CRCC relief to direct billers on May 1, 1986. Medicare Part B data does not reflect these changes.

- Medicare prevailing charges for pathology services are also affected by the lack of accurate historical charge data. Many carriers used "gap filling" techniques to establish pathology prevailings during 1983 through 1986. The gap filling methodology is normally applied to only a small number of services that a specialty provides (such as services involving totally new technology) and is used only as a temporary way of establishing a payment limitation until actual charge data is available. In the case of pathologists, however, gap filling was used extensively, and the physician fee freeze kept the artificially developed prevailings in place until May 1, 1986.

  Even now, Medicare prevailing charges continue to be developed by the merger of CRCC and non-CRCC customary charge data. The result is unreasonably low prevailing charges in some instances.

We anticipate that 1987-1988 data on pathology Part B services will be free of some of the problems which I have outlined. We expect that when a fee schedule is developed for physician services in general pathology could be included in that fee schedule.

Conclusion

The College supports equitable reform of the Medicare Part B physician payment system. We are opposed to the arbitrary selection of a subset of physicians for inclusion in a payment methodology for which there is no experience, unacceptable data, and which holds potential for significant disruption in quality medical care. The College supports a reform methodology which involves correction of current inequities in the Part B system and which reforms payment methodology across all physicians in a reasonable manner.

The College of American Pathologists appreciates the opportunity of sharing with the Senate Finance Committee its views on the RAP-DRG proposal and on Medicare physician payment reform. The College will be glad to provide additional information to the Committee.

Statement on
Medicare Capital Reimbursement Policy
Submitted to the
Committee on Finance
of the
United States Senate
by the
COALITION FOR FAIR CAPITAL REIMBURSEMENT

Mr. Chairman, the Coalition for Fair Capital Reimbursement (the "CFCR") is pleased to submit this written statement to the Committee for inclusion in the record of the July 8, 1987 hearing on FY 1988 Medicare Budget Reconciliation Proposals. The CFCR fully supports the testimony on the issue of Medicare capital reimbursement given at this hearing by the American Hospital Association ("AHA") and the Federation of American Health Systems.

The CFCR is comprised of thirteen of the nation's most renowned major teaching hospitals:

University of Michigan Hospitals
University of Minnesota Hospitals and Clinics
Brigham and Women's Hospital
Mount Sinai Medical Center (Cleveland)
Queen's Medical Center (Honolulu)
Stanford University Hospital
University of Virginia Hospitals
West Virginia University Hospitals
Montefiore Medical Center (New York)
Mount Sinai Medical Center (New York)
New York Hospital
Presbyterian Hospital in the City of New York
at Columbia-Presbyterian Medical Center
St. Luke's-Roosevelt Hospital Center (New York)

Each of these institutions is undergoing or has recently completed a major building project to renovate or replace an antiquated, substandard, and in many cases, code-deficient facility. Accordingly, each of these institutions, like other hospitals with recent or pending building projects, has a critical interest in the Medicare Program's new reimbursement policy for capital-related costs.

Although an improvement compared to the Department's 1986 proposal, the capital regulations proposed by the Department of Health and Human services ("HHS") on May 19, 1987 still fall far short of providing a rational system for prospective payment of capital-related costs. For institutions like those of the CFCR, incorporating capital into PPS as proposed would be devastating. In fact, the CFCR institutions would suffer a 25% cut in their Medicare capital reimbursement over five years and a 30% cut over ten years if the proposed regulations were implemented. An analysis of the impact of the proposed regulations on the CFCR institutions, prepared by Dr. John Cogan of the Hoover Institution, is attached hereto as Exhibit "A". The proposed HHS policy would greatly harm hospitals with recent or pending necessary construction projects while providing windfalls to hospitals with low capital costs -- all without achieving any concrete programmatic goals beyond the substitution of one payment system for another. Making a commitment to prospective payment for capital

before developing a well-designed methodology is simply not rational.

The CFCR has been working with other hospital industry representatives since the beginning of this year to develop a unified position on the issue of Medicare capital reimbursement. Despite the best efforts of both the government and the hospitals to develop an adequate and equitable method for folding Medicare capital payments into PPS, no fair system has yet been proposed. Accordingly, the CFCR, together with the entire hospital industry, urges Congress to continue the current capital cost pass-through and defer the Administration's capital regulations for four years in accordance with the plan developed by the Health Subcommittee of the House Ways and Means Committee. As demonstrated by the testimony presented to this Committee by the AHA and the Federation, this position has the broad support of the hospital industry and reflects a strong consensus among hospitals in all parts of the nation.

Exhibit "A"

June 30, 1987

IMPACT ANALYSIS OF ADMINISTRATION POLICY

($ in millions)

	5-Year	10-Year	1988-2000
IMPACT OF ADMINISTRATION REGULATION[1/] RELATIVE TO COST REIMBURSEMENT			
Cost Based Payments.....	672.0	1455.0	1882.6
Administration Regulation..	506.1	1032.1	1309.2
Reduction.....	165.9	422.9	573.4
(Percent Reduction).....	(24.7%)	(29.1%)	(30.5%)
IMPACT OF ADMINISTRATION REGULATION RELATIVE TO CURRENT LAW REIMBURSEMENT			
Current Law Payments.....	606.7	1311.4	1696.2
Administration Regulation..	506.1	1032.1	1309.2
Reduction.....	100.6	279.3	387.0
(Percent Reduction).....	(16.6%)	(21.3%)	(22.8%)

1/ Administration policy impact does not include estimates of yet unspecified outlier policy. Interest allocation based on current medicare principles.

Hospitals included: Brigham and Women's, University of Michigan, University of Minnesota, Montefiore, Mt. Sinai at Cleveland, Mt. Sinai at N.Y., New York Hosp., Presbyterian Hosp. in N.Y., Queen's in Honolulu, St. Luke's\Roosevelt, Stanford University, University of Virginia, West Virginia Hosp.

LOSSES DUE TO ADMINISTRATION REGULATION
(Relative to Cost Based)

	5-year	10-year	1988-2000
BRIGHAM AND WOMEN'S HOSPITAL	7.3 (23.5%)	12.6 (19.9%)	10.3 (12.7%)
UNIVERSITY OF MICHIGAN	8.1 (19.3%)	15.2 (18.4%)	16.6 (16.9%)
UNIVERSITY OF MINNESOTA	9.2 (27.9%)	26.3 (37.6%)	36.6 (41.7%)
MONTEFIORE	28.9 (26.1%)	61.1 (27.5%)	79.4 (27.5%)
MOUNT SINAI, CLEVELAND	5.5 (20.8%)	10.7 (20.4%)	11.8 (17.6%)
MOUNT SINAI, NEW YORK	27.2 (28.2%)	64.5 (32.8%)	90.5 (35.3%)
THE NEW YORK HOSPITAL	21.7 (26.0%)	63.1 (33.5%)	92.2 (37.4%)
PRESBYTERIAN HOSPITAL	22.6 (29.0%)	52.8 (32.5%)	70.4 (33.2%)
QUEEN'S MEDICAL CENTER	6.8 (22.6%)	17.7 (28.6%)	24.3 (31.9%)
ST. LUKE'S\ROOSEVELT	10.1 (19.2%)	52.5 (32.3%)	82.5 (36.6%)
STANFORD UNIVERSITY	6.5 (20.0%)	16.1 (22.9%)	20.2 (23.1%)
UNIVERSITY OF VIRGINIA	7.6 (22.9%)	18.6 (24.8%)	23.5 (24.7%)
WEST VIRGINIA UNIVERSITY	4.4 (19.5%)	11.6 (24.8%)	15.2 (25.1%)
TOTAL LOSS	165.9 (24.7%)	422.9 (29.1%)	573.4 (30.5%)

Administration policy impact does not include estimates as of yet unspecified outlier policy. Interest allocation based on current medicare principles.

LOSSES DUE TO ADMINISTRATION REGULATION
(Relative to Current Law)

	5-year	10-year	1988-2000
BRIGHAM AND WOMEN'S HOSPITAL	4.4 (15.5%)	6.5 (11.3%)	2.3 (3.2%)
UNIVERSITY OF MICHIGAN	4.0 (10.5%)	7.0 (9.4%)	6.9 (7.8%)
UNIVERSITY OF MINNESOTA	5.9 (20.0%)	19.4 (30.7%)	27.8 (35.3%)
MONTEFIORE	18.3 (18.3%)	39.4 (19.7%)	51.0 (19.5%)
MOUNT SINAI, CLEVELAND	3.0 (12.4%)	5.6 (11.8%)	5.2 (8.6%)
MOUNT SINAI, NEW YORK	17.7 (20.4%)	45.0 (25.4%)	65.0 (28.2%)
THE NEW YORK HOSPITAL	13.6 (18.1%)	44.5 (26.2%)	67.8 (30.5%)
PRESBYTERIAN HOSPITAL	15.0 (21.4%)	36.8 (25.1%)	49.4 (25.9%)
QUEEN'S MEDICAL CENTER	3.8 (14.2%)	11.6 (20.8%)	16.7 (24.4%)
ST. LUKE'S\ROOSEVELT	4.9 (10.4%)	36.4 (24.8%)	60.1 (29.6%)
STANFORD UNIVERSITY	3.3 (11.1%)	9.1 (14.4%)	11.5 (14.6%)
UNIVERSITY OF VIRGINIA	4.3 (14.4%)	11.1 (16.5%)	14.0 (16.3%)
WEST VIRGINIA UNIVERSITY	2.2 (11.0%)	7.0 (16.6%)	9.3 (16.9%)
TOTAL LOSS	100.6 (16.6%)	279.3 (21.3%)	387.0 (22.8%)

Administration policy impact does not include estimates as of yet unspecified outlier policy. Interest allocation based on current medicare principles.

NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK, INC.

The National Federation of Societies for Clinical Social Work is pleased to have this opportunity to present the views of the clinical social work profession on issues relating to mental health coverage under the Medicare program. The National Federation represents thousands of clinical social workers around the country who are engaged in providing mental health services to individuals, families and groups, in private practice, in group practice settings, in HMOs, PPOs, EPOs, IPAs, in public and private clinics and agencies, and in hospitals.

THE NEED FOR IMPROVED OUTPATIENT MENTAL HEALTH COVERAGE UNDER MEDICARE

Medicare's outpatient mental health benefit may have been adequate when it was established over 20 years ago, when we knew very little about mental illness, but our understanding and treatment of mental health disorders have improved dramatically since then. Yet the amount that Medicare will pay for outpatient treatment of mental health problems has remained the same, even in the face of 20 years of inflation.

By limiting coverage to $250 a year for outpatient mental health treatment, Medicare clearly discriminates against mental illness by treating it as less significant than physical ailments. This difference in coverage of physical and mental illness should not be tolerated any longer. Our progressive understanding of health in recent years has increased our awareness that physical and mental health are inextricably connected. Studies have consistently shown that many patients going to physicians' offices for physical complaints have emotional and psychological problems which either have caused or aggravated the physical condition.

We urge Congress to end the discriminatory treatment of mental illness under Medicare and enact a meaningful increase in

the outpatient mental health benefit. This year, the House Ways and Means and Energy and Commerce Committees have voted to increase the outpatient mental health benefit by raising the current annual outpatient limit from $250 to $1,000. We applaud the efforts of both committees to improve mental health coverage under Medicare; however, we suggest that the dollar limit be changed to a visit limit in order to avoid the need to amend the law as the purchasing power of the dollar limit fluctuates over the years. Furthermore, in order to maximize the cost-effectiveness of the covered service, we urge that beneficiaries be given freedom of choice, so they can obtain covered services from any qualified mental health professional without regard to professional discipline. Specifically, we endorse the following approach to outpatient benefits, proposed recently by the Mental Health Law Project with the support of numerous mental health organizations:

> "Twenty-five visits to an eligible mental health professional for individual, group or family, or other form of psychotherapy should be covered. The eligible professional should be determined by state licensure and professional practice laws. Both public and private individual and group practice arrangements would be eligible to provide services.

MEDICARE'S RESTRICTIVE REIMBURSEMENT POLICY

Although an increase in the outpatient mental health benefit would do much to help some elderly beneficiaries pay for needed mental health services, as well as begin to bridge the gap in coverage between physical and mental health care, it would do little to make mental health services available to a large segment of the Medicare population unless it is coupled with freedom of choice among qualified providers. The mental health delivery system in the United States has grown up over the years around the availability of a number of qualified mental health professionals, without regard to the discipline of the provider, yet Medicare currently will only pay for services rendered by a physician. The law does not even require that the services be performed by a

trained mental health professional -- any physician will do. In this respect, the 20-year old Medicare program is out of step with the realities of today's mental health delivery system, which is universally recognized to consist of four "core disciplines" -- psychiatry, psychology, clinical social work, and psychiatric nursing. Consequently, many of the nation's elderly are often denied the freedom to select from a range of qualified providers simply because the therapist of their choice may be a clinical social worker and is excluded from the Medicare financing structure.

UNMET MENTAL HEALTH NEEDS OF THE ELDERLY

Several years ago, the President's Commission on Mental Health conducted an analysis of governmental policy in the area of mental health service delivery, with particular focus on underserved populations. Many older Americans were found to have insufficient access to services or to personnel trained to respond to the special needs of the elderly.1/ Moreover, the Commission found that the elderly have a greater need for mental health services than the general population (up to 25% of older persons are estimated to have significant mental health problems).2/

Since then, other studies and reports have confirmed the findings of the President's Commission. A recent General Accounting Office report determined once again that the elderly do not have adequate access to mental health services.3/ And a 1984 study by the Department of Health and Human Services found that less than 4 percent of psychiatrists' visits are provided to persons over age 65, even though this age group accounts for almost 20 percent of office visits generally.4/ Further, the study documents the fact that four out of five persons age 65 or older with a mental illness are seen by non-psychiatrist physicians.5/

THE NEED FOR FREEDOM OF CHOICE

Insufficient access to mental health services and to trained mental health professionals led the President's Commission

to recommend that Medicare and other publicly financed mental health service programs should provide direct reimbursement to all independent qualified mental health professionals including the four core disciplines, who meet the requisite standards of education, experience and professional licensure/certification.6/ The fundamental point made by the Commission was that federal financing mechanisms should be based upon the appropriateness of care, not the discipline of the provider.7/

It is particularly ironic that Congress, on the one hand, has appropriated funds over the years to train clinical social workers, under such programs as the National Mental Health Act of 1946, and, on the other hand, has excluded them from participation in the Medicare delivery system:

> ". . . [A] major barrier to outpatient care for populations with special needs is imposed by the public mechanisms for financing their mental health care -- Medicare and Medicaid . . . . Federal financing mechanisms have often worked at cross-purposes to federally initiated service delivery programs."8/

It is also ironic that at the same time Congress has guaranteed the patient through the Medicare law "freedom of choice" in selecting a provider, it has restricted that choice to only one class of provider -- physicians.

The President's Commission on Mental Health has not been alone in urging that the mental health delivery structure allow the consumer "freedom of choice" in selecting among qualified providers. Several years ago, Lewin and Associates, Inc. published the results of a study prepared for the Federal Trade Commission on competition among health practitioners, which examined the influence of the medical profession on the health manpower market. The study concluded that one of the principal ways to broaden consumer choice, and to diminish the monopoly power of physicians, was to allow consumers the freedom to select among a variety of health professionals. "If carefully designed, a system based on broadened choice could preserve professional competency while in-

creasing competition among providers on the basis of the service they provide, quality, and price."9/ The study warned that "unreasonable resistance to change in present manpower arrangements has, in some cases, prevented appropriate utilization of health resources and possibly raised the cost of care."10/

There is no basis for concern that expanding the provider pool to include qualified non-physician mental health professionals will adversely affect therapeutic outcome. To the contrary, research has demonstrated there is no measurable difference in outcome on the basis of provider discipline.11/

"Freedom of choice" can be a critical element in the patient's acknowledgment that he or she needs treatment, in the patient's actual resort to treatment, and in the relationship of trust and confidence in the psychotherapist necessary to make that treatment successful. Medicare beneficiaries should not be denied the opportunity to select from a range of qualified providers merely because the therapist of their choice is a clinical social worker, and not a physician.

THE FEHBP AND CHAMPUS EXPERIENCE

Other federally funded health insurance programs have recognized the importance of utilizing the services of clinical social workers and other qualified non-physician mental health professionals. A 1986 study conducted by the Office of Personnel Management examined the effects of providing direct reimbursement to clinical social workers and other non-physician providers under the Federal Employees Health Benefits Program (FEHBP). The results of the study were encouraging. OPM concluded there was no basis to anticipate adverse impact on cost or quality of care from mandating coverage of non-physician providers, including clinical social workers.12/

The CHAMPUS program reports a similar experience. In 1980 Congress directed CHAMPUS to conduct a demonstration project by

including clinical social workers as independent providers of covered services for a period of two years, in order to assess the impact on cost and utilization. In 1982, following the experimental period, Congress authorized continuation of the independent provider status, based on the finding from the demonstration project that "no quality of care problems have arisen, and reimbursement of clinical social workers costs less than the traditional physician gate-keeper approach.13/

COST OFFSETS OF MENTAL HEALTH TREATMENT

In past years, some opponents of freedom of choice have argued that expanding the available provider base will cause a large increase in utilization, at additional cost to the government. Even if utilization were to increase with the inclusion of clinical social workers in the Medicare provider base, overall program costs would not necessarily increase proportionately. To the contrary, the evidence strongly suggests that increased utilization would be offset by corresponding cost savings.

For example, the President's Commission on Mental Health concluded that increased utilization of mental health services yields decreased utilization of (more expensive) doctors, hospitals and surgery. "[A]s a group, this research is most striking", the Commission reported. "Research from health maintenance organizations (HMO's), from industrial programs, and from regular health insurance plans suggests that providing outpatient mental health services can reduce overall health services utilization and overall health costs.14/

The Commission also determined that as many as 60 percent or more of physician visits are from sufferers of emotional distress rather than diagnosable illness.15/ A similar finding was reported by the Department of Health and Human Services, in its study report titled "The Hidden Mental Health Network."16/

An article published by Jones and Vischi of the Alcohol, Drug Abuse and Mental Health Administration, summarized the results of twelve separate studies which have demonstrated that the cost of providing mental health services was offset by a significant decline in medical utilization.17/

One of the most recent studies relating to the offset effect of mental health treatment on medical costs is a 1983 study on outpatient mental health treatment following the onset of a chronic disease. The findings indicate that outpatient psychotherapy beginning within one year of the diagnosis of one of four chronic diseases is associated with reduced charges for medical services by the third year following the diagnosis.18/ The authors conclude that the study "adds weight to the conclusion drawn from the reviews of the scientific literature that the inclusion of outpatient psychotherapy in medical care systems can improve the quality and appropriateness of care and also lower costs of providing it."19/

CONCLUSION

It is clear that the cost of leaving the mental health needs of our elderly unattended are enormous both in human and social terms. From the standpoint of just the dollars and cents involved, it has to cost more to keep paying the physician, laboratory, x-ray, surgical and hospital bills to treat the symptoms of underlying mental and emotional problems which can be more effectively (and inexpensively) dealt with by a trained mental health professional -- physician or non-physician.

It is time that benefit levels be updated to account for decades of inflation, and that the Medicare delivery system recognize as independent providers clinical social workers and other qualified non-physician mental health professionals who are currently providing the majority of the mental health services throughout the country.

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