S. HRG. 103-168

ADMINISTRATION'S 1994 HEALTH BUDGET

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

APRIL 1, 1993

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

70-096—CC WASHINGTON : 1993

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-041401-6

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ADMINISTRATION'S 1994 HEALTH BUDGET

THURSDAY, APRIL 1, 1993

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

The hearing was convened, pursuant to notice, at 10:10 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Pryor, Riegle, Daschle, Breaux, Conrad, Packwood, Danforth, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H–10, March 24, 1993]

FINANCE COMMITTEE SCHEDULES HEARING ON ADMINISTRATION'S 1994 HEALTH BUDGET

Senator Daniel Patrick Moynihan (D.–N.Y.), Chairman of the Senate Committee on Finance, announced today that the Committee will hold a hearing to examine the administration's health budget for fiscal year 1994.

Witnesses will include Health and Human Services Secretary Donna Shalala and representatives of the American Medical Association, the American Hospital Association and the American Association of Medical Colleges.

The hearing will begin at *10:00 a.m. on Thursday, April 1* in room SD–215, Dirksen Senate Office Building.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our distinguished witness, the Secretary of Health and Human Services, and to our guests.

This is a hearing that will give Secretary Shalala the opportunity to expound on and explicate the President's proposals for the spending reductions and cost cutting in the Medicare and Medicaid aspect of the President's budget.

I would take the liberty, if I can ask my colleagues' indulgence, to point out that in both respects these are provisions of the Social Security Act. And the centrality of Social Security to our social policy in the United States is easily overlooked.

During this last phase of the budget resolution, at one point, we had a proposal to cut Medicare costs by a very large amount. The statement we were given on the Senate floor was that these cuts exclude Social Security. You had to make the point that we were talking about title XVIII of the Social Security Act. The connection is just not made.

This is not just our most faceted program, but if my colleagues on this side will permit me to say so, it is perhaps the Democratic Party's greatest achievement in social policy.

Franklin Roosevelt signed the bill 58 years ago this August. And Frances Perkins, who was very much around in the age of the Kennedy administration, she wrote in 1946 that Roosevelt always regarded the Social Security Act as the cornerstone of his administration. I think he derived greater satisfaction from it than from anything else he achieved on the domestic front.

And properly so, the program has all but eliminated poverty from among the aged. We have 41 million recipients, of which 26 million are retired workers, 7 million survivors, 3 million disabled workers, and 5 million spouses and children of retired or disabled workers.

There are about 135 million workers paying into the system. The system itself is in a excellent financial state. It will run a $65 billion surplus this year.

Medicare is in surplus. Every time you say that, you are told that one day it will not be. Well, one day, we will not be either. [Laughter.]

There used to be a wonderful sign, in fact, over on the walls of the House Committee on Ways and Means in the 1960's. It said, "Owing to the shortage of experienced carpenters, the end of the world has been indefinitely postponed."

But in the meantime in this veil of tears, there is a problem with the public perception of Social Security. The majority of non-retired adults do not think they will get their Social Security.

And in one of the most memorable events that I have seen in my experience here, former administrators of the Social Security Administration, once a position of great trust, have begun, in my view, to abuse that trust by making money sending terrorist letters to the American public.

Two of the last three administrators of Social Security have now joined really a rapacious organization that sends terrifying letters to senior people, telling them that the Social Security fund is broke, it has been looted, it has gone off, it has been abandoned, and they will be abandoned, and now all is lost unless you send $15 immediately.

I refer to Ms. Martha McSteen and to Ms. Dorcas Hardy. There was a time when this would never have happened. Nobody who had been given the high honor and responsibility of that position would dream of abusing it in this manner. They now do.

We held a hearing on this. It has not deterred anyone. A new organization has been formed. The mailings from Ms. Hardy are now arriving.

Mind you, we did not help when in 1984, President Reagan proposed making Social Security voluntary, which would mean to disestablish it altogether. His budget director referred to it as a Ponzi scheme and closet socialism and said that the world's largest bankruptcy was about to take place.

Then, in the 1992 campaign, the Democratic candidate proposed a form of taxation, a flat tax that would eliminate the Social Security payment altogether, and replace it with the benefit structure of contributory insurance.

If we do not watch out, we will have discredited the most important social insurance system we have. We must learn something about this.

There was a time when an administrator of the Social Security Administration would not dream of sending threatening letters, which is what they are.

The U.S. Attorney, we do not have one right now, but if we had a U.S. Attorney, I wonder why one should not inquire as to the legitimacy of the extortion of money by terrifying older persons.

That would never have happened in an earlier time. But the Social Security Administration has become so isolated from the government. The decision to build the headquarters outside of Washington was an important one.

The new generation of American political leaders do not think this is as important as it elementally is. And it is in trouble.

I say this to Dr. Shalala. She knows my views. I know her concerns.

But it is now April. This administration was, in effect, elected on November 2, 1992. And we do not have a Social Security Administrator. We do not have a name. We will evidently be getting one soon. And as soon as we get one, we will put one in place.

But I think it is not inappropriate, as we begin to discuss Social Security provisions, to just say this statement of concern by the Senator from New York that we are frittering away a national treasure. I hope we will not do it.

I know you, Secretary, would not dream of it, but events do not move with you, as you know.

With that note, I conclude and ask Senator Packwood, if you would like to say something cheerful?

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. No. I think I will follow your lead. [Laughter.]

First, let me publicly thank you for the Oregon Medicaid wavier. I told you privately that we twisted and turned and did everything we could to get it out of the previous Administration unsuccessfully. And we are very appreciative of your granting it rather expeditiously.

Two, on the Medicaid and Medicare costs, they are now running close to 15 percent of our spending. They will go, by 1988, to 21 percent on a baseline.

And even so far with the suggested reforms, it is 21 percent because it is a relatively modest trimming from a $1.65 trillion worth of spending for these two programs in the next 5 years.

And I know there is some argument that one way or another, perhaps they will be folded into a health care reform or we will get all of the cost under control, but so far on Medicare and Medicaid, we have been—and I mean us, Congress, Presidents, everybody—has been unsuccessful in controlling them.

Third, if you look at just Medicare and Medicaid and then add to it Social Security, which the chairman has been talking about, and other retirement programs in the Federal Government, and this is mainly military and civilian retirement, just those four pro-

grams plus interest are now 54 percent of the budget. And in 10 years, they go to 69 percent of the budget.

That is not to say these programs are insolvent. I do not want to run up a red flag of surrender, but it does mean that they are going to take an ever increasing portion of our total spending unless we increase taxes to accommodate other programs that will get cut out or cut back if we just go on a baseline basis.

So I would appreciate your thoughts on that.

And lastly, I have been very intrigued with the statements I have been reading in the paper and what I have heard that you may have said privately or that Mr. Magaziner said is price controls, that they do not work.

And it is my understanding that you may have indicated to some people that you think they do not work. And I would be interested in your thoughts as to whether or not price controls will work to control prices in any kind of health reform bill that we may pass.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

Senator Danforth.

Senator DANFORTH. I will wait for the witness.

The CHAIRMAN. Senator Conrad.

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator CONRAD. Well, I thank the chair.

I just very briefly want to say that we are very pleased that the Secretary is coming to North Dakota to participate in a series of health hearings with the North Dakota Congressional Delegation. And I think that is going to be very valuable.

The Secretary has a tie to the State of North Dakota because her sister is married to a North Dakota farmer. And so she is going to have a chance to spend some family time in North Dakota as well.

I am looking forward to our April break.

The CHAIRMAN. Are you going to be skiing? No. You do not have ski slopes. [Laughter.]

Senator CONRAD. Yes. We have what we call cross-country skiing. [Laughter.]

I thank the chair.

The CHAIRMAN. Senator Grassley.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Well, I am going to put a long statement in the record and read right now two short sentences.

I am particularly concerned about the Administration's proposal for the Medicare program and about how those proposals might affect rural hospitals in my State.

I am sure that Senator Conrad has the same concern. So you will be obviously looking at that.

As I understand it, the administration has included a proposal to extend the Medicare Dependent Hospital Program. If this is correct, that is good news. In a budget, in which there is not much good news. And I have 55 hospitals in my State that fall into this category.

I will put the rest of my statement in the record.

[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. Could I say then on a cheerful note just to have everybody feel better? Joe Califano has a wonderful account in the Washington Post this morning on the way the Medicare began.

Senator Kerr and Representative Mills put together a program in 1960 to help rural hospitals. And then, by the time President Johnson was in office, they found that most of the money was going to New York and California.

So they thought up Medicaid and Medicare as a way to solve that problem, which they obviously did. Now, we are solving their solution. I got tangled up there, but in any event, it all started with the rural hospitals. [Laughter.]

Senator Pryor.

Senator GRASSLEY. I knew I could not afford to say that. Is that because it's me or I'm a Republican? [Laughter.]

The CHAIRMAN. Kerr, Mills, Johnson, all pure Southern Democrats.

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Thank you, Mr. Chairman.

We welcome Dr. Shalala.

Mr. Chairman, you have brought up, I think, a very, very good point this morning. And just to elaborate further on the issue that you have raised, there is this new organization, Americans for Social Security Reform. This group is a child of a larger group called the National Center for Privatization.

The National Center for Privatization has been granted a nonprofit mailing permit. So all the taxpayers of our country are once again subsidizing one additional group that is out there to raise money from seniors.

And I just think that this is beginning to go too far. And I think that we have allowed a proliferation of hundreds and hundreds, perhaps thousands of nonprofit organizations that, in some instances, abuse the mailing permits.

And I think that this is something that should be subject to further scrutiny by this committee. I appreciate the chairman raising this. And I pledge my best efforts.

[The prepared statement of Senator Pryor appears in the appendix.]

The CHAIRMAN. Thank you, Senator Pryor.

May I make a point that probably should be emphasized that Gwendolyn King, who was the last administrator, has in no way involved herself in these matters or rather scrupulously has not done.

But if you would like to see it, I will pass it around. This is the front page. It says, "Dorcas Hardy, former U.S. Commissioner for Social Security. Inside, "Former Social Security Commissioner reveals the crisis facing Social Security."

And then, it says, "$1,000 reward. Permit Holder offers $1,000 reward for information leading to the arrest and conviction of any

person or persons illegally interfering with or destroying the enclosed documents." [Laughter.]

And then, "Yes. I have signed the enclosed petition forms. I have also completed the survey. I am rushing back to you $10, $15, $20, $25."

The Postmaster General lets that stuff through the mail?

Senator PRYOR. That was mailed for 3.6 cents, I might note.

The CHAIRMAN. Well, I think we are going to have a hearing on this, don't you think? Don't you all think we should? [Laughter.]

Well, at long last, Dr. Shalala.

STATEMENT OF HON. DONNA E. SHALALA, PH.D., SECRETARY, HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. SHALALA. Thank you very much, Mr. Chairman.

I feel like I did at my defense for my PhD. at Syracuse. It was a far more interesting conversation going on among the questioners than there was information coming from me. [Laughter.]

If I remember that time, I sort of kept my mouth shut for about 2 hours while the discussion went on.

Mr. Chairman and members of the committee, let me begin by commenting on the issue raised by Senator Moynihan because it is an issue of professional ethics and that touches on the public service and the high expectations that we have for those of us that serve in the public service and what we do afterwards.

I think it is unfortunate that the new President had to have a series of ethics rules that will prevent these kinds of activities, at least for some period of time by people who hold high office.

And I share your outrage that a former Commissioner of Social Security could put our most vulnerable citizens through such agony because that is really what the issue is.

It is more than unprofessional. It is unethical and outrageous that they should do such a thing.

And if there is anything that I or this administration can do, let me assure you that in my conversations with everyone that I interviewed for high office at HHS, I talked to them about not simply the ethics rules, but what our high expectations were for their behavior both in government as well as when they left.

And that was particularly true of the group of people that I talked to about Social Security.

I am honored to appear before you today to discuss the proposals in President Clinton's economic package. I will confine most of my oral remarks to the health proposal, since that is the focus of today's hearing.

And with your permission, you will put my full statement in the record.

The CHAIRMAN. We will put your statement in the record.

[The prepared statement of Dr. Shalala appear in the appendix.]

Dr. SHALALA. The President has obviously undertaken an ambitious agenda to strengthen the economy, create jobs, and promote economic security for American families.

To protect our future, he has presented to Congress and the American people a bold plan that will stimulate economic growth both by investing wisely in the American people and by cutting the Federal deficit.

And we believe we must take this historic opportunity to do both. And we must act quickly.

Important changes in the major programs within the committee's jurisdiction are central to this investment and deficit reduction process.

And the success of major portions of the President's plan rests in your hands. We will rely on your considerable expertise and your involvement in our efforts. And we are very eager to work with you.

In the area of health care, one of the most significant investments in America's future will be to reform our health care system.

As a member of the Task Force on Health Care Reform, chaired by Mrs. Clinton, I would like to express my appreciation to this committee for its diligence in working toward consensus on health care reform over the years.

And I know that we will all benefit from your experiences and your expertise as we continue to work for fundamental systemic change.

Neither long-term deficit reduction nor serious investment in America's future can be accomplished in the absence of health care reform.

One-half of the projected increase in the Federal deficit over fiscal years 1994 through 1998 is due to growth in Medicare and Medicaid spending.

Health care spending will rise from 14 percent to 19 percent of the GDP by the end of this decade, crowding out other demands for resources and opportunities for economic security.

The President has promised that the health care reform plan he presents to you in May will control health care costs and guarantee families the security of health coverage.

In doing so, the plan will build a stronger, more rational health care service delivery system that relies on prevention and primary care and protects quality that guards against bureaucratic inefficiencies and that responds to the needs of real people.

The daunting task of cost containment must include measures and comprehensive reforms to stabilize public and private health care spending in the long run.

This task begins in the President's deficit reduction plan. And our proposed Medicare savings are a down payment on our overall cost control effort.

These proposals are intended to reduce the deficit without major structural reforms. Structural reforms are considered more appropriate in the context of overall health care reform.

The Medicare deficit reduction proposals are not cuts. Rather, they will curb the rate of Medicare spending growth from 13 percent to 11 percent annually.

Most of the savings are from health care services providers, not beneficiaries. In Medicare Part A, the President has proposed an extension of the current policy of increasing hospital payments at a rate less than the market basket rate of increase and moving this annual increase from October to January, similar to the update for other Medicare services.

Other changes under Medicare Part A include: gradually lowering Medicare indirect medical education payments to teaching hos-

pitals; extending the current provision in statute whereby inpatient hospital capital payments are reduced by 10 percent; revising Medicare direct medical education subsidies to favor training for primary care and basing payments on a national per-resident amount, rather than a hospital-specific amount; eliminating the hospital-based home health agencies' upward adjustment to their per-visit cost limits; and eliminating Medicare return on equity payments to proprietary skilled nursing facilities.

In Medicare Part B, current law provisions set the premium at specific dollar amounts through 1995. Our proposal would index the 1995 premium by the Social Security Cost of Living Adjustment to establish the 1996 premium.

In 1997 and subsequent years, the premium would be set to finance the same proportion of program costs as was financed by the premium in 1996.

Other Medicare Part B proposals include: extending the current requirement that hospital outpatient capital payments be reduced by 10 percent; reducing caps for clinical laboratory services and extending the current law 2 percent ceiling on updates; providing the full update for primary care services and 2 percentage points less than the full update for non-primary care services; beginning movement towards a resource-based system for practice expenses under the physician fee schedule; and changing the default formulas under the Medicare volume performance standard program to provide for a spending growth rate that is closer to the GDP.

We also intend to bundle payments for inpatient radiology, anesthesiology, and pathology services into a fixed payment per discharge.

We will encourage the submission of Part B claims via electronic format by reducing payments by $1 per paper claim beginning in 1996.

And we will establish a single fee for surgery regardless of whether the primary surgeon uses an assistant at surgery.

We also intend to extend physician ownership and referral prohibitions to additional services; reducing payments for durable medical equipment by tightening the national limits, reclassifying certain items, and giving Medicare contractors more authority and flexibility in certain areas; and reducing payment for EPO from $11 per 1,000 units to $10 per 1,000 units.

For Medicare Parts A and B, we propose to extend and standardize secondary payment rules for certain disabled beneficiaries and for beneficiaries with end stage renal disease.

Under the Medicaid program, the administration wants to give States the option of paying for personal care services outside of an individual's home. Under current law, this would be mandatory in 1995.

Our other Medicaid proposals include: allowing States to use drug formularies that would give the States more flexibility to ensure more effective use of Medicaid drugs; tightening numerous loopholes in the current laws that allow persons with substantial assets to qualify for Medicaid; and reducing the Federal administrative cost matching rate to 50 percent of the jointly administered Federal/State programs.

The administrative cost matching also would apply to the Aid to Families with Dependent Children and Food Stamp programs.

In addition, we will continue our efforts to identify cases where Medicare and Medicaid made a mistaken primary payment for services when a beneficiary had other primary insurance, either public or private.

Also under the topic of health care, I would like to highlight another important program within your jurisdiction, the Maternal and Child Health Block Grant.

Mr. Chairman and members of this committee, we are committed to improving the health status of our children. And this program is a key element in that goal.

For fiscal year 1994, the President's economic and deficit reduction plan proposes major funding increases that will improve maternal and child health, such as the expansion of the Head Start program, early childhood immunization services, WIC nutrition programs at the Department of Agriculture, and other preventive health programs at HHS.

Finally, I would like to discuss briefly the proposals in the area of welfare and family support programs and in Social Security.

Mr. Chairman, your efforts to improve the status of low-income and disadvantaged people for your entire career have been exemplary and have yielded significant progress already.

The President and I have pledged to join with you to move further, to strengthen child support enforcement, to improve family support services, and to end welfare as we know it.

President Clinton's budget includes a start on this welfare reform agenda. The budget already contains a major increase in the Earned Income Tax Credit and some changes in the child support enforcement system.

The President's plan also includes measures to further strengthen American families, a new capped entitlement program for innovative child welfare services, new discretionary funds for drug treatment programs, a major expansion of the Head Start program, and additional funding for the Child Care and Development Block Grant.

In the Social Security program, we are proposing stimulus monies and long-term investments in the efficiency and services of the Social Security Administration.

The President believes that all groups must contribute to deficit reduction. And we have, therefore, proposed to increase the percentage of taxable Social Security benefits for individuals who are already taxed and a charge a fee to States for which the Social Security Administration administers a State supplement of the Federal Supplemental Security Income program.

In conclusion, President Clinton's economic package, we believe, provides a strong foundation for our national prosperity by stimulating the economy, by investing in our future, and by reducing the deficit.

Our impending health care reform package and our future welfare reform actions will build upon this foundation.

Mr. Chairman and members of the committee, I look forward to working closely with you as we move through the budget reconciliation process, as we strive for health care and welfare reform and

as we develop subsequent initiatives to improve the lives of all Americans.

And I would be happy to try to answer any questions you have of any parts of my statement. Thank you.

The CHAIRMAN. We thank you very much, Madam Secretary.

There are specifics about, for example, bundling payments for inpatient radiology, but we will get through those in detail.

I just wanted to make the point that you were very generous in raising this question of welfare which is so central to our National condition at this time.

About one-third of American children will be on welfare before they are age 8. And you are very generous to say that our efforts in this committee have yielded significant progress.

Would you like to give me an example of any progress we have had with respect to the condition of American families?

Dr. SHALALA. Well, I think that while the statistics may not demonstrate as much progress as this committee would like, the Family Support Act certainly is a breakthrough in terms of our attitudes and the kinds of programmatic approaches that the government has in this area.

And we need to build on that, as I have indicated before, Mr. Chairman.

The CHAIRMAN. We thank you.

I certainly want to say that in the budget resolution which was just passed there will be some more funds for disability benefits.

And we thank you very much for that treatise on the Social Security Administration.

But the condition of children in our country today is vastly worse than it was 30 years ago, incomparably worse.

And the one basic Social Security provision we have is the Aid to Families with Dependent Children. And that benefit today is about half of what it was 30 years ago. I see no effort to do anything about that.

Every time I hear the words "services, treatment, investment," I know somebody with a college degree is going to be hired to give some good advice to someone without one.

It is a formula known as feeding the sparrows by feeding the horses. And I worry about it. I mean, there is this——

Dr. SHALALA. And I share your worry, Senator. As you know, the President has proposed an Earned Income Tax Credit which we believe will help in terms of raising——

The CHAIRMAN. Have you ever tried to make out that form?

Dr. SHALALA. Pardon?

The CHAIRMAN. Have you ever seen the quadruplicate form you have to make out to get the Earned Income Tax Credit?

Dr. SHALALA. Yes.

The CHAIRMAN. Have you?

Dr. SHALALA. Yes. I actually have seen the form. And I have seen the——

The CHAIRMAN. Have you ever tried to make it out?

Dr. SHALALA. No.

The CHAIRMAN. I assure you. I have seen it, but I would not dare try to make it out. If you could make it out, you would not need it. [Laughter.]

That's against taking a tick off the payroll tax.

The services strategy is fraught with big government and ineffective and clogged institutions that we have seen in health care. And there is no money in the President's budget for welfare change.

I do not want to press you because this is not our subject. But one remove or another, every problem we are talking about in this country, such as improving health care for the aged, is a dependent variable of the breakdown of families.

I mean, immunization. Are there any significant number of children in two-parent families who do not get their immunizations, their shots, as we say? Not many really.

Dr. SHALALA. Well, there is——

The CHAIRMAN. If there are, tell me. I am not asserting.

Dr. SHALALA [continuing.] Only about—well, it is well under 60 percent of American children are getting their shots now. We, as you probably know, are announcing an immunization program today.

A number of them are two-parent families. But you are right. The large majority of those who do not get their children immunized are single-parent families and are children who grow up in poverty.

We do intend to make an extraordinary effort in that program and will be talking about that a little later today.

The CHAIRMAN. Well, I will make the point that if the family structure were different, you would not need another government program. And government programs in these things invariably require less of the families. So it tends to end up weaker.

Senator Packwood.

Senator PACKWOOD. And I quote from Mr. Magaziner: "I doubt we would try to repeat something that was ineffective." He is referring to the price controls.

I understand that you may have indicated some similar feelings privately. What are your views about price controls in terms of trying to restrain health prices and health costs?

Dr. SHALALA. Well, I think that we had some experience in the government in rate setting, for example. And I would like to distinguish between price controls and rate setting.

I think the literature on price controls does indicate that at most, you will get some short-term effects, depending on how you do them. We are a little more sophisticated these days.

In terms of the discussion of price controls or rate setting or some other way to get some front-end cost savings as part of health care reform, all I can say is that all of it is on the table and we are all arguing about it in light of what the research says.

To be fair to Mr. Magaziner, what he was revealing was that there is a discussion going on, which hopefully will be concluded in the next 3 or 4 weeks. The discussion includes how to get some short-term cost savings while a new program is being put in place; whether it is possible to do that, and what the effects of previous experience on price controls is on the rest of the economy.

So I think it is a quality discussion and all of us have various points of view. I have not come down one way or another, but like most academics, I have argued both sides of the question at the table to make sure that the issue is properly vented.

Senator PACKWOOD. Tell me the difference between rate setting and price controls.

Dr. SHALALA. What we are doing in many ways is trying to hold down some of our costs with the regulations on Medicare to slow down some of the increases. And we can set specific rates for certain kinds of services and try to hold things down.

Senator PACKWOOD. But isn't that—if you say a doctor can get no more than $1,000 for an appendectomy, is that a price control or a rate setting?

Dr. SHALALA. Well, I think from my point of view, what we have been doing in the government, with these programs, is more rate setting than price controls, using regulations.

Senator PACKWOOD. I do not understand the difference.

Dr. SHALALA. Well, I think that I am just not ready to discuss that right now, Senator.

Senator PACKWOOD. Well, that is a fair answer.

Let's go back then to the four programs I mentioned, Social Security, Medicare, Medicaid, and other retirement. And 99 percent of the other retirement costs are Federal civilian and military retirement and interest, 54 percent of all of our spending now and 69 percent of all our spending in 10 years on baseline CBO.

And this is before the baby boom retires. And the administration has a very modest—and currently we are backing off of that—restraints on retirement programs.

Apparently, it is only going to be applied now to the military until they are aged 62 and not anybody civilian. Nothing on Social Security is touched.

On Medicare and Medicaid, we will spend $1.65 trillion over the next 5 years on baseline. If all of the administration's reforms are adopted, we will restrain that. You are right. It is not a cut. We will restrain it by $56 billion, but it still goes up tremendously.

Should we be making an effort to get those programs to be less a proportion of our total budgetary spending or not?

Or do you suggest not much restraint in those programs, but instead we will have to increase taxes to hold the others even at baseline? I mean, even education and highways and airport safety and all of that.

Dr. SHALALA. Well, what you are talking about it is the growth in the Medicare program. There are some explanations for the rise in the prices, including non-physician staff salaries, equipment, supplies, and malpractice.

We do have some growing administrative requirements, some changes in billing practices. So there is a combination of price increases, but they have also been volume increases. And——

Senator PACKWOOD. That is the problem. That is one of the reasons price controls has the dickens of a time working. Volume seems to drive the total expenditures.

Dr. SHALALA. Yes. Our response to this is why we have to get into health care reform. While we have tried to squeeze the program through a variety of methods, what has happened is that either volume has increased or the intensity of use has increased. That has kept our increases going up.

So what it requires is more systemic change than that, perhaps a more competitive market place.

Senator PACKWOOD. It is going to require much more systemic change than just the five-year recommendations of the administration or we are not going to even make a dent in the increase.

Dr. SHALALA. And we have conceded that, Senator. We have——

Senator PACKWOOD. I am not being critical.

Dr. SHALALA. Yes.

Senator PACKWOOD. But what I fear, there is not a great enthusiasm for raising taxes in this country to continue to cover other programs.

If these four plus interest eat up a bigger and bigger and bigger proportion of the total, the others are going to get squeezed down and down, unless we restrain.

And I am curious that you think that we ought to attempt to restrain those major four programs in some respect.

Dr. SHALALA. What we have been trying to do is to restrain the programs. And what we need to do is to try to get more systemic reform.

What we have demonstrated is that the techniques that we have for restraints simply do not work very well and that that requires more systemic reform.

And we have done a series of things to try to slow down the increases in this budget, but we have also conceded that it is systemic reform that needs to take place.

Senator PACKWOOD. Thank you.

The CHAIRMAN. Thank you, Senator Packwood.

Senator Danforth.

Senator DANFORTH. Mr. Chairman, thank you. And Madam Secretary, thank you.

I want to follow up on the same questions that Senator Packwood was asking, perhaps with the boldness of a soon to be political retiree.

Would you agree with me in the conclusion that I have reached that an economic program that does not control the growth of entitlements cannot strengthen the economy?

Dr. SHALALA. I think that it depends on what you are talking about, whether you are talking about eliminating entitlements or having reasonable increases in the cost of entitlements.

Senator DANFORTH. Right.

Dr. SHALALA. And I would like to be careful about——

Senator DANFORTH. I am talking about controlling the growth.

Dr. SHALALA. There is no question that one of the things that we have been doing in the health area is getting inside of entitlements to see if we can restrain the growth in those entitlements because they are eating up and having an impact on our economy.

Senator DANFORTH. We have to control the growth of entitlements if we are going to have a healthy economy certainly.

Dr. SHALALA. Yes. We do need to control their growth, but we need to try to do that in a way that does not destroy the quality of the programs or alter the intent of the program in the first place.

Senator DANFORTH. Oh, sure. I am sure that there are various ways to control the growth. But my proposition is just the very simple proposition—and if anybody would like to debate it, I really welcome the debate—the proposition is that controlling the growth

of entitlements is the sinequanone for a healthy economy and that no economic program is going to be adequate unless it controls the growth of entitlement programs. Do you agree?

Dr. SHALALA. I think the answer is yes, Senator.

Senator DANFORTH. All right.

Now, the second proposition I would offer is that this is the hardest thing for us to do, controlling entitlements. A front page article in the Washington Post this morning, "Lawmakers Back Off on COLA Cuts," is just the latest example of the difficulty of doing anything about entitlements.

Last week, a bipartisan group of Senators offered an amendment on the floor of the Senate to provide a cap on entitlement growth.

And basically what it proposed was doing nothing for a couple of years. And then, after a couple of years, reducing the growth of entitlements to CPI plus 1 percent plus the growth of the population.

And we came within, I think, four or five votes of a majority. We did better than we did last April on a similar proposition.

But in any event, the point was made in the argument against this entitlement cap proposal was that we were jumping the gun because the Administration is going to be proposing its health care reforms. And therefore, let's wait for the health care reforms.

Our argument in offering the amendment is that whatever we do in health care reforms, however they are structured, they must have the effect of controlling the growth of the Federal Government's portion of health care costs.

I am not saying that there should not be overall reform, but I am saying that as a part of whatever we are doing, we cannot have a continued increase of the total cost of health care.

Dr. SHALALA. The point is that a cap on entitlements, while it sounds like it is quick and easy to fix the deficit problem, in reality, is hard to implement. What we have tried to do in this budget is point out that we have to get our arms around health care costs, but in a more systemic way when we have gone in and tried to fool with the system, to try to hold down the increases.

In fact, we have done just that again in this budget because we have gone in with what we hope is a scalpel as opposed to a club. But when you have an entitlement and try to cap it, you have to get answers to questions.

Do you intend, for example, if you cap Medicare and Medicaid, to say to new beneficiaries that they cannot participate in the program?

Senator DANFORTH. No, no. We made that clear. We said population increases are allowed in the proposal. And I am not at all quarreling with the idea of systemic change.

Dr. SHALALA. Right.

Senator DANFORTH. We all agree on that, we need a systemic effort here. And we need to try to deal with the overall question of health care, both the governmental portion and the nongovernmental portion.

But my question to you is this, Madam Secretary, granted that we want to deal with health care as a whole, granted that we want to maintain quality of health care, still whatever we come out with has to control the growth of what the government is spending for health care, I think.

And what really alarms me is apparently, there has been a memorandum circulating within the administration that says the cost of the program that is being considered is going to be an additional $30 to $90 billion per year for just the government's share of it. I think one newspaper said that it was going to be a total over 5 years of $175 billion. So it is in the same ballpark.

My point is that I just do not understand how we are going to have a healthy economy if whatever we are proposing has within it a boost of government spending in health care in the neighborhood of $30 to $90 billion a year.

Dr. SHALALA. Senator, as you know, health care reform has a number of different parts. And one part is increasing access. And while I cannot comment on that particular paper that is circulating, there are so many papers circulating when you have 20 working groups, and I have not read that particular one, let me say that the fundamental intent of President Clinton is to get cost under some kind of control with systemic change.

Simultaneously, we do want to do some access. And what that will mean in terms of the total package, I cannot tell you at this point in time.

But we share your belief in the need for systemic access. And I look forward to meeting with you after we make an announcement to see if I can get your support for that systemic change.

Senator DANFORTH. Thank you.

The CHAIRMAN. He will be easy. He just loves to do good. It is his nature. [Laughter.]

Can I say to my friend, Senator Danforth? In that quite revealing article this morning by Califano——

Senator GRASSLEY. I gave it back.

The CHAIRMAN. He mentions that when he, Lyndon Johnson in that manic 1964, 1965 mood, said that we are going to get Medicare and Medicaid and we will work it out to take care of rural hospitals, somebody said that if you are going to have more health care, we are going to need more doctors, right? And rightfully, we will have a program to take more doctors. We will double the number of doctors.

And, indeed, in 1963, there were 140 physicians for each 100,000 persons. And today, there are 240. And by the year 2020, which things are pretty much in the pipeline, they say they would have reached almost 300 from past that level in the 1960's.

And Says Law dictates that supply creates demand. If you are going to double the number of physicians per capita, you are going to double something like you are doing, quadruple the cost.

Senator PACKWOOD. Quadruple the cost.

The CHAIRMAN. That is something where government got involved with the natural allocation of resources in the society.

And Dr. Shalala, you are going to have to resolve that.

Dr. SHALALA. With your help, Senator.

The CHAIRMAN. Well, it is our job to be helpful. And we thank you for that. [Laughter.]

Senator Grassley.

Senator GRASSLEY. I would like to tell the Senator from New York City that supply does not create demand, at least in last year's corn crop, let me tell you that. [Laughter.]

The CHAIRMAN. You wait until the farm subsidies get out of the agriculture committees. You will be surprised. [Laughter.]

Senator GRASSLEY. I would like to ask some questions on a little finer level of detail, kind of nuts and bolts question on the every day operations of hospitals and health care in rural America.

I raised a question, this first question with you earlier when you appeared before the Budget Committee, but I did not have an opportunity or time to finish it at that hearing.

I note that the President's proposal calls for reducing annual Medicare update for hospitals by 1 percent. And it is not clear to me what the proposal involves for rural hospitals.

Currently, as I understand it, under current law they are scheduled to get their market basket plus 1.5 percent in 1994 and enough to match the urban rate in 1995.

Does this proposal call for 1 percent less than what is proposed in current law or 1 percent under market basket?

Dr. SHALALA. Here is what I can tell you right now.

Rural hospitals are going to get the 1.5 percent add on to the market basket update, which is the same one the urban hospitals are going to get.

And then, we will have a calendar year update. So in fiscal year 1994, rural hospitals should end up with an update of 3.6 percent. The 1994 market basket would be 4.5 percent.

And in 1993, I should point out that the rural hospitals got an update of 3.5 percent. So the package is just a tiny bit higher.

We were very sensitive as we went through. We did obviously need to squeeze down the package. And we did try to be sensitive to the issues that involve and the effect our proposals would have on rural hospitals. I should note that, Senator.

Senator GRASSLEY. I do not need to go through a background of telling you about the concern that my hospital leaders have, even a lot of them saying the very existence of the hospital is at stake.

Obviously, the stake is the differential in that particular approach that you just stated would be helpful.

Now, I want to bring some attention to Medicare dependent hospital programs. We included in H.R. 11 last year several provisions pertaining to rural health care. And this was one of them.

Senator Dole has reintroduced that legislation, and I have cosponsored it. I recently learned that your budget proposal calls for an extension of that program. Am I correct on that?

Dr. SHALALA. Yes. As I understand it, that law was actually to expire today.

Senator GRASSLEY. Yesterday.

Dr. SHALALA. Or yesterday.

Senator GRASSLEY. Yes.

Dr. SHALALA. And I believe that we do intend to extend that.

Senator GRASSLEY. Well, I am pleased to hear that.

Let me follow up then. Right now, the urban-rural differential in the perspective payment standardized amounts is scheduled to be eliminated as of October 1, 1994.

Does your proposal also call for elimination of the rural-urban differential by October 1st? And if so, can you tell me what the rural standardized amount would be for fiscal year 1995?

Dr. SHALALA. We are still on schedule for fiscal year 1995.

Senator GRASSLEY. Okay. Well, that will be also good news.

The CHAIRMAN. How much good news can you take, Senator? [Laughter.]

Senator GRASSLEY. Well, let me tell you, get the price of corn up and then, I will answer that. [Laughter.]

This proposal, as I understand it, calls for $115 million to be spent over 3 years. This is for the medical dependent hospitals and also for the rural referral program.

Last year, our Medicare dependent hospitals proposal in H.R. 11 was to cost $135 million by itself over 3 years.

Is the difference in the figures an error in estimating. Or does the difference reflect a difference in the way that you are going to extend these programs as opposed to what we had in H.R. 11?

If you are not able to tell us now, we would appreciate it very much if you could submit some further detail on that specific point, if possible.

Dr. SHALALA. I think the cost estimates have come from our department's Office of the Actuary and they are consistent with the H.R. 11 estimates.

The difference in the estimates for the small rural hospitals and Medicare dependent small rural hospitals is somewhat larger. I will look into that specifically for you to get you an answer.

But it was our intent that we be consistent with H.R. 11.

Senator GRASSLEY. Okay. Now, will it be retroactive? Because a lot of hospitals have dropped out of the program.

Dr. SHALALA. I do not think I know the answer to that question.

Senator GRASSLEY. Okay.

Dr. SHALALA. I will get back to you.

Senator GRASSLEY. Well, it is this March 31st date.

Dr. SHALALA. Right.

Senator GRASSLEY. And you understand that some hospitals had to end at the end of their fiscal year.

Dr. SHALALA. Right.

Senator GRASSLEY. So some hospitals ended back on June 30th of the last year. And they were hoping that we would get this reinstituted last fall. It would not have been such a lag.

Dr. SHALALA. I will provide that for the record, Senator.

[The information requested follows:]

SENATOR GRASSLEY. Okay. Now that we have gone by that date, will it be retroactive? Because a lot of hospitals have dropped out of the program.

SECRETARY. It is the Administration's intention to make the Rural Referral Center and Medicare Dependent Hospital provisions consistent with those contained in H.R. 11. This is the policy reflected in *A Vision for Change* released on February 17, 1993.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Dr. Shalala, we very much thank you for your candor in all of these matters. And obviously, you do not have an answer to every question. We will all submit questions in writing, and as you can, please get back to us.

[The questions of Senators Chafee, Hatch, and Wallop appear in the appendix.]

The CHAIRMAN. Thank you very much, Senator Grassley.

Senator Riegle.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN

Senator RIEGLE. Thank you, Mr. Chairman.

Let me say, Madam Secretary, how much I appreciate the strong leadership you are giving.

These issues are a lot easier to talk about than they are to solve. And you are new on deck. And I appreciate the fact that you are steering directly into them.

And also, I want to thank you for coming to Michigan the other day for the health care reform that we had. It lasted about 6 hours. We got a lot of good input from people in Michigan.

And I appreciated your effort there and will again this afternoon when we have the chance to meet and elaborate on the immunization issue which you touched on earlier, which I think is a very important step for the country to take.

Just a couple of comments with respect to what is in the plan now. I think it is essential that we view what can be done to improve Medicare and Medicaid in terms of cost efficiency and other aspects.

It has to be done in the context of the overall health care reform effort. And I see through the cuts that the administration is expecting to slow the rate of growth in Medicare from about 13 percent to 11 percent a year. It is still a very high number, but obviously, an effort to try to restrain those percentages.

I am also glad to see that an effort was made to limit the cuts in Medicaid, the States which are already struggling, of course, to try to meet the problem and pay for their share of the program.

I do want to express a concern about one detail of the proposal, and that goes to the reduction of the indirect medical education adjustment for payments to teaching hospitals.

I know you have some familiarity with that, but this IME adjustment which compensates teaching hospitals for the cost of training residents and serving sicker patients is very important in my State.

We have many teaching hospitals in Michigan, including the University of Michigan that serve very wide regions within the State. So I would just express my concern about that and that we look carefully at that.

Let me move to Social Security for a minute. And I want to thank the President through you and thank you directly for including in the budget for fiscal year 1993, $302 million for improving the processing of disability insurance claims.

As Chairman Moynihan knows, we have had a terrible problem with people who are out there who have legitimate claims that we have not acted on in a timely way.

And I think that has been a serious shortfall. Some have had to wait 6 months or longer to find out whether they are eligible for disability payments when, in fact, many are.

And I think particularly in that situation, there is really no excuse for that. I think that was worse than an administrative lapse. I think that was too fall that short in that area of need, I think you almost have to have a perverse intent.

In any event, you have moved to deal with it. And I appreciate that fact. And I am very much interested in seeing what will come of that.

Finally, let me just say that with respect to the overall health care reform proposal, we are not here to talk about that today, but it has come up two or three times.

My advice to you would be to be as bold as possible. There are going to be all kinds of people that will attempt to pull anything apart from whatever direction and, in effect, become defenders of the status quo.

I think the status quo is not working and will not work. So I just want you to know that you can sign my name up on the list of people that says let's be bold and let's really hit the problem head on.

There will be difficult tradeoffs. Everybody understands that. The public certainly understands that. And the lobbying forces that are loose, such as they are, defending their own piece of the puzzle, I think, have to stand second in line on this.

I know that is your view. And there is support for that view.

Dr. SHALALA. Thank you very much, Senator. And thank you for your leadership on immunization.

If I might comment on the indirect and direct medical education cuts. We did continue the disproportionate share adjustment for hospitals and we are not proposing to reduce that adjustment.

We do not believe the reduction that we are proposing will be too burdensome. It is less than what was actually recommended by PROPAC.

And again, your point that these are just a down payment on fundamental reform. I will, as you well know, continue to keep my eye on the teaching hospitals. We need them there.

We cannot substitute something for them. But in this case, we thought that if we very gently went in we could take a fair share adjustment in that area.

On my trip to Michigan, I enjoyed the trip. I learned a lot more after sitting there for 6 hours and more recently for 13 hours. I have a lot more sympathy for elected members of this body who have to sit for long hours at hearings.

My mother called and asked whether there was something wrong with me because she had never seen me sit that still for that long.

It was a good experience listening to residents of your State tell us of their problems with the current health care program.

Senator RIEGLE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Riegle.

Could I just make a point? The teaching hospitals are the research hospitals of our country. And most of the medical science in the world, not all, comes out of the United States and comes out of those hospitals in the main.

Dr. SHALALA. The extraordinary contributions of the New York hospitals in particular in your State.

The CHAIRMAN. Yes.

Dr. SHALALA. In terms of the number of both researchers as well as fine physicians that come out of those programs.

The CHAIRMAN. Thank you.

Senator Durenberger.

Well, Senator Breaux.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you very much, Mr. Chairman.

I hope we are all going to be as bold on health care reform when it comes to paying for it as we are going to be on designing it, which is going to be the $100 billion question.

I thank you, Madam Secretary, for being with us. Let me ask you a health care related question as well.

I support the concept that has become the likely starting point for health care reform, that is, in managed competition. I also support the idea that if everybody in the country is eligible to have a health insurance policy that covers a standardized package of benefits, that we do not need Medicaid. Every poor person in the country will have a health insurance policy to pay for their health benefits as people now pay for them who have health insurance.

My concern, however, is that my State of Louisiana is somewhat unique in the sense that we have a major charity hospital system. There are other areas of the country that have the same type of system, Cook County, for instance, Harlem Hospital in New York, that are major, public type of institutions that use Medicaid to fund their operations and pay for their services.

I support this move towards a standardized health insurance plan for everyone and moving away from Medicaid.

But my real concern, if you have any thoughts about it, is how do we help these institutions that already exist make the transition to a time when there would be no more Medicaid payments coming from the Federal Government?

I know in Louisiana, none of those hospitals would be able to exist unless they somehow worked into the package that people would go to them voluntarily.

And the concern is that their standards are not as high perhaps as a private system. So if you have an insurance policy, I will not go to the old charity system. I will go to the private hospital and give them my insurance policy. Do you have any thoughts on that?

Dr. SHALALA. Well, there are many people who believe that if we adopt some version of managed something, whether it is competition or whatever, it ends up being named, that it will give a new lease on life to public hospitals, given the proper transition opportunities.

It may well diversify the patients that they get, and we see them as players. And we are sensitive about their special roles they play in their community. And I do not think that there is any reason to believe that we in any way to cut them out.

More importantly, I do not think that any of us believe as we move more to a system that there is not a role in public health. The question is how we should define that role. But whether it is focusing on prevention services that go beyond what the current options are is something that is being thought through at this moment.

But I can assure you that we see this as building on the strong public-private enterprise that we have. We are looking for ways to make it more accessible and more efficient.

And there is no reason to believe that public hospitals need to be any less efficient. The New York hospitals have demonstrated that they can run fairly efficient operations, from an administration point of view, even with very low—large numbers of indigent or low-paying clients.

Senator BREAUX. I appreciate that response and the show of concern that we share. And hopefully, we can work towards a solution for this serious problem.

Let me ask you about another subject, welfare. Since 1965, we spent over $3 trillion on anti-poverty programs in this country.

Yet, despite that, I think that it is pretty clear that conditions in poor communities have generally gotten worse and not better and that welfare is failing both the needy people that it was intended to help and the working people who happen to be paying for it.

And I note that Senator Moynihan in his opening comments mentioned that there was no money in the President's budget proposal for welfare reform.

I think it is going to cost us some money when we transfer welfare recipients to working programs, either in the public sector or in the private sector.

And I want to have an assurance because this Member and I know many other Members want to make it a priority in this Congress.

And I wonder if you can comment on how this administration plans to approach this. I know that health care is on the table and that it is a priority, but where is welfare reform on the table?

Dr. SHALALA. Well, it certainly is on the table for us. And we have already started working on a proposal.

But there are elements of welfare reform and new initiatives or at least building on existing initiatives in this budget, whether it is the Earned Income Tax Credit or increasing Child Support Enforcement, resources for the HIPI program or for family support kinds of activities.

So there are some elements of it. And we intend to come back to the President with a more expansive program, more integrated, building on the Family Support Act, as I indicated to the Senator.

And while it is clear that we do not have multi-billion dollars of new resources other than for the Earned Income Tax Credit and Head Start and some of those kinds of things, in this budget, you can expect us to do two things: Reorganize what we have and have the President make a decision on whether he wants something in addition as we come to the table with that proposal.

Senator BREAUX. Can I ask just one follow-up question? This is a simple question. Are we to expect that there will be a specific welfare reform legislative package submitted to this Congress in this session?

Dr. SHALALA. I have said before that I anticipate that that is what we intend to do. And that will involve conversations with all of you. But we are certainly working towards developing a proposal right now.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. I thank you, Senator.

May I just note that Senator Breaux is the new Chairman of the Subcommittee on Social Security and Family Policy. And this is very much a matter of interest to him.

May I also note that the Earned Income Tax Credit has nothing to do with welfare. It was begun to offset an increase in the payroll tax for the Federal Insurance Contribution Act.

Head Start may or may not be. But again, who gets the money? Not the welfare child. We will remember that.

Senator Daschle, you have had a long wait, sir.

OPENING STATEMENT OF HON. THOMAS A. DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Thank you, Mr. Chairman.

Dr. Shalala, I also want to thank you for coming and express my gratitude to you for the leadership that you have already shown in so many areas.

I appreciated some of the remarks you made with regard to controlling entitlements, and do not think there is any objection to this idea.

Caps, however, are not necessarily an approach that enjoys a good deal of support, if they are imposed without broader reform.

So while I think there is unanimity about the need to control entitlements, we really do not have much unanimity about the approach to do so.

Caps address the symptom. They do not really address the problem. And so what I hope that we will see a good deal of leadership from your office with regard to ways in which to reform entitlement programs.

One concern that I have related to the cost of entitlements is our inability to calculate their real cost, both in terms of Federal dollars and dollars at the State and local levels.

We have been trying for a long period of time to calculate, for example, what the entire cost of health care is for individuals as well as for businesses.

And I have been amazed at the lack of clarity that exists today with regard to our budgeting of health costs in this country.

If you ask a person today how much he or she is spending on health care, they may be able to give you the cost of a premium. They may be able to give you the cost of their out-of-pocket expenses.

They may be able to tell you what their deduction is for Medicare. But they cannot tell you how much in health costs they are paying at the State level, how much they are paying at the local level, how much in all of the hidden costs they are paying in pass throughs in hospitals and doctor's offices. And therein lies the problem.

How can we control costs if we cannot even calculate them? And so I would hope that as you look at entitlements, we come to grips with this problem of cost calculation.

There is a big difference between new costs and hidden costs. I hear a lot of concern expressed about how much this new system is going to cost us.

Well, I think there is a big difference between drawing out those hidden costs and finally putting them on the table and adding to the new costs and whatever new services we may provide.

I would like you to respond to that concern and give me some indication of how we might address the problem and what you consider doing.

Dr. SHALALA. Senator, your point is very well taken, as part of the process of making the case for health care reform we have to be very upfront about what the real costs are. We know there is cost shifting that is taking place—in fact, there are some hospitals that actually, when they bill you, tell you what part of your bill is really pass through costs that you are paying part of the costs of the uninsured now to give people a sense of what is going, which is very a interesting way to account for the high cost of a hospital stay.

But I think your point is well taken. And you have actually given me an idea for what we might do on the front end of the health care reform as we begin to present it, that we talk about the real cost.

There has been an attempt and analytical effort to get a hold of this. I think the President has been very frustrated as he has asked these kinds of questions that we did not have the proper analytical effort, either in the public or the private sector to get our arms around it.

We certainly can describe where the hidden parts of the costs are.

I also should note that as a resident of your State, in rural and more frontier areas of this country, because people pay their premiums directly or if they do not have any health insurance and they have to pay the cost of their own health, they are much more aware and have much better records of what their health costs are.

When we went to Iowa, rural farmers showed us what their real bills were. As I asked friends of mine who live in urban areas who work for companies or work for government, they are much less aware of what the total is, in part because they are involved in a co-payment system or something else.

So I think that as we make the case for systemic change, we ought to take into account what people know and what they don't and what they need to know, and that is they need to know these costs are all over the place as well as their impacts.

Senator DASCHLE. Well, I would hope that HHS would put a high priority on coming up with a way in which to calculate real costs. HCFA cannot tell me. CBO cannot tell me. OMB cannot tell me.

Now, someone has got to be able to calculate the real cost before we start contemplating reforming that system.

Dr. SHALALA. Right.

Senator DASCHLE. Based upon a system that will be designed to control cost.

Dr. SHALALA. One of the things that happened at HHS, as you well know, is the analytical effort of HHS was literally destroyed over the last dozen or 8 years. And rebuilding that analytical effort has been one of our goals.

Senator DASCHLE. One of the current cost containment efforts that has worked as long as the current system is in place, of course, is the DRG system.

There have been efforts on the part of Congress to require HHS to develop plans for prospectively reimbursing outpatient departments.

The Bush administration was required to do so and missed the deadline. And rural hospitals, of course, now continue to live with the fragmented payment system.

Do you consider the DRG system to be effective in reducing costs? And what are your plans for responding to the congressional mandate that HHS develop a plan for OPD services?

Dr. SHALALA. Well, with respect to the Payment Assessment Commission, efforts to give us proposals to hold down costs has been more effective than anything that we did before.

In fact, in my answer to Senator Packwood, which was no answer at all, the difference between our more sophisticated system of rate setting in which we have a lot more data using DRGs that focus on both price and volume, has been more effective than trying to freeze in existing prices which freezes in inefficiency.

We have a long way to go in terms of adding data, but we are working on a report to Congress on this issue. And we will be making some recommendations in the future.

And this increased sophistication allows us to know more about real costs. And using an outside commission to take a look at this data, using their assessment, the PROPAC Commission has been very useful as we have worked through these issues.

Senator DASCHLE. Can you give the committee any idea when the plan might be complete?

Dr. SHALALA. I think we are very close to a report. We are less than a year away. We really are working on that.

One of the things that has happened is the same people that are working on that report to Congress are obviously deeply involved in health care reform.

So it is just like musical chairs around the department at this moment because it is the same kind of analytical effort that is going on.

Senator DASCHLE. Thank you, Dr. Shalala.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Daschle.

No member of this committee has been more deeply involved in health matters than Senator Durenberger who finally will have an opportunity to question.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, I thank you.

Like many members of this committee, I am also on the Environment and Public Works Committee. Today we were debating an issue involving CEQ in a new department of environment. I regret that I have been bouncing in and out of this hearing.

And I apologize to you, Madam Secretary.

I have a statement that I would like to be made a part of the record, Mr. Chairman.

The CHAIRMAN. Of course.

[The prepared statement of Senator Durenberger appears in the appendix.]

Senator DURENBERGER. I have questions that I would like to ask on a number of subjects and will submit them in writing.

First, why is the administration proposing budget cuts in the enforcement against Medicare fraud and abuse? The Washington Post reported last week that the Department of Health and Human Service's Office of Investigators has been told to plan on less funding in fiscal year 1994.

Second, I have a question I am going to direct to you on graduate medical education and how that relates to primary care and family medicine.

Third, I am submitting a question on Medicaid vouchers and how we can move quickly in the reform area to getting a very specific dollar amount with which the elderly in Minnesota could use to buy accountable health plans. In doing so, we will abandon the DRGs and all the rest of that sort of thing.

Fourth, I also have a question on disproportionate share payment hospitals—DSH. If you are looking for ideas, there is a huge chunk of money in Medicaid right now that is being spent disproportionately across this country. For example, my State of Minnesota only has 1.1 percent of our money going to our four disproportionate share hospitals. We have our share of low-income people, but we are just not abusing the system like everybody else.

There is a big chunk of money in there that you can better utilize to fund additional coverage for low-income individuals.

Finally, I have a question on maternal and child health. Right now, the appropriations for maternal and child health are right up against the authorizing level, about $686 million, proving this is a pretty good program.

I would like to increase that authorization over the next 2 to 3 years by $250 million to about $936. I encourage you to think about using that money, as you already may be doing for school-based health services and co-location of other services in and around schools. You are probably way ahead of me on this issue. And I hope you are.

I understand Jack Danforth raised the issue of a national spending goal, like CPI plus 1 percent, while I was out of the room. We lost on that one because the people at the Whitehouse called the Democrats and said, "don't vote for it." I am not sure that was a wise thing, but I suppose timing-wise, it was important.

I think what I heard people here say and what I heard you say in response to Tom Daschle's question about an analytical effort regarding health costs, is that there is a need for a target. I just want to endorse the use of some kind of targets so we know how well we are doing as we progress in health reform.

Most people here, on both sides of the aisle, are probably going to oppose price controls and specific things that get in the way of market reform. But I would hope that we will all endorse some kind of a targeting process so that everybody in the country is able to judge how well we are doing in tackling this problem.

That is what our colleague from Missouri was trying to help us deal with the other night—entitlement caps of CPI plus 1 percent. And you would have 3 years to figure out how to achieve that goal.

The providers in Minnesota would clearly come in under the CPI. They are already well below it. Hopefully, you'll ask how we are doing it? Stop calling us crazy Norwegians and note that Minnesota must be doing something right up there. What is it?

And in Florida, when they come in at CPI plus 10 percent, as they consistently do, you can say something has got to be done about the fact that Minnesotans keep shipping their payroll taxes to Florida to be wasted on system that rewards such inefficiency.

That is the last point I would love to make to your colleagues here, Madam Secretary. .

The CHAIRMAN. You are not sure. It is not really PC to speak of crazy Norwegians unless you mention Swedes and Serbians at the same time.

Senator DURENBERGER. Yes. And there is a series of Danes, Icelanders, and others whom we usually lump into that category.

But I am so excited about what the Secretary is bringing to the table and what the President and the First Lady are bringing to the table.

The issue here for all of us is what is the most appropriate role of government, as the chairman pointed just a little bit earlier, and the way in which government can dysfunction a market place?

If you go back to the 1930's, a law suit by the American Medical Association against Group Health raised its so-called ugly head. If the government had supported Group Health in those days, we would have had accountable health plans way back in the 1930's. We would not have had to wait until the 1990's because Group Health had organized as an accountable health plan.

The CHAIRMAN. Yes.

Senator DURENBERGER. It worked with its members. They were the consumers in the health care delivery system.

Of course, we all insisted on beating down that effort. When we got into the post-World War II period, everybody thought it would be a good idea to make employers accountable for health care or health insurance for their employees.

We organized the employer into what we now call a purchasing group or a purchasing cooperative. Instead of using that employer to access people to an accountable health plan, we, the government, said we were going to make it possible for you to insulate all these people from the cost of their care by giving them free health care. In other words, the employees would not have to pay for it.

And so we had the notion of purchasing groups then, which could have been endorsed in combination with accountable health plans at that time—nearly 60 years ago. But the Federal Government undermined it.

We undermined it again in 1965 when we created Medicaid and Medicare.

The CHAIRMAN. How?

Senator DURENBERGER. Because what we did there was two-fold. Number one, we sent the bill for the services to somebody else. We didn't charge beneficiaries for services. Instead, we sent it to all the workers who were then being insulated from the cost of their own

care as well. We did not insist that they use an accountable health plan as an access to the market.

We said, "Government will buy your health care for you." Similarly, some people are now saying, let's go to Canada and have the government pay for the system.

We again missed an opportunity to get at the heart of what Tom Daschle was getting at, which is how do we get people more involved in the decisions about their health care?

The point I want to make, Madam Secretary, is that when we talk about managed competition, a lot of Republicans think that it is an effort to have you manage the system. It is not.

It is not at all. It is an effort to have people, employers, the private sector, in effect, manage this system. An accountable health plan, like Group Health, was in existence way back in the 1930's. The government's role should have been to facilitate that market rather than to dictate how it should come out.

I have to make that point in the hopes that some of my more conservative friends are watching this, and also some of your more liberal friends who think this market cannot be trusted and we need to end up in Canada.

But managed competition, if it is managed the way we could have managed it from the 1930's on in this country, is the solution to our problem.

[The questions appear in the appendix.]

Dr. SHALALA. Senator, thank you. And we would be happy to answer your questions for the record.

Let me say three quick things. Number one, I know Senator Moynihan does not like it when I make athletic references, but I did want to congratulate you on the Gophers' victory last night.

Number two, on the Inspector General——

The CHAIRMAN. Keep that up and we are going to ask you to recite "On Wisconsin." [Laughter.]

Dr. SHALALA. And the Inspector General, the President announced this morning the new Inspector General for the Department of HHS will be June Brown. She is one of the premier Inspector Generals in the country from Hawaii and is currently the Inspector General of the Pacific Fleet. And she will be coming very quickly to join the department.

Dr. SHALALA. There have been cuts right through the last few years, but we did not cut the number of investigators. We are cutting some administrative costs, therefore, some offices.

And rather than me trying to catch up with that, since she will be here next week, one of her first assignments is going to be to look at what she needs for the department.

And you can be assured that we could not attract someone of her high integrity and quality unless we were prepared to make a serious commitment in the Inspector General's office.

So we are pleased that the announcements are made and that she will be joining us shortly.

Senator DURENBERGER. I am glad to have given you the opportunity to say that. And I appreciate any time a Badger recognizes the value of being right next door to Minnesota.

Dr. SHALALA. Thank you. As painful as it is, Senator, I also want to thank you for your leadership on health care. And we look forward to——

The CHAIRMAN. Stop it. These crazy Norwegians. [Laughter.]

Dr. SHALALA. You will notice, Senator, that I avoided any of the ethnic——

The CHAIRMAN. Not for nothing, I remember the Clinton Administration. You know that. [Laughter.]

Dr. Shalala, we appreciate your candor. No answer when you do not have an answer is the right answer. And you have been very open on that matter.

I hope you have the sense, as I know I do and I think Senator Packwood does, that we are going to work together as a committee here. Not on the tax measure, that, I think, is probably agreed.

But on health measures, we are a committee that has as much interest and ability on both sides. We do not have sides. This is a semi-circle here. And we are all very much together. Wouldn't you agree on that?

Senator PACKWOOD. Whatever division there is going to be on this one, I think, is not going to be partisan. It will be on taxes as the chairman said.

But on this—and I think it is probably because, on taxes, all of us know what we think ought to be done, even though we are wrong on it.

The CHAIRMAN. Yes.

Senator PACKWOOD. On this one, I am not sure that any of us are exactly sure what ought to be done. So we are all searching.

The CHAIRMAN. And we are going to be looking very much to you for counsel.

Dr. SHALALA. Thank you.

The CHAIRMAN. And thank you very much.

Dr. SHALALA. You are welcome.

The CHAIRMAN. And congratulations on your Inspector General.

Dr. SHALALA. Thank you very much.

[Pause.]

The CHAIRMAN. Senator Durenberger, if you want to hear what the American Medical Association has to say, they are coming up. [Laughter.]

We are now going to combine our last two panels.

First, Raymond Scheppach, who is executive director of the National Governors' Association, is going to speak to us.

And Mr. Scheppach, you will not mind being joined, I am sure, by your associates in these matters, Dr. Spencer Foreman.

Good morning, Dr. Foreman.

He is the president of the Association of the American Medical Colleges and president of the Montefiore Medical Center.

Rick Pollack who is the executive vice president for Federal Relations of the American Hospital Association. And he will be accompanied by Jim Bentley.

Mr. Bentley, there you are, sir.

And finally, Jerald Schenken who is a member of the board of trustees of the American Medical Association.

This is a little bit irregular, but we do not have rigid rules. Since the American Medical Association subject has been raised and

since Senator Durenberger cannot be here indefinitely, I wonder if we can start with you, sir.

And if there are any questions that you have, Senator Durenberger, you can ask them. Otherwise, we will hear the whole panel.

And good morning, gentlemen. And thank you for coming.

Dr. Schenken.

STATEMENT OF JERALD R. SCHENKEN, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, OMAHA, NE

Dr. SCHENKEN. Good morning, Mr. Chairman.

My name is Jerald Schenken. I am a practicing pathologist from Omaha, NE, and a member of the board of trustees of the AMA.

As a starting point, we must all recognize that Medicare and Medicare cuts cannot be viewed in a vacuum. With momentous changes in how health care services are provided and covered fast approaching, the AMA is not treating Medicare and Medicaid budget cuts and the reconciliation process as business as usual.

However, in order to make sure that the cure is not worst than the problem, we must always keep in mind and address the complex constellation of factors which collectively drive up our health care costs: New technology, increasing and aging population, general inflation, healthy lifestyles, public expectation, and medical liability concerns, in addition to hospitals and physicians' fees.

The AMA and physicians are cognizant of the need to reduce the budget deficit and to control spending. And we recognize such decisions are never easy.

We suggest that you consider the following principles: avoid micro-management; use reconciliation to set directions for reasonable program improvements; maintain the integrity of Medicare's new Physician Payment System; refrain from actions that could increase the regulatory burden; and use caution in program expansion as new benefits invariably cost more than projected.

From this framework, the AMA has reviewed the President's recommendations. And it should come as no surprise that the AMA does not support all of the proposed initiatives. However, we take very seriously the challenge to find potential program modifications which will achieve the required level of savings.

While all of the actions we are recommending in our detailed statement have yet to be scored, we estimate that taking these actions will result in savings of over $7.5 billion in the next fiscal year and over approximately $31 billion in the next 4 fiscal years. Should estimates by others differ, our staff would appreciate the opportunity to work with you to examine the facts and assumptions and reconcile those differences.

Mr. Chairman, as you know, this exercise is not new to the AMA and the others who are before the committee today. What is new, however, is our message and commitment to you that we want to be viewed as, and accepted as, part of the solution.

The CHAIRMAN. Yes.

Dr. SCHENKEN. To a certainty, we will continue to oppose those proposals that will harm our patients and that will splinter the medical profession. Proposals, such as RAP DRG roll-in, the establishment of Medicaid drug formularies, the evisceration of the RBRVS through arbitrary reductions in the practice component and

modifications of the default formula, and setting a single fee for surgical services—regardless of the value provided by an assistant surgeon—are clear examples of where medicine is united.

Our reasons and supporting arguments on each of these and other proposals are available to you in our formal statement, and further statements if you so desire.

The CHAIRMAN. We do indeed.

[The prepared statement of Dr. Schenken appears in the appendix.]

Dr. SCHENKEN. We also recognize our responsibility to aid you in taking actions that will produce the needed savings from or revenue for the Medicare and Medicaid programs.

That is what we mean by telling you and the Nation of our desire for a new partnership. In the spirit of shared sacrifice, the AMA supports proposals to achieve dollar savings from physician provided services from the amount paid to clinical laboratory testing and from the unethical practices of self referral.

In addition, to give you an alternative to proposals such as RAP DRG, single surgery payment, and the practice component reduction, we have discussed the possibility of suggesting a 6-month delay in all Part B updates rather than the series of disruptive cuts proposed by the administration. Such a delay would provide significant 1994 savings and not disrupt the achievements of the RBRVS and physician payment reform.

However, there are potential serious consequences in making this suggestion in light of its impact on many rural and inner city areas and some practitioners who are on the margin of making a go of their practices. And these must be addressed before this should be considered.

Nevertheless, we estimate that delaying the payment update will result in additional savings of about $2 billion in fiscal year 1994. This is a real and readily achievable savings that does not come at the expense of more Medicare micro-management or at the expense of our patients. We would be pleased to work with you to see what accommodations can be achieved.

In conclusion, we cannot lose sight of the fact that the Medicare and Medicaid programs provide vital health and medical services to more than 60 million Americans. Because of this reality, we stand firm in saying that substantive changes in the operations of these programs should be made within the context of the needs of the beneficiaries, not just to meet a budget target.

I thank you, Mr. Chairman. I will be pleased to answer such questions as you might have.

The CHAIRMAN. Thank you, doctor.

And just because of the two places at one time problem we have, Senator Durenberger, would you like to ask some questions.

Senator DURENBERGER. Mr. Chairman, I am sorry. I gave you the wrong impression regarding my need to return to the Environment and Public Works Committee hearing. I should not have done that.

The CHAIRMAN. You should waiver in moments like this.

Senator DURENBERGER. I would love to stay in here for all of it.

The CHAIRMAN. Good. Then, we will go to Mr. Scheppach who represents the Governors' Association.

STATEMENT OF RAYMOND SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS' ASSOCIATION, WASHINGTON, DC

Mr. SCHEPPACH. Thank you, Mr. Chairman.

We appreciate the opportunity to appear before you today on behalf of the Nation's Governors to discuss the administration's proposals for Medicaid savings.

As you know, Mr. Chairman, Medicaid spending during the 1981 through 1988 period was relatively stable and grew at less than 10 percent per year on average.

In the last several years, the growth rate has exploded to over 20 percent. This has caused major budget problems for most States, since this was also a period of recession with little State revenue growth.

States were forced to cut education, welfare programs, economic development, and other critical programs to, in fact, fund the growth in Medicaid.

This has been particularly disruptive to a number of States because they have put off long-run investments in order to fund the Medicaid growth.

The Governors believe that members of Congress recognize this crisis and are willing and interested in relieving these budget problems at the State level.

With respect to the administrations's proposal, with exception of the cut in the matching rates, the Governors can support all of the proposals by the administration.

Concerning the cut in the matching rates, this is plain and simple a cost shift to the States. There were good public policy reasons to put in these enhanced matches. And those reasons essentially continue at this time.

One of the more serious ones, of course, is the critical need to develop management information system.

As was discussed earlier, this is not the time to cut information sources. We need all the information that we can get on current spending as we begin to approach reform.

It also is true that a lot of these current contracts are multi-year contracts. So States would have particular problems if, in fact, they would have to go back and cancel them.

Similarly, on the skilled professional and medical personnel and nursing facility surveys, certification, and peer review, these enhanced matches are very important in terms of maintaining quality assurance.

In terms of the total cost shift, it would be about 10 percent on average to States, but it has a differential impact. Four States would have more than a 20 percent shift, 9 States, more than a 15 percent shift.

The CHAIRMAN. You have those States by name.

Mr. SCHEPPACH. I think they are in the attachment.

The CHAIRMAN. They are.

Mr. SCHEPPACH. Overall, we agree with the House Committee Report on the budget resolution when it stated that the administration's proposal would seriously undermine the ability of States to carry out mandated activities.

We are, however, supportive of the administration's proposal to remove the prohibition on formularies. Our sense is that we can run them cost effectively. This is what hospitals do. This is what HMOs do. We believe that the States can do it also.

The Governors also support tightening the rules regarding the transfer of assets as well as the administration's recommendation to correct the drafting error that establishes a personal care service mandate as of 1995.

Finally, the Governors support action that would identify third party payers to ensure that the appropriate insurer pays for care before Medicaid.

So with the exception of the Medicaid matching, we are supportive of all of the administration's proposals.

I would be happy to answer any questions, Mr. Chairman.

[The prepared statement of Mr. Scheppach appears in the appendix.]

The CHAIRMAN. I think you have answered a great many in that last statement. We will just go right through our panel now.

Dr. Foreman, we welcome you, sir.

Dr. FOREMAN. Thank you very much.

The CHAIRMAN. And you are appearing on behalf of the Association of American Medical Colleges, of which your own is one of the most distinguished in the world.

STATEMENT OF SPENCER FOREMAN, M.D., PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AND PRESIDENT, MONTEFIORE MEDICAL CENTER, BRONX, NY

Dr. FOREMAN. Thank you very much, Senator. It is a pleasure to be with you this morning and other members of the committee.

Although we are very much concerned with all of the administration's Medicare proposals, I will focus today only on three: the reduction of the indirect medical education—IME—payments——

The CHAIRMAN. Spencer, would you just hold that a little closer. They will be able to hear you better in the back.

Dr. FOREMAN. This is better, sir?

The CHAIRMAN. Yes.

Dr. FOREMAN. Thank you.

The changes in the direct medical education—DGME—payments and the reductions in hospital out-patient payments.

Underlying the proposal to reduce IME, is the belief that the shortcomings and the prospective payment system for which IME was originally designed are gradually being addressed by refinements in other elements of the Medicare prospective payment system—PPS. Therefore, continuation of those IME payments at the current level is unjustified.

I believe that this reasoning is flawed for the following reasons. First, the IME was never a precise tool. Unlike the direct medical education payments, it was not based on specific costs.

The IME was intended as a surrogate to compensate for the inadequacies of the PPS to account fully for such things as severity of illness.

More recently, it has been used by the Congress to stabilize teaching hospitals by ensuring them total margins roughly comparable to non-teaching hospitals.

While teaching hospitals have done very well with their prospective payment system margins and those margins have been somewhat larger than non-teaching hospitals, their total margins have been substantial less.

And a very great concern to us is that in 1992, our data indicate that the prospect of payment margins in academic medical center hospitals dropped dramatically from slightly less than 6 percent in 1990 to 3.87 percent in 1992.

If IME were cut as proposed, the PPS margins would plunge to minus 3 percent and the total margins would fall through the floor.

$3.6 billion is being proposed to be taken out of the teaching hospital system by the year 1998. That would cost Montefiore Medical Center $9 million a year.

And there is——

The CHAIRMAN. And that is Montefiore?

Dr. FOREMAN. Yes, sir.

And there is little doubt that these reductions would seriously harm teaching hospitals.

Now, the proposal to reduce the DGME payments has two different rationales. First, its critics contend that there are large unjustified variations in payments among teaching hospitals and, second, that the present payment system encourages the training of the wrong kinds of doctors.

Unlike the IME, there is an historical cost basis for the direct medical educational payments. These costs include the salaries and benefits of residents and supervising physicians, to provide payment for such overhead costs as supplies and clerical support, and teaching or classroom space.

Variations in DME costs derive from the fact that teaching hospitals rely on multiple funding streams to support graduate medical education.

These funding streams include faculty earnings such as Medicare Part B payments, State appropriations, Veterans' Administration appropriations, municipal hospital affiliations, gifts and grants, and finally, Medicare Part A payments, which is the DME. The proportion of these other funding streams received from these sources varies considerably by institution.

For example, inner city hospitals with limited faculty practice income and hospitals with no State subsidy tend to have much greater reliance on Part A payments than dc other teaching hospitals and, therefore, have higher DGME costs. Those teaching hospitals with other sources of support often have lower DGME costs.

But one way or the other, the costs of education have to be paid. If a teaching hospital has a low DGME per-resident ammount, it is not as though that institution has found a cheap way of providing a quality education. Rather, an institution with low Medicare Part A DGME costs, is subsidizing its educational costs by other income streams.

The administration's proposal average Part A payments—or DGME payments—will have its greatest effect on institutions for whom Part A has been the principle funding source. And many of these institutions serve vulnerable inner city populations. The major teaching hospitals in New York will be severely hurt. New York stands to lose $200 million of the $350 million annually to be

taken out of the system. And Montefiore would lose $14 million a year. However, some are teaching hospitals with small training programs.

With respect to the argument regarding the training of the wrong kinds of specialists, the Association of American Medical Colleges strongly agrees that we are producing too few generalists and too many specialists and is committed to trying to reverse that trend.

We believe, however, that the principle barrier to the selection of primary care residencies is the perception by the graduating medical students that primary care is an unattractive profession. It is not the unavailability or inadequacy of training opportunities. There are already many more training opportunities.

The CHAIRMAN. Please finish, doctor.

Dr. FOREMAN. Thank you, sir.

The CHAIRMAN. Take your time and finish.

Dr. FOREMAN. Thank you.

In fact, there are many more primary care residency training slots than there are applicants. Additionally, there is no evidence that available positions are going unfilled because they are either unattractive or of low quality.

Therefore, improving the payments to hospitals to increase the number of positions or to improve the quality of their primary care training programs is not likely to increase applications for those positions.

Moving to a weighted payment system would simply reduce the total DME outlay as primary care residense training positions remain unfilled. That reduction will save Medicare money, but it will severely damage teaching hospitals.

Finally, with respect to the proposed reductions in outpatient payments, unlike the reduction in IME and DME, there seems to be no philosophical underpinning for proposing reductions in outpatient payments except to save money.

Hospital-based out-patient clinics are very important sources of care. Their cost reflect a severity and complexity of illness among the poor and the inefficiency of episodic discontinuous care.

We believe that a prospective payment system is a better approach to controlling these costs. And we urge it.

I thank you for the opportunity to make these comments.

[The prepared statement of Dr. Foreman appears in the appendix.]

The CHAIRMAN. We thank you for those comments, Dr. Foreman.

And now, to conclude, Rick Pollack on behalf of the——

Mr. POLLACK. The American Hospital Association.

The CHAIRMAN. The American Hospital Association.

Mr. POLLACK. That is correct.

The CHAIRMAN. Of course, you are. [Laughter.]

Mr. Rick Pollack.

STATEMENT OF RICK POLLACK, EXECUTIVE VICE PRESIDENT FOR FEDERAL RELATIONS, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC, ACCOMPANIED BY JIM BENTLEY, SENIOR VICE PRESIDENT FOR POLICY

Mr. POLLACK. Thank you, Mr. Chairman.

I would like to make three points very briefly. First, we are obviously very concerned about the impact of further Medicare savings on hospitals in the communities they serve.

While we appreciate and understand the need for shared sacrifice for all Americans, including hospitals, it is also important to recognize that these budget proposals will cause general hardship, particularly to many small rural hospitals and inner city urban hospitals who are already in financial peril.

According to the Prospective Payment Assessment Commission, average PPS operating margins in 1990 were negative 8.3 percent with over two-thirds of the Nation's hospitals subsidizing the cost of treating Medicare patients.

I might add that those figures are 2 years old. And the trend lines continue to go downward. Clearly, these new budget proposals that include delays and reductions in update factors, cuts in graduate medical education and further reduce out-patient payments will exacerbate this already fragile situation.

It is also important to recognize that hospitals have already contributed significantly towards deficit reduction over the past decade.

The last reconciliation bill alone, enacted in 1990, reduced Medicare hospital payments by $16 billion over a multi-year period yet to be completed.

I must say that we are also quite disappointed that some promises of using Medicare savings to help finance expanded coverage to the uninsured have essentially been broken.

Given what we see coming through the doors of our emergency rooms, our operating rooms, and our delivery rooms every day, we will never understand the reluctance to use some of these savings as investments to provide basic health care—starting first with moms and kids.

Nevertheless, Mr. Chairman, as a practical political matter, we understand that this committee must meet the savings mark set by the budget resolution.

And we hope to work with you in developing a fair, responsible, and balanced package that is sensitive to the legitimate needs of our most fragile institutions and our most vulnerable populations.

At the same time, we do, however, insist that any short-term budget actions be inextricably linked to the development of a health care reform package that provides both universal access and a restructured health care delivery system.

Speaking of reform, my second point is that if we really do need more Medicare savings, it must be achieved through real reform rather than continued tinkering with a broken system.

As you may know, AHA has called for a significant restructuring of the health care delivery system.

It involves providing strong incentives to establish community care networks. These networks would link together providers and

other stake-olders to provide all services needed by patients from preventive care to long-term care.

And they would give patients a single entry and coordination point for all services financed through integrated payment or capitation.

On the other hand, attempting to improve the current system by puttering and achieve further efficiencies through ratcheting is like driving a car while looking through the rear view mirror rather than looking out the windshield.

The truth is that if additional savings are needed to keep the Medicare Trust Fund viable in the long term, creating a more efficient delivery system for Medicare beneficiaries as well as all citizens must be part of the solution.

A thoughtful restructuring of the health care delivery system that includes Medicare and provides beneficiaries with a seamless system of health care security would generate savings.

It would address the inefficiencies that result from overlapping and duplication of services. It would address the issue of excess capacity.

And it would address the inefficiencies created by the perverse incentives of our fee for service system that result in more and more services generated in the name of piece work and fewer and fewer services provided in the pursuit of wellness and prevention.

In conclusion, my third point is also as a practical matter, we recognize that PPS will not go away overnight. And there are some stop-gap measures that should be taken to ensure equity in the system.

In this regard, we are pleased that the President has included in the investment section of his budget provisions which re-authorize several important programs to assist rural hospitals in maintaining necessary services for communities.

We also support S. 176, the Medicare Amendments of 1993 which is pending before the committee. And it also contains important equity provisions.

Moreover, we remain committed to eliminating the urban-rural differential by October 1, 1994, as under current law.

Finally, our written statement includes our views in regard to a variety of other equity provisions that have been proposed by both HCFA and PROPAC in regard to labor market areas and outlying payments.

Mr. Chairman, thanks again for giving us the opportunity to share these views with you.

[The prepared statement of Mr. Pollack appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Pollack. And do not go away.

Mr. Bentley, did you want to speak?

Mr. BENTLEY. No. Thank you.

The CHAIRMAN. Well, first of all, may I just say that I wish that Secretary Shalala could have had the opportunity to still be here to see how positive this testimony has been.

Don't you find it so?

Senator PACKWOOD. Yes.

The CHAIRMAN. I mean, we are going to try to do this thing.

I have only one comment I would like to make and I put it in the form of a quiz, and that is, which of you, I hope all of you, is familiar with Baumol's disease?

Dr. Schenken.

Dr. SCHENKEN. Not me.

The CHAIRMAN. Dr. Foreman.

Dr. FOREMAN. I pass. [Laughter.]

The CHAIRMAN. Baumol's disease.

Dr. FOREMAN. I do not think I have it, Senator. [Laughter.]

The CHAIRMAN. I think you have got it. You do not have it. Montefiore has it.

Just to make a quick simple point. Bill Baumol is a professor of economics at Princeton and NYU. He is the president of the American Economic Association.

And like a lot of important things he learned in the world, it came through kind of indirectly. He is an opera fan. He and his wife are opera fans. They love opera.

Around the 1960's, he thought, why is the Metropolitan Opera always broke? And why is the symphony orchestra always on strike? And he got to thinking about this and thinking about it.

And he suddenly realized it is a question of comparative costs. Comparative costs change enormously over time in societies. And we do not notice it.

It comes down to the simple fact that it takes just as much time today to play a Mozart quartet as it did when Mozart first played in Vienna. Try as you will, it takes four people, four stringed instruments, 43 minutes.

If you play the Minute Waltz in 50 seconds, it just is not productivity. [Laughter.]

And so inevitably, some sectors do not respond to productivity changes. Others do. So comparative costs will shift over time.

And he calls it cost disease. The profession likes to call it Baumol's disease.

A professor of medicine at Montefiore taking what, six interns through a ward, how long did it take you? Montefiore was opened around 1870, wasn't it?

Dr. FOREMAN. 1880, sir.

The CHAIRMAN. 1880. How long did it take that professor to take six interns through a ward in 1880?

Dr. FOREMAN. The same as it takes now.

The CHAIRMAN. There you are, sir. You got Baumol's disease. [Laughter.]

Dr. SCHENKEN. Mr. Chairman, the problem, of course, is that if Mozart had a headache and it was a tumor, we would not have had Mozart. But today, he would have had CAT scan and probably been cured. So the productivity and the product have to be balanced.

The CHAIRMAN. There are changes in productivity. Technological curves are extraordinary. But some aspects simply reflect the fact that there are certain amounts of time and attention that goes into producing a doctor that you cannot automate.

I will not go into it, but one little detail. You will love this. The real wages in Elizabethan England reached the lowest point between the 13th century and the 19th century.

And a consequence of that, you could get a play that ran 2 weeks at the Globe Theater return all of its money. Today, it takes a year in the west end of London.

And so Shakespeare could have produced 37 plays in 23 years. Whereas anybody who gets six in their lifetime is lucky.

It is just cost disease. I do not think that we should ignore things that you cannot do anything about and do not want to do anything about.

It takes one doctor and six interns an hour to go through that ward.

Senator Packwood.

Senator PACKWOOD. Dr. Schenken, on page 2 of your statement, you say, "We believe a partnership can be forged between the medical profession and the government to assure quality of care and budget predictability in setting fair negotiations."

Just so we are using the same terms, will you tell me what you mean by budget predictability?

Dr. SCHENKEN. Well, the—yes, sir. And I think it may be about as precise as semantics competition, but I will do the best I can.

We recognize that just as doctors and hospitals and families have problems which require them to pay attention to budgets, so does the country and so does the Federal Government.

Where we are troubled is that the demand side is so diffuse out there. I mentioned all the factors.

So what we would be trying to do would be to work with the administration, the Congress, and whatever and maybe local, State, and insurance companies to try to see if we can predict in advance, taking into account all of these factors, as to what the technology is going to be. Obviously, you cannot do it for 10 years, but for 1 or 2 years. And see if we can say is this a budget that everybody agrees to?

But in order to do that——

Senator PACKWOOD. Wait a minute. Are you working at this basically from the front end to the cost? You are saying that we are going to add up all the technologies and the doctors and the hospitals, and the cost is "X." That is budget predictability.

Dr. SCHENKEN. That would be one way to get at it. "Y" would be how much is available and can we work backwards?

And our position is I think we have to do both of them because we have to. For example, if we are going to ask the physicians in the hospitals and the political people and other people to take this responsibility, is it fair for us then, for instance, to permit people to continue to voluntarily smoke and drink and not wear safety belts and not wear helmets and all these things which many people estimate could be maybe 20 percent of the whole health care cost, totally unnecessary.

And so the challenge is to see if we can balance the responsibility side and the availability side with the cost on the budget side.

It is not going to be easy, but as we said before, the status quo compound interest. We cannot continue to have a 15 percent or so increase.

Senator PACKWOOD. Mr. Chairman, I am doubly glad I asked the question now because I would not have used the term budget predictability the way he uses it.

Here is what I would say is budget predictability. At the moment, we are projected to spend $1.65 trillion on Medicare and Medicaid over the next 5 years on baseline. And that may be wrong, but that is just our projection.

Dr. SCHENKEN. Yes.

Senator PACKWOOD. Budget predictability would be we cannot afford to spend that much. We just can't. So we are going to try to cut that to $1.3 trillion.

And we are going to make the services fit within the $1.3 trillion. That is budget predictability. It may be bad medicine. But it is budget predictability. Otherwise, we have no predictability.

Dr. SCHENKEN. Well, Mr. Packwood, that might be budget predictability. And it might even be in certain circumstances an accepted budget predictability, but the physicians also have some responsibility when people come in to do what they are supposed to do.

And I can just tell you. I am sorry Mr. Breaux is not here. I worked for the State of Louisiana for 10 years prior to Medicare.

And we had budget predictability budget because the State of Louisiana gave us so millions to run the largest charity hospital in the United States, New Orleans Charity.

Twice during that time, we ran out of money. And I know exactly what we did. We shut the hospital down for routine care and only had it open for emergencies until the thing was over.

Now, that it is not—that is budget predictability, but that is not good medical care. And the challenge I think we have is can we bridge that difference?

Senator PACKWOOD. We never have so far.

Dr. SCHENKEN. That is correct. And I do not think it is necessarily a bad goal to try to continue to aim that way.

I think that is what Oregon may well be trying to find out if it can be done.

Senator PACKWOOD. Well, Oregon, however, is coming about in a reverse—they are coming about in the budget predictability on the Medicaid.

They are saying, okay, here is the procedure, one to 709, as I recall. And number one is the most cost benefit and number 709 is the least cost benefit.

We only have enough money to pay for 588. And that is all we are going to fund. That is budget predictability.

Dr. SCHENKEN. The American Medical Association has supported the Oregon waiver from the beginning, not because we necessarily agree that it will work, but we felt it was important that we find out if it would work. But it is a compromise that the people of Oregon all, including the medical people have decided they would try to do.

Senator PACKWOOD. An interesting question will come with Oregon. They say we only have enough money to fund the 588. If the money isn't enough to fund the 588, then, you marginally cut back.

Well, at this stage, you have said, we are going to pay for the 588. You are going to have this kind of an operation. You will receive money.

I do not know if mid-way along, Oregon says, we are going to cut back to 365 or rather, they try to pare back proportionally on the

588 to make it come under the predictability. I do not think that decision has been made yet.

Dr. SCHENKEN. But the political problem, of course, is where that line floats up and down between 500 and 300 or wherever it does.

Who makes that decision when the patient comes into the office who has some reasonably medical need and there is risk? And the answer is that where the risk is to the patient. It is not an easy problem.

The CHAIRMAN. Dr. Schenken, I am going to have to interrupt and tell Senator Packwood, we have a vote in just a few moments.

Senator PACKWOOD. Oh, I did not know that.

The CHAIRMAN. Would you mind waiting just a minute. We will be back in 10 minutes.

Dr. SCHENKEN. I would be delighted.

Senator PACKWOOD. I do not have anymore questions.

The CHAIRMAN. Well, we do not have anymore questions.

We will just say thank you very much. We are indebted to you. We know your views. And we look forward to what is going to be one hell of year.

[The prepared statements of Senators Mitchell, Durenberger, and Hatch appear in the appendix.]

[Whereupon, at 12:10 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR MAX BAUCUS

Mr. Chairman, good morning. My remarks will be brief for I want to hear the testimony of Secretary Shalala and our other witnesses on this most important subject.

I am particularly interested in exploring the issue of reimbursement for graduate medical education, particularly the indirect medical education (IME) adjustment. It has been suggested that this funding be reduced to reflect the real costs incurred. With cost-effectiveness still in mind, I would make a counter proposal to retain this funding, but in a fundamentally restructured IME program that addresses the need of all America, including its rural areas.

The issues surrounding health care are many, complex, and frustrating, but I am encouraged that the great national debate on health care reform that is presently transfixing the nation's attention will ultimately result in a more rational, understandable, high quality, humane system that uses our limited dollars wisely. Our present task of reviewing President Clinton's proposed health budget is but one step, but a progressive one, up a steep path towards a health system that works for all of us.

One of the issues that is most troubling to rural states is the shortage of physicians, more specifically, primary care physicians. In Montana eight of 56 counties have no physician and 22 have no physician who will deliver a baby. While there are many factors that contribute to this bleak situation, one major factor is the way the nation uses Medicare money to develop and educate physicians. Many experts believe that the current arrangement of Medicare payments for graduate medical education has led to a system that is top heavy with specialists located in the cities and suburbs, and has failed to produce enough generalists and physicians to practice in rural America. No one will deny that we have far too few residencies in rural areas under the present arrangement.

What needs to be done? A recasting of the graduate medical education system is indeed in order, and I am pleased to see the Administration's proposals in this regard. The proposed reform of the direct medical education program appears to be on target. This proposal would base GME payments on a national average per resident amount, and would give greater weight to primary care residencies. Using national averages would address present inequities, whereby some providers are paid five times as much per resident as others. Moreover, this proposal would provide an incentive for programs to recruit and train primary care residents.

With regard to the other component of graduate medical education costs, the indirect medical education adjustment, I would suggest that rather than simply reducing these funds as the proposal recommends, we consider leaving these funds in a new, fundamentally restructured program. The intent here is to address the shortage of primary care physicians. This is a problem that won't go away and money spent here could generate a real return on the dollar by creating more residencies in rural America. I look forward to exploring this possibility with Secretary Shalala and our other witnesses.

Thank you.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

Mr. Chairman, I am pleased that we have an opportunity to discuss the Administration's fiscal year 1994 budget proposal. regret that we will not learn of some of

the specifics until next week and therefore it is difficult to respond completely at this time.

Like many of my colleagues on this Committee, I have been at this business of Medicare and Medicaid budgets since I came to the Senate in 1978. I commend the President for continuing to focus his attention on the health care crisis in America. However, I can't help but notice that many of the proposed Medicare and Medicaid reductions have shown up in past Administration budgets. At a time when the public is demanding change, this seems like business as usual.

The incremental changes in the system, as proposed in the Administration's budget, are not going to address the underlying problems. Standing alone, they will continue to shift costs onto the private sector and further distort the system, causing serious harm to the quality of health in this country. Ultimately they will fail to achieve the President's objective of cost containment in health care.

In Medicare, we have tried to change how we pay for medical services as a way to reduce expenditure growth. However, these efforts are simply not enough. And, they never will be. We need get to the true source of the problem. We have to move beyond tinkering with the payment system. We must abandon the fee-for-service model, and move toward restructuring the delivery system. Instead of a fragmented, unmanaged environment, we must provide strong incentives for integrated systems of care paid on a capitated basis.

The best way to get delivery reform is to make sure that the buyers make demands on the system. We in Congress are the buyers of health care for the 31 million beneficiaries of Medicare and the nearly 29 million beneficiaries of Medicaid. Despite our best efforts to date, we have not been responsible purchasers of care. Managed competition is the right direction for us to move toward as responsible buyers.

Mr. Chairman, I have no doubt that when Medicare beneficiaries move from a fee-for-service system into integrated systems of care like HMOs, the quality of care will improve and the costs will go down.

That is not to say however that we should not improve Medicare payment now, pending health reform. Or, put another way, we shouldn't make it worse. For example, physician payment reform was intended to encourage and reward primary care services and equalize reimbursement among geographic areas. It seems that the Medicare fee schedule will remain in place as we transition into comprehensive reform. Therefore, we should not give up on efforts to build rewards for efficiency into the present system. Also, we should demand greater productivity from the existing system. Primary care is cost effective. Simply put, as buyers we get better access to quality care for fewer health care dollars. When the budget is delivered to Congress next week and we can better address the specific provisions, I urge this Committee to consider the impact of incremental cuts and especially their impact on access to primary care services.

In responding to the Administration's budget proposals, one of my constituents wrote, "It seems that health care reform should be less directed at specific physician and hospital reimbursement reductions than at structural reforms as they have been undertaken in Minnesota . . . ." America needs comprehensive health care reform. States like Minnesota need the flexibility to continue with their innovative plans to expand coverage.

Mr. Chairman, Medicare and Medicaid can be leaders in the health care reform process, rather than distant followers of a dynamic private marketplace. Today's discussion brings us closer to identifying the problems in the current delivery system. Hopefully, we will be persuaded to refocus our efforts toward debating the solution.

PREPARED STATEMENT OF SPENCER FOREMAN

Mr. Chairman and members of the committee, I am pleased to appear before you to discuss the administration's Medicare budget proposals with respect to hospital payments. I am Spencer Foreman, M.D., chairman of the Association of American Medical Colleges (AAMC) and president of the Montefiore Medical Center in Bronx, New York. The AAMC represents all of the nation's medical schools, 92 faculty societies, over 350 major teaching hospitals that participate in the Medicare program, and over 140,000 men and women in medical training as students and residents. In 1992, nonfederal members of the AAMC's Council of Teaching Hospitals (COTH) accounted for nearly 2 million Medicare inpatient discharges.

All of the administration's health care budget proposals are of concern to the nation's teaching hospitals. This morning, however, I would like to address three specific Medicare proposals that are of particular concern to teaching hospitals. As out-

lined in the President's budget document, **A Vision of Change for America** (February 17, 1993), they are the:

- proposed gradual reduction in the indirect medical education (IME) adjustment in the inpatient prospective payment system (PPS), from its current 7.7 percent to 5.65 percent for each 0.1 increase in the intern and resident-to-bed ratio (IRB);
- proposed changes in payments for direct graduate medical education (DGME) costs that would base these payments on a national per resident amount derived solely from the average of salaries paid to residents, and would weight them based on the specialty area of the trainee and the length of the residency; and
- proposed reductions in hospital outpatient payments that extend the OBRA 1990 provision of reducing the reasonable cost portion of the payment by 5.8 percent, imposing an additional reduction of 4.2 percent on these services, and extending the 10 percent reduction in payments for outpatient capital costs.

Montefiore depends heavily on these payments for its financial viability. The medical center is the single largest provider of inpatient acute care to the 1.2 million residents of the Bronx, the poorest borough in New York City. The hospital has 1,256 licensed inpatient beds providing care to 15 percent of the Bronx residents and 30 percent of the borough's tertiary care services. The medical center also is the major teaching hospital for the Albert Einstein College of Medicine and supports the educational and research environments necessary to train more than 650 residents to serve future generations and to advance medical knowledge. Service to a large Medicare population and the size of its teaching program qualifies Montefiore for substantial IME and DGME payments. Any reduction in these payments would severely harm Montefiore's ability to sustain its education, research and patient care missions.

While the academic medical community understands the need and the commitment by the administration and the Congress to reduce the Federal budget deficit and the growth in Medicare expenditures, teaching hospitals would be particularly harmed by these proposed reductions. The Medicare proposals reducing payments to providers would reduce Federal spending by approximately $28 billion over four years. While many of these proposals would affect both teaching and nonteaching hospitals, the proposed reductions in IME and DGME payments account for nearly $3.3 billion, over 10 percent of the total planned cuts. The proposed outpatient payment reductions would further reduce Medicare payments by an approximately $1.2 billion.

I shall focus my testimony on the three proposed reductions, which if implemented would seriously threaten teaching hospitals' financial stability, access to care for large segments of the population and the quality of care received by Medicare beneficiaries and other patients. Teaching hospitals are a critical component in our health care delivery system, and they could be easily damaged unless changes are crafted carefully and are based on an extensive understanding of the multiple missions of teaching hospitals.

INDIRECT MEDICAL EDUCATION ADJUSTMENT

Since the inception of the prospective payment system, Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented their Medicare inpatient payments with the IME adjustment in the PPS. Unfortunately, the IME adjustment is mislabeled and frequently misunderstood. While its label has led many to believe this adjustment to the DRG payments compensates teaching hospitals solely for graduate medical education, its purpose is much broader. Both the House Ways and Means and the Senate Finance Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in 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 (House Ways and Means Committee Report, No. 98–25, March 4, 1983 and Senate Finance Committee Report, No. 98–23, March 11, 1983).

Some policy makers have maintained that a significant portion of the IME adjustment is intended to help defray uncompensated care costs. Further, they argue, in

a reformed health care system where more individuals are covered by health insurance, teaching hospitals' burden of uncompensated care would be reduced and would justify a significant reduction in IME payments.

The AAMC has noted repeatedly the purpose of the IME adjustment is not to provide financing for uncompensated care, but to recognize factors that increase costs in teaching hospitals. Analysis by government and private researchers consistently has shown an empirical basis for a differential payment to teaching hospitals based on their costs. The justification for a special adjustment for these institutions traces back to the Medicare routine cost limits of the late 1970s and the inception of the PPS in 1983. Even if the health care system is reformed to improve access, legitimate cost differences between teaching and nonteaching hospitals will continue to exist. Teaching hospitals continue to have higher inpatient operating costs because of the types of patients they treat, comprehensive and intensive services they offer, and residents that are in training.

In recent years, Congress has indicated the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Similarly, the Prospective Payment Assessment Commission (ProPAC) has recognized that the financial success or failure of teaching hospitals could affect access to care and quality of care, and has tried to assure "rough justice" among hospital groups. "Rough justice" refers to a policy objective of maintaining the overall financial viability of teaching hospitals as measured by total margins.

In making its recommendation to decrease the level of the IME adjustment to 7.0 percent for FY 1994, the ProPAC has urged caution in implementing a precipitous drop in the IME adjustment. While teaching hospitals' PPS inpatient operating margins are on average higher than those of nonteaching hospitals, teaching hospitals' total margins have remained consistently lower than PPS margins. ProPAC analysis of data from the eighth-year of PPS (1991), the most recent information publicly available, show average PPS margins for all hospitals have reached a new low of -3.2 percent while hospitals that received both IME and disproportionate share (DSH) payments posted PPS operating margins of about 5 percent. However, their average total margin was 3.4 percent compared with an average total margin for all hospitals 4.2 percent. Hospitals that received only DSH payments had the highest total margins of any group at 5.6 percent. (Presented Orally at ProPAC Public Meeting, Dec. 11–12, 1992.)

Teaching institutions are vital national and community resources, often taking care of the most disadvantaged members of society. Yet their overall financial viability, on average, tends to be more precarious than nonteaching hospitals. Any reduction in the IME adjustment would further harm their financial position. In October 1992 the AAMC collected FY 1992 financial data from its members and shared the results with commissioners of ProPAC in a letter dated December 10, 1992. Data from 51 academic medical center hospitals showed PPS operating margins dropped dramatically in 1992, falling from an average PPS margin of 5.9 percent in 1990 to 3.8 percent in 1992.

As proposed, the reduction in the IME adjustment for all teaching hospitals would save $1.9 billion over four years, beginning in FY 1996. In an analysis utilizing the administration's proposed payment level of 5.65 percent, AAMC staff have estimated that if the IME adjustment were reduced to this level the average PPS operating margin for these 51 academic medical center hospitals would decrease to −3.0 percent. (See attachment A.)

This table also demonstrates that teaching hospitals depend heavily on the IME and DSH payments to maintain their PPS margins. On average, PPS margins calculated without the IME or DSH payment adjustments, that is, including only DRG, outlier, and "high End Stage Renal Disease (ESRD) use" payments, are −52.0 percent. The IME adjustment makes a significant contribution to decreasing the average negative PPS margin from −52.0 to −9.4 percent. The addition of the DSH payment to the margin calculation moves the average PPS margin to 3.8 percent.

The approximately 550 hospitals that received only IME payments and no DSH payment would be particularly harmed by a reduction in the IME adjustment. According to the ProPAC, these institutions had average PPS margins of −2.7 percent in PPS–8. Their total margins, while higher than the hospitals that received both IME and DSH payments, were lower than the hospital group that did not receive any IME or DSH payment and the group that received only DSH payments.

The IME payment is an important equity factor in the Medicare PPS, compensating teaching hospitals for the severity of their patients' illnesses, the scope of services provided, and the impact of educational programs on hospital operating costs. AAMC data for federal fiscal year 1991 show that IME payments account for 24 percent of total PPS payments. A reduction in the IME adjustment would hinder teach-

ing hospitals' future capability to support adverse selection within the DRGs, high technology care, high cost services for referred patients, and unique community services such as burn and trauma units. The AAMC urges the Congress to consider carefully the impact of any reduction in the IME adjustment on the financial stability of the nation's teaching hospitals and their ability to assure access to quality care for Medicare beneficiaries and other patients.

DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS

Our present system for graduate medical education and its financing has much to commend it. However, the system needs to change. The Association recognizes the present system has failed to produce the number of generalist physicians that society believes it will need in a reformed health care system. To that end, the AAMC has committed itself to identifying ways to reverse the significant under representation of generalist physicians among practitioners in the United States. A recent Association policy statement calls for:

> an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine and general pediatrics) and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time.

The policy document identifies and recommends strategies for the Association, schools of medicine, graduate medical education programs and the practice environment to facilitate reaching the goal. Its foundation rests on the implementation of voluntary, private sector initiatives. Among them is creating and maintaining incentive programs aimed at individual medical students, resident trainees, and practicing physicians as the preferred methods of inducing career choices in certain specialties.

We may all agree that the shortage of generalist physicians is unacceptable to society. The Association's policy statement on the generalist physician strongly endorses that private sector organizations and governmental bodies should join together in a partnership to eliminate the many barriers that exist to meeting the need for more generalist physicians. First among these strategies is reducing the marked disparity in income expectations resulting from our current system of physician payment. A second strategy is the development of appropriate training experiences in ambulatory, community-based non-hospital settings. As hospitals encourage shorter stays by more acutely ill patients, training in ambulatory and long-term care settings is needed to supplement the educational experience provided in hospitals to assure that residents receive comprehensive clinical training. The AAMC policy statement recommends:

- The Medicare program and other third-party payers should accelerate the transition to a resource-based fee schedule and should adopt other reforms in physician payment designed to compensate generalist physicians more equitably.
- Mechanisms employed to finance the direct costs of graduate medical education should not create nor perpetuate barriers to shifting the balance between generalist and non-generalist training.

Some changes in direct GME funding will almost certainly be required to encourage residency training in non-hospital sites and to provide the resources for other initiatives designed to make the generalist specialties more attractive to medical students. However, the AAMC is not convinced that weighting Medicare hospital payments for graduate medical education by specialty will have a positive effect on the decisions senior medical students make with respect to specialty choice. Before proceeding directly to the debate on this issue, I shall provide some background on graduate medical education and its current method of financing.

THE ENVIRONMENT FOR GRADUATE MEDICAL EDUCATION

The nature of graduate medical education is changing. Many factors in the current environment are contributing to changes in how graduate medical education is conducted and how it may be financed in the future. Residency and fellowship education is a system of learning by participation in the care of individual patients and, therefore, includes elements of both education and service. However, as hospitals increasingly are called on to improve efficiency, residency programs are under constant pressure to emphasize service over their educational role. Additionally, while graduate medical education is organized primarily in hospitals and has been focused mainly on inpatients, its involvement with ambulatory patients is increasing.

Residency programs require long-term, stable funding commitments to provide an appropriate education and to enhance the quality of patient services. Graduate med-

ical education has been funded primarily by patient service revenues to hospitals, with significant appropriations supporting some municipal- and state-supported hospitals and all military and Veterans Affairs (VA) hospitals. AAMC data show that, on average, hospital patient revenues supported 85 percent of resident stipends and benefits and 58 percent of clinical fellow stipends and benefits, excluding VA hospitals in 1991–92. (See Attachment B.) If anything, these data overstate the role of the hospital in financing graduate medical education, particularly for subspecialty clinical fellows, who are often not funded by the hospital, and therefore may not be included in the institution's records.

Faced with pressure to restrain health care expenditures, public and private third-party payers are adopting payment systems that limit or even decline to provide payments for graduate medical education costs. The costs associated with the training of physicians may not be recognized by payers as they shift to fixed price systems for defined "bundles" or packages of services, capitated payments, and negotiated contracts for selected services.

THE MEDICARE PROGRAM'S ROLE IN GRADUATE MEDICAL EDUCATION FINANCING

To provide experientially-based clinical training for physicians, dentists, nurses, and allied health professionals, hospitals incur educational costs related to patient care. For graduate medical education, these added costs include resident stipends and benefits, salaries and benefits for faculty who supervise residents in the care of patients, classroom space, supplies, clerical support, and allocated overhead. The Medicare program makes an explicit payment to teaching hospitals for its share of allowable direct graduate medical education and other health professions education costs. This payment is separate from, and should not be confused with, the purpose or methodology of the IME adjustment in the Medicare PPS. Historically, Medicare has shared in the direct costs of approved education activities on a reasonable cost basis.

The passage of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (P.L. 99–272) in 1986 changed the method of payment for direct graduate medical education costs and placed limitations on Medicare reimbursement for physicians in graduate medical training (residents). COBRA replaced a cost pass-through methodology with a prospective amount for each resident. The calculation of a hospital-specific per resident amount is based on the 1984 or 1985 cost reporting year (called the base year per resident amount) and is updated annually by an inflation factor. Each hospital's per resident amount is determined by dividing its allowable base year costs by the number of full-time equivalent (FTE) interns and residents at the hospital during that base year. The per resident amount is then updated for inflation and multiplied by the number of FTE interns and residents in the hospital complex during the payment period. Residents are weighted at 1.0 FTE for the residency period required for initial board certification plus one year, not to exceed a total of five years. Beyond the lesser of these two limits, residents who remain in approved programs are to be weighted at 0.5 FTE. Medicare's share of the aggregate payment amount is based on the ratio of Medicare inpatient days to total inpatient days.

This change in payment methodology, which the AAMC did not oppose, terminated the previous open-ended commitment to financing graduate medical education. Although COBRA limits direct GME payments, it still acknowledges the historical scope of direct medical education costs, including the salaries and fringe benefits of residents and supervising faculty physicians and institutional overhead costs.

THE ADMINISTRATION'S PROPOSAL TO CHANGE MEDICARE PAYMENTS FOR DIRECT GME COSTS

This year, the administration has proposed changes in Medicare payments for GME costs that are intended to provide incentives to encourage the training of generalist physicians and to eliminate the variation in the hospital-specific per resident amount. Additionally, this proposal would reduce the Medicare program's role in GME funding. This recommendation, which is similar to proposals made by the previous administration would save $1.4 billion over four years by basing:

> . . . Medicare DGME payments on a national per resident amount derived solely from the average of salaries paid to residents. Direct medical education payments would reflect differential weighting of the national average resident's salary, based on the specialty area a resident is pursuing and the length of the residency. A resident in a primary care specialty would be weighted at 240 percent, a non-primary care resident in the initial residency period would be weighted at 140 percent, and a non-primary care

resident beyond the initial residency period would be weighted at 100 percent. The average weight would be 175 percent of the national average resident's salary, down from the average weight of about 215 percent under current law.

If adopted, this proposal would replace the current Medicare payment methodology for direct GME costs with a system based on three national rates. Thus, a hospital's total direct GME payment would be based not on its costs, but on the specialty mix of its trainees. The administration believes this proposal will not only eliminate the variation in direct GME payments, but also is intended to offer incentives to produce more primary care physicians. The proposal would accomplish this by paying relatively favorable amounts for primary care residencies, and substantially less favorable payment amounts for all other residencies. The administration's proposal does not define primary care residency programs and it does not indicate the national average resident's salary.

To estimate the impact of the administration's proposal on the AAMC membership, we assume that the national average resident's salary is $31,795. This is the 1992–93 (FY 1993) average salary/stipend for the 3rd post-MD year based on the AAMC Council of Teaching Hospitals' (COTH) **Survey of Housestaff Stipends, Benefits and Funding, 1992.** Three differential weighting percentages would then be applied to this amount ($31,795) depending on the resident's specialty:

- primary care residents would be weighted at 240 percent of the national average resident salary $31,795 X 240% = $76,308
- non-primary care residents in their initial residency period would be weighted at 140 percent $31,795 X 140% = $44,513
- non-primary care residents beyond the initial residency period would be weighted at 100 percent $31,795 X 100% = $31,795

Medicare's share of the aggregate payment amount is then based on the hospital's ratio of Medicare inpatient days to total inpatient days. The effect of this differential payment method is that the scope of direct graduate medical education costs for trainees in all specialties will not be fully recognized particularly for non-primary care residents beyond the initial residency period.

This proposal would have a negative effect on most hospitals' Medicare payments for direct graduate medical education costs, depending on the hospital's specialty mix of resident trainees. According to data on the audited and updated per resident payment amounts provided by the Health Care Financing Administration (HCFA) and calculated by the AAMC, the median per resident amount in **1991** was $48,804 (based on 1,214 providers). Under the administration's proposal, the Medicare program would pay significantly lower per resident amounts for non-primary care residents beyond the initial residency period ($31,795 in **1993**) and for non-primary care residents in their initial residency period ($44,513 in **1993**).

Although the AAMC strongly supports more individuals entering generalist practice, the Association does not believe this proposal would achieve its intended objective of encouraging the training of more generalist physicians. The Association opposes proposals that intend to stimulate the production of generalist physicians by weighting direct GME payments by specialty and length of training. There is no evidence that medical students' selection of residency training programs is related to Medicare payments to hospitals and there is no evidence that teaching hospitals will change the distribution of residency positions based on this incentive.

In its circulating draft chapter on training physicians for its March 31 report to the Congress, the Physician Payment Review Commission (PPRC) concludes that weighting DGME payments to hospitals is undesirable. The commission believes there are many existing slots for generalist training (which are unfilled), and weighting would have little influence on the decision making of hospital management and residency program directors. Finally, the PPRC concluded that weighting may not sufficiently penalize institutions oriented toward subspecialty training. In that regard, AAMC data for federal fiscal year 1991 indicate that Medicare patients constitute only 30 percent of patient days for academic medical center hospitals.

The administration's proposal would, however, eliminate the variation in the current per resident payment amount across teaching hospitals and reduce support for physicians in training. There are legitimate reasons why there have been variations in institutional costs among residency training programs, including the way the law has been interpreted by the Medicare fiscal intermediaries and providers, and differences in historical accounting practices.

The Congress should examine carefully the effect of this proposal on hospitals with small training programs. AAMC analysis of the HCFA data for the 56 teaching hospitals with per resident amounts in excess of $90,000 reveals that these hospitals

tend to have small training programs. The average training program in these 56 hospitals had 23 FTE resident trainees with a range from 2 to 269 residents. On average academic medical centers have 253 residents in training.

It is important to understand the internal institutional dynamics that will result from the implementation of preferential weighting proposals. Those disciplines with an increased weighting factor will argue that they deserve "more" of the direct GME funds for their residency programs. At the same time, other disciplines, as a result of reductions in fee revenue attributable to the implementation of the Medicare resource-based relative value scale, will increase pressure for more faculty salary support.

While supporters of preferential weighting proposals indicate that a higher payment differential will be enacted only for primary care disciplines, it is likely many clinical specialties will argue they also deserve a "special weighting factor." The AAMC notes that emergency medicine was added as a primary care category to the House Ways and Means Committee proposal two years ago, and physical medicine and child psychiatry immediately made a case for inclusion because these specialties are in short supply.

It is important to recognize that hospitals have not fully experienced the impact of the change in Medicare DGME payments legislated by COBRA. This legislation represented a major change in Medicare payment policy from an open ended system to a prospective, capitated amount. Implementing regulations were not issued until September 1989, and audits are not complete. Some hospitals have still yet to be paid under this "new" system.

Medical students' selection of residency training programs is not affected by Medicare payments to hospitals. On the contrary, personal incentives such as loan forgiveness, tax benefits, and other inducements are more likely to result in greater numbers of U.S. medical school graduates entering the generalist disciplines. If monetary incentives are to be provided, they should be aimed at individuals, not hospitals and their sponsored residency programs.

Pressure from both federal and private payers to constrain the growth in health care expenditures, and changes in medical care delivery have produced significant tensions for residency and fellowship training programs. At the same time, the Association recognizes the frustration of government policymakers in assuring the public has access to generalist physician services. The AAMC supports strategies to develop additional generalist physician manpower, but this proposal to weight Medicare DGME payments based on specialty and length of training will only contribute to the instability of GME funding. Strong residency programs require continuity of effort and stable support. If future generations of Americans are to have appropriate access to well-trained physicians, we must maintain and strengthen our medical education system, including its residency training component.

HOSPITAL OUTPATIENT DEPARTMENT PAYMENTS

By enacting the Medicare PPS in 1983 as a way to pay hospitals for the cost of inpatient services, the federal government intended to slow the growth in health care expenditures and to give hospitals a financial incentive to provide services efficiently. One of the ways in which hospitals responded to these incentives was to shift the provision of some traditionally inpatient services to the outpatient setting. As a result, utilization of outpatient services has increased. In recent years, Congress has identified the need to control growth in Medicare outpatient expenditures and has modified the traditional cost-based reimbursement of hospital outpatient services in anticipation of a fully prospective payment system for all outpatient services. Some prospective pricing methods of payment have already been mandated for clinical laboratory services, many surgical services, and a number of outpatient diagnostic services. These different methods of payment constitute an interim step in the reform of the Medicare outpatient payment system.

While the details of a completely prospective payment system for outpatient services are still under consideration, the administration has proposed:

. . . reductions in hospital outpatient payments that extend the provision in OBRA 1990 of reasonable costs minus 5.8 percent, impose a further reduction of 4.2 percent on those services, and extend the 10 percent reduction in payments for outpatient capital costs.

The administration has offered no rationale or empirical evidence for these proposed reductions other than the need to control growth in expenditures for Medicare hospital outpatient services. The budget document estimates these proposals would save $1.2 billion over four years.

The burden of this arbitrary proposed policy would fall disproportionately on teaching hospitals, potentially affecting access to services and quality of care available to Medicare beneficiaries and other individuals. Major teaching hospitals are larger and have more outpatient and emergency visits than community hospitals. In 1991, nonfederal members of the AAMC's Council of Teaching Hospitals (COTH) provided 56 million non-emergency outpatient visits. Although accounting for nearly 6 percent of the nation's hospitals, COTH members had 25 percent of all non-emergency outpatient visits. Many teaching hospitals, located primarily in urban areas, have established large clinics and primary care services to meet neighborhood health care needs and to provide a well-rounded educational experience for medical students and residents.

Recent changes in third party reimbursement, the growth of managed care, increased competition, controlled health care spending by state and local governments has caused teaching hospitals to experience financial stress with these financial implications ultimately impacting patient care and educational programs. The AAMC urges the Congress to consider carefully the overall impact of any reductions in these payments on the health care delivery system.

ATTACHMENT A

Table 1: **Contribution of PPS Payments to Academic Medical Center Hospitals' PPS Margins: FY 1992**
Ranked by DRG Payment, Outliers, DSH and IME @ 5.65%

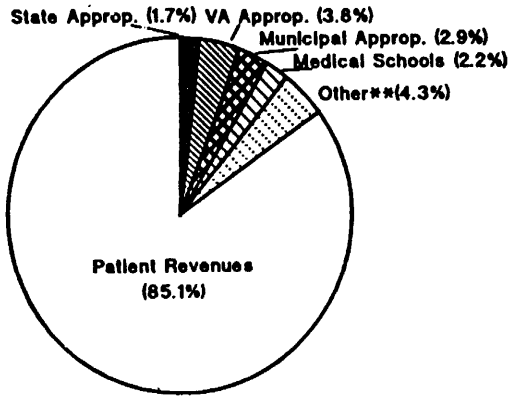
Hospital	DRG Payment Less Operating Costs	DRG Payment Plus Outliers and ESRD	DRG Payment Plus Outliers, ESRD and IME	DRG Payment Plus Outliers, ESRD, IME and DSH (Current Policy)	DRG Payment Plus Outliers, ESRD, DSH and IME at 5.65% (Proposed Policy)
A	−135.6 %	−123.3 %	−58.8 %	−31.9 %	−40.9 %
B	−157.0	−135.9	−53.8	−28.5	−39.3
C	−96.2	−83.6	−40.9	−26.1	−33.5
D	−133.0	−97.8	−46.0	−25.5	−33.4
F	−97.2	−77.3	−26.5	−21.1	−30.7
H	−108.7	−81.2	−23.3	−18.0	−28.5
E	−106.2	−93.1	−50.9	−21.3	−27.3
G	−79.1	−71.5	−30.1	−18.2	−25.5
I	−66.8	−51.8	−15.8	−15.8	−23.6
J	−93.0	−81.4	−27.2	−11.3	−19.6
K	−67.4	−57.3	−12.7	−9.3	−17.9
L	−116.4	−103.5	−37.7	−8.9	−16.8
M	−66.7	−59.3	−15.2	−7.5	−15.4
O	−69.7	−63.6	−12.5	−5.8	−14.8
N	−67.3	−59.5	−14.5	−6.3	−14.3
P	−45.7	−36.6	−5.7	−5.7	−12.5
S	−65.5	−59.0	−6.8	−2.0	−11.3
R	−51.9	−47.0	−14.6	−3.8	−9.6
T	−76.7	−59.8	−12.4	−1.4	−9.2
U	−93.2	−86.3	−23.3	−0.7	−8.6
V	−47.6	−40.9	−2.2	−0.1	−7.8
Q	−35.6	−30.5	−21.3	−5.2	−6.9
W	−50.6	−45.0	−5.1	0.9	−6.5
X	−77.3	−56.5	−6.0	3.6	−4.5
Y	−49.3	−43.0	1.4	4.1	−4.3
AA	−56.1	−44.1	−5.6	5.0	−1.5
AB	−73.2	−63.4	−12.2	5.8	−1.3
Z	−55.6	−40.3	−5.7	4.8	−1.1
AE	−39.5	−32.1	7.8	9.1	1.3
AC	−76.0	−48.9	−6.8	8.2	1.9
AD	−49.7	−41.8	−3.8	8.6	2.5
AG	−49.2	−39.5	5.2	11.2	3.5
AH	−43.8	−38.7	4.0	12.9	5.8
AI	−49.2	−38.1	3.1	12.9	6.2
AF	−34.2	−29.4	−1.3	11.0	6.2
AJ	−34.9	−31.8	11.2	14.8	7.1
AK	−33.5	−28.0	6.9	14.9	8.9
AL	−48.9	−44.0	−1.9	15.1	9.3
AM	−67.0	−53.5	−4.2	16.2	10.0
AO	−44.5	−40.8	4.9	17.8	11.2
AP	−38.9	−32.7	10.9	18.9	11.9
AN	−39.4	−32.0	−5.6	17.0	13.4
AR	−36.1	−31.5	6.0	20.2	14.7
AQ	−67.3	−58.7	−22.4	19.8	16.5
AS	−24.8	−22.9	16.4	25.5	19.4
AT	−32.2	−25.8	8.1	25.9	21.4
AU	−36.8	−34.9	7.6	28.4	23.4
AV	−24.3	−24.3	8.5	30.4	26.5
AW	−20.6	−18.4	9.9	31.5	28.0
AX	−16.2	−11.2	18.2	35.0	31.1
AY	−3.4	−3.1	24.4	36.7	32.7
Mean:	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Median:	−51.9	[illegible]	[illegible]	4.8	−1.5

Source: *1990 – 1992 Medicare Cost Reports (HCFA Form 2552–89) and*
1990 – 1991 COTH Surveys of Hospitals' Financial and General Operating Data

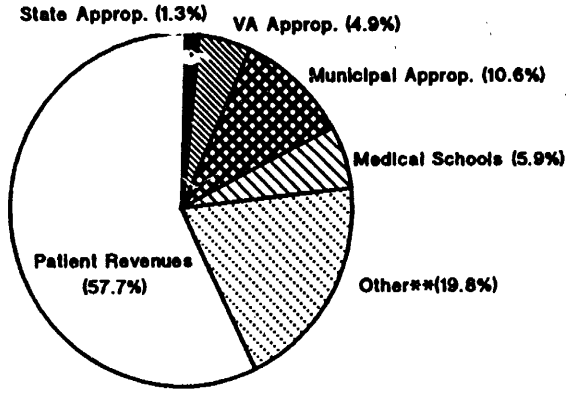
Sources of Funding for Housestaff Stipends and Benefits

All Hospitals, 1992-93*

Resident Stipends and Benefits



Clinical Fellow Stipends and Benefits



* Excludes Veterans Administration hospitals

** Includes Physician Fee Revenue, NIH and other federal agency funds, endowment income, and foundation grants.

List of Participating Academic Medical Center Hospitals

CINCINNATI
COLORADO
CRAW. LONG
GEORGETOWN
GWU
HARRIS CO.
HERSHEY
HITCHCOCK
HOWARD
HUP
ILLINOIS
INDIANA
JEFFERSON
KANSAS
KENTUCKY
LA COUNTY
LSU
MCGAW
MCV
MED COL GA
MED COL OHIO
MED COL PA
MEMPHIS
MICHIGAN
MINNESOTA
MISSISSIPPI
MISSOURI
N CAROLINA
NC BAPTIST
NEBRASKA
NEW MEXICO
OHIO STATE
OKLAHOMA
OREGON
PRESBY–PITT
RUSH
S CAROLINA
SHANDS
ST. LOUIS
TRUMAN
TULANE
U C DAVIS
U VA
UC IRVINE
UCLA
UCSF
UMDNJ
UNIV OF WASH
UTAH
VANDERBILT
WISCONSIN

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Thank you, Mr. Chairman.

I appreciate the opportunity to hear from Secretary Shalala on the Administration's budget proposals for the Department of Health and Human Services.

I have several concerns about those proposals.

I am particularly concerned about the Administration's proposals for the Medicare program and about how those proposals might affect the rural hospitals in my state.

As I understand it, the Administration has included a proposal to extend the Medicare Dependent Hospitals Program. If this is correct, it is good news in a budget in which there is not very much good news.

I have about fifty-five hospitals in my state that qualified for that designation. Around 35 of those hospitals were using that designation when their fiscal years ended last year. Only two other states in the nation had that many hospitals that qualified for the program.

Senator Dole and I drafted legislation to extend the program last year. That legislation was included in H.R. 11 which President Bush vetoed. Senator Dole reintroduced it this year as part of S. 176.

I would like to ask Secretary Shalala to elaborate a bit for us on what exactly the Administration is proposing for this program, since it is not completely clear from what I have seen so far of the budget proposals.

I am also concerned about the Administration's proposal to increase the tax on the Social Security benefits of some Social Security retirees. I stated my views on this matter at some length on the Senate floor, and I do not intend to belabor the point here.

I will only say that I hope that this Committee proceeds cautiously on this proposal. The Director of Iowa's Department of Elder Affairs has emphasized to me that many older people in Iowa exhaust their assets long before they die. Enactment of this proposal is going to speed up exhaustion of those assets.

That is all I have for the moment, Mr. President. I am looking forward to the testimony.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Thank you, Mr. Chairman. I am looking forward to hearing the testimony of our witnesses. I am particularly pleased to welcome our first witness, the distinguished Secretary of Health and Human Services, Dr. Donna Shalala. I supported Dr. Shalala's nomination and look forward to working closely with her as we address health care concerns. While our views may differ on a number of issues, we nevertheless share a commitment to improving our nation's health care system.

As we begin consideration of the Administration's 1994 Health and Human Services budget, we cannot ignore this country's terrible health care predicament.

The facts are daunting. We already spend more than 14 percent of our GDP on health care. If nothing is changed, health care costs will continue to spiral out of control, reaching a dizzying 32 percent of our nation's GDP by the year 2020. The bottomline is this: we cannot allow health care cost escalation to continue. That is why I am firmly committed to health care reform. And, that is why it is critical for us to carefully review the budget proposals that will be discussed today.

Our health care system has three components that must be addressed by any proposed remedy: the *cost* of care, *access* to care, and the *quality* of care that individuals receive. The challenge is to reduce the rate of cost growth while expanding access and maintaining quality. In my view, health care reform will be accomplished only when all three of these objectives are addressed and resolved.

The objectives of health care reform must be considered in tandem with the budget and objectives of the Department of Health and Human Services.

For example, in my home state of Utah, this triad of cost, access, and quality comes into sharper focus. Concerns move from the abstract into reality such as when citizens from Utah's rural areas confront difficulty not only in paying for skyrocketing medical expenses, but also in simply finding and receiving medical care. Many Americans may not realize, for example, that there are 360,000 people living in 221 counties throughout our country that have no physician at all. In Utah alone, we have 29 areas designated as health care professional shortage areas. This is only one example of the problems that we must consider as we evaluate the administration's budget.

Once again, Mr. Chairman, I look forward to working with you, the members of the committee, and Secretary Shalala toward an equitable, realistic budget proposal.

PREPARED STATEMENT OF SENATOR GEORGE J. MITCHELL

I commend the Chairman of the Senate Finance Committee, Senator Moynihan, for holding this important hearing today. I want to join the Chairman in welcoming Secretary Shalala to the Committee to present the President's proposed health budget.

This Committee has the responsibility to assure that Medicare and Medicaid beneficiaries receive the benefits to which they are entitled. At the same time we have an obligation to control the rapidly escalating costs of these programs. Nearly 50% of the growth in the federal budget deficit in the next four years is attributable to Medicare and Medicaid spending.

Today, Medicare and Medicaid together make up 29% of all mandatory spending. If the rate of increase isn't controlled, ten years from now the rate of growth is estimated to be 20% annually.

If we don't restrain the cost increases in these programs, in ten years' time Medicaid and Medicare alone will equal the combined costs of the defense budget, the foreign aid budget and every other discretionary federal dollar spent.

This budget proposal underscores our growing consensus—we must slow the rate of health spending with real structural changes in how we finance and deliver health care. Government funding for major public programs must be part of the solution.

The reductions in Medicare and Medicaid spending contained in this budget will not solve the health care cost crisis. But it is a modest first step which is consistent with comprehensive health care reform efforts which are currently underway.

The rationale for this budget is grounded in a commitment to retain quality *and* to contain costs in our two largest federal health care programs.

We are proposing to slow the projected rate of growth in these programs. In fact, the change in the Medicare premium rate will actually save out-of-pocket beneficiary costs in the long run over what beneficiaries would otherwise be paying under current law.

Some of my colleagues have proposed capping all so-called entitlement programs—including Medicare and Medicaid.

The result of capping entitlements would be an escalation in cost shifting to private payers. This drives up the cost to employers and other private payers—often resulting in a reduction of private insurance coverage—and increasing the number of uninsured Americans. Health care reform should involve expanding access and universal basic coverage—not arbitrarily limiting and cutting already limited health entitlements.

Medicare and Medicaid don't provide trivial services for the idle. Medicaid provides essential health care coverage for the poorest people in our nation, many of whom are also Medicare eligible. Medicare is a fundamental health care safety net for more than 41 million older and disabled Americans.

This budget confronts a reality—health care costs are exploding. The only way they can be controlled is through comprehensive health care reform. We cannot control the costs of Medicare and Medicaid unless we control all health care spending

The President understands that the recommendations contained in his budget which affect the Medicare and Medicaid programs are only a modest first step toward limiting the rate growth in health care spending.

We have learned through the failure of piecemeal approaches that the only way to control skyrocketing health care costs is to enact meaningful health care reform. We cannot control health care costs by controlling only part of the health care system—we must control all health care spending.

The President's proposed health budget is the first step toward a sustainable and achievable solution.

I look forward to the Secretary's testimony here today and hope that all members of this committee will work with her and the President to protect access to health care for poor, elderly and disabled Americans who are served by Medicare and Medicaid Programs.

PREPARED STATEMENT OF RICK POLLACK

Mr. Chairman, I am Rick Pollack, Executive Vice-President for Federal Relations at AHA. I am accompanied by Jim Bentley, Senior Vice-President for Policy. On behalf of AHA's 5,300 institutional members, I am pleased to testify today on the President's FY 1994 budget proposal .

I would like to cover three basic points in my testimony this morning. First, the AHA is very concerned about the impact further Medicare and Medicaid savings will have on the nation's hospitals and the communities they serve. Second, although some short-term budget savings may be necessary, it is imperative that they be linked to the long-term goal of a health care reform package that provides both universal access and a restructuring of the delivery system. Finally, while we work on real reform, we must address the need for fairness and accuracy in the current Medicare program.

As you know, the Administration's FY 1994 budget proposals for Medicare and Medicaid are one part of an economic package that aims to stimulate the economy, create long-term job growth and reduce the federal budget deficit. We support these goals and believe it is in the best interests of the communities we serve that the nation's economy gets back on track. We further recognize that a strong economy generates job growth and health coverage in the private sector. To achieve deficit reduction and economic growth, the President has asked for sacrifices to be made. We understand that hospitals need to participate in the shared sacrifice required of all Americans in the short term to attain our shared long-term goals.

Yet, as we work toward these laudable goals, we must ensure that the sacrifice is fair and that budget decisions lead toward, not away from, a solution to our nation's health care crisis. To accomplish real and fair health care reform, everyone needs to understand how budget decisions made today will affect hospitals and their communities.

In May, when the President presents his comprehensive health care reform plan to the Congress and the American public, we will all be engaged in an important discussion about the future of our nation's health care system. While we look forward to that dialogue and are eager to work with this Committee and the Congress, we must ensure that existing federal programs do not undermine providers' ability to meet the legitimate needs of their patients. Purely budget-driven decisions can exacerbate our nation's health care problems and weaken the infrastructure upon which a reformed system must be built. Consequently, we need to carefully examine President Clinton's FY 1994 budget proposal in terms of its impact on hospitals and the communities they serve.

MEDICARE AND MEDICAID SAVINGS IMPACT

The President's budget proposal calls for nearly $60 billion in savings for Medicare and Medicaid over the next five years. This comes at a time when the Prospective Payment Assessment Commission (ProPAC) estimates that for FY 1992 the aggregate PPS margin--for both urban and rural hospitals--was negative 8.3 percent and AHA estimates that for FY 1993, two-thirds of the nation's hospitals were forced to subsidize the cost of treating Medicare patients. AHA further estimates that four-fifths of all hospitals lost money treating Medicaid patients in FY 1991. Many of these vulnerable hospitals provide the only access to health care services for specific populations such as the poor, elderly and rural Americans. Reductions in Medicare spending have exacerbated shortfalls between payments and costs in ways that hospitals cannot sustain.

UPDATE FACTOR/CAPITAL

The President's budget proposal delays the FY 1994 PPS update by three months until January 1, 1994, limits the growth in these factors for FYs 1994 and 1995, and extends the 10 percent reduction in capital payments. Clearly, these proposals would exacerbate an already difficult situation for those institutions experiencing losses and place increased pressure on their ability to continue providing high quality services to Medicare beneficiaries.

OUTPATIENT PAYMENTS

The proposals offered by the Administration serve only to further fragment outpatient payment policies without taking any steps toward comprehensive reform. Continued

tinkering with the numerous payment systems currently used to pay for outpatient services meets short-term budget needs only. While we look forward to examining the Administration's proposal for reform of outpatient payment, we believe that only with systemic reform will these issues be adequately resolved.

GRADUATE MEDICAL EDUCATION

The President's budget proposes significant cuts in payments to hospitals that train physicians. First is a reduction in indirect medical education payments, provided to cover the indirect costs of running teaching programs. It has long been recognized, and deemed appropriate, that these payments also compensate for the additional costs associated with the patients these hospitals treat. In the context of their broader mission of education, teaching hospitals typically care for a greater number of indigent patients and those with higher severity of illness. Care must be taken, before further reducing this adjustment without enacting simultaneous access reforms, to ensure that these patients continue to receive appropriate care.

Second, the budget recommends basing direct medical education payments on a national per-resident amount--using resident salaries only--and further modifying payments by differential weighting depending on choice of specialty. We understand the need to implement incentives to train more primary care physicians, but do not believe that paying hospitals less for training other, non-primary care, physicians is the incentive that will most affect the choices of graduating medical students. Only long-term, comprehensive reform of the delivery and financing of health care will properly align incentives in the direction of primary care.

These cuts in graduate medical education could exacerbate the financial situation of teaching hospitals--many in our nation's inner cities--where residents in training provide a large portion of the care to the medically indigent. The Association of American Medical Colleges will present detailed testimony at this hearing on these issues. We share their commitment to protect those vital hospitals.

PAYMENT FOR INPATIENT RADIOLOGY, ANESTHESIA AND PATHOLOGY

AHA is encouraged by the Administration's apparent commitment to aligning hospital and physician incentives as a method of controlling spending across all sites of care. In fact, a bundled payment is consistent with our vision of reform and the need for integrated payments. However, until these incentives are broad-based and the delivery system is restructured at the local level by collaborative arrangements among hospitals and physicians, hospitals should not be unfairly burdened by a federal requirement imposing a new relationship on hospitals and their medical staffs.

HOSPITAL-BASED HOME HEALTH SERVICES

The President's budget proposes to reduce payments for services provided by hospital-based home health agencies. These reductions could result in access limitations for some beneficiaries. A 1992 General Accounting Office report indicated that add-on payments for hospital-based home health agencies (HHAs) are consistent with Medicare reimbursement principles, recognizing that mandatory Medicare cost-reporting procedures result in approximately 13 percent more overhead costs attributed to hospital-based programs. In commenting on this report, the Department of Health and Human Services also pointed out that "hospital-based HHAs can offer more services to the beneficiaries and offer a continuum of care not available from freestanding HHAs . . . where hospital-based [HHAs] are adversely affected by eliminating the add-on, beneficiary access to certain quality services may be reduced." It logically follows that eliminating payment adjustments that reimburse hospitals for legitimate cost differences and promote access to services are not in the best interest of the communities we serve.

MEDICAID ADMINISTRATIVE MATCH

The President's budget proposal calls for approximately $8.4 billion savings in Medicaid program savings over the next five years. AHA asks that the options for controlling future Medicaid program spending be evaluated in broader terms than simply the dollar amount of budget savings. The Medicaid program serves as the insurer of last resort for the most vulnerable of all Americans--it is the safety net for the poor and medically indigent. Reductions in a program that is already underfunded to the point that it can

only pay 82 cents for each dollar of acute care it purchases must be carefully planned so we do not deny access to quality health care to those most in need of public support.

A significant portion of the Medicaid savings called for in the President's budget proposals will be realized through decreases in the federal portion of the administrative expense of operating the Medicaid program at the state level. This comes at a time when states are facing severe fiscal pressures. A closer look at the many different administrative functions performed at the state level shows that program administration focuses on much more than eligibility processing and claims payment. Certain administrative functions are critical to protecting the financial integrity of the program; examples include anti-fraud and abuse units, audit programs, and coordination of payment with other insurers. Limiting these activities may result in higher program costs in the long run if the states are less able to ensure the fiscal integrity of their programs.

There are other costs of reducing administrative expenditures that cannot be measured solely on a dollar basis. These are the human costs of limiting programs designed to assure that Medicaid beneficiaries have access to high quality services. Utilization review is one type of program designed to safeguard the quality of care; facility certification/licensure is another.

AHA'S VISION FOR HEALTH CARE REFORM

These proposed Medicare and Medicaid hospital savings in the President's plan total over $30 billion for FYs 1994-1998. They must be viewed, however, in a broader context. Hospitals have made significant contributions to deficit reduction in past budget bills; Medicare hospital savings alone in the Omnibus Budget Reconciliation Act of 1990, for example, totaled almost $16 billion. And any reductions in the Medicaid program must be subject to the keenest scrutiny to evaluate both their dollar savings and their human costs because adversely affecting the health of the elderly poor, and indigent mothers and children is too high a price to pay for short-term stimulus of the economy.

Despite the magnitude of these savings, this year presents us with an opportunity we have not had in past years. It is imperative that whatever budget savings are ultimately enacted in the short term are accomplished fairly and that we remain focused on the long-term goal of meaningful reform that achieves universal access and a restructured health care delivery system.

Further, we must ensure that these measures do not freeze the current fragmented health care system in place. The solution to our nation's health care crisis is not in tinkering with current flawed payment systems such as Medicare PPS. Indeed, meaningful health reform can only come about through universal access and restructuring both the financing and delivery system to encourage more prudent and appropriate behavior by providers, payers, and consumers at the local level. Only in this way will we achieve universal access to needed services at a cost this country can afford.

The AHA's top priorities are achieving universal access and restructuring health care delivery around Community Care Networks.℠ These networks would be consortia of hospitals and other institutional providers, physicians and other health care professionals, insurers, employers, unions and others groups.

Networks would be expected to provide patients with a broad, coordinated continuum of care, focused on improving the health status of their enrollees. In return, community care networks would be paid on a capitated basis, receiving a fixed annual payment per individual. The allocation of resources among providers within the network, including the method and level of payment to various participating providers, would be determined within each network.

Networks would give providers greater freedom to make decisions without micro-management by government payers and insurers. In exchange, networks must be accountable. Networks might provide regular reports to communities on health status improvement, patient satisfaction, and provider satisfaction with network relationships.

The AHA believes that community care networks hold the best promise for reducing inappropriate competition within our system; improving patient care; and eliminating unnecessary care, duplication of services and excess capacity. Restructuring our health care system into capitated networks will increase the focus on prevention and primary care services.

TRANSITIONAL ISSUES

While we work toward reform, hospitals must continue to operate under Medicare PPS. There are a number of areas where this system could provide more equitable payments to hospitals.

LABOR MARKET AREAS

The movement away from the use of metropolitan statistical areas (MSAs) to define labor areas, and toward a definition more specifically representative of local labor costs is a much needed conceptual improvement. ProPAC has presented a proposal on this subject in its March report. We would expect such a modification to minimize the differences in wage index values between neighboring areas and to prevent the grouping under a single wage index of hospitals separated by several hundred miles, as is currently the case for [illegible] rural hospitals.

AHA appreciates the complexity of the task ProPAC has undertaken in trying to identify more appropriate labor markets and feels that they have made excellent progress in this direction. We look forward to additional details on the methods as well as further impact analyses to determine the appropriateness of the significant payment redistributions that such a change would likely entail.

OUTLIER PAYMENT

The AHA continues to support *measured* movement away from day outlier payments, toward a greater emphasis on cost outlier payments. ProPAC's recommendation to completely eliminate day outlier payments within three years, however, would cause severe disruption of payment for a significant number of hospitals. We feel that any such change should be phased in over a longer period.

The suggested increase in the outlier pool to six percent of total PPS payments (from the current 5.1 percent) should be deferred until the effects of eliminating the day outlier payment are better understood and there is real assurance that all currently reserved outlier funds will be fully disbursed.

PPS EQUITY

In discussing equity adjustments to the existing Medicare system, we must not forget the numerous proposals passed by the Congress last year as part of H.R. 11, but vetoed by President Bush. H.R. 11 reauthorized the Essential Access Community Hospital program, provided for separate payment for the interpretation of EKGs, phased in changes in outlier payments, and contained important provisions to assist hospitals to keep their Medicare dependent and rural referral center status until the urban/rural differential is eliminated. AHA fully supports these proposals and, like ProPAC, we continue to support the elimination of the urban-rural differential by October 1, 1994, as mandated by Congress.

AHA commends the members of this Committee for their leadership in helping to pass these provisions last year and we are pleased to see that Sen. Dole has introduced--in S. 176, the Medicare Amendments of 1993, with seven Finance Committee members among the cosponsors--a number of these provisions, including Medicare dependent hospitals, rural referral centers, and payment for interpretation of EKGs. We are also heartened that President Clinton included, in the public investment section of his FY 1994 budget package, a rural health initiative that includes the Medicare dependent rural hospital reauthorization and the rural referral center provision.

We urge the Committee to include <u>all</u> of H.R 11's important Medicare equity proposals in this year's reconciliation package.

CONCLUSION

As America's hospitals prepare for health care reform they must continue to operate under the current system, complete with a flawed and inequitable Medicare program and a Medicaid program that struggles to serve as the current safety net for the medically indigent. Both the members of this Committee and ProPAC have supported important improvements to PPS. We stand ready to work with you to achieve these goals as well as to make the difficult choices required to meet the President's goal of a stronger economy. The President has asked for shared sacrifice from all Americans, including the nation's hospitals--many of which are financially vulnerable because of continued tinkering and past deficit reduction efforts.

We have worked with our members to develop a constructive approach to respond to the nation's health care crisis and look forward to working with you and the Administration in the months ahead. AHA is committed to meaningful health care reform that achieves universal access and a restructured health care delivery system.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Good morning. Mr. Chairman, I would like to thank you for holding this hearing. I would also like to offer a warm welcome to Secretary Shalala. We face critical problems in our health care system, and I am pleased to join in this important effort to address them.

The budget cuts we are considering today are not easy ones. But they must not be taken out of the context of the President's efforts to reform our health care system. I would hope that everyone would look at this whole package in terms of how it relates to our other goals—such as increased access to affordable health care and the reining in of sky-rocketing costs.

Overall cost containment will help to solve problems we often associate with the Medicare and Medicaid programs. For example, cost shifting to the private sector and uncompensated care will be reduced. Very soon the President will present us with his health care reform plan. This may be our best chance—and our last chance—for comprehensive health reform. That is why this budget proposal we are considering today is so important.

I am pleased to see that the budget includes much of the Aging Committee's work on reducing fraud and abuse in Medicare's durable medical equipment program. Also, Mr. Chairman, I applaud the Administration's efforts to reduce Medicare expenditures for the biological EPO, which is used in the Medicare ESRD program. The Medicare program is the primary payer for this biological, buying over $400 million in 1992, and spending over $1 billion for the product since 1989. However, if we want to reduce the federal government's EPO costs, we should focus more on containing the costs of the product, rather than reducing reimbursement to dialysis facilities.

Many dialysis facilities, especially those in rural areas, may be unable to administer the appropriate amount of the biological at this reimbursement rate. Worst of all, it does little to reduce the Medicare program costs for the product. I want to work with you, Mr. Chairman, to see that we find a more equitable way to reduce EPO product expenditures.

Mr. Chairman, I also want to say a few words about the Administration's proposal to allow states to use Medicaid drug formularies. In the evolving world of managed competition, drug formularies will be the primary management tool that health plans will use to contain their drug costs. Hospitals and HMOs—in which millions of Medicare, Medicaid, and federal employees have received health care services—use drug formularies.

Appropriate safeguards are usually built into each and every formulary system to protect the patient's access to needed medications and the physician's right to prescribe the medication which is best for the patient. If these same safeguards are adopted for state Medicaid drug programs, then we should seriously consider giving them the flexibility to use drug formularies. I want to work with you, the state Medicaid programs, and patient advocacy groups to assure that we craft a responsible proposal.

Mr. Chairman, Secretary Shalala should be commended for seeing to it that the Administration's stimulus plan includes investments to improve SSA's service to the public. In particular, HHS is requesting funds to reduce the growing backlog of dis-

ability claims. HHS's request signals the Clinton Administration's commitment to ensuring that disabled Americans are not forced to wait for months or years while their claims are being processed by SSA. We should work to ensure that Congress fully approves this funding request.

I think one of the bigger questions we may face this year is whether to try to repair the current way that Medicare pays for graduate medical education or to try instead to reform the entire graduate medical education system. I am concerned that under Medicare at present we may have too little leverage to make a change in the number of persons who choose family medicine, general pediatrics and general internal medicine. To do this, we may have to rebuild the whole house.

The Physician Payment Review Commission has developed comprehensive recommendations for a new graduate medical education program that could substantially increase primary care residencies and reduce the excess of specialties. Soon, the Aging Committee will hold a forum to examine these recommendations.

While I have noted a few of my primary concerns, there are a host of issues that we will face as we work on the budget and health care reform. I want to work with you, Mr. Chairman, Secretary Shalala, and all the interested groups to assure that we craft a responsible budget in the context of health care reform. I look forward to hearing the testimony from Secretary Shalala and the rest of our distinguished panel of witnesses.

PREPARED STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV

I am glad to have the opportunity to discuss President Clinton's proposed budget for Medicare and Medicaid. I deeply regret that I am unable to attend today's hearing. The National Commission on Children's final effort—a Summit on Children and Families—is taking place at the same time. As the Chairman of the Commission, I have the duty and the honor to preside over that historic event.

Before we begin to discuss the details of this budget, I think it is critically important to put this discussion in context. Context is everything. For the first time in my Senate career, the President of the United States has submitted a budget to Congress that honestly attempts to deal with an insidious problem that has haunted this country for over a decade—the deficit. No more smoke and mirrors. This budget makes tough choices—not haplessly and not hopelessly—in the context of pending national health care reform.

The truth is, many of us may not like some of the individual proposals in President Clinton's proposed budget. The cuts are deep. As the Chairman of the Medicare and Long Term Care Subcommittee, I have some serious reservations about individual items and understandable concern about the level of cuts proposed.

On the other hand, it's also very apparent that the projected growth—unless we act—of the Medicare and Medicaid programs are unsustainable. Health care is the most rapidly growing component of the federal budget. Bob Reischauer, Director of CBO, has testified that "controlling federal spending and reducing the budget deficit will be extremely difficult—if not impossible—if no change takes place in current patterns of spending on health care.

But it is not just the federal budget that is under severe stress by rising health care costs. Our country's businesses and our families are being weighted down by double digit increases in health care costs. We need a *comprehensive* solution to the health care cost problem.

We now have a President who understands the need for a comprehensive health plan, and who is committed to enacting a comprehensive plan *this year*. Merely trying to control the federal government's health care spending, which has been the focus over the past decade, just passes the buck—and I mean that literally—to the private sector.

That brings me back to my original point. Context. As a Senator who is desperate for systemic health care reform, I will do everything I can to accept this level of cuts because I firmly believe that it is the only way to achieve national health care reform. I suggest to all of you who will be making comparisons and, offering constructive criticisms, we must not forget that these budget proposals are not merely stop gap measures designed to do little more than get us through another year. Unlike past budget proposals, these are not proposals that scrimp and save dollars from our existing entitlement programs—programs that have admirably provided basic health care coverage for most of our nation's elderly and disabled, and for poor pregnant women and children—without a prayer of broader coverage. These proposals aren't offered cynically. They are offered with the hope that working together, we can finally address the deficit that plagues us. These proposals are submitted with a promise of comprehensive health care reform that will offer every American

the peace of mind of basic health care coverage. It is a promise that is our responsibility to help the President fulfill. That promise makes all the difference.

I welcome the Secretary of Health and Human Services, Donna Shalala and our other witnesses this morning. I will give your testimony full attention.

PREPARED STATEMENT OF JERALD R. SCHENKEN

Mr. Chair and Members of the Committee: My name is Jerald R. Schenken, MD. I am a practicing pathologist from Omaha, Nebraska, and a member of the Board of Trustees of the American Medical Association. With me is Bruce Blehart from the Association's Division of Federal Legislation. The AMA appreciates this opportunity to appear today to discuss the subject of Medicare and Medicaid Budget proposals for FY 1994.

As a starting point, we all must recognize that yet another round of Medicare and Medicaid program cuts cannot be viewed in a vacuum. Your actions this year will be part of a profound series of changes that will alter forever how health and medical care are received in America. As you know, Mr. Chairman, the AMA is proud to be able to say that physicians are leaders in calling for major reform of our health care system. The status quo that has allowed so many of our citizens and patients to have inadequate or even no coverage for health and medical care simply is unacceptable. We recognize the need for universal coverage and that attaining this essential goal will not be easy. We support changes that will end discriminatory underwriting in health insurance so that small businesses can afford coverage. We support portability of coverage and real competition in the health benefits market.

We believe a partnership can be forged between the medical profession and the government to assure quality of care and budget predictability in a setting of fair negotiations. We support outcomes assessment research and the use of practice parameters to assure the value of medical care.

This is our starting point, and we are pleased to see that movement in this direction is coming and coming soon. With these momentous changes in the offing and with the real desire to effect positive change in the health care delivery system for all Americans, we urge caution in treating Medicare and Medicaid budget cuts and the reconciliation process as "business-as-usual." While we accept that government programs, including Medicare and Medicaid, must be subjected to cuts in the name of deficit reduction and government belt tightening, it must be recognized that changes made in the government's primary health care programs will send a clear signal as to how physicians, beneficiaries and others can expect to be treated by the federal government in a reformed health care system. Modifications that create further or increased hassles or even appear to be unfair will only make it more difficult to effectuate the kind of change we want for the entire health care system.

Whatever changes are visited upon the Medicare and Medicaid programs through this year's impending budget reconciliation process should have the dual purpose of savings and program improvement. Unfortunately, the blueprint from the past illustrates the difficulty in attaining this goal. The President's recently released series of proposed substantive program modifications is designed to achieve savings. We are concerned that this follows a pattern of huge Medicare reconciliation packages that have involved literally hundreds of substantive changes over the last decade. These budget driven changes have created substantial turmoil and confusion and the Medicare law is one of the most complex statutes in existence with thousands of pages of seemingly constantly changing instructions and interpretations.

Budget based proposals, such as the Medicare denial of payment for interpretation of most EKGs and arbitrary reductions in physician payments during the first four years of their billing the Medicare program, represent arbitrary actions of highly questionable merit even in terms of potential savings. These provisions did not make good operational sense and, last year, both Houses of Congress voted to repeal them in a budget neutral manner. For this corrective action, we thank the Chairman and this Committee for supporting the necessary legislation. However, this corrective legislation was vetoed for unrelated purposes, and again we are asking for your support to reverse these past legislative actions.

The American Medical Association is cognizant of the need to reduce the budget deficit and to control spending appropriately. Such decisions are never easy. However, the way in which Medicare program cuts are achieved is very important to program operations and the impact on program beneficiaries. With this Committee now facing a reconciliation target of savings that must be achieved, we suggest that you consider the following principles concerning the Medicare and Medicaid programs.

- Micro-management of Medicare is not an effective way to obtain budget savings. Such program changes disrupt the delivery of services and continue the administrative turmoil that has shadowed the program for more than a decade. For example, we do not believe that the proposal to make a single payment for inpatient radiology, anesthesia and pathology services, as the Administration proposes, should not be adopted. Providing no savings in 1994, the proposal would substantially disrupt the existing relationships between hospitals, patients and this select group of physicians.
- The reconciliation process is not the place to determine, through arbitrary reductions in Medicare payments for direct medical education costs, how to solve physician workforce issues or how to encourage more physicians to train in the primary care fields. Such decisions should be made within the context of a comprehensive overview of the medical education process, not as a budget fix.
- Maintain the integrity of Medicare's new Physician Payment System that is based on a Resource Based Relative Value Schedule (RBRVS). In its second year of a five year transition, it is important to achieve the goals of a sound method of determining physician reimbursement and to encourage the delivery of needed care. Changes that break down the relationship between input and resource costs and reimbursement for services will undo a major accomplishment of establishing a rational basis for determining Medicare reimbursement. This Committee has long been a supporter of the RBRVS. The AMA was also a leader in calling for the development of an RBRVS and worked closely with various Members in seeing the RBRVS go from idea to completion. While we continue to have problems with some features of the new payment system, we still support this methodology.
- Avoid increased program costs by refraining from enactment of increased regulatory burdens. Implementation of the Clinical Laboratory Improvement Amendments of 1988, the OSHA Bloodborne Pathogen Standard, and the Americans with Disabilities Act in just one year have added significantly to the costs of providing medical care. Compliance with CLIA–88 alone is costing individual physicians thousands of dollars per year.
- Program benefits should not be expanded at the same time you are trying to find major savings. New benefits invariably cost more than projected.
- Comprehensive health system reform should serve as a vehicle for evaluating the role of Medicare in a competitive environment as well as the place for a comprehensive review of physician workforce issues including the best ways of addressing physician specialty issues.

From this framework, the AMA has reviewed the President's recommendations. It should come as no surprise that the AMA will not support all of the President's initiatives. However, we take very seriously the challenge to find potential program modifications that will achieve the desired level of savings. In addition to considering the Administration's budget proposals, we also suggest that the Committee look to items that had been proposed by previous Administrations and others that would reduce costs without disrupting care. For example, bringing state and local government workers hired before April, 1986, into the Medicare program would raise $1.2 billion in first year revenues alone. Because most of these workers usually wind up receiving Medicare coverage through a spouse or non-governmental employment, it only makes sense that they pay their fair share during their full working careers.

The following sets out our position on the President's Medicare and Medicaid budget proposals. While all of the actions we are recommending have yet to be "scored," we estimate that taking these actions would result in savings of over $7.5 billion in the next fiscal year and over $30.00 billion over the next four fiscal year period.

MEDICARE PART B

Reduce Physician Fees in 1994 Except Primary Care—This proposal would give the full payment schedule update for primary care services. The update would be reduced by about two percentage points for all other care.

The AMA does not support this proposal. Since 1984, the update for physician services has been substantially reduced by budget driven reconciliation action. Another round of reductions, especially a reduction that differentiates between services, will not be easily accepted by the medical community. While we agree with the intent behind the proposed differential, making primary care a more attractive career path for physicians, we do not believe the annual RBRVS payment adjustment is the best means for effecting such policy. Differential updates undermine resource-cost basis of the payment schedule. There are considerably more direct means avail-

able for fostering primary care. The AMA maintains that RBRVS updates should be consistent and across the board.

To address the Committee's need to find Medicare/Medicaid savings in a manner that avoids further micro-management, is consistent with our principles, and provides a simple and viable alternative to proposals such as the RAP DRG roll-in, single surgical payment, and the practice component reduction, we have discussed the possibility of suggesting a six month delay in all Part B updates rather than the series of disruptive cuts proposed by the Administration.

Such a delay would provide significant 1994 savings of about $2.1 billion and not disrupt the achievements of the RBRVS in physician payment reform. However, there are consequences in making this suggestion in light of its impact in many rural and inner-city areas and for some practitioners who are on the margin of making a go of their practices. Nevertheless, a straight forward six month delay in all Part B updates would be far preferable to the series of highly disruptive cuts proposed by the Administration. Such a delay would provide significant savings. It would not disrupt the achievements of the RBRVS in physician payment reform, and it would not come at the expense of our patients or more Medicare micro-management. To address the possibility of protecting those providing rural or inner-city care or others where the six month delay would create extensive problems, we would be pleased to work with you to see what accommodations can be achieved.

Resource-based Practice Expenses Phase-in—This proposal would phase-in a resource-based system for practice expenses under the physician payment schedule beginning in 1997 (a 1993 PPRC suggestion). As an interim step to this phase-in, practice expense RVUs would be reduced in 1994, 1995 and 1996.

The AMA does not support this major reduction in the RBRVS. Rebasing practice expenses in this manner, especially during the initial RBRVS phase-in period, would be highly disruptive. While there are anomalies in the practice expense component that need to be addressed, moving to a resource based methodology can be achieved without again extracting huge sums out of the Medicare program. Our concern is that the proposed process to reset the payments for practice expenses would be contrary to the RBRVS by skewing distribution for budget purposes as opposed to setting payments based on accurate data.

We believe that legislation should be enacted to give HCFA the authority to correct anamolies in the current practice expense values. For example, pericardectomy performed with a bypass currently pays $250 less than the same procedure without a bypass. HCFA does not believe that it has the authority to correct such situations. We also agree with the PPRC that HCFA should be directed to collect data on physicians' actual practice expenses. HCFA should use these data to develop a resource-based practice cost methodology that would better reflect these actual costs, and HCFA should report to the Congress by 1996 on a methodology that could be implemented beginning in 1997 (after complete phase-in of the RBRVS).

Reduce Physician MVPS and Update "Default" Formulas—This proposal would refine the method by which Medicare increases payments to physicians. The proposal would reduce the default formula. The projection for the potential rate of growth also would be lowered.

The AMA does not support setting the assumption for Medicare growth on the rate of growth in the gross domestic product (GDP). Historically, the growth in costs for providing health and medical care has exceeded the GDP, and there is no basis to assume that the Medicare program that provides coverage for the majority of care received by the elderly and disabled populations (those with the greatest need for health and medical care), especially outside of major health system reform, can have its rate of growth slowed to the rate of growth in the GDP.

Bundle Inpatient Radiology. Anesthesia and Pathology (RAP) Payments—Medicare payments for inpatient radiology, anesthesia and pathology would be bundled into a fixed payment per discharge. Payment would be made either to the hospital or the medical staff, and beneficiary coinsurance would be set at 20% of the bundled amount. The proposal states that this approach would give physicians and hospitals incentives to be cost-conscious, provide only medically necessary services and eliminate the provision of marginal services.

Every time this proposal has surfaced, the AMA has opposed it. The past reasons for opposition are still true, and we continue to oppose this concept. The DRG payment concept for these services would limit physician patient relationships, and would set an inappropriate precedent for bundling physicians' services. The so-called RAP services generally are provided at the request of an ordering physician. While marginal services need to be eliminated, it is very difficult to see how this would occur for the services of an anesthesiologist for a patient undergoing surgery, the services of a pathologist who conducts and interprets a laboratory test, or the services of a radiologist in responding to a STAT request for X-ray or other services.

Even if instances could be identified where this care could accurately be described as marginal, savings would be unlikely as the waiver of liability provision probably would apply. Also, this is an example of micro-management that would be contrary to directions taken when the RBRVS was instituted.

Single Fee for Surgery—This proposal would not allow Medicare payment above the level allowed for the primary surgeon for the services of an assistant at surgery. While exceptions would be allowed for "particularly difficult cases," Medicare payments to the primary surgeon would be reduced by the amount of any payments for an assistant at surgery.

The AMA does not support this proposal. It would come on the heels of just implemented 1990 legislation that already severely limits the use of and payment for assistants at surgery, and it simply is contrary to optimal patient care needs. Also, many hospital medical staff bylaws require the use of assistants at surgery as a means of optimizing patient care during particularly hazardous moments in the provision of care, and it is questionable why such a patient care standard should be limited.

Part B Premium at 1995 Percentage of Program Costs with a Limit of 27% of Program Costs—The Part B Premium is set by law at 25% of program costs. As the budget proposals would lower program costs, the premium should also come down. This proposal would still decrease the dollar amount of the premium while raising funds by setting the premium for 1996 and 1997 at 27%.

Recognizing that the proposal would not result in individuals paying a higher premium in dollar terms, the AMA supports this action that is consistent with the fact that the premium was supposed to cover 50% of program costs when Medicare was instituted. The AMA also believes that consideration and support should be given to a proposal put forth in the previous Administration calling for an increase in the premium rate for individuals with annual income of more than $100,000 and for couples with annual income of more than $125,000. This reasonable means testing proposal, as recommended in 1991, was slated to accrue $313 million in annual revenue, or approximately $1.25 billion over four years.

Increase Hospital Outpatient Cut—This proposal would extend the current cost reduction of setting these payments at 94.2% of costs to 90% of costs, beginning with services rendered during FY 1996 and thereafter.

While the Association previously has opposed such cuts, we recognize that the still growing volume of services provided in hospital outpatient departments has the potential to offset the proposal. Also, with all elements of the health care spectrum being asked to contribute to the need to lower spending, this seems a reasonable action to maintain the playing field between those who provide care and to address the substantial growth in costs associated with hospital outpatient departments.

Reduce Payment for Clinical Laboratory Services and Provide No Update to Laboratory Payments through 1998—The laboratory payment schedule currently is set at 88% of the national median, and it would be reduced to 76%. In addition, no annual update in these payment amounts would be allowed through 1998.

The AMA recommends partial support for the President's proposal, by modifying it so that the payment cap would not be lowered below 80% of the national median. While we would prefer not to see lower payment amounts for these services, it is noted that setting the payment cap based on a median will result in payment for many of these services not being affected. Also, the lower payment amount might have the desirable effect of lowering the volume of questionable laboratory services.

Physician Ownership/Referral—This would extend ownership/referral prohibitions applied for clinical laboratory services to services such as: physical and occupational therapy; radiology and other diagnostics; radiation therapy; durable medical equipment, and parenteral/enteral nutrition equipment and supplies.

The AMA supports this proposal if it is drafted in a manner that is consistent with exceptions for community need as specified in the related report by our Council on Ethical and Judicial Affairs. Where physician investment is the springboard for allowing patient access to previously unavailable care or improved care that will benefit those patients, care must be taken to assure that a blanket prohibition does not jeopardize that care. We hope to work with the Chairman and the Committee in addressing issues such as patient access exceptions, shared laboratories, the divestiture period, and clarifications for group practice situations.

Electronic Billing Incentive—This proposal would create an incentive to encourage submission of Medicare Part B claims via electronic formats by charging $1 per paper claim beginning January 1, 1996.

The AMA does not support this proposal. While we know that there are positive benefits of moving to electronic billing and taking advantage of other computerization benefits, this should not be achieved through disincentives. Where the proposed penalty would be applied, it is likely to hit hardest those who provide a small vol-

ume of Medicare covered primary care services that already are provided at a low fee level. With the development of a uniform claims format and software down the road, it is likely that more and more physicians and others will move to electronic billing, and the proposed savings still will be realized without the penalty being applied.

Durable Medical Equipment (DME) Proposals—DME payments would be reduced by: "tightening" the national payment limits; reclassifying certain items; restoring the carriers ability to adjust payments where the amount is grossly excessive or deficient based on price information; and give carriers flexibility to require demonstration of medical need in advance of delivery of the DME to the patient. The payment schedule for orthotics and prosthetics would be changed to the DME payment schedule. A payment schedule would be established for parental and enteral nutrients and supplies, with parenteral and enteral equipment paid on the same basis as DME.

The AMA recommends support for this provision as a reasonable action to address costs associated with the provision of DME.

Set EPO at Non-US Market Rates ($10 per 1.000) Units—The proposed payment reduction of $1 per 1,000 units would reduce the disparity between Medicare's current reimbursement rate and the actual cost that facilities pay for EPO based on recent findings of the HHS IG.

The AMA recommends having the government purchase the EPO directly from the manufacturer when the intended use is to facilitate treatment of patients with ESRD. Anecdotes from physicians who provide ESRD services tell of situations where the provision of EPO is inadequately reimbursed in some instances. Without limiting the availability of EPO, we believe that possibly an even greater savings can be achieved with an end to hassles facing those physicians treating patients with ESRD by having the government purchase the EPO directly from the manufacturer and in turn supplying the drug to physicians and others.

Extend IRS/SSA/Data Match—This proposal, aimed at enhancing determinations of Medicare secondary payor status, would extend the authorization of the data match through 1998.

Extended Provision Requiring Secondary Payment for Certain Disabled Beneficiaries—This proposal would make permanent the authority setting Medicare as the secondary payor in situations where potentially eligible disabled individuals have other employer based group health care coverage. The current authority is set to end at the end of FY 1995.

Extended Provision Requiring Secondary Payment for Certain Beneficiaries with End Stage Renal Disease (ESRD)—This proposal would make permanent the authority setting Medicare as the secondary payor in situations where potentially eligible individuals receiving ESRD services have other employer based group health care coverage. Secondary status pertains for an 18 month period. The current authority is set to end at the end of FY 1995.

Medicare Secondary Payor Reforms—This proposal would make all of the employer thresholds for determining secondary payor status consistent with the aged provisions (employers of 20 or more). This would lower the disabled eligibility threshold from employers of 100 or more and set a threshold for ESRD patients.

The AMA historically has supported Medicare being a secondary payor where other coverage is available, and we recommend support for these four proposals.

MEDICARE PART A

Phase in a Reduction in the Indirect Medical Education (IME) Payment Adjustment Ratio—This proposal would alter the IME adjustment formula to reduce these payment amounts beginning in FY 1996.

The AMA recommends support for reducing the IME adjustment to 7%, as also called for by PROPAC, and for a study on how to best finance graduate medical education (GME) to go forward. The AMA historically has supported the IME adjustment as a means of recognizing the added costs incurred by teaching institutions for teaching and as a proxy for uncompensated care. Where initial IME payment amounts were set at a level considerably higher than the added costs of medical education, we have supported reductions to an amount that is adequate to meet the actual, education associated costs that are incurred. To determine the real value and the appropriate IME payment amount, we support conducting a study conducted that will involve physicians, the public, the institutions and others with a stake in GME.

Reform Payments for the Direct Medical Education (DME) Costs—This proposal would base payments on a national average per resident amount, with greater weight for primary care.

The AMA supports action to establish uniform accounting for these services, especially in light of the wide variation of cost per resident reported among institutions. With the mean cost for resident services at approximately $51,000, the reported variation between $7,500 and $187,000 must be addressed. By moving to uniform accounting, it is certain that some savings would result. The AMA opposes using a national average in setting the DME payment, as this will underpay in many inner-city areas and overpay in other situations. Also, using a national average overlooks the fact that residency training costs necessarily must vary by specialty and to account for other factors. Again, we recognize the need for this issue to be subject to scrutiny as the manner in which our nation finances GME is examined.

Eliminate Add-on for Hospital-based Home Health Agencies (HHAs)—This proposal would eliminate the differential, subjecting hospital-based HHAs to the same cost limits as freestanding HHAs.

The AMA questions the wisdom of continuing to pay hospitals more for the provision of HHA services, and we support this proposal.

Eliminate Return on Equity Payments for Proprietary Skilled Nursing Facilities—This proposal would eliminate Medicare ROE payments to proprietary SNFs, to create "fair competition" between SNFs.

The AMA has no position on this proposal.

Extend the 10% Reduction in Hospital Capital Payments—Under current law, hospital capital payments (inpatient Part A and outpatient Part B) are reduced through FY 1995 by 10%. This proposal, consistent with a recent HHS IG report, would make the reduction permanent.

The AMA supports this provision. We note that capital costs have been reduced in this manner pending conversion of capital payments into the prospective payment system as an add on. If this proposal is not adopted, there would be a 10% increase in payment for hospital capital costs.

Hospital Update at Market Basket Minus 1% in FYs 1994 and 1995—This proposal would set a hospital update amount below the market basket used to set this annual increase.

The AMA historically has called for the hospital update to be made at least at the full market basket amount, and we oppose this proposal. With many hospitals reporting net operating losses, it is particularly difficult to support an update below the market basket amount.

Move the Annual Changes in the PPS Updates to January 1 of Each Year—This proposal would move the PPS update from October 1 to the following January 1.

Recognizing the need to achieve savings, the AMA supports this provision. If a higher level of savings are needed, the AMA also would support a one-time delay in this update to July 1, 1994, with future Part A updates occurring on January 1 thereafter.

MEDICAID

Remove Prohibition on Medicaid Drug Formularies—States now must provide drug coverage for all drugs where they are listed in the medical literature and where the manufacturers have signed rebate agreements. This provision would allow states more flexibility in setting drug coverage.

The AMA continues to oppose arbitrary and budget driven drug formularies as they could be overly restrictive. By eliminating the medical literature requirement, the proposal clearly will limit drug availability, and this will occur to the detriment of patients.

Personal Care Services—This proposal corrects a so-called "drafting error" that would have placed a new mandate as of 1995 on state programs. As proposed, states would maintain the option of paying for personal care services provided outside of a beneficiary's home.

The AMA has no position on this proposal.

Reduce Medicaid Administrative Match to 50%—This proposal would match all administrative costs at 50%.

The AMA recommends that where federal Medicaid law has imposed administrative duties on the states, the initial matching payment should be set at a higher level. However, the administrative match should be phased down to a lower level as higher start-up costs are accrued. States should be allowed the option of petitioning for maintaining higher administrative matches where reductions are considered.

Tighten Estate Recoveries/Transfer of Assets—This proposal would close unspecified loopholes and ensure that those with substantial personal assets pay a fair share for nursing home care and other medical services before Medicaid starts to pay and require recovery from estates of deceased recipients with substantial assets.

The AMA supports the Medicaid program as a health care coverage policy of last resort for those earning below 200% of a state adjusted poverty level. This proposal is consistent with that policy, and we recommend support.

Third Party Liability—This proposal would establish a central clearinghouse to identify third party liability and would ensure that the appropriate insurer paid for care. All federal health care programs would participate. Employers would be required to verify the existence of health insurance information and initiate payment by the appropriate payor.

The AMA supports this provision as it is consistent with support for the Medicare secondary payor programs. Problems have been identified where physicians and others without adequate information having the responsibility of determining liability, and this proposal could address this concern.

ADDITIONAL MEDICARE AND MEDICAID PROPOSALS

Medicare

Duplicate Payment Offset—The Bush Administration proposed this Part A reduction in 1991. This proposal called for the elimination of hospital payments that are offset by the amount of separate payments made to direct billing non-physician practitioners whose services are considered in setting the PPS update. This was projected as saving $10 million in FY 1992.

The AMA again supports this proposal.

State and Local Employee Coverage Expansion—The Bush Administration made this proposal in 1991 and 1992. This would require state and local government employees hired prior to April 1, 1986 to be included under Medicare. In 1991, this proposal was projected as generating $1.2 billion in revenues in FY 1992.

The AMA supports taking this initiative. The proposal is consistent with the concept of universal Medicare coverage for all people eligible by reason of age. With most of these workers likely to be eligible for Medicare by reason of other employment prior to reaching age 65, it does not make sense to allow this special exemption.

Increasing the Age for Eligibility—When the AMA developed its proposal to restructure the Medicare program (in the late 1980's), an element of this proposal was support for an increase in the age used for setting Medicare eligibility. This proposal called for an eight year, phased-in increase in Medicare eligibility to age 67. The proposed rate for this change was set at three months per year.

The rationale for this change remains: it is a fact that the age of eligibility for federally funded health care for the elderly is arbitrary, and changing trends in terms of employment, health status, and longevity of our citizens should be recognized. Since this was proposed initially in the mid-1980's, there has been greater application of the Medicare Secondary Payor program and increasing the age of Medicare eligibility actually is closer to reality.

Medicaid

Parent Responsibility—States would be required to have noncustodial parents maintain health insurance coverage for their children.

The AMA previously considered this Bush Administration proposal in 1992, and recommended support. This is consistent with many ongoing state initiatives, and it also is good policy.

CONCLUSION

The Medicare and Medicaid programs provide vital health and medical services to more than 60 million Americans. Substantive changes in program operation should be made in a comprehensive fashion within the context of the needs of the beneficiaries, not put together just to meet a budget reconciliation target. This is especially important as we negotiate our way to national health system reform.

PREPARED STATEMENT OF RAYMOND C. SCHEPPACH

Good morning, Mr. Chairman, members of the committee. I am Raymond C. Scheppach, executive director of the National Governors' Association. I appreciate the opportunity to appear before you today, on behalf of the nation's Governors, to discuss the administration's proposals for Medicaid savings.

Before I discuss the President's recommendations for Medicaid savings, I would like to take a moment to comment generally on the current state of the Medicaid program. The program remains one of significant concern to our nation's Governors. At their winter meeting this past February, they again called for relief from Medic-

aid's rising costs. They remain interested in greater flexibility in financing and implementing the program and seek additional financial assistance from the federal government. Simply stated, rising Medicaid costs are skyrocketing and breaking state budgets. States cannot sustain the current rate of growth.

As you are well aware, Medicaid expenditures were relatively steady from 1981 through 1988—somewhat less than 10 percent annual growth. Since 1989, however, growth has been radically different. In the last several years, annual program growth has exceeded 20 percent. Understanding the source of this growth is rather complex and experts have found that it is almost impossible to pinpoint a single reason. However, major factors include federal mandates imposed on the states in the last decade, increased program enrollment, tremendous growth in medical prices, and court-imposed increases in hospital and nursing home reimbursement rates. While one may argue about the relative impact of these pressures, one fact is certain: important services for vulnerable populations are at risk and state funds for education, welfare, and other public health programs are being diverted to cover the costs of Medicaid. The Governors believe that members of Congress and the administration recognize the crisis facing states and are willing and interested in relieving the pressures that this program has generated for the last half decade.

It is within this context, Mr. Chairman, and members of the committee, that I appear before you today to discuss President Clinton's proposals for Medicaid savings. With one exception, the proposals can be supported by the Governors. For the most part, these proposals give states greater flexibility in the design of their programs, increase the probability that only those who truly meet the criteria for care obtain it, and assure that *all* payers of health care are held accountable before the federal and state governments cover the costs. While the administration is to be commended for its proposals, one important one cannot be supported by Governors. That is, the administration's proposal to reduce matching funds for all Medicaid administrative costs to 50 percent.

REDUCTION OF ADMINISTRATIVE MATCH

Mr. Chairman, this proposal can be rationalized in many ways, but this is the bottom line: it is nothing more than a cost shift to the states—a cost shift when states are least able to afford such actions. When Congress and the administration made the decision to implement enhanced administrative matching strategies, the Governors believe that they did so to meet a compelling public policy need. I no case has that compelling need changed. I would like to take several minutes to discuss some of the components of Medicaid administration that will be affected by this proposal.

Medicaid Management Information Systems (MMIS).—MMIS is a specially designed data processing system that tracks data on beneficiaries and providers and is used to process Medicaid claims. This system was established to ensure that data systems among states had sufficient uniformity and administrative sophistication to meet the growing data and financial needs of both the federal and state governments. By 1991, 49 states had MMIS in operation or under development. The need for such a system remains as great today as ever. In fact, if the nation moves to a national health care system, the Governors believe that the federal government will have an even greater need to ensure that sophisticated computer systems are available to make the necessary modifications in a timely and accurate manner.

In discussing this proposal with our membership, states have reported that they have multiyear contracts with vendors to both develop and operate their computer systems. These contracts have been negotiated with the assumption that certain federal funds would be available. Reducing federal funds now could have serious and deleterious impact on the fulfillment of those contracts.

Skilled Professional Medical Personnel.—Skilled medical personnel play a key role in ensuring quality in the program. The enhanced match for this function encourages states to employ medical professionals with the highest skill levels. Both states and the federal government benefit from this policy objective, and it should be continued.

Nursing Facility Survey and Certification and Peer Review Organizations, and Fraud and Abuse Units.—Nursing facility survey and certification ensures that Medicaid beneficiaries are given care in facilities that meet standards. The Omnibus Budget Reconciliation Act (OBRA) of 1987 strengthened facility requirements, federally prescribed a review process for states, and reaffirmed the federal importance of this function through an enhanced federal commitment. State responsibilities have increased substantially as a result of this statute and now is not the time to retreat from the commitment of enhanced financial support.

The Governors also believe that the enhanced match for peer review organizations (PROs) should be maintained. Utilization review, quality and medical review are the cornerstones of quality assurance. Last session, the Governors were supporting changes in Title XIX that would have facilitated the implementation of Medicaid managed care systems. These changes were met with strong federal concerns for quality under managed care. Maintaining the enhanced federal match for PROs for managed care and all other quality assurance functions is consistent with that federal public policy objective.

Finally, fraud and abuse units play a key role in ensuring the integrity of the program. These units are also instrumental in recovering funds that were claimed illegally.

Drug Use Review.—OBRA '90 made significant changes to the prescription drug program in Medicaid. One of those changes was a federal mandate to establish drug utilization review programs. These programs are intended to ensure that drug use patterns are within predetermined standards. The enhanced match softened the impact of this mandate and should be retained.

Effects of Administrative Reductions on States.—A state-by-state analysis of the impact of the administrative match reductions has been performed Federal Funds Information for States (FFIS), an affiliate of the National Governors' Association. (The FFIS report, issued March 8, 1993, is attached.) FFIS calculated for fiscal 1994, the cost shift to states—expressed as a percentage of total administrative dollars—if this proposal was enacted (see Table 3). While nationally there would be a cost shift of approximately 10 percent, states are affected differentially. Four states would experience a shift of more than 20 percent, and nine states would experience a shift of 15 percent or greater. Such shifts are unbearable and unacceptable.

If this proposal is implemented, states must either raise revenues to make up for the cost shift or they must find other parts of their program that could be reduced. Regarding revenue increases, one thing is certain. *It is no easier for a state to raise revenues to make up for administrative shortfalls than it is to raise revenues to fund program expansions.* The Governors hope an alternative can be found. They agree with the Committee on the Budget (*Report on the Concurrent Resolution of the Budget for Fiscal Year 1994*) when they said that ". . . the Administration's proposal to cap the administration match rate for Medicaid at 50/50 would seriously undermine the ability of states to carry out mandated activities." States are currently looking for other changes to the Medicaid program that could be made without engendering a cost shift. The Governors are interested in working with Congress and the administration to find such alternatives.

MEDICAID DRUG FORMULARIES

Prescription drugs are an important part of the Medicaid program—a program where states are committed to maintaining and improving the health of Medicaid beneficiaries through cost-efficient program administration. The Governors believe that removing the prohibition on formularies is consistent with this focus. If designed correctly, quality care to beneficiaries will not suffer and states will have one more important cost containment tool in a program that has too few tools currently. The Governors believe that states, like hospitals and health maintenance organizations, can impose formularies without sacrificing quality care.

For example, in implementing formularies, states could ensure that all clinically appropriate therapies for conditions that are medically necessary are available, and that every medically necessary therapeutic class of drugs is represented by at least one drug. Moreover, states could be required to establish procedures so that if a patient is unable to achieve the desired physician's outcome using the drug on the formulary, a non-formulary drug could be approved for use. Almost every hospital and health maintenance organization that uses formularies has such a patient safety procedure in place. There is no reason to believe that this could not work for Medicaid, and states should be given the opportunity to do so.

TRANSFER OF ASSETS AND ESTATE RECOVERY

The Governors support a comprehensive national long-term care policy. In its absence, the burden and the cost of care will continue to fall primarily on individuals and their families. Aside from Medicaid and a private long-term insurance market that is not perceived as viable, most individuals and families must rely on personal income and assets to pay for care. In many cases, the high cost of care ultimately forces individuals to spend their life savings and turn to Medicaid for assistance.

The Medicare Catastrophic Care Act of 1988 established some rules to protect individuals and their spouses from becoming impoverished by adjusting Medicaid eligibility rules to shelter some income and assets. However, anecdotal evidence is

mounting that some non-poor elderly people are using techniques to shelter assets that would otherwise have made them ineligible for Medicaid. The prevalence of this practice is unknown; however, even if relatively few people are pursuing this technique, it is a program abuse.

The Governors support tightening the rules regarding transfer of assets so that people with the resources are held accountable to pay for their share of nursing care. These changes must be crafted carefully so that people who rightly belong in the program are neither denied coverage nor are expected to pay more than is reasonable.

As part of policy adopted by the Governors in the summer of 1992, the following areas were identified where asset transfer policy might be tightened.

- Extend the current 30-month "look-back" period for the transfer of assets at less than fair market value for the purpose of qualifying for Medicaid.
- Strengthen the current penalties for transferring assets at less than fair market value. Under current law, states can only impose a penalty equal to *the lesser of* 30 months of coverage or the number of months resulting from dividing the uncompensated value of the transferred resource by the statewide average room rate for a Medicaid facility.
- Review trust laws to allow access to assets that now are sheltered from consideration in Medicaid eligibility.

The President's recommendation to require states to recover assets from the estates of deceased Medicaid beneficiaries requires careful consideration. The Governors currently have no policy that would either support or oppose a federally required Medicaid estate recovery program. In considering the President's proposal, Congress might also consider a policy that retains estate recovery as a state option, but allows states that aggressively engage in estate recovery to retain a greater percentage of the funds recovered.

MEDICAID PERSONAL CARE SERVICES AND THIRD PARTY LIABILITY

Consistent with the Governors' policy of establishing options in the Medicaid program, they support the President's recommendation to correct the drafting error that establishes personal care services as a mandate in 1995.

Finally, the Governors also support actions that would identify third party payers and ensure that the appropriate insurer pays for care before Medicaid.

CONCLUSION

Mr. Chairman and members of the committee, thank you for the opportunity to appear before you today. With one notable exception, the Governors are supportive of the President's recommendations for Medicaid savings. They and their staffs look forward to working with you and the President to develop the details of these proposals, and they are committed to finding suitable alternatives to the reductions in administrative match that can only result in cost shifts to states.

IssueBrief

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March 8, 1993, Vol. 93-4

Administrative Matching Rate Proposals in the Clinton Economic Plan

Summary

President Clinton's economic plan released on February 17, 1993, would set the matching rates for the administrative costs for medicaid, aid to families with dependent children (AFDC), and food stamps at 50 percent starting in the second half of federal fiscal year 1994. According to the plan, this change would save the federal government $200 million in 1994 and $1.8 billion between 1994 and 1997. This brief analyzes the potential impact of this proposal on state medicaid and AFDC programs.

Background

As a requirement of participating in the medicaid and AFDC programs, states must provide the administrative institutions necessary to operate the programs at the state level. The costs for developing the administrative capacity to run an efficient program is shared between the federal government and the states. In most cases, the two levels of government each pay 50 percent of administrative costs. The federal government pays a larger percentage for certain administrative activities and systems that it wishes to promote, for example, fraud and abuse control. Currently, about 30 percent of all medicaid administrative costs are matched at an enhanced rate, while only 7 percent of all AFDC administrative costs receive a matching rate of more than 50 percent.

Medicaid Administration

Each state designates one agency to operate its medicaid program. The administrative responsibilities of these agencies include determining eligibility, assessing provider qualifications, developing systems for processing claims, monitoring program efficiency and effectiveness, and detecting fraud and abuse.

The federal government and the states share the costs of administering medicaid according to matching rates that vary by function. For example, 90 percent of the costs of installing a medicaid management information system are paid by the federal government, while the costs for outstationed eligibility workers are shared evenly. For 1993, the Health Care Finance Administration estimates that administering medicaid will cost a total of $5.1 billion. The 1993 state share of this total is estimated at $2.2 billion.

Table 1 shows estimated federal spending for medicaid administration by category for 1994. The descriptions below explain the purpose and matching rate for each category.

Immigration Status Verification Systems (ISVS) - 100 percent. For medicaid applicants who are not U.S. citizens, states must verify immigration status. Medicaid pays for services for eligible non-citizens with permanent resident status. Medicaid must also cover services for illegal aliens in emergency situations.

Medicaid Management Information Systems (MMIS) Installation and Operation- 90 percent/75 percent. MMIS is a model data processing system that tracks data on beneficiaries and providers and processes medicaid claims. The Mental Health Systems Act (P.L. 96-398) required all states to install an approved MMIS by September 30, 1982, or face a reduction in federal payments for administration

Table I. Distribution of Federal Medicaid Administration Payments by Matching Rates, 1994
(federal fiscal years, dollars in thousands)

	100%	90%		75%						50%				
State	SIVS	MMIS	OTHER	MMIS	SPMP	PRO	DRUGU	PASR	DRUGI	ADP	OTHER	NAT	OEW	TOTAL
Alabama	50	5,402	5,135	$15,864	$1,648	$0	$0	$606	$0	$448	$9,344	$0	$0	$37,891
Alaska	0	257	0	5,379	615	318	0	370	0	536	3,975	88	0	11,538
Arizona	8	0	40	0	2,807	204	0	705	0	9,436	43,725	14	0	56,936
Arkansas	14	0	0	4,181	1,165	1,375	0	1,042	0	0	13,801	1,383	317	22,308
California	5,000	334	0	83,041	34,761	0	0	0	0	5,016	499,173	0	0	623,314
Colorado	0	225	0	7,377	545	1,938	170	789	0	0	12,553	311	0	23,888
Connecticut	0	157	0	5,060	800	428	126	757	0	4,575	17,892	41	0	29,836
Delaware	0	1,000	0	2,340	1,231	143	0	900	0	0	4,490	0	0	10,114
Dist of Col	0	1,086	0	3,073	1,311	392	0	0	0	0	8,170	0	0	13,982
Florida	142	0	0	16,128	5,810	140	0	4,347	0	18,232	95,650	0	0	140,249
Georgia	0	0	0	22,740	13,075	0	0	2,975	0	1,797	43,522	2,344	0	86,351
Hawaii	0	0	0	5,135	676	0	180	0	0	0	4,622	0	0	10,613
Idaho	8	119	0	6,104	1,043	600	0	141	0	666	6,848	160	0	15,683
Illinois	4	22	0	34,783	3,846	879	0	6,114	0	0	85,132	468	0	131,248
Indiana	0	0	0	0	195	0	0	2,814	0	1,404	25,000	0	0	29,413
Iowa	2	664	0	5,818	126	2,953	0	75	0	1,370	13,442	60	15	24,559
Kansas	0	0	0	5,995	388	1,345	0	125	0	0	8,451	0	0	16,304
Kentucky	4	144	0	8,025	648	2,295	225	900	0	0	15,682	1,000	0	28,923
Louisiana	0	0	0	17,223	808	0	0	2,842	0	0	38,114	913	0	59,895
Maine	0	0	0	3,981	511	0	0	75	0	0	8,911	0	0	13,478
Maryland	38	6,134	0	1,930	6,185	3,344	0	2,079	0	0	45,865	1,938	0	75,823
Massachusetts	0	0	45	13,063	2,930	0	0	1,408	0	166	145	1,224	0	63,983
Michigan	0	382	0	22,008	1,833	605	194	4,648	0	727	152	3,661	2,400	102,604
Minnesota	0	6,495	0	4,339	3,405	840	0	164	0	4,842	49,454	0	0	69,339
Mississippi	0	261	0	9,158	656	1,575	0	863	0	1,200	9,500	588	0	23,801
Missouri	0	0	0	6,186	719	0	0	1,856	0	0	26,580	29	170	35,516
Montana	0	0	0	1,265	53	283	248	149	0	0	4,915	161	0	7,074
Nebraska	0	180	0	4,495	565	750	0	840	0	0	9,423	120	0	16,373
Nevada	0	9,818	531	0	1,314	870	0	68	0	693	7,598	313	0	21,215
New Hampshire	0	172	0	5,750	653	148	0	103	0	0	4,831	0	0	11,657
New Jersey	0	0	3,922	9,990	6,543	120	188	1,295	0	180	74,155	0	1,500	97,893
New Mexico	1	0	28	3,984	1,014	900	0	450	0	0	6,509	80	0	12,966
New York	0	360	8,910	67,089	21,675	7,500	0	879	0	0	174,300	6,310	0	287 133
North Carolina	0	0	0	6,683	1,279	495	0	229	0	1,430	49,500	55	0	59 671
North Dakota	0	0	0	821	393	120	22	153	0	0	4,868	260	0	6,637
Ohio	0	1,852	0	15,160	6,972	1,451	38	2,350	0	1,354	67,251	100	0	96 650
Oklahoma	1	0	416	6,080	4,051	411	20	1,622	31	0	35,838	0	0	48 470
Oregon	0	739	266	12,059	3,936	135	0	625	0	0	37,172	619	0	55 351
Pennsylvania	8	86	0	30,769	5,878	0	450	792	0	0	89,019	0	768	127 770
Rhode Island	5	5,266	0	0	342	0	0	140	0	3,811	6,658	15	608	16 845
South Carolina	0	450	1,995	7,253	4,056	342	0	2,001	0	0	19,444	226	668	36 455
South Dakota	0	0	0	720	270	120	64	6	0	0	3,440	86	0	4,706
Tennessee	525	0	0	8,273	2,590	1,037	119	1,558	0	0	25,539	0	1,215	40 856
Texas	115	172	248	36,756	6,784	0	0	5,230	100	10,509	78,821	842	3,028	140 605
Utah	0	918	0	6,359	1,913	0	0	0	0	0	10,075	182	0	19 347
Vermont	0	488	0	2,597	683	0	0	104	0	350	3,125	38	0	9 332
Virginia	0	86	0	8,359	1,765	0	102	2,813	42	0	13,556	668	10.001	37 392
Washington	0	277	36	9,861	4,797	0	210	0	0	0	47,073	0	184	62.438
West Virginia	0	0	0	3,492	1,851	963	0	201	0	0	10,856	68	72	17 503
Wisconsin	4	142	0	8,730	116	1,049	0	740	0	5,323	17,350	402	0	33 856
Wyoming	0	545	40	1,511	387	151	0	244	0	0	1,987	30	0	4 905
Puerto Rico	0	0	0	0	0	0	0	0	0	0	7,000	0	0	7 000
Virgin Islands	0	0	0	0	0	0	0	0	0	0	441	0	0	441
Territories	0	0	0	0	84	0	0	0	0	0	451	0	0	535
Total	$8,871	$38,991	$16,313	$661,128	$167,514	$38,908	$3,356	$89,749	$173	$73,930	$2,013,587	$24,497	$21,146	$3,021,669

Abbreviations: SIVS - Immigration Status Verification System. MMIS - Medicaid Management Information System.
SPMP - Skilled Professional Medical Personnel. PRO - Peer Review Organizations. DRUGU - Drug Utilization Review. PASR - Preadmission Screening
DRUGI - Drug Implementation costs. ADP - Automated Data Processing. NAT - Nurse Aide Training. OEW - Outstationed Eligibility Workers.
Source: HCFA Form 37, December 1992.

By 1991, 49 states had an MMIS in operation or under development. The installation costs are matched at 90 percent; the matching rate for system operating costs is 75 percent.

Skilled Professional Medical Personnel - 75 percent. This category applies to the compensation and training of professional medical personnel, and staff directly supporting medical personnel used in program administration.

Medical/Institutional Review and Peer Review Organizations - 75 percent. States are required to conduct ongoing internal reviews of the appropriateness of care provided by each institution. These activities are carried on by a utilization review committee at each institution, usually made up of the facility's own physicians and other professionals.

Drug Use Review - 75 percent. The Omnibus Budget and Reconciliation Act of 1990 required states to implement a drug utilization review program by January 1, 1993. These programs compare actual drug use data to a predetermined set of standards to expose any patterns of inefficiency.

Preadmission Screening Review - 75 percent. Preadmission screening review programs determine the efficacy of admitting a person to a hospital or nursing home before they are actually admitted.

All Other Administrative Costs - 50 percent. The federal share of medicaid administration covers 50 percent of all other medicaid administrative costs. These costs include those for: establishing a drug rebate system, installing and operating a non-MMIS automated data processing system, nurses aide training, and outstationed eligibility workers.

AFDC Administration

Under current law, the AFDC program provides enhanced matching rates for three categories of administrative costs. The full cost of installing a systematic alien verification of entitlement (SAVE) system, which determines applicant immigration status, is covered by federal funds. Federal funds may also be used to cover 90 percent of the costs of planning, design, development, and operation of statewide automated data processing systems. The matching rate for the establishment and implementation of fraud prevention programs is 75 percent. Table 2 shows the distribution of administrative costs among these functions.

Proposed Reduction in Administrative Matching Rates

The Administration's proposal would lower the federal matching rate for all medicaid, AFDC, and food stamp administrative costs to 50 percent starting on April 1, 1994.[1] According to documents supporting the plan, some states could receive waivers in "hardship cases". Those in favor of reducing these matching rates argue that the need for the incentives they provide has expired. For example, all state medicaid programs have automated data processing systems and fraud control programs Reducing the matching rates would encourage administrative efficiency. Opponents of the proposal believe that it would force states to reduce administrative costs at the expense of program efficiency, higher error rates, or reduced fraud control efforts.

Tables 3 and 4 show the effects on federal payments to states for medicaid and AFDC administration if the matching rates were lowered for all of fiscal year 1994. The Clinton administration's proposal would only affect payments for the second half of the fiscal year. As a rule of thumb, the effect of the

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A recent Congressional Budget Office study indicated that 4/5 of the total savings would come from medicaid, while AFDC and food stamps would account for the remaining savings. Data to calculate the impact on food stamp administration is not available at this time.

Table 2. Distribution of Federal AFDC Administration Payments by Matching Rates, 1994

(federal fiscal years, dollars in thousands)

State	Federal Share 100% SAVE	90% FAMIS	75% CFA	50% Other	TOTAL	Percent Matched at 100%	90%	75%	50%
Alabama	$1	$0	$525	$15,125	$15,651	0.01%	0.00%	3.35%	96.64%
Alaska	0	506	285	4,896	5,687	0.00%	8.89%	5.01%	86.09%
Arizona	20	557	0	22,246	22,823	0.09%	2.44%	0.00%	97.47%
Arkansas	2	200	500	6,231	6,932	0.03%	2.88%	7.21%	89.88%
California	15,000	0	15,000	429,350	459,350	3.27%	0.00%	3.27%	93.47%
Colorado	5	839	1,938	12,350	15,132	0.03%	5.67%	12.79%	81.51%
Connecticut	0	0	0	15,845	15,845	0.00%	0.00%	0.00%	100.00%
Delaware	0	706	96	4,138	4,940	0.00%	14.28%	1.94%	83.77%
Dist of Col	0	1,748	364	11,926	14,038	0.00%	12.45%	2.59%	84.96%
Florida	15	1,647	2,760	47,782	52,204	0.03%	3.15%	5.29%	91.53%
Georgia	1	1,083	1,471	28,298	30,854	0.00%	3.51%	4.77%	91.72%
Hawaii	1	697	0	5,828	6,526	0.02%	10.68%	0.00%	89.30%
Idaho	0	415	92	5,132	5,639	0.00%	7.36%	1.64%	91.01%
Illinois	17	1,495	0	37,666	39,178	0.04%	3.82%	0.00%	96.14%
Indiana	0	3,668	0	18,938	22,606	0.00%	16.22%	0.00%	83.78%
Iowa	1	342	0	8,371	8,714	0.01%	3.92%	0.00%	96.06%
Kansas	0	77	551	7,938	8,566	0.00%	0.89%	6.44%	92.67%
Kentucky	0	6,709	0	20,498	27,207	0.00%	24.66%	0.00%	75.34%
Louisiana	0	79	41	12,530	12,650	0.00%	0.63%	0.32%	99.05%
Maine	0	0	62	6,130	6,192	0.00%	0.00%	0.99%	99.01%
Maryland	21	1,419	627	27,342	29,409	0.07%	4.83%	2.13%	92.97%
Massachusetts	0	2,256	0	36,550	38,806	0.00%	5.81%	0.00%	94.19%
Michigan	0	6,504	0	81,237	87,741	0.00%	7.41%	0.00%	92.59%
Minnesota	0	6,165	2,730	24,966	33,861	0.00%	18.21%	8.06%	73.73%
Mississippi	0	653	0	7,662	8,315	0.00%	7.85%	0.00%	92.15%
Missouri	3	2,192	0	13,905	16,100	0.02%	13.62%	0.00%	86.36%
Montana	0	0	24	3,387	3,411	0.00%	0.00%	0.70%	99.30%
Nebraska	1	0	0	6,601	6,602	0.02%	0.00%	0.00%	99.98%
Nevada	11	1,467	279	6,863	8,620	0.13%	17.02%	3.24%	79.62%
New Hampshire	0	0	0	2,163	2,163	0.00%	0.00%	0.00%	100.00%
New Jersey	10	360	8,675	80,882	89,927	0.01%	0.40%	9.65%	89.94%
New Mexico	2	0	128	6,034	6,164	0.03%	0.00%	2.07%	97.90%
New York	0	0	0	265,524	265,524	0.00%	0.00%	0.00%	100.00%
North Carolina	1	0	0	29,627	29,628	0.00%	0.00%	0.00%	100.00%
North Dakota	1	432	0	1,832	2,265	0.04%	19.07%	0.00%	80.88%
Ohio	0	9,266	0	67,262	76,528	0.00%	12.11%	0.00%	87.89%
Oklahoma	1	827	446	20,196	21,470	0.00%	3.85%	2.08%	94.07%
Oregon	0	0	564	15,735	16,300	0.00%	0.00%	3.46%	96.54%
Pennsylvania	42	0	722	57,647	58,411	0.07%	0.00%	1.24%	98.69%
Rhode Island	290	90	0	3,032	3,412	8.50%	2.64%	0.00%	88.86%
South Carolina	0	2,724	0	9,027	11,751	0.00%	23.18%	0.00%	76.82%
South Dakota	0	142	47	1,956	2,145	0.00%	6.63%	2.17%	91.20%
Tennessee	1	3,677	221	15,612	19,511	0.01%	18.84%	1.13%	80.02%
Texas	99	477	2,004	44,794	47,373	0.21%	1.01%	4.23%	94.55%
Utah	15	891	3	5,986	6,895	0.22%	12.92%	0.04%	86.82%
Vermont	0	103	0	2,749	2,852	0.00%	3.60%	0.00%	96.40%
Virginia	0	130	8	20,786	20,923	0.00%	0.62%	0.04%	99.34%
Washington	100	0	0	36,257	36,357	0.28%	0.00%	0.00%	99.72%
West Virginia	1	1,689	0	3,511	5,201	0.02%	32.48%	0.00%	67.50%
Wisconsin	6	2,925	3,464	24,355	30,750	0.02%	9.51%	11.26%	79.20%
Wyoming	15	1,605	0	1,431	3,051	0.49%	52.60%	0.00%	46.91%
Total	**$15,683**	**$66,781**	**$43,625**	**$1,646,129**	**$1,772,218**	**0.88%**	**3.77%**	**2.46%**	**92.89%**

Abbreviations: SAVE - Systematic Alien Verification of Entitlement, FAMIS - Family Assistance Management Information System CFA - Control of Fraud and Abuse

Source: Administration for Children and Families, Form FSA-231, April 1992.

Table 3. Possible Full-Year Effects of Reducing Administrative Matching Rates for Medicaid to 50 Percent
(federal fiscal years, dollars in thousands)

State	Amount Matched at 100%	90%	75%	50%	1994 Total	Percent Matched at 100%	90%	75%	50%	Possible Cost Shift to States* Dollars	Percent
Alabama	$0	$387	$17,312	$9,992	$27,891	0.00%	2.10%	62.07%	35.83%	$6,052	21.63%
Alaska	0	257	6,682	4,599	11,538	0.00%	2.23%	57.91%	39.86%	2,342	20.29%
Arizona	8	40	3,713	53,175	56,936	0.01%	0.07%	6.52%	93.39%	1,259	2.21%
Arkansas	14	0	7,663	14,631	22,308	0.06%	0.00%	34.35%	65.59%	2,561	11.48%
California	3,000	324	117,802	500,188	623,314	0.80%	0.05%	18.90%	80.25%	41,911	6.72%
Colorado	0	273	10,829	12,834	23,888	0.00%	0.94%	45.33%	53.75%	3,710	15.53%
Connecticut	0	157	7,171	22,508	29,836	0.00%	0.53%	24.03%	75.44%	2,460	8.25%
Delaware	0	1,050	4,594	4,490	10,114	0.00%	10.18%	45.42%	44.39%	1,989	19.67%
Dist of Col	0	1,036	4,776	8,170	13,982	0.00%	7.41%	34.16%	58.43%	2,052	14.68%
Florida	142	0	26,225	113,882	140,249	0.10%	0.00%	18.70%	81.20%	8,813	6.28%
Georgia	0	0	38,788	49,563	88,351	0.00%	0.00%	43.90%	56.10%	12,929	14.63%
Hawaii	0	0	3,991	6,522	10,513	0.00%	0.00%	37.60%	62.40%	1,330	12.53%
Idaho	0	119	7,888	7,676	15,683	0.00%	0.76%	50.30%	48.94%	2,682	17.10%
Illinois	4	22	35,822	85,600	121,248	0.00%	0.02%	29.38%	70.60%	11,886	9.80%
Indiana	0	0	3,009	26,404	29,413	0.00%	0.00%	10.23%	89.77%	1,005	3.41%
Iowa	2	684	8,766	15,107	24,559	0.01%	2.79%	35.69%	61.51%	3,227	13.14%
Kansas	0	0	7,853	8,451	16,304	0.00%	0.00%	48.17%	51.83%	2,618	16.06%
Kentucky	4	144	12,093	16,682	28,923	0.01%	0.50%	41.81%	57.68%	4,097	14.17%
Louisiana	0	0	20,868	39,027	59,895	0.00%	0.00%	34.84%	65.16%	6,956	11.61%
Maine	0	0	4,567	8,911	13,478	0.00%	0.00%	33.88%	66.12%	1,522	11.29%
Maryland	38	6,134	20,528	48,905	75,623	0.05%	8.14%	27.15%	64.67%	9,597	12.69%
Massachusetts	0	45	17,401	46,537	63,983	0.00%	0.07%	27.20%	72.73%	5,820	9.10%
Michigan	0	382	29,282	72,940	102,604	0.00%	0.37%	28.54%	71.09%	9,930	9.68%
Minnesota	0	6,495	8,548	54,296	69,339	0.00%	9.37%	12.33%	78.31%	5,736	8.27%
Mississippi	0	261	12,252	11,288	23,801	0.00%	1.10%	51.48%	47.43%	4,200	17.65%
Missouri	0	0	8,739	26,779	35,518	0.00%	0.00%	24.60%	75.40%	2,913	8.20%
Montana	0	0	1,998	5,076	7,074	0.00%	0.00%	28.24%	71.76%	666	9.41%
Nebraska	0	180	6,650	9,543	16,373	0.00%	1.10%	40.62%	58.28%	2,297	14.03%
Nevada	0	10,349	2,282	8,604	21,215	0.00%	48.78%	10.66%	40.56%	5,354	25.23%
New Hampshire	0	172	6,654	4,831	11,657	0.00%	1.48%	57.08%	41.44%	2,294	19.68%
New Jersey	0	3,922	18,136	75,835	97,893	0.00%	4.01%	18.53%	77.47%	7,788	7.96%
New Mexico	1	28	6,348	6,589	12,966	0.01%	0.22%	48.96%	50.82%	2,129	16.42%
New York	0	9,270	97,153	180,710	287,133	0.00%	3.23%	33.84%	62.94%	36,504	12.71%
North Carolina	0	0	8,686	50,985	59,671	0.00%	0.00%	14.56%	85.44%	2,895	4.85%
North Dakota	0	0	1,509	5,128	6 637	0.00%	0.00%	22.74%	77.26%	503	7.58%
Ohio	0	1,632	26,471	68,747	96,850	0.00%	1.69%	27.33%	70.98%	9 549	9 86%
Oklahoma	1	416	12,184	35,869	48,470	0.00%	0.86%	25.14%	74.00%	4,247	8.76%
Oregon	0	1,005	16,755	37,791	55,551	0.00%	1.81%	30.16%	68.03%	6,032	10.86%
Pennsylvania	8	86	37,889	89,787	127,770	0.01%	0.07%	29.65%	70.27%	12,672	9.92%
Rhode Island	5	5,266	482	11,092	16.845	0.03%	31.26%	2.86%	65.85%	2,504	14.86%
South Carolina	0	2,045	13,632	20,778	36.455	0.00%	5.61%	37.39%	57.00%	5,453	14.96%
South Dakota	0	0	1,180	3,526	4,706	0.00%	0.00%	25.07%	74.93%	393	8.36%
Tennessee	525	0	13,579	26,754	40.858	1.28%	0.00%	33.23%	65.48%	4,789	11.72%
Texas	115	420	48,770	91,300	140 605	0.08%	0.30%	34.69%	64.93%	16.501	11.74%
Utah	0	918	8,172	10,257	19 347	0.00%	4.74%	42.24%	53.02%	3,132	16.19%
Vermont	0	406	3,744	5,372	9 522	0.00%	4.26%	39.32%	56.42%	1,428	15.00%
Virginia	0	86	15,039	24,267	37,392	0.00%	0.23%	34.87%	64.90%	4,385	11.73%
Washington	0	313	14 846	47,257	62,438	0.00%	0.50%	23.81%	75.69%	5,095	8.16%
West Virginia	0	0	6,507	10,996	17 503	0.00%	0.00%	37.18%	62.82%	2,189	12.39%
Wisconsin	6	142	10,635	23,075	33 856	0.01%	0.42%	31.41%	68.16%	3,610	10.66%
Wyoming	0	585	2,505	2,017	4 905	0.00%	11.93%	46.95%	41.12%	1,028	20.95%
Puerto Rico	0	0	0	7,000	7 000	0.00%	0.00%	0.00%	100.00%	0	0.00%
Virgin Islands	0	0	0	441	441	0.00%	0.00%	0.00%	100.00%	0	0.00%
Territories	0	0	84	451	535	0.00%	0.00%	15.70%	84.30%	28	5.23%
Total	$6,871	$48,283	$836,683	$2,133,333	$3,021,089	0.19%	1.83%	27.36%	70.61%	$303,021	10.03%

*These estimates assume that the matching rates are lowered at the beginning of FY 1994, October 1, 1993.
The Clinton administration's proposal would not go into effect until April 1, 1994
Source: HCFA Form 37, December 1992.

Table 4. Possible Full-Year Effects of Reducing Administrative Matching Rates for AFDC to 50 Percent
(federal fiscal years, dollars in thousands)

State	1994 Total AFDC Administration	Possible Cost Shift to States* SAVE	FAMIS	CFA	TOTAL	Percent Reduction
Alabama	$15,451	$1	30	$175	$176	1.12%
Alaska	5,687	0	225	95	320	5.62%
Arizona	22,823	10	248	0	258	1.13%
Arkansas	6,932	1	89	167	256	3.70%
California	459,350	7,500	0	5,000	12,500	2.72%
Colorado	15,152	3	382	646	1,030	6.80%
Connecticut	15,845	0	0	0	0	0.00%
Delaware	4,940	0	314	32	346	7.00%
Dist of Col	14,038	0	777	121	898	6.40%
Florida	52,204	8	732	920	1,660	3.18%
Georgia	30,854	1	482	490	973	3.15%
Hawaii	6,526	1	310	0	310	4.75%
Idaho	5,639	0	184	31	215	3.82%
Illinois	39,178	9	664	0	673	1.72%
Indiana	22,606	0	1,630	0	1,630	7.21%
Iowa	8,714	1	152	0	153	1.75%
Kansas	8,566	0	34	184	218	2.54%
Kentucky	27,207	0	2,982	0	2,982	10.96%
Louisiana	12,650	0	35	14	49	0.38%
Maine	6,192	0	0	21	21	0.33%
Maryland	29,409	11	631	209	850	2.89%
Massachusetts	38,806	0	1,003	0	1,003	2.58%
Michigan	87,741	0	2,891	0	2,891	3.29%
Minnesota	33,861	0	2,740	910	3,650	10.78%
Mississippi	8,315	0	290	0	290	3.49%
Missouri	16,100	2	974	0	976	6.06%
Montana	3,411	0	0	8	8	0.23%
Nebraska	6,602	1	0	0	1	0.01%
Nevada	8,620	6	652	93	751	8.71%
New Hampshire	2,163	0	0	0	0	0.00%
New Jersey	89,927	5	160	2,892	3,057	3.40%
New Mexico	6,164	1	0	43	44	0.71%
New York	265,524	0	0	0	0	0.00%
North Carolina	29,628	1	0	0	1	0.00%
North Dakota	2,265	1	192	0	193	8.50%
Ohio	76,528	0	4,118	0	4,118	5.38%
Oklahoma	21,470	0	368	149	517	2.41%
Oregon	16,300	0	0	188	188	1.15%
Pennsylvania	58,411	21	0	241	262	0.45%
Rhode Island	3,412	145	40	0	185	5.42%
South Carolina	11,751	0	1,211	0	1,211	10.30%
South Dakota	2,145	0	63	16	79	3.67%
Tennessee	19,511	1	1,634	74	1,708	8.76%
Texas	47,373	49	212	668	929	1.96%
Utah	6,895	8	396	1	405	5.87%
Vermont	2,852	0	46	0	46	1.60%
Virginia	20,923	0	58	3	60	0.29%
Washington	36,357	50	0	0	50	0.14%
West Virginia	5,201	1	751	0	751	14.44%
Wisconsin	30,750	3	1,300	1,155	2,458	7.99%
Wyoming	3,051	8	713	0	721	23.62%
Total	$1,772,218	$7,843	$29,680	$14,542	$52,063	2.94%

Abbreviations: SAVE - Systematic Alien Verification of Entitlement, FAMIS - Family Assistance Management Information System
CFA - Control of Fraud and Abuse

*These estimates assume that the matching rates are lowered at the beginning of FY 1994, October 1, 1993.
The Clinton administration's proposal would not go into effect until April 1, 1994.
Source: Administration for Children and Families, Form FSA-231, April 1992.

Administration's proposal would be about half of that shown in table 3 and 4. However, states might respond to the proposal by shifting more administrative costs into the first half of the fiscal year. The tables are intended to show the relative impact of the proposal on each state.

In general, states with relatively large proportions of their funds matched at more than 50 percent would experience the largest cost shifts. For medicaid, the largest reductions in federal funding would occur in Nevada (-$5.5 million, 25.2%), Alabama (-$6.0 million 21.6%), Wyoming (-$1.0 million, 21%), Alaska (-$2.4 million, 20.3%), New Hampshire (-$2.3 million, 19.7%), and Delaware (-$2.0 million, 19.7%). Of the total savings of $303 million, 32 percent would come from savings in California (-$42 million, 6.8%), New York (-$37 million, 12.7%), and Texas (-$16.5 million, 11.8%).

Reducing the AFDC administrative matching rates starting October 1, 1993, would save the federal government $52 million, a 2.9% reduction from current estimates. States most affected by a reduction in administrative matching rates for AFDC include Wyoming (-$721 thousand, 23.6%), West Virginia ($751 thousand, 14.4%), Kentucky (-$2.9 million, 11.0%), Minnesota (-$3.7 million, 10.8%), and South Carolina (-$1.2 million, 10.3%). Connecticut and New York, which currently share all of their administrative costs at 50 percent, would not be affected by the proposal. Nebraska and North Carolina would receive reductions of less than $1,000.

Outlook

Specific information on this proposal will likely be included in the Administration's *1994 Budget*, scheduled to be released on April 5, 1993. Congress will then consider the proposal as part of the 1993 Congressional budget resolution and reconciliation bill later this spring and summer. A similar proposal was rejected by Congress when the Bush administration included it in its *1990 Budget*.

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PREPARED STATEMENT OF DONNA E. SHALALA

Mr Chairman and members of the Committee. I am honored to appear before you today to discuss the proposals in President Clinton's economic package that fall within this Committee's jurisdiction. Although most of the decisions on proposals affecting the programs within the Committee's jurisdiction have been made, details regarding a few proposals are still being developed. I will keep the Committee informed of all final decisions.

The President has undertaken an ambitious agenda to strengthen the economy, create jobs, and promote economic security for American families. To protect our future, he has presented to Congress and the American people a bold plan that will stimulate economic growth both by investing wisely in the American people and by cutting the Federal deficit. We must take this historic opportunity to do both, and we must act quickly.

Important changes in the major programs within the Committee's jurisdiction are central to this investment and deficit reduction process. The success of major portions of the President's plan rests in your hands. We will rely on your considerable expertise and your involvement in our efforts. We are eager to work with you. Now, I would like to address the proposals under the topics of Health Care Reform, Welfare and Family support Programs, and Social Security.

HEALTH CARE REFORM AND MEDICARE/MEDICAID

In the area of health care, one of the most significant investments in America's future will be to reform our health care system. As a member of the Task Force on Health Care Reform, chaired by Mrs. Clinton, I would like to express my appreciation to this Committee for its diligence in working toward consensus on health care reform over the years. I know that we will all benefit from your experiences as we continue to work for fundamental systemic change.

You know as well as I that neither long-term deficit reduction nor serious investment in America's future can be accomplished in the absence of health care reform. One half of the projected increase in the Federal deficit over Fiscal Years 1994 through 1998 is due to growth in Medicare and Medicaid spending. Health care spending will rise from 14 percent to 19 percent of the gross domestic product (GDP) by the end of this decade, crowding out other demands for resources and opportunities for economic security.

The President has promised that the health care reform plan he presents to you in May will control health care costs and guarantee families the security of health coverage. In so doing, the plan will build a stronger, more rational health care service delivery system that relies on prevention and primary care, protects quality, guards against bureaucratic inefficiencies, and responds to the needs of real people.

The daunting task of cost containment must include short term measures and more comprehensive reforms to stabilize public and private health care spending in the long run.

This task begins in the President's deficit reduction plan. Our proposed Medicare savings are a *down payment* on our overall cost control effort. These proposals are intended to reduce the deficit without major structural reforms. structural reforms are considered more appropriate within the context of overall health care reform.

The Medicare deficit reduction proposals are not "cuts." Rather, they will curb the rate of Medicare spending growth from 13 percent to 11 percent annually. Most of the savings are from health care services providers, not beneficiaries. We have intentionally limited reductions in Medicaid.

A more detailed written description of the Medicare and Medicaid proposals, as well as those for human services and social security, are attached to my statement, which, with your permission, I would like to provide for the hearing record.

In *Medicare Part A*, the President has proposed an extension of the current policy of increasing hospital payments at a rate less than the market basket rate of increase and moving this annual increase from October to January similar to the update for other Medicare services. Other changes under Medicare Part A include:

- Gradually lowering Medicare indirect medical education payments to teaching hospitals;
- Extending the current provision in statute whereby inpatient hospital capital payments are reduced by 10 percent;
- Revising Medicare direct medical education subsidies to favor training for primary care and basing payments on a national per-resident amount, rather than a hospital-specific amount;
- Eliminating the hospital-based home health agencies' upward adjustment to their per-visit cost limits; and

- Eliminating Medicare return on equity payments to proprietary skilled nursing facilities.

In *Medicare Part B,* current law provision sets the premium at specific dollar amounts through 1995. our proposal would index the 1995 premium by the Social Security Cost of Living Adjustment (COLA) to establish the 1996 premium. In 1997 and subsequent years, the premium would be set to finance the same proportion of program costs as was financed by the premium in 1996.

Other Medicare Part B proposals include:

- Extending the current requirement that hospital outpatient capital payments be reduced by 10 percent;
- Reducing caps for clinical laboratory services and extending the current law 2 percent ceiling on updates;
- Providing the full update for primary care services and 2 percentage points less than the full update for non-primary care services;
- Beginning movement towards a resource-based system for practice expenses under the physician fee schedule;
- Changing the default formulas under the Medicare volume performance standard (MVPS) program to provide for a spending growth rate that is closer to that for GDP;
- Bundling payments for inpatient radiology, anesthesia and pathology services into a fixed payment per discharge;
- Encouraging the submission of Part S claims via electronic format by reducing payments by $1 per paper claim beginning in 1996;
- Establishing a single fee for surgery regardless of whether the primary surgeon uses an assistant-at-surgery;
- Extending physician ownership and referral prohibitions to additional services;
- Reducing payments for durable medical equipment by tightening the national limits; reclassifying certain items; and giving Medicare's contractors more authority and flexibility in certain areas; and
- Reducing payment for epogen (EPO) from $11 per 1,000 units to $10 per 1,000 units.

For *Medicare Parts A and D,* we propose to extend and standardize secondary payment rules for certain disabled beneficiaries and for beneficiaries with end stage renal disease.

Under the *Medicaid* program, the Administration proposes to give States the option of paying for personal care services outside of an individual's home. Under current law, this would be mandatory in 1995.

Other Medicaid proposals include:

- Allowing States to use drug formularies that would give the States more flexibility to insure more effective use of Medicaid drugs;
- Tightening numerous loopholes in the current laws that allow persons with substantial assets to qualify for Medicaid; and
- Reducing the Federal administrative cost matching rate to 50 percent for the jointly administered Federal/State programs. The administrative cost matching also would apply to the Aid to Families with Dependent Children (AFDC) and Food Stamp programs.

In addition, we will continue our efforts to identify cases where *Medicare and Medicaid* made a mistaken primary payment for services when a beneficiary had other primary insurance, either public or private.

Also under the topic of health care, I would like to highlight another important program with your jurisdiction: the *Maternal and Child Health Block Grant.* Administered as a Federal/State partnership, this program provides funds to all States to provide a broad range of health services, including preventive and primary care services and assistance for children with special health care needs.

Mr. Chairman, we are committed to improving the health status of our children, and this program is a key element in achieving that goal. For Fiscal Year 1994, the President's economic and deficit reduction plan proposes major funding increases that will improve maternal and child health such as the expansion of the Head Start program, early childhood immunization services, Women, Infant and Children (WIC) nutrition programs at the Department of Agriculture, and other preventive health programs at Health and Human Services (HHS).

WELFARE AND FAMILY SUPPORT PROGRAMS

Chairman Moynihan, your efforts to improve the status of low-income and disadvantaged people have been exemplary and have yielded significant progress al-

ready. The President and I have pledged to join with you to move further—to strengthen child support enforcement, to improve family support services, and to end welfare as we know it.

Any meaningful further efforts must obviously focus on moving people off welfare and out of poverty through increased opportunity and responsibility. They must emphasize the need for people to have real control over their lives, to live in dignity, and to support and nurture their families.

I want to take this opportunity to reiterate that this Administration is committed to reforming our welfare system. Our goal is to change the welfare system by:

- Making work pay; people who work should not be poor.
- Transforming the child support enforcement system to hold absent parents financially responsible for their children;
- Providing people who can work with the training and support they need to move off of welfare; and
- Making cash welfare a transitional program.

President Clinton's budget already includes a bold start on this reform agenda. The budget contains a major increase in the Earned Income Tax Credit (EITC). The money reinforces work by providing tax credits for working families. This amounts to a pay raise for the working poor. The majority of working poor families have two parents. This will help end their poverty. Single parents on welfare can't escape welfare if work does not pay. The EITC expansion represents the first part of a strongly pro-family, pro-work agenda.

The budget also contains some changes in the child support enforcement system. We will move rapidly to insure that paternities are established in the hospital, at birth, through voluntary paternity acknowledgement. Experiments in several states have demonstrated remarkable success in increasing paternities and reducing administrative costs in this way. We will also seek to insure that medical support orders are obtained as part of every child support award. such a strategy would help ensure that children get the medical protection they deserve and would eliminate unnecessary Medicaid expenditures when an absent parent can provide coverage.

These are not the end of the welfare reform process, they are the beginning. Health reform will protect people who currently hesitate to leave welfare for fear of losing their Medicaid coverage. Welfare reform will do even more to substitute work for welfare. Much more will be done on child support enforcement. And transitional welfare strategies are still to come. The budget is a powerful downpayment on the President's commitment to end to welfare as we know it.

The President's plan also includes measures to further strengthen American families. The President recently announced that he will submit a proposal for a new capped entitlement program for innovative child welfare services such as family preservation and for community-based parenting and family support services. This program will total $60 million in 1994 and rise to $600 million in 1997. In addition, over five years, $2.74 billion in new discretionary funds will be allocated for drug treatment programs through Public Health Service grants. Priority in these grants will be given to women and children involved with, or at-risk of being involved with, the child welfare system. I look forward to working with this committee to ensure the speedy passage of this important legislation.

In addition, we propose a major expansion of the Head start program, beginning with $500 million in the economic stimulus package for the continuation of programs through this summer. Further rapid increases will bring the program to $7.7 billion in Fiscal Year 1998. As we expand Head start services, we will focus on the need to improve its quality and responsiveness to the needs of the families and communities it serves. This is a vital program, providing comprehensive services and support to children and their families.

Finally, the President's plan includes additional funding for the Child Care and Development Block Grant. This program provides much needed support to help low-income families who need child care services in order to work.

With these proposals, we will begin, with your help, to provide all families with the ability to move their families out of poverty.

SOCIAL SECURITY

For over fifty years, Social Security—the largest Federal program of all—has been a source of financial security and stability for millions of Americans. No single program—public or private—has protected the financial well-being of as many people as social security, and we must continue to invest in it. President Clinton is pursuing the twin goals of investment and deficit reduction in the social security program

by proposing stimulus monies and long term investments in the efficiency and services of the Social Security Administration (SSA).

The President's Fiscal Year 1993 Supplemental Budget Request includes monies to reduce the backlog of disability claims, SSA's most pressing problem, and to improve automation and infrastructure. Multi-year investments will be used to continue the critical modernization of SSA. This investment will permit a long-needed computer system redesign and lay the groundwork for more advanced automation systems that are necessary to "modernize" our social security operation.

President Clinton also believes that all groups must contribute to deficit reduction. Therefore, he proposes to increase the percentage of taxable Social Security benefits for individuals who are already taxed. I want to emphasize that this will not increase the number of people paying taxes on their Social Security benefits. Only those with higher incomes, who already pay some taxes on benefits, will have those taxes increased.

Second, we propose to charge a fee to States for which the Social Security Administration administers a State Supplement of the Federal Supplemental Security Income (551) program. The Federal government incurs costs for all States for which it administers the State Supplement, and we are asking that States pay their share of these costs.

CONCLUSION

President Clinton's economic package provides a strong foundation for our national prosperity by stimulating the economy, investing in our future, and reducing the deficit. Our impending health care reform package and our future welfare reform actions will build upon this foundation.

Mr. Chairman, I look forward to working closely with this Committee as we move through the budget reconciliation process, strive for health care and welfare reform, and develop subsequent initiatives to improve the lives of all Americans. I will be happy to answer any questions you may have.

Attachments.

PROPOSALS

MEDICARE - PART A

1. **Extend the 10% Reduction Hospital Capital Payments**

Under current law, Medicare payments for hospital capital under both Part A (inpatient) and Part B (outpatient) are reduced by 10 percent, through FY 1995. This proposal would permanently extend that 10% reduction. Paying hospitals less than their full cost of capital provides a strong incentive to evaluate the need for capital investment and thus places an important brake on the unnecessary proliferation of plant and equipment. In addition, hospital occupancy rates have averaged below 70% for several years; Medicare should not subsidize this excess capacity. This proposal is consistent with the Department's Inspector General recommendations.

Savings (in millions)

	FY 1994	4-Year Total
Part A	$0	$680
Part B	$0	$260

2. **Set the PPS Hospital Update at Market Basket Minus 1% in FY 1994 and FY 1995**

This proposal would continue the current practice of setting hospital updates below the market basket rate of increase by setting the update at the market basket rate of increase minus one percentage point for each of FYs 1994 and 1995. Maintaining an update less than the full market basket rate of increase provides continuing incentives for hospitals to increase efficiency in operations. It would also offset a previous forecast error. This reduction is consistent with the recommendation Prospective Payment Assessment Commission (ProPAC) is expected to make for FY 1994.

Savings (in millions)

FY 1994	4-Year Total
$550	$5,190

3. **Move the Annual Changes in the Prospective Payment System (PPS) Updates to January 1 of Each Year, Beginning with FY 1994**

Under current law, the annual PPS changes and updates become effective each year on October 1, absent Congressional action. This proposal would move the effective date for annual PPS changes to January 1, to conform to the January update cycle for most of the Medicare program. In addition, a definite January 1 date would alleviate the uncertainty and disruption which occurs when the Congressional legislative cycle goes beyond October 1.

Savings (in millions)

FY 1994	4-Year Total
$1,000	$4,610

4. **Phase In a Reduction in the IME Payment Adjustment Ratio**

Under current law, Medicare pays hospitals for its share of the indirect medical education (IME) costs associated with the use of interns and residents. The IME payment factor is derived from a formula that relates operating costs per case to the intensity of the hospital's teaching program. This proposal would alter the adjustment formula to reduce the extra payment amounts beginning in FY 1996. Numerous studies by HCFA, the Prospective Payment Assessment Commission (ProPAC), the GAO and the IG show that the current adjustment formula overstates the increase in costs resulting from the presence of interns and residents.

Savings (in millions)

FY 1994	4-Year Total
$0	$1,940

5. **Reform Medicare Payments for Direct Medical Education Costs**

Under current law, Medicare payment for the direct costs of graduate medical education (GME) are based on each hospital's per resident costs. This proposal would base GME payments on a national average per resident amount, and would give greater weight to primary care residencies. Using national averages would address present inequities in direct GME payments, whereby some providers are paid five times as much per resident as others. Moreover, this proposal would provide an incentive for programs to recruit and train primary care residents.

Savings (in millions)

FY 1994	4-Year Total
$350	$1,360

6. **Eliminate Add-on for Hospital-based Home Health Agencies (HHAs)**

Under current law, hospital based home health agencies (HHAs) receive an upward adjustment to their per-visit cost limits. This proposal would eliminate this adjustment, making freestanding and hospital-based HHAs subject to the same cost limits. The current adjustment is not necessary; roughly half of hospital-based HHAs do not exceed the cost limits for freestanding clinics. Eliminating the adjustment would provide incentives for the remaining hospital-based HHAs to become more efficient, and would level the playing field so that hospital-based HHAs do not have a competitive advantage over freestanding HHAs.

Savings (in millions)

FY 1994	4-Year Total
$160	$840

7. **Eliminate Return On Equity Payments to Proprietary Skilled Nursing Facilities**

Proprietary Skilled Nursing Facilities (SNFs) are the only remaining category of providers that receive payment for Return on Equity (ROE) from Medicare. Non-proprieta_ SNFs do not

receive ROE payments. This proposal would eliminate Medicare ROE payments to proprietary SNFs, thus creating fair competition between SNFs.

Savings (in millions)

FY 1994	4-Year Total
$110	$560

MEDICARE - PART B

1. Maintain Part B Premium as Proportion of Program Costs

Under current law, the amount of the Part B premium is set in law through 1995. The premium amounts were set by Congress in OBRA 90 so as to finance approximately 25 percent of program costs through premium collections. The proposal would index the 1995 premium by the Social Security Cost of Living Adjustment (COLA) to establish the 1996 premium. In 1997 and subsequent years, the premium would be set to finance the same proportion of program costs as was financed by the premium in 1996.

Savings (in millions)

FY 1994	4-Year Total
$0	$5,015

2. Increase Hospital Outpatient Cut

Currently, certain outpatient services are paid at 94.2% of costs. This proposal would extend that reduction and would further reduce the level to 90% of costs beginning with services rendered during fiscal years 1996 and thereafter making the reduction consistent with the reduction in payment for outpatient capital.

Savings (in millions)

FY 1994	4-Year Total
$0	$1,640

3. Reduce Payments for Clinical Laboratory Services and Adjust Fees for Market Factors

This proposal would limit the Medicare Part B laboratory fee schedule to 76 percent of the median of all fees. This revised fee schedule would be updated annually by 2 percent-- an extension of the current law established in OBRA-90. Finally, based on market surveys, the Secretary of HHS would make additional adjustments in Medicare rates to laboratories to reflect technological changes and other factors. Studies indicate that Medicare payments to laboratories are excessive, and they should more closely reflect decreased costs attributed to technological advances such as increased automation, and changes in the market, such as lower cost equipment.

Savings (in millions)

FY 1994	4-Year Total
$420	$3,830

4. **Reduce Physician Fees in 1994 Except Primary Care**

For FY 1994, this proposal would give the full physician fee schedule update for primary care services, and approximately two percentage points less than the full update for all other services. Medicare spending on physicians increased extensively during the 1980s.

Savings (in millions)

FY 1994	4-Year Total
$200	$1,250

5. **Resource-Based Practice Expenses Phase-In**

This proposal would phase-in to a resource-based system for practice expenses under the physician fee schedule beginning in 1997, a suggestion made by the 1993 Physician Payment Review Commission. As an interim step toward such a system, this proposal would reduce practice expense relative value units in 1994, 1995 and 1996. A cushion on reductions would be provided while the methods and details to implement a full resource-based system for practice expenses are developed between now and 1997.

Savings (in millions)

FY 1994	4-Year Total
$100	$2,025

6. **Reduce Physician MVPS and Update "Default" Formulas**

This proposal refines the method by which Medicare increases payments to physicians. If Congress does not set the rate of increase in Medicare physician expenditures (the Volume Performance Standard) or the update, a default formula specified in law automatically applies. This proposal would reduce the target for FY 1994 and thereafter by reducing the amount that the default formula would allow. The proposal would similarly reduce the formula for the default update.

Currently there are only modest reductions in this rate of growth. This proposal would lower the rate of growth to be more in line with recommendations made by the Physician Payment Review Commission.

Savings (in millions)

FY 1994	4-Year Total
$0	$850

7. **Bundle Inpatient Radiology, Anesthesia and Pathology Payments**

Medicare payments for radiology, anesthesia and pathology services provided in the hospital setting would be bundled into the DRG. Payment would be made to the hospital or to its medical staff which would then make payments to individual physicians. Beneficiary coinsurance would be 20 percent of the bundled payment.

Bundling payment for inpatient radiology, anesthesia and pathology services is a structural reform that deals with the total expenditures of these services, rather than on the fee for each specific service. This approach would give physicians and hospitals incentives to be cost-conscious, provide only medically necessary services and eliminate the provision of marginal services.

Savings (in millions)

FY 1994	4-Year Total
$0	$390

8. **Single Fee For Surgery**

Under this proposal, Medicare would make the same payment for a surgical procedure regardless of whether the primary surgeon used an assistant-at-surgery, a practice that varies greatly throughout the country. Medicare payment for the primary surgeon would be reduced by the amount of any separate payment for assistant-at-surgery used by the surgeon. Exceptions would be allowed if necessary for particularly difficult cases.

Data on extensive geographic variation in use of assistants-at-surgery and extensive use of primary care physicians as assistants strongly suggests that use of assistants-at-surgery is related to practice styles of individual surgeons and customary patterns in local areas, rather than the characteristics of specific patients (such as severity). This proposal would create a level playing field between surgeons who do and do not use assistants-at-surgery.

Savings (in millions)

FY 1994	4-Year Total
$50	$380

9. **Physician Ownership and Referral**

Physicians cannot refer a Medicare patient to a clinical laboratory in which the physician, or the physician's relative, has a financial relationship. This proposal would extend ownership and referral prohibitions to additional services such as: physical and occupational therapy; radiology and other diagnostics; radiation therapy; durable medical equipment, parenteral/enteral nutrition equipment and supplies. Various studies have demonstrated that physicians who have ownership interests make referrals at a higher rate than non-owners. The extension of the referral ban should help to reduce unnecessary utilization of services.

Savings (in millions)

FY 1994	4-Year Total
$0	$250

10. **Electronic Billing Incentive**

This proposal would create an incentive to encourage submission of Medicare Part B claims via electronic format by charging $1 per paper claim beginning January 1, 1996. This incentive is

critical to containing and lowering Medicare administrative costs. The lead time will give physician and suppliers time to adjust their systems or arrange to purchase electronic billing services.

Savings (in millions)

FY 1994	4-Year Total
$0	$265

11. **DME Proposals**

Payment for durable medical equipment (DME) is based on carrier fee schedules with national limits at the average value across all carriers. Payment for DME would be reduced by: tightening the national limits; reclassifying certain items; restoring Medicare's contractors authority to make adjustments to the fee schedules if the payments amounts are grossly excessive or deficient based on current price information; and giving Medicare's contractors flexibility to require that the medical need of an item be demonstrated in advance of delivery to the patient.

In addition, the fee schedule for prosthetics and orthotics would be tightened by using the DME payment rules with the national median as the limit. Finally, the budget proposes to establish a fee schedule to pay for parenteral and enteral nutrients and supplies, and to pay for parenteral and enteral equipment under the same fee schedule and methodology used for DME.

These proposals as a package will reduce excessive variation in payment amounts and strengthen administration of the DME benefit.

Savings (in millions)

FY 1994	4-Year Total
$75	$510

12. **Set EPO at Non-U.S. Market Rates ($10 per 1,000 Units**

Under current law, Medicare pays $11 per 1,000 units of EPO. Under this proposal, that amount would be reduced to $10 per 1,000 units of EPO.

Unlike other drugs in the medical marketplace, only one pharmaceutical company manufactures EPO, and Medicare purchases 90 percent of EPO supplies. This lack of competition in the marketplace has grossly inflated the cost of EPO and has contributed to consistent price increases over time.

The proposed payment amount would reduce the disparity between Medicare's current reimbursement rate and the actual cost that facilities pay for EPO, based on recent findings from the Department's Inspector General.

Savings (in millions)

FY 1994	4-Year Total
$30	$160

MEDICARE - PART A & B

1. **Extend IRS/SSA/Data Match**

OBRA 89 created a program for using data available to the government in conjunction with questionnaires to employers to identify situations where Medicare made a mistaken primary payment rather than the secondary payment required under the law for certain beneficiaries. This program is expected to lead to the recovery of billions of dollars of mistaken payments. This proposal would extend the authorization of the data match through 1998.

Savings (in millions)

FY 1994	4-Year Total
$0	$165

2. **Extended Provision Requiring Secondary Payment for Certain Disabled Beneficiaries**

Under current law, Medicare makes a secondary, rather than primary, payment for disabled beneficiaries who have health coverage through certain employer group health plans. This results in savings to the program and allows Medicare dollars to be spent on services for individuals who do not have employment related health insurance coverage. The authority for this provisions expires at the end of fiscal year 1995. This proposal would make the authority permanent.

Savings (in millions)

FY 1994	4-Year Total
$0	$1,610

3. **Extended Provision Requiring Secondary Payment for Certain Beneficiaries with End Stage Renal Disease (ESRD)**

Under current law, Medicare makes a secondary, rather than primary, payment for beneficiaries with ESRD who have health coverage through a group health plan. Medicare makes these secondary payments for the first 18 months of entitlement. After this 18-month period, Medicare makes primary payment. As with the provision related to the disabled described above, this policy results in savings to the program. The authority for this provision expires at the end of 1995. This proposal would make the authority permanent.

Savings (in millions)

FY 1994	4-Year Total
$0	$70

4. **Medicare Secondary Payor Reforms**

Under current law, Medicare is the secondary payor for certain beneficiaries with coverage through group health plan. Rules for determining whether a beneficiary is subject to these provisions differ depending on whether the beneficiary is aged, disabled or has ESRD. This proposal would make all of the employer thresholds consistent with the aged provisions (employers of 20 or more). The threshold for disability provision would be

reduced from 100 to 20 and a threshold would be created for beneficiaries with ESRD (currently there is none). In addition, the provisions for the disabled would be liberalized to tie directly to employment status as is the case with the aged provisions. Finally, the exemption from the MSP provisions for persons with ESRD who are also aged or disabled would be eliminated. Payments for these individuals would be treated the same as with payment for beneficiaries entitled to Medicare solely because of ESRD. These provisions will simplify the Medicare Secondary Payor program and generate budget savings. In addition to these changes to simplify the MSP program, the budget includes a number of minor proposals to strengthen program administration.

Savings (in millions)

FY 1994	4-Year Total
$127	$947

MEDICARE AND MEDICAID

1. Third Party Liability

This proposal would remove many of the structural impediments hindering proper identification and billing of third party liability (TPL) by: 1) requiring employers to report employment based health coverage data annually on the W-2; 2) granting access to this data to all federally-assisted and financed health programs (Medicare, Medicaid, Veterans Affairs Health, CHAMPUS, and others); 3) reinforcing existing coordination of benefits (which payer pays and in what order) laws and regulation; and 4) removing impediments that hinder States from collecting from private insurers.

Savings (in millions)

FY 1994	4-Year Total
$0	$800

MEDICAID

1. Medicaid Personal Care Services

This proposal maintains as a State option that the Medicaid program pay for personal care services outside of an individual's home. This proposal corrects a legislative drafting error that would have placed a new mandate on State Medicaid programs effective in 1995.

Savings (in millions)

FY 1994	4-Year Total
$0	$4,085

2. Reduce Medicaid Administrative Match to 50 Percent

The Federal administrative cost matching rate for jointly administered Federal/State welfare programs like Aid to Families with Dependent Children, Food Stamps, and Medicaid is generally 50 percent. A higher rate of up to 90 percent has been set to encourage States to undertake certain types of activities such as automated management systems and fraud control. Since States have

now had the opportunity over several years to initiate these activities, this proposal would match all administrative costs at 50 percent.

Savings (in millions)

FY 1994	4-Year Total
$160	$1,490

3. Remove Prohibition on Medicaid Drug Formularies

Before the enactment of the Medicaid drug rebate program, States could use drug formularies (lists of drugs) to indicate which drugs would be covered. Now they are required to cover all drugs of manufacturers that have signed rebate agreements. This means that States have less control over what drugs will be covered under Medicaid. This provision would allow States more flexibility to insure more effective use of Medicaid funds.

Savings (in millions)

FY 1994	4-Year Total
$10	$70

4. Tighten Estate Recoveries/ Transfer of Assets

There are numerous loopholes in the Medicaid law which allow persons with substantial assets to qualify for Medicaid. This proposal would close those loopholes and ensure that those with substantial personal assets pay a fair share for nursing home care and other medical services before Medicaid starts to pay and encourage recovery from estates of deceased recipients with substantial assets.

Savings (in millions)

FY 1994	4-Year Total
$25	$395

HUMAN SERVICES

1. Low Income Home Energy Assistance

An additional $3 billion in funds in FY 1995-1998 will be requested to alleviate the impact of the energy tax increase on low income households. LIHEAP funds help low income households to meet the costs of home heating and cooling needs, deal with energy-related crises and pay for energy-related repairs to make their homes more energy efficient.

2. Child Care and Development Block Grant (CCDBG)

To support low income families who need child care to work, the President's Budget includes an additional investment of $40 million in FY 1994 and $795 million over five years for CCDBG.

3. **Family Preservation and Support**

A new capped entitlement will be created to fund: 1) innovative child welfare services such as family preservation, family reunification, and other follow-up services; and 2) community-based preventive and supportive services. This will total $60 million in 1994, with a five-year total of $1.7 billion. $2.74 billion in new discretionary funds will be allocated for drug treatment programs through PHS grants. Priority will be given to women and children involved, or at-risk of involvement, with the child welfare system. Together, these will parallel the child welfare provisions that were contained in H.R. 11 last year.

4. **Child Support Enforcement**

Expanded child support activities include increased paternity establishment, including hospital based programs to establish paternity at the time of birth, and increased access by children to their parents' employment-based health insurance. The proposals are targeted to produce billions of dollars in increased child support collections and medical support. Federal savings are currently estimated at $27 million in FY 1994 and $505 million over FY 1994-1998.

5. **Medicaid and AFDC State Administrative Expenses**

Beginning April 1, 1994, match all Medicaid and AFDC state administrative expenses at 50 percent. Food Stamps match rates would also be set at 50 percent. Limited hardship waivers will be available. Savings are $200 million in FY 1994, and $2.4 billion over five years.

SOCIAL SECURITY ADMINISTRATION (SSA)

1. **Disability Insurance Processing**

This proposal would provide $302 million in FY 1993 to help SSA prevent further delays in processing of disability insurance claims, review cases earlier, and make other improvements in the delivery of services. There has been a dramatic increase in Social Security and Supplemental Security Income (SSI) disability claims in recent years, and tremendous backlogs have resulted.

Cost (in millions):
FY 1993 - $302
FY 1994 - $120
4 year total - $720

2. **Modernizing SSA Computer Systems**

SSA relies heavily on its information systems to provide services and pay benefits. To meet current and future demands, SSA and State Disability Determination Services (DDSs) must abandon their labor-intensive, paper-driven tradition, and automate. The proposal would invest in pilot-tested Intelligence Workstations and Local Area Networks (IWS/LAN), creating a state-of-the-art, computing network for all of SSA and the DDSs. The funding provides for modular workstations, design and site preparation, and installation.

Cost (in millions):
FY 1994 - $145
4 year total - $880

3. SSA Fee for State SSI Administration

This provision would charge the States a small fee for the cost of Federal administration of State supplements to the Federal SSI benefit.

Saving over 4 years: $520 million

4. Conform Taxation of Benefits to Private Pensions

Up to 50 percent of Social Security (and Railroad Retirement Social Security Equivalent Benefits and Railroad Retirement) benefits are currently taxed for those recipients with income exceeding thresholds of $25,000 for individuals, and $32,000 for couples. This proposal would tax up to 85 percent of benefits for those exceeding the thresholds. This would make the treatment of Social Security benefits more consistent with that of private pensions which, under current law, are subject to taxation once benefits exceed the individual's contributions.

Extending this approach to Social Security without maintaining current income thresholds would make benefits taxable for nearly all recipients. By maintaining the existing income thresholds, most low and middle-income beneficiaries will continue to be exempted from benefit taxation.

Savings (in billions):
FY 1994 - $2.7
4 year total - $21.4

RESPONSES OF DR. SHALALA TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

QUESTION #1:

Last week an amendment was offered to the budget resolution on the Senate floor that would have arbitrarily capped entitlement programs -- including Medicare and Medicaid. The cap proposed would have arbitrarily limited increases in Medicare and Medicaid to the CPI, plus growth in number of beneficiaries, plus an adjustment of 1% in 1996, 1% in 1997 and 0% thereafter. Can you please describe the effects this type of entitlement cap would have on Medicare and Medicaid? I am interested in knowing the exact magnitude of the cuts that would be needed to enforce such a cap and the likely effect an arbitrary cap would have on the private sector and their health care spending.

ANSWER:

- While there could be problems in implementing and enforcing this approach, if it were assumed that such an amendment became law with an effective date of January 1, 1994, and if it were assumed that such a cap were effective, the financial effect would be as follows:

($ in Billions)

	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
Medicare					
Part A	$-4.8	$-11.4	$-18.9	$-25.1	$-31.8
Part B	-3.8	-10.6	-17.2	-24.7	-34.1
Total	-8.6	-22.0	-26.1	-49.8	-65.9
Medicaid	-4.7	-12.1	-19.6	-27.1	-35.3

- In order to determine the effect that such a cap would have on private sector health care spending, one would need to determine to what extent providers would (1) increase prices to other payors, (2) absorb the impact of the cap themselves (perhaps by finding ways to operate more efficiently), or (3) reduce services to Medicare and Medicaid beneficiaries. Cost containment measures such as this one quite often result in the providers, especially hospitals, finding ways to operate more efficiently. These changes produce savings indirectly for the private sector.

NOTE: Under Medicaid this would be impacted to some extent by what the States would do.

QUESTION #2:

Secretary Shalala, I have just written you a letter over my concern about a recent report that HHS was cutting back on its investigations of fraud and abuse in the Medicare program. I held a hearing in the Finance subcommittee on Medicare and Long Term Care last spring on this issue. Not only was there intense interest among my colleagues, but there was a great deal of evidence to suggest that HHS needs to do a great deal more in detecting waste, fraud and abuse -- and certainly not less.

As you know, the public believe that waste, fraud, and abuse is rampant in our current health care system and is a major driving force behind high health care costs. While clearly there are other reasons why our health care costs are going up so rapidly, waste, fraud and abuse, according to some, amounts to about 10% of our total health care bill. $80 - $90 billion is quite a large sum of money.

I sincerely hope that you will reconsider any plans to cut back in this extremely important area. I would appreciate hearing from you as soon as possible to further discuss HHS's plans in this area.

ANSWER:

- The Administration is reviewing fraud and abuse issues as part of the work of the task force on health care reform. Cost containment is being scrutinized very carefully and mechanisms to reduce fraud and abuse are an important part of this effort. The work conducted by the Office of Inspector General (OIG) is being considered as part of this effort. I would also mention that the findings and unimplemented recommendations of the OIG are also being considered by the National Performance Review Task Force, which is being chaired by the Vice President.

- In response to your concern regarding staffing levels of the OIG's investigative activities, I share your concern about the need to maintain a strong enforcement presence to fight fraud and abuse, particularly in our health care system. I am deeply committed to reducing fraud, abuse and waste in programs administered by this Department, as is the President.

- As evidence of that commitment, on April 1, 1993, the President announced his intent to nominate Ms. June Gibbs Brown to be the Department's Inspector General (IG). Ms. Brown is a veteran of the IG community, having served with distinction as IG of the Departments of Defense and Interior and the National Aeronautics and Space Administration. I have met with Ms. Brown and know that she shares my commitment to the critical importance of the OIG's work, especially in helping to curb health care fraud and abuse.

- I want to assure you that I am closely examining the Department's allocation of resources, including those of the OIG, and will maintain the prevention and detection of fraud, waste and abuse as a high priority. In addition, I have asked Ms. Brown, once confirmed, to scrutinize the deployment of staff within the OIG to assure that a strong, as well as prudently managed, enforcement activity will be maintained.

QUESTION #3:

Last year, the Finance Committee attached a package of time-sensitive Medicare amendments to a bill, H.R. 11, that was later vetoed by President Bush. I have been told that the Administration plans to include a number of these time-sensitive provisions in its budget proposal that will be sent to Congress shortly. I support those plans.

I would like to highlight a small but important demonstration project for Alzheimer's patients which is scheduled to shut down mid-May of this year. There are 8 Alzheimer's disease demonstration sites across the country, including a rural demonstration site in West Virginia. I'm told that these demonstration programs have not used all the funding that had been designated for their programs. I hope that since HCFA has broad authority to conduct research and demonstration projects, the Department of HHS can administratively extend these important demonstration projects for an additional year, or at least until the end of this fiscal year.

Because of an unusually high attrition rate, extending the demonstration project by an additional year would greatly improve the quality of information that will ultimately help Congress and HCFA figure out the types of long term care services most beneficial to Alzheimer's patients living in the community and their families. Given that the demonstration sites must begin phasing-out its programs very soon if an extension is not granted I hope to hear back from you very soon on this matter.

ANSWER:

- After reviewing the authorizing legislation, we have determined that the project began on December 1, 1989, when we officially started enrolling clients in the demonstration project, <u>not</u> on May 30, 1989, when Congress authorized the demonstration project to begin. Therefore, we are continuing this comprehensive demonstration project until November 30, 1993 in all eight sites. There is also a provision in HR 21 that would extend this project until November 1994. The Department does not oppose the extension.

- In order to better assess the results of this demonstration, HCFA has entered into an agreement with the University of California at San Francisco to analyze the data collected from approximately 6,000 demonstration participants. I would be happy to share this important information with you when it becomes available, and discuss future long term care options to help those afflicted by Alzheimer's.

QUESTION #4:

I am heartened that the Administration's budget recognizes the need to emphasize the importance of enhancing the environment for primary care practitioners. I think you know that I am passionate about addressing some of our critical workforce shortage problems, especially the dearth of primary care practitioners, in our health care reform legislation. Secretary Shalala, would you like to comment on the Department's commitment to address this issue more comprehensively in reform?

ANSWER:

- The Administration is supportive of providing incentives for physicians to enter into primary care and has forwarded several proposals, including those in the President's budget, to encourage participation in this field of medicine. The Task Force is studying the access problem and the lack of primary care physicians in rural and inner city areas. This is just one of the many important issues we will address in health care reform.

QUESTION #5:

I am concerned about the proposal to reduce the Federal administrative matching rates to states as well. West Virginia's Medicaid programs will continue to suffer from a heavier and heavier case load, health care inflation, and increased reliance on Medicaid services. The NGA characterizes this as a flat out cost-shift to States. Would you please tell us what the rationale is behind the reduction in administrative matches from States?

ANSWER:

- The enhanced Federal matching rate for certain administrative costs was intended to encourage States to undertake activities to improve the administration of their Medicaid program. We do not believe that Congress intended for the Federal Government to continue to fund the activities at an enhanced match once they were implemented, which is now the case.

QUESTION #6:

The Administration's budget proposes a progressive reduction in the Indirect Medical Education adjustment used as part of the Prospective Payment System for teaching hospitals. It has been widely recognized that only a fraction of this adjustment is actually for education, with much being added as an acknowledgement of the fact that patients in these hospitals tend to be sicker and require more services. What are the Department's plans to refine this adjustment? Will there be any effort made to provide a more appropriate pass-through to hospitals to adjust for the true costs of both teaching and patient acuity?

ANSWER:

- Our proposal to reduce the IME adjustment factor from 7.7 percent to 5.65 percent by FY 1998 is consistent with ProPAC's finding on the appropriate level of IME payment. The IME adjustment is intended to recognize hospitals' indirect costs of operating approved graduate medical education programs. It is difficult to precisely specify

the various components that make up the total of the indirect costs in IME, including those factors that account for more serious medical conditions which require additional medical services. The proposal does not begin to phase-in until 1996 so that hospitals will have time to plan for the change.

QUESTION #7:

The Administration's budget proposes that the Direct Medical Education support from Medicare to teaching hospitals be weighted favoring primary care training positions. Would you comment on the anticipated effect of this, especially given that the Physician Payment Review Commission has rejected weighting saying it would be ineffective in getting institutions to reduce specialty residency positions? And since we will need at least some specialists to take care of Medicare beneficiaries, would it not be fair to pay the full freight for all approved positions, even if we try to reduce the total number of positions available?

ANSWER:

- There is general consensus that we need more primary care physicians. Through this specific proposal and other policy initiatives we are restructuring the incentives for medical school graduates to consider primary care residencies. We believe these techniques will have the desired effect.

- The physician fee schedule was structured to bring primary care physician payments more in line with specialist payments, thus making primary care more attractive. In addition, our budget proposal to reduce the scheduled physician fee update exempted primary care physicians from any reductions.

- While it is true that at present, a majority of residents intend to pursue specialty training for a variety of reasons, it is also true that teaching institutions prefer specialty residents because they can charge more for their services than for primary care residents. It is against this backdrop that we offer our proposal.

- In reference to paying the full freight, even reducing the total number of positions available would not necessarily produce the desired change in the specialist/generalist mix.

QUESTION #8:

I appreciate and share your commitment to work on initiatives to strengthen American families. As you may know, I have sponsored, S. 596 the Family Preservation and Child Protection Reform Act, which also calls for new capped entitlements to promote family preservation. I look forward to working closely with you on child welfare reform.

In addition to new investments in family preservation, I also urge you to consider including key provisions to strengthen foster care and provide adoption assistance which are desperately needed.

I would appreciate your review and comment on provisions in S. 596 regarding: dissolved adoptions, extension of the definition of children with special needs, consideration of some financial relief on adoption expenses, and permanent authorization of the Independent Living program.

Have you had a chance to review the Supreme Court decision on the Suter case, and consider provisions to respond to this issue and the need to define reasonable efforts requirements for state plans.

ANSWER:

- As you know, the Clinton Administration has developed and submitted to Congress legislation that will create a new capped entitlement program for: (1) family preservation services including family reunification and other services to work with families to keep them together and help prevent foster care placement; and (2) community-based family support services to help improve parenting skills and support families. Funding will total $60 million in 1994 and rise to $600 million in 1998, for a total of $1.395 billion over five years.

- In addition, over five years, $2.74 billion in new discretionary funds will be allocated for drug treatment programs through existing PHS grants. While these grants offer services to a broader population, to receive these funds, one of the priority areas that applicants will be required to address will be women and children involved, or at risk of involvement, with the child welfare system.

- The bill also includes several amendments designed to strengthen the foster care and adoption assistance program under title IV-E, which would have the effect of increasing Federal costs for this program. Total costs of these provisions are estimated to be $192 million over five years. Specifically, the bill would eliminate the barriers to the Federal matching for children who return to the title IV-E system as the result of failed adoptive placements, and for children voluntarily placed in foster care for whom a judicial determination was made more than 180 days after the placement. It would permanently extend the independent living program, and would permit States to disregard, for proposes of eligibility for foster care and Medicaid benefits, reasonable amounts of assets accumulated, by a child enrolled in this program, to establish a household or otherwise complete the transition to independence.

- Finally, our bill includes a provision which clarifies Congressional intent (in light of the Suter v. Artist M.) with respect to the enforceability of Social Security Act provisions reflected in States plan. It limits the holding to the particular statutory provision included in that case.

- Together, these efforts will build on the hard work of the National Commission on Children, the Senate Finance Committee, the House Ways and Means Committee, and children's advocates who have pushed to do more for families at risk, especially those at risk of foster care placement. It will also assist families by providing nurturing and stimulating environments for their children.

- We have been keeping your staff informed of our efforts, and I look forward to continuing to work with you on this exciting legislative effort.

QUESTION #9:

I support the initiatives in the budget to strengthen child support enforcement, and understand that the Administration intends to develop a comprehensive welfare reform initiative that will include additional enhancement for child support enforcement.

Have you also considered a demonstration of child support assurance as a potential strategy as part of a comprehensive welfare reform effort to move parents from welfare to work? The National Commission on Children suggested such a demonstration as outlined in my bill, S. 663, and I believe it has tremendous potential to encourage single parents to work.

ANSWER:

- I appreciate your support for the child support proposals outlined in the budget. These initiatives will bolster the child support enforcement effort and will serve to complement the larger measures which will be undertaken by the President's welfare reform task force.

- As a major participant on the task force, the Department will be working hard to improve our child support enforcement system. I can assure you that the task force will carefully examine child support assurance along with other possible avenues for addressing the problem of nonsupport in formulating a plan to end welfare as we know it.

RESPONSES OF DR. SHALALA TO QUESTIONS SUBMITTED BY SENATOR CHAFEE

QUESTION #1:

Over the years, I've been a strong supporter of improving the health status of our most vulnerable citizens, low income children and pregnant women. During the past few years this Committee has taken a number of steps to improve the Medicaid coverage of these needy families. At the same time, we also provide the same types of services through the Maternal and Child Health program and the Community Health Centers program. How can we make sure that these programs work as closely together as possible so we can get the most from the money we spend to take care of low income children and pregnant women?

ANSWER:

- The statute requires that HCFA coordinate the Medicaid program with programs funded under Title V. We have consistently met this requirement. HCFA has also sought to work competitively with other existing programs such as CHCs. This past Spring, HCFA's Medicaid Bureau convened a multi-agency workgroup to map out steps to improve the effectiveness of Medicaid's child health program. The State Medicaid agency, Public Health Service, and HCFA co-chair a workgroup. This workgroup represents various HCFA, and PHS components, State public health agencies, the American Public Welfare Association, the Association of Maternal and Child Health Programs are involved. The workgroup is currently identifying issues and obstacles that impede participation in Medicaid's child health program, Early Periodic Screening Diagnosis and Treatment, and have begun planning strategies to overcome these impediments. In addition, the group is focusing on ways programs supported by categorical and discretionary public health grants can help achieve Medicaid objectives of improved outreach and enrollment of children, provider recruitment and retention, and capturing data from multiple sources. With efforts such as these, these important programs will operate more efficiently to meet the needs of children and pregnant women.

QUESTION #2:

In 1990, I sponsored legislation to create a new option for Medicare supplemental insurance policies so beneficiaries could buy a supplemental insurance policy linked to a managed care network like an HMO. Although the Senate passed the proposal and became a part of OBRA 1990, during conference with the House, the program was limited to 15 States. Unfortunately, more than 15 States were already permitting the sale of these Medigap policies and the arbitrary limit creates a problem with deciding the states eligible to permit these policies. Last year, I introduced legislation to remove this limitation and to make other technical corrections and it became part of the Urban Aid package, HR 11. But that Act was vetoed. When I reintroduce this proposal again, will I be able to count on your's and the Administration's support to remove the limit and improve its provisions?

ANSWER:

- The Medicare Select program is relatively new and is being closely monitored by HCFA and the 15 participating States. At this time there are no concrete data available to accurately assess how the program is doing. We are currently gathering information and would like to study its progress over the next year. I would be happy to provide information to you and your staff as it becomes available.

QUESTION #3:

Providence and Boston are both major metropolitan areas within 35 miles of one another similar to a commute from Washington to Annapolis. Yet Rhode Island physicians report to me that they are paid less for Medicare services than a physician of exactly the same training and experience in Boston. Would you provide me two items for the record.

First, a complete list of Medicare approved payments for physician services in Providence, Rhode Island and Boston. In other words, I want to see all the services for which Medicare pays physicians and the amounts paid for each service for each metropolitan area so that I can see the differences between Boston and Providence.

Second, please provide an explanation of why the difference in payment rates exists. I assume your Department has good reasons for what is reported to me are the inequities in the payment rates and I'd like to see them in writing.

ANSWER:

- The overall geographic adjustment factors (the weighted average of three cost components) is 1.046 for urban Massachusetts and .989 for Rhode Island. This indicates that, in general, Medicare payments under a fully implemented fee schedule will be about five and one half percent higher in Massachusetts than in Rhode Island.

- The Physician Fee Schedule was designed to eliminate large geographic variances. Current large cost variances between fees in Boston and fees in Rhode Island are in part due to the fact that the physician fee schedule is in a transition phase until 1996 when it will be fully implemented.

- In reference to your request for Boston and Rhode Island physician service payment rates, the information is in the possession of the regional carrier. The data encompass approximately 16,000 pages and cannot be transmitted easily. However, we could provide examples that you might specify.

QUESTION #4:

According to the Social Security Administration (SSA), by the end of fiscal year (FY) 1993, SSA was expected to have a backlog of 1.4 million cases in determining Social Security eligibility for disabled individuals. It is my understanding that this situation results from a lack of staff in both Federal and regional offices. Has that estimate proven true?

For the record, how many cases are still pending? What is the average number of days or months needed to determine eligibility for current applicants? What size staff and budget increases would be needed to eliminate the backlog and reduce the delay in determining eligibility?

ANSWER:

- Through FY 1992, SSA had approximately 678,000 disability cases pending in the Disability Determination Services (DDSs), including 533,000 initial disability determinations. The average number of days needed to determine eligibility for disability benefits for September 1992 was about 104 days.

- As you know, the backlog in disability cases is SSA's most critical problem. The unprecedented increase in Disability Insurance and Supplemental Security Income disability claims has severely strained our resources.

- SSA recently received additional contingency funding to continue the momentum established in FY 1992 and the first half of FY 1993 to process disability cases and to begin addressing the backlogs in the Office of Hearings and Appeals. We now estimate that by the end of FY 1993, more than 1 million disability cases (including 773,000 initial disability determinations) could be pending in the DDSs. While the current processing time is about 103 days, this means that claimants could wait an additional month for their cases to be processed.

- In order to maintain the current service levels in FY 1994 (e.g. reduce the initial disability determination pending workload in the Disability Determination Services to about 870,000 cases, or about 16 weeks of work on hand at the end of September 1994), we would need to process an additional 451,000 initial disability determinations, as well as the reconsiderations, hearing and appeals which flow from the backlog of completion.

- Last year, based on a general model, SSA indicated it would need about $100 million and 1,000 Federal work years to process an additional 100,000 initial disability determinations, as well as the reconsiderations hearings and appeals. More recent experience shows the cost to process 100,000 is expected to be about $15 million lower. Using the general model developed for the FY 1994 budget, SSA would need about $85 million and 900 Federal work years to process an additional 100,000 disability cases. Given current workload projections, we estimate that $300-$400 million and 3,000-4,000 Federal work years would be need to be added to process 400,000-500,000 additional initial disability determinations, as well as the reconsiderations, hearings and appeals which flow from the backlog to completion in FY 1994.

RESPONSES OF DR. SHALALA TO QUESTIONS SUBMITTED BY SENATOR DURENBERGER

QUESTION #1:

The President's budget proposes to reduce physician fees in 1994 by two percent. One goal of physician payment reform was to shift payments from procedure oriented services to primary care. I agree with the Administration that the exemption of primary care from the cuts is critical to reverse the trend toward over specialization at the expense of primary care.

In the United States, the proportion of specialists is about 67 percent. Whereas other industrialized countries have 50-75 percent of their physicians practicing primary care. Last month, the New England Journal of Medicine published a study regarding geographic variation in expenditures for physicians' services. The study concluded that the "practice style in a given community appears to be influenced not by the aggregate supply of physicians but rather by the mixture of primary care physicians and specialists".

Does the Administration believe that the decline in the number and proportion of physicians going into primary care is an issue that should be addressed by Congress this year? If so, are there other legislative changes to rebuild primary care that the Administration favors? Can we expect to see additional recommendations in this area in the President's health reform proposal?

ANSWER:

- The Administration is supportive of providing incentives for physicians to enter into primary care and has forwarded several proposals to encourage participation in this field of medicine. The Task Force is studying the access problem and the lack of primary care physicians in rural and inner city areas. This is just one of the many important issues we will address in health care reform.

QUESTION #2:

The skyrocketing cost of health care is often associated with waste, corruption and profiteering. In fact, an estimated 10 percent ($80 billion) of Medicare spending is linked to fraudulent reimbursement. One of the most effective ways we can reduce spending is through enforcement against health care fraud. Statistics show that there is a 13:1 ratio of return on investment to savings when fraud is pursued. The public wants fraud and abuse to be addressed. Congress has focused on this issue the past few years. We will not be perceived as serious about reform if we are not aggressive against fraud and abuse.

Last week, The Washington Post reported that the I.G. has been told to plan on a fiscal year 1994 budget that is 3 percent lower than 1993 levels. How can the Administration justify its proposed decrease in funds to the OIG when cost containment is one of the ultimate goals of health reform?

ANSWER:

- The Administration is reviewing fraud and abuse issues as part of the work of the task force on health care reform. Cost containment is being scrutinized very carefully and

mechanisms to reduce fraud and abuse are an important part of this effort. The work conducted by the Office of Inspector General (OIG) is being considered as part of this effort. I would also mention that the findings and unimplemented recommendations of the OIG are also being considered by the National Performance Review Task Force, which is being chaired by the Vice President.

- In response to your concern regarding staffing levels of the OIG's investigative activities, I share your concern about the need to maintain a strong enforcement presence to fight fraud and abuse, particularly in our health care system. I am deeply committed to reducing fraud, abuse and waste in programs administered by this Department, as is the President.

- As evidence of that commitment, on April 1, 1993, the President announced his intent to nominate June Gibbs Brown to be the Department's Inspector General (IG). The Ms. Brown is a veteran of the IG community, having served with distinction as IG of the Departments of Defense and Interior and the National Aeronautics and Space Administration. I have met with Ms. Brown and know that she shares my commitment to the critical importance of the OIG's work, especially in helping to curb health care fraud and abuse.

- In FY 1993, the OIG received an appropriation of almost $99 million, with 1,330 FTEs. The President's FY 1994 budget maintains the OIG's budget at the same level, with 1,283 FTEs. I am confident that Ms. Brown will be able to maintain the OIG's activities vital mission within this to fulfil this budget level through judicious resource utilization to target those programs and localities most at risk for loss in terms of tax dollars and service to the public.

- I want to assure you that I am closely examining the Department's allocation of resources, including those of the OIG, and will maintain the prevention and detection of fraud, waste and abuse as a high priority. In addition, I have asked the Inspector General-designate, once confirmed, to scrutinize the deployment of staff within the OIG to assure that a strong, as well as prudently managed, enforcement activity will be maintained.

QUESTION #3:

There is no question that we have a shortage of primary care doctors. If health reform were implemented tomorrow, we could not provide everyone access to primary care. There is also no question that we have an oversupply of medical specialists. This imbalance between primary and specialty care affects both the quality of our health care and the costs.

GME payments exacerbate this problem by pumping large sums of money into hospital based specialty training programs (as much as $8 billion) and rarely pay for outpatient training where most of the primary care takes place.

Will the Clinton health plan include reform of the GME payments to support primary care? What other reforms are you contemplating to increase the supply of primary care doctors and reduce the number of specialists?

ANSWER:

- Decisions on health care reform are still to be made. Therefore, it is difficult to discuss the various options before the Task Force formally releases its plan. However, primary care is recognized by this Administration as a vitally important part of the vision we have for our health care system. To this end, we are looking at various strategies that will increase the number of primary care doctors to make health care accessible.

QUESTION #4:

There is a lot of interest in modifying the Part B Medicare updates and the Medicare Volume Performance Standard methodology. Currently, there are two updates -- one for surgical services, one for non-surgical. Most reform interest is directed toward the number of updates -- one or three. However, I also am concerned that any system based on historical behavior is inherently unfair to providers and states that operate efficiently.

The Urban Institute conducted a study that examined the geographic disparity in doctor bills for all Medicare patients in 59 selected MSAs in 1989. In terms of physician charges, Miami is the most expensive major metropolitan area in the country for a senior citizen to get sick. Minneapolis is one of the least expensive.

Targeting physician behavior should not be addressed through across-the-board reductions, whether in the current system or in health care reform. That unfairly punishes efficient provider areas. Is the Administration looking at establishing Volume performance Standards by specialty or by region?

ANSWER:

- While additional separate Medicare Volume Performance Standard categories might further strengthen the incentives for physicians to moderate the growth in services, some have argued that separate State standards could take advantage of State level institutional infrastructures that might be used to influence physician response to the performance standards, such as peer review organizations, State medical societies, and State medical licensure boards. Issues relating to the feasibility of establishing separate volume performance standards for different types of medical services, specialty, and different geographic regions are being studied. HCFA is currently refining a system to be used as a source of the data needed to establish, update, and monitor larger numbers of Performance standards.

QUESTION #5:

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 set a national level or cap of 12% for disproportionate share payment hospitals (DSH). Those states that were above 12% were frozen at their current dollar expenditure level until it reached 12%. Those states that were under the 12% cap would receive their base year allotment as well as a growth factor. However, national DSH payments ended up being above the 12% cap. HCFA' solution was to allow <u>each state</u> to spend no more on DSH in FY 1993 than in 1992 -- punishing the good along with the bad.

Minnesota is a very low DSH state. FY 1992 DSH spending was only 1.1% of total Medicaid spending of $1.92 billion. Minnesota has 4 DSH hospitals: 3 children's hospitals and HCMC. Gillette Hospital is 40% Medicaid. Minneapolis Children's is 1/3rd Medicaid. Saint Paul is 8% Medicaid.

In light of the goal of increasing coverage in health care reform, wouldn't it be a more efficient use of funds to eliminate the formula for DSH payments and put those Federal funds toward financing coverage for the uninsured for whom DSH funds were originally intended? It seems to me we wouldn't need to supplement these hospitals if universal coverage is achieved.

ANSWER:

- The Administration is in the process of reviewing plans on health care reform and disproportionate share payments are part of this discussion. Of course it would seem that once universal coverage is achieved there should no longer be a need for disproportionate share payments. However, in looking at this option, as with others in the context of Health Care Reform, we must be careful to balance these changes in such a way so as not to hurt those "safety net" facilities who provide the bulk of care to people who are currently not insured.

- You will be happy to know that we recently negotiated an agreement with the National Governors Association which will allow low-DSH States, such as Minnesota, to receive their growth allotment.

QUESTION #6:

On March 23rd I introduced legislation of critical importance to the health of children and adolescents in this country. The legislation would increase the authorization level for the Maternal and Child Health Block Grant Program (MCH) by $250 over the next three years from $686 million to $936 million. As you perhaps know, current appropriations for MCH are right up against that authorized level, so any expansion in the program will require an increase in the authorization.

In addition, my bill would specifically authorize the use of MCH funds for school-based clinics in major urban areas around the country, in part because it has so much flexibility to allow each community to determine how it's used.

With all that in mind, I'd be curious to know how the Administration feels about using an expanded MCH Block Grant to expand health services delivered in school settings?

I'd also be curious to know how school based health services -- and public health services in general -- will fit into the Administration's comprehensive health care reform proposal.

And, finally, regardless of what's done to increase Federal funding, what does the Administration intend to do to remove barriers in existing programs to combining funding from different federal health, education and social service programs in school and community settings.

ANSWER:

- The Administration is requesting $704,534,000 for the Maternal and Child Health Block Grant program for Fiscal Year 1994. This is some $18.5 million above the current authorization level. It is likely that a legislative proposal increasing the authorization level, contained in Title V of the Social Security Act, will be submitted.

- While the Administration has taken no formal position on your legislation, it does support the use of Title V resources for local communities as a strategy to extend the availability of primary care services. State MCH programs have the flexibility to work with communities and providers to develop those services in a variety of settings, including schools.

- There are no administrative barriers under Title V which prevent the involvement of other federal health, education and social services programs in school-based health care. Currently, an estimated 66 percent of State Title V programs support school-based programs, providing about 17 percent of total funds for school-based health clinics. About 55 percent of schools with school-based health clinics report using State health department funds for their support; 43 percent specifically report use of Title V funds.

- Support for school based services under the MCH Block Grant is consistent with the Administration's efforts to support the provision of services for children and adolescents and to improve the capability of current delivery system to increase access to comprehensive health care services for adolescents.

- Support for school-based or linked services is not restricted to the MCH Block. About one-third of the clinics and health care for the homeless grantees report some form of school based or linked program.

QUESTION #7:

The President's budget treads quite lightly on the Medicaid program in terms of cuts. Yet, the costs of the Medicaid program have been rising at an alarming rate.

In a recent report that I authored, I proposed that the Federal Government take over financing access to acute care services and relieving the states of the Medicaid acute care burden. I would then swap responsibilities with the states, and return many of the categorical programs to them. This is similar to a swap that President Reagan proposed back in the early 80's.

A number of states have expressed great interest in this proposal. Would the Administration support a swap like this?

ANSWER:

- As the Health Care Reform Task Force reviews many different options for the President's health care reform proposal, we will be looking at ways to finance basic health care for all Americans. I expect to be discussing this and other alternatives with you and our colleagues after the new health care proposal is released.

RESPONSES OF DR. SHALALA TO QUESTIONS SUBMITTED BY SENATOR HATCH

QUESTION #1:

I recently received a letter from the Utah Department of Health about the Administration's Medicare and Medicaid proposals. The letter is too lengthy to read in its entirety, due to our time constraints today. So, I am going to leave a copy with your staff, Dr. Shalala, and I hope you will give it careful consideration. The impact of your proposed changes is very important to Utah.

Let me just ask you one question, and that is about your proposal to reduce the administrative match under Medicaid to 50%. Utah has been very innovative in the past few years in reducing claims costs through automated reforms. We are very proud of the fact that even though the claims volume for Medicaid has risen dramatically, we have been able to hold administrative costs flat.

It seems that your proposal then, would penalize States such as Utah, which are doing the very thing we've been urging them: holding down administrative costs. Could you comment?

ANSWER:

- The purpose of the enhanced administrative match under Medicaid was to provide incentives for States to implement new systems to reduce administrative costs. The enhanced match has been in effect for years, and many States, including Utah, have risen to meet the challenge of controlling administrative costs in their Medicaid programs. As a result, these incentives have served their purpose most effectively and are no longer necessary to motivate States to continue their efforts in these areas.

QUESTION #2:

What do you think of such ideas to "tap" premium revenues in order to created new sources of funding for programs such as GME or institutions such as NIH? I am especially interested to hear your comments about their impact on health care reform efforts.

ANSWER:

- We are looking at all aspects of the Department, including NIH, as part of the health care reform because health care reform is more than a financing mechanism. It will also reflect the President's commitment to public health as well as the need for investment and research. At this time, many options are being considered on how to fund health care reform, including specific activities such as GME and NIH research. I will be happy to discuss this issue further when the reform package is released.

QUESTION #3:

As you may be aware, in about three weeks, the Judiciary Committee -- on which I serve as Ranking Republican -- will be holding a hearing on health care fraud. I have a proposal on this, as do many of my colleagues.

The General Accounting Office has looked into this issue, and has been citing a figure of $80 billion in annual costs attributable to health care fraud. That's about 10% of our health care

expenditures. If you use the 10% figure as a rough guideline -- and I know there's some contention on that -- we could save almost $23 billion this year in Federal Medicare and Medicaid expenditures alone.

Is health care fraud a topic of study by the Administration's Task Force, and, if so, can you shed any light on what types of solutions you are looking at?

ANSWER:

- Health care fraud is a very real and disturbing problem that effects all sectors of society. Many efforts have been undertaken by the Department, the Inspector General and the Department of Justice to investigate claims of fraud and abuse, gather evidence and successfully prosecute those who have committed such crimes. The Administration is committed to providing the resources necessary to continue efforts to combat this problem. The Health Care Task Force is also looking at ways to reduce and deter health care fraud and abuse. I will be happy to discuss these efforts with you after the Task Force releases its health care reform proposals.

QUESTION #4:

There have been recent articles in the New York Times and the Washington Post referring to a lack of resources in the OIG, and the possibility that certain states would not be serviced by the OIG because they don't have the manpower.

I want you to know that I think your IG -- when you get one on board -- can be a very valuable resource in the health care reform debate. I'd like to probe you a little bit on this.

--How are you using the IG's office in your health care reform deliberations?

--Has their work on health care fraud and abuse been take into consideration by your task force?

--And on a broader plane, is it true that they are understaffed or underfunded? -- Because I would be very concerned if this is true.

--If you feel they are lacking resources, may we count on you to forward recommendations on this?

ANSWER:

- The Administration is reviewing fraud and abuse issues as part of the task force on health reform. Cost containment is being scrutinized very carefully and mechanism to reduce fraud and abuse are an important part of this effort. The work conducted by the Office of Inspector General (OIG) is being considered as part of this effort. I would also mention that the findings and unimplemented recommendations of the OIG are also being considered by the National Performance Review Task Force, which is being chaired by the Vice President.

- In response to your concern regarding staffing levels of the OIG's investigative activities, I share your concern about the need to maintain a strong enforcement presence to fight fraud and abuse, particularly in our health care system. I am deeply committed to reducing fraud, abuse and waste in this Department, as is the President.

- As evidence of that commitment, on April 1, 1993, the President announced his intent to nominate June Gibbs Brown to be the Department's Inspector General (IG). Ms. Brown is a veteran of the IG community, having served with distinction as IG of the Departments of Defense and Interior and the National Aeronautics and Space Administration. I have met with Ms. Brown and know that she shares my commitment to the critical importance of the OIG's work, especially in helping to curb health care fraud and abuse.

- In FY 1993, the OIG received an appropriation of almost $99 million, with 1,330 FTEs. The President's FY 1994 budget maintains the OIG's budget at the same level, with 1,283 FTEs. I am confident that Ms. Brown will be able to maintain the OIG's vital mission activities within this budget level through judicious resource utilization to target those programs and localities most at risk for loss in terms of tax dollars and service to the public.

- I want to assure you that I am closely examining the Department's allocation of resources, including those of the OIG, and will maintain the prevention and detection of fraud, waste and abuse as a high priority. In addition, I have asked Ms. Brown, once confirmed, to scrutinize the deployment of staff within the OIG to assure that a strong, as well as prudently managed, enforcement activity will be maintained.

RESPONSES OF DR. SHALALA TO QUESTIONS SUBMITTED BY SENATOR WALLOP

QUESTION #1:

HHS has issued regulations on physician ownership of medical testing facilities to which they refer patients in response to Federal statute. The proposal is a major hardship to rural areas where few investors other than the medical rural community reside. The Inspector General's office at HHS had prepared new "safe harbor" regulations to protect rural communities with limited investors. However, your Administration had blocked issuance of the regulations in a misguided effort to fight "fraud and abuse." Will these regulations be issued in a timely manner so that rural areas will not lose needed health facilities?

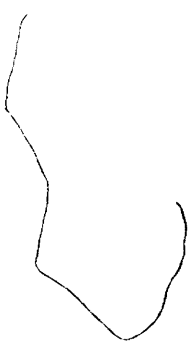
ANSWER:

- Intent of the rural safe harbor provisions:
One of the initial "safe harbor" provisions issued in July 1991 concerning investment interests was designed to protect payments to investors who engage in business with the entity in which they have invested. The investment interest safe harbor contained two so-called "60-40" rules. The first, the "60-40 investor rule," requires that no more than 40 percent of the investment interests of the entity be held by investors who are in a position to make or influence referrals to, or generate business for, the entity. The second, the "60-40 revenue rule," requires that no more than 40 percent of the gross revenue of the entity may come from referrals or business otherwise generated from investors.

- We have become aware that many rural areas have had an especially difficult time complying with these two standards because physicians in these areas may be the only source of capital, and they may have no alternative facility to which they can refer.

- As a result, we are currently in the process of clearing new proposed safe harbors that would, among other things, eliminate these two 60-40 rules for entities serving rural areas. In their place, we intend to propose a more flexible standard that will still assure that referring sources, specifically physicians, are not inappropriately selected as investors. We propose to require rural entities to make a bona fide offer of the investment interest to any individual or entity irrespective of whether such prospective investor is in a position to make or influence referrals to entity. We remain concerned, however, that a sham joint venture structure could be established that does not intend to serve the rural area in which it is located, and are we working to incorporate appropriate safeguards.

- Timing on the issuance of these proposed safe harbors: The development and clearance of this proposed rule extends back over three and a half years. This has included both extended OMB reviews of this rule and the previous Administration's moratorium on the issuance of specific regulations. We are currently reviewing this document and we hope to have these new proposed safe harbor provisions issued for public comments in later this summer.



COMMUNICATIONS

STATEMENT OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

The American Association of Nurse Anesthetists (AANA) is the professional association that represents over 25,000 certified registered nurse anesthetists (CRNAs), which is more than 96 percent of the nurse anesthetists in the United States. For those new members of the committee who may be unfamiliar with CRNA practice, we will provide some background information for you in an attachment to this testimony.

The AANA appreciates the opportunity to provide testimony regarding the Administration's Fiscal Year 1994 budget proposal to bundle payments for inpatient radiology, anesthesiology, and pathology services into a hospital DRG payment (a RAP DRG).

AANA SUPPORTS ANESTHESIA REFORM BUT OPPOSES A RAP DRG

The AANA supports the need for health care reform in this country, due to skyrocketing health care costs and lack of access to health care by millions of Americans. We believe that anesthesia providers must do our part in terms of helping to reform inefficiencies in the anesthesia system that result in unnecessarily high federal expenditures. But the AANA opposes the Administration's RAP DRG proposal because its methodology does not appropriately address the role that CRNAs play in providing patients access to safe, cost-effective anesthesia services. The proposal ignores the fact that since 1989, CRNAs have the authority to be paid directly under Medicare Part B. The proposal only mentions medical staff and individual physicians.

CRNA PRACTICE ARRANGEMENTS

The 1992 AANA Membership Survey data indicates that approximately 42% of CRNAs are employed by a hospital, 33% are employed by a CRNA/anesthesiologist group, and 15% are self-employed, work for CRNA groups, or work as locum tenens (providing vacation/temporary relief). The remainder work in offices, clinics, surgicenters, universities, the military, the Veterans Administration, or the U.S. Public Health Service. AANA has historically believed that the marketplace should decide what CRNA/anesthesiologist practice arrangements should be.

The Administration's RAP DRG payment would be made to the medical staff, or to the hospital if the medical staff did not want to receive the payment. AANA's reason for opposing the proposal can be graphically depicted by the following possible scenario: a hospital contracts out for radiology and pathology services from a radiology/pathology group, but employs CRNAs to provide anesthesia services. Under the Administration's proposal, the radiology/pathology group could receive the Medicare RAP DRG payment and then the hospital would be required to negotiate with that group for its portion of the payment for CRNA services. The AANA does not believe that hospitals should be placed in the position of having to negotiate with a radiology/pathology group to receive its appropriate share of payment for the services of its CRNA employees.

SUMMARY

The AANA believes that there must be reform in anesthesia payment under Medicare. However, the AANA opposes the Administration's RAP DRG proposal because its methodology does not appropriately address the role that CRNAs play in providing patients access to safe, cost-effective anesthesia services.

The AANA appreciates the support that this committee has historically shown for the value of CRNA services. Thank you for your consideration of our views on this issue. We request the opportunity to orally testify on any additional proposals for anesthesia payment reform that may come before the committee during this congressional session.

BACKGROUND ON CRNA PRACTICE

This attachment provides background information for you on the following CRNA issues:

1. History of nurse anesthesia,
2. Educational preparation,
3. Patient access,
4. Quality of care,
5. Cost-effectiveness of care,
6. Physician liability,
7. Clinical privileges,
8. History of Medicare anesthesia payment, and
9. CRNA Medicare rates.

History of Nurse Anesthesia

Nurses have been providing anesthesia services to patients within the U.S. since the late 1870's. Because there had been significant morbidity and mortality associated with the use of the "occasional anesthetist" for the administration of anesthesia, surgeons in the U.S. encouraged nurses to specialize in this field. At first, most nurse anesthetists learned their anesthesia in on-the-job training programs (similar to medical residencies of that day). The educational preparation and practice of CRNAs is quite different today.

Educational Preparation

There are currently 92 accredited nurse anesthesia education programs. The requirements for admission to a nurse anesthesia education program are:

- A Bachelor of Science in Nursing or another appropriate baccalaureate degree,
- A license as a registered nurse, and
- A minimum of one year of acute care nursing experience.

Nurse anesthesia education programs comprise 24-36 months of graduate course work including both classroom and clinical experience. The classroom curriculum emphasizes anatomy, physiology, pathophysiology, biochemistry, chemistry, physics and pharmacology as they relate to anesthesia. The major clinical component provides experience with a variety of anesthesia techniques and procedures for all types of surgery and obstetrics. Of the 92 nurse anesthesia education programs, 80% offer a master's degree. The other 20% of programs are modifying their curriculum to meet the requirement that all programs offer a master's degree beginning in 1998.

Patient Access Increased

CRNAs increase access to anesthesia services, by administering 65% of the 26 million anesthetics given in the United States annually. CRNAs are the sole anesthesia providers in 85% of rural hospitals. CRNAs provide anesthesia services for all types of surgeries, in all types of facilities, and for all levels of patient acuity.

Quality of Care Provided by CRNAs

CRNAs have the legal authority to practice anesthesia in all 50 states, without anesthesiologist supervision. There is no study which shows that the anesthesia care provided by an anesthesiologist is superior to that provided by a CRNA. In fact, the only studies that exist suggest that the quality of care is not significantly different.

The practice of anesthesia has gotten safer in recent years due to improvements in medications and technology advances that allow for increased patient monitoring. In fact, in 1990 the Centers for Disease Control (CDC) decided not to conduct a national multi-million dollar morbidity and mortality study on anesthesia. Doug Klauke, MD, Assistant Director for Science, Division of Surveillance and Epidemiologic Studies, Epidemiology Program Office, CDC, publicly stated that "the expected benefit of this multi-million study is clearly not justified."

Cost-effectiveness of CRNA Practice

A 1990 Department of Health and Human Services report presented the results of a study of nurse anesthesia manpower needs by the Health Economics Research, Inc. It estimated that the cost of delivering anesthesia services in a model that underutilizes CRNAs and overutilizes anesthesiologists will be $1.2 billion more in 2010 than it would be under a more efficient model.

CRNAs have accepted mandatory assignment under Medicare. Anesthesiologists can balance bill Medicare beneficiaries. In 1992, only 49.3% of anesthesiologists were participating physicians.

Physician Liability

A physician or authorized provider is not automatically liable when working with a CRNA, nor is the physician immune from liability when working with an anesthesiologist. In Schneider v. Einstein Medical Center, 390 A.2d 1271 (Penn. 1978) and Kitto v. Gilbert, 570 P.2d 544 (Colo. 1977), the court found the physicians liable for the negligence of anesthesiologists because the physicians were in control of the anesthesiologist's actions. The question, as in the case of a physician working with CRNAs, is whether the physician was in control of the acts of the anesthesiologists. Usually, this is a factual inquiry, and not a conclusion of law. There are many cases in which the courts have found that the surgeon was not in control of the CRNA and, therefore, not liable for the negligence of the CRNA. Cavero v. Franklin Benevolence Society (223 P. 2d 471, California, 1950), Fortson v. McNamara (508 So. 2d 35, Florida, 1987), Hughes v. St. Paul Fire and Marine Insurance Company (401 So. 2d 448, Louisiana, 1981), Kemalyan v. Henderson (227 P. 2d 372, Washington, 1954), Parks v. Perry (68 N.C. App. 22, North Carolina, 1984), Sesselman v. Mulenberg Hospital (306 A.2d 474, New Jersey, 1954). Numerous cases hold that mere supervision or direction of a CRNA is insufficient evidence to hold a physician liable for the CRNA's negligence. See, for example, Baird v. Sickler, 69 Ohio St.2d 652 (1982); McCullough v. Bethany Medical Center, 235 Kan. 7[illegible] (1984); Elizondo v. Tavarez, 596 S.W. 2d 667 (Texas, 1980); Parker v. Vanderbilt, 767 S.W. 2d 412 (Tenn., 1988); Whitfield v. Whittaker Memorial Hospital, 210 Va. 176 (1969). It is clear from the case law that in order for a physician to be liable for the acts of the anesthesia administrator, the physician must be in control of the administrator's actions and not merely be supervising or directing the administrator.

There is no greater liability when surgeons or obstetricians work with CRNAs. The principles governing liability of a surgeon when working with a CRNA are the same as those governing the liability of a surgeon when working with an anesthesiologist. The courts do not look at the status of the anesthesia administrator but, in most states, at the degree of control the physician exercises over the administrator - whether that administrator is a CRNA or an anesthesiologist. The issue in each case is the extent to which the physician has control over the anesthesia administrator. Thus, a court may render different conclusions for cases that involve a physician working with a CRNA - or, for that matter, a physician working with an anesthesiologist - if the physician controlled the CRNA in one case but not in another. Every state permits CRNAs to work without anesthesiologist supervision. Some state licensing laws require that CRNAs work under the "supervision" or "direction" of a physician. Such "supervision" or "direction" does not require that the CRNA be supervised by an anesthesiologist. The Joint Commission on Accreditation of Healthcare Organizations does not require that CRNAs be supervised by an anesthesiologist.

The nature of anesthes a requires the constant vigilance of the anesthesia provider. Studies of anesthesia related incidents show that most are avoidable. Most mishaps result from a failure of the practitioner to vigilently monitor the patient, not from lack of education. Vigilance has been the hallmark of nurse anesthesia education since the profession's creation. The AANA has been publishing standards calling for increased monitoring since 1974. In 1986, after publication of studies of anesthesia related

incidents showed that most could have been avoided, the HARVARD MINIMAL MONITORING STANDARDS ON ANESTHESIA CARE were published in the Journal of the American Medical Association (the AANA was the first organization to endorse the then controversial Harvard Standards). Since then, the AANA has issued even more explicit monitoring standards.

The most substantial difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists first receive medical education while CRNAs first receive nursing education. However, the anesthesia part of the education is very similar for both providers. CRNAs and anesthesiologists are both educated to use the same anesthesia process in the provision of anesthesia and related services.

Regarding malpractice insurance, St. Paul Fire and Marine Insurance Company has been the underwriter for the AANA's Professional Liability Insurance Program for more than eight years. St. Paul, the largest medical malpractice underwriter in the United States, bases their yearly professional insurance premium for CRNAs on previous claim losses. For the last three years, there has been an average annual decrease of 6% in CRNA professional liability insurance premiums due to the decreased number of claim losses.

Clinical Privileges

If there is insufficient reimbursement for medically directed CRNA services, then hospitals or anesthesiologist groups may no longer want to employ CRNAs. As a result, CRNAs may be forced to become independent practitioners and compete with anesthesiologists. However, there is not always an equal opportunity to compete. CRNAs are required in most hospitals to practice under a clinical privileging process. But it is sometimes difficult for CRNAs to secure hospital/facility clinical privileges due to exclusive contracts and restrictive medical staff bylaws which either prohibit or deter applications based on the class of provider, or require recommendation and/or approval by the Physician Chief of the Anesthesiology Department. These factors are often difficult to surmount because CRNAs with hospital/facility clinical privileges may be viewed as competitors of the anesthesiologists on staff at the hospital/facility. Consequently, the AANA urges Congress to mandate an open and equitable privileging process in all health care facilities receiving federal funding, which would allow access to all classes of providers.

History of Medicare Anesthesia Reimbursement

The issue of how to pay for anesthesia services when provided by CRNAs and anesthesiologists working together is not new. It is something that Congress, the Health Care Financing Administration (HCFA), and professional anesthesia associations have struggled with since the inception of Medicare in 1965. The following is a brief historical perspective on anesthesia reimbursement under Medicare.

1. As enacted in 1965, Medicare (Title XVIII of the Social Security Act) reimbursed hospitals under Part A for "reasonable costs" of anesthesia services provided by hospital-employed CRNAs. Anesthesiologists who employed and supervised CRNAs could bill under Part B as if they personally performed the case. Anesthesiologists who supervised CRNAs

who were employed by a hospital could bill the same base units as if they did the case themselves, but their time units were halved.

2. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established conditions that anesthesiologists must fulfill in order to be paid for medically directing CRNAs. In addition, TEFRA limited to four the number of concurrent cases of medically directing CRNAs that an anesthesiologist could be reimbursed for.

3. The Social Security Amendments of 1983 created the Prospective Payment System (PPS). Under PPS, all hospital Part A payments were bundled into diagnosis-related groupings (DRGs). Hospitals would have been forced to pay for their CRNA employee costs out of the fixed DRG payments which they would receive. However, the CRNA costs included within the global DRGs had been very undervalued. Therefore, hospitals could not have recouped their actual CRNA costs through Medicare payments. This created a disincentive for hospitals to employ CRNAs. In addition, PPS precluded the unbundling of services. Therefore, anesthesiologists who employed CRNAs that worked in a hospital would have been forced to contract with that hospital to get the CRNA portion of the DRG.

4. The Deficit Reduction Act of 1984 established a pass-through provision for hospital-employed CRNA costs for a three-year period, assuring hospitals that they would not lose money by employing CRNAs. It also allowed an exception to the unbundling provisions in PPS, to accommodate anesthesiologists billing for their CRNA employees. However, due to the temporary nature of the pass-through provision, AANA immediately sought a legislative remedy that would provide for direct CRNA Medicare reimbursement.

5. The Omnibus Budget Reconciliation Act of 1986 (OBRA86) established direct reimbursement for CRNAs under Medicare Part B, effective on January 1, 1989. It also continued the existing forms of hospital and anesthesiologist billing for CRNA services under Medicare until December 31, 1988.

6. The Omnibus Budget Reconciliation Act of 1987 imposed reductions in base units for anesthesiologists who medically directed CRNAs. Anesthesiologists' base units were reduced by 10% when medically directing CRNAs in two concurrent procedures, 25% for three procedures, and 40% for four procedures.

7. The Omnibus Budget Reconciliation Act of 1989 created the resource-based relative value scale (RBRVS) system. During the implementation of RBRVS, the services of anesthesiologists were found to be 29% overvalued, not 18%, as had been originally estimated.

8. The Omnibus Budget Reconciliation Act of 1990 (OBRA90) statutorily established higher Medicare conversion factors for CRNAs. It is noteworthy that Congress did not view CRNA fees as overvalued, on the contrary, it increased CRNA conversion factors just a year after decreasing anesthesiologist conversion factors. OBRA90 also extended the 10%, 25%, and 40% reduction in base units for the concurrent medical direction of two, three, and four CRNAs respectively, until December 31, 1995. In

addition, it reduced the weighted national average conversion factor for anesthesiology services by 7% in 1991, adjusted by geographic indices.

9. Under the RBRVS phase-in, 1992 payments per service for anesthesiologists were reduced on average by 11%.

Increased CRNA Medicare Rates Needed to Provide Equity

CRNA Medicare conversion factors have risen in recent years to correct a huge inequity in the CRNA conversion factors that HCFA established under the CRNA direct reimbursement law. OBRA86 directed HCFA to develop a CRNA fee schedule under which total payments for CRNA services would equal the estimated total amounts that would have been paid in 1989, if the services were included as inpatient hospitals services. In January 1989, HCFA published an interim CRNA fee schedule that was 35% below what would have been paid under a continued Medicare Part A pass-through.

HCFA's low CRNA conversion factors occurred for two reasons. First, there was a technical error in the fee schedule legislation. A two-step budget neutrality requirement forced HCFA to calculate the CRNA conversion factors using only the monies paid for CRNA services under Part A (which represented only 65% of the total CRNA costs). Left out of the equation were the other 35% of costs of CRNAs who were physician-employed. Therefore, the interim CRNA fee schedule attempted to pay 100% of CRNAs with only 65% of the money that had paid out for CRNA services in the previous year. Second, HCFA admittedly undervalued CRNA services by not using the most current and accurate AANA data. This undervaluing problem was eventually corrected in the CRNA final fee schedule published on July 31, 1992, and financial corrections were made by HCFA. However, the only way to remedy the technical error in OBRA86 regarding physician-employed CRNA costs, that resulted in inequities in the 1989 interim fee schedule, was for AANA to return to the legislative arena to secure fair Medicare CRNA conversion factors.

When HCFA was developing the 1989 CRNA conversion factors, AANA had repeatedly contended that the average amount per unit that would have been paid under a cost-based system in 1989 for a non-medically directed CRNA was $21.83; the average amount per unit for a medically directed CRNA was $13.85. These $21.83 and $13.85 figures were the basis for the legislation in the 102nd Congress which sought a $21.00 conversion factor for non-medically directed CRNAs and a $14.00 conversion factor for medically directed CRNAs. AANA contended that the $21/$14 fee schedule would more fairly approximate what Medicare would have paid in 1989 if the CRNA Medicare direct reimbursement hadn't been enacted.

Congress agreed with AANA on the need to increase CRNA conversion factors. OBRA90 included statutorily-determined Medicare CRNA conversion factors, effective January 1, 1991. (See Appendix 7) While the original AANA-supported legislation in the 102nd Congress would have created a national Medicare CRNA payment rate of $21 per unit for non-medically directed CRNAs and a $14 per unit for medically directed CRNAs, our efforts were stymied by the severe budget deficit facing the nation. Congress was only willing to accept a fee schedule proposal that would reimburse non-medically directed CRNAs at the same level that anesthesiologists would be in 1996, at the end of the RBRVS transition. At that time, anesthesiologist services were

estimated to be, on average, 18% overvalued. It was envisioned that the 1990 anesthesiologist average conversion factor of $20.42 would be gradually decreased under RBRVS until in 1996 it would reach 82% of $20.42, which is $16.75.

Non-medically Directed CRNA Rates

Therefore, the non-medically directed CRNA conversion factors were set to begin in 1991 at $15.50 and increase $0.25 per year until they reached $16.75 in 1996 (adjusted by geographic indices). The $16.75 is the same rate that anesthesiologists were predicted to receive in 1996.

1991 - $15.50
1992 - $15.75
1993 - $16.00
1994 - $16.25
1995 - $16.50
1996 - $16.75

Medically Directed CRNA Rates

The medically directed CRNA conversion factors were set at 70% of the non-medically directed CRNA conversion factors. Therefore, they would begin in 1991 at $10.50 and increase $0.25 per year until they reached $11.70 in 1996 (adjusted by geographic indices).

1991 - $10.50
1992 - $10.75
1993 - $11.00
1994 - $11.25
1995 - $11.50
1996 - $11.70

When the CRNA rates under OBRA90 were created, no one envisioned that anesthesiologist services would eventually be viewed as 29% overvalued under RBRVS. The fact that anesthesiologist services were ultimately viewed as 29% overvalued, versus 18% as originally projected, is the reason that anesthesiologist conversion factors have declined so dramatically in recent years.

The fact that anesthesiologist rates have declined, however, does not diminish the fact that the CRNA increases under Medicare are justified by the fact that they are not higher than they would have been if CRNA services were still paid for under the hospital reasonable cost pass-through. Any attempt to utilize a snapshot of CRNA Medicare conversion factors for 1990-1992 as a way of legitimizing future CRNA payment cuts is a misrepresentation of the history of CRNA payment under Medicare. The higher OBRA90 CRNA conversion factors merely brought equity to CRNA Medicare payment, which had been underpaid since 1989.

The AANA fought very hard to secure for direct CRNA reimbursement under Medicare. We have also consistently urged the Physician Payment Review Commission and Congress to establish a payment policy that determines the value of an anesthesia service and then pays that amount to whoever provides the service.

STATEMENT OF THE AMERICAN CLINICAL LABORATORY ASSOCIATION

The American Clinical Laboratory Association ("ACLA") is pleased to have this opportunity to comment on the Administration's budget proposals affecting reimbursement for clinical laboratory testing. ACLA is a trade association of federally regulated, independent clinical laboratories. ACLA represents national, regional, and local laboratories located throughout the United States. ACLA members will be significantly affected by the Administration's proposals for laboratories.

In the budget submitted to Congress, the new Administration has proposed reducing the national limitation amounts for laboratories from their current level of 88 percent of the fee schedule medians, to 76 percent of the medians. Further, the Administration has proposed limiting the update in the fee schedules to 2 percent, rather than raising them by the increase in the CPI, as was originally contemplated when the fee schedules were established. The update was set at 2 percent by OBRA'90 for 1991 through 1993, after which time it was to return to the full amount of the CPI. See §1833(h)(2)(A)(ii). Finally, the Administration has suggested allowing the Secretary of HHS to adjust Medicare payment rates to laboratories "to account for technological changes or other market factors."

For many years, ACLA has appeared before this Subcommittee to offer our views and our cooperation on ways to lower the federal deficit through equitable reductions in Medicare outlays for laboratory testing. In 1984, we assisted in the development of the Medicare fee schedule, which substantially reduced the amounts that Medicare paid to laboratories. In 1987, 1989, and 1990, we worked with Congress in suggesting other savings that could be achieved by lowering the national limitation amounts. As a result of the budget agreement reached in 1990, a proposal that ACLA supported, clinical laboratories will absorb additional cuts of $1.2 billion between 1991 and 1996.[1]

ACLA has always participated in this process because we recognize our responsibility to help reduce the federal budget deficit. In addition, like other providers, we also recognize the need to assist in the on-going effort to reform the health care system. Thus, this year, we believe it is necessary to discuss not just our response to the new Administration's proposed reductions in laboratory reimbursement, but also our views on how laboratory services should be treated under health care reform. As discussed below, these two issues are inextricably linked, for ACLA can accept additional cuts in Medicare reimbursement, but only if the fundamental structural problems plaguing the laboratory market are corrected as part of health care reform.

In the past, ACLA has urged that changes be instituted in the industry through passage of a federal direct billing law, which would require that laboratories that perform testing bill the appropriate payor for that work. In view of the new cuts proposed by the Administration and the efforts to reform health care generally, it is imperative that direct billing now become a reality. Direct billing will result in a more efficient

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1/ Committee on Ways and Means, Overview of Entitlement Programs ("The Green Book") at 209 (1991).

laboratory market that will ultimately benefit all payors, including Medicare. Further, an independent study discussed below shows that enactment of direct billing could reduce non-Medicare health care costs generally by between $2.4 and $3.2 billion a year. Such reductions are urgently needed to help fund other health care reforms. If direct billing is enacted, ACLA members would be better able to absorb the cuts in reimbursement that are being proposed. In addition, the enactment of direct billing would also allow laboratories to absorb reductions in reimbursement received from private payors, as detailed in the attached health reform proposal. (See Appendix 1.) Without the enactment of direct billing, additional Medicare cuts will simply force many laboratories to reduce services and could force some laboratories to close entirely, thereby reducing access to testing services.

In our testimony today, we would first like to give some information on the background of laboratory reimbursement and the need for change. Then, we will address the Administration's current proposals and detail our proposal for reform.

1. The Value of Laboratory Testing.

Laboratory testing is an important, life-saving and cost-containing health care tool, which permits the early detection and treatment of a variety of conditions. Laboratory testing is instrumental in the early diagnosis of diseases such as AIDS, Hepatitis and countless others. Other tests, such as therapeutic drug monitoring ("TDM") assays, are used routinely to track the effects of life-saving medications prescribed for cancer and other serious illnesses. Concern about coronary heart disease has caused an increased awareness of the need to perform regular cholesterol testing and related measurements of HDL and LDL. The early diagnosis and treatment permitted by appropriate testing ultimately saves money for all health care payors, including Medicare. Indeed, the greatest value of clinical laboratory testing is its ability to lead to the early diagnosis of disease and to prompt, cost-effective treatment.

Since 1984, laboratories, like many providers, have repeatedly had to confront reduced Medicare reimbursement. The caps on the fee schedules, which were initially set at 115 percent of the fee schedule medians, were subsequently reduced to 100 percent in 1988; to 93 percent in 1990; and then to 88 percent in 1991. At the same time, there have also been reductions in the CPI updates and freezes on other payments.

Appendix 2, which is attached to this testimony, shows the impact of these repeated reductions in reimbursement for clinical laboratory services. The five different budget bills enacted between 1984 and 1990 slashed clinical laboratory reimbursement by an estimated $3.5 billion. According to the most recent information, the Administration's latest budget request would impose an additional $2.8 billion in cuts over the next five years.

At the same time, the costs of laboratory testing have increased substantially. For example, as a result of the emergence of AIDS and Hepatitis B, laboratories now take additional precautions to protect workers from bloodborne pathogens, as required by the Occupational Safety and Health Administration, including paying for workers' vaccinations. In addition, the new requirements imposed by the Clinical Laboratory Improvement Amendments of 1988 ("CLIA'88") and other regulations, such as those related to medical waste removal and treatment, have further added to laboratory expenditures. ACLA does not argue with the need to protect workers, safeguard quality control or protect the public health and our environment; nonetheless, implementing these requirements is expensive.

In addition, laboratory labor costs have also dramatically increased over the past five years. For example, a recent report by the American Society of Clinical Pathologists ("ASCP") shows that salaries for phlebotomists, the individuals who draw blood, have risen by almost 20 percent since 1990. Cytologist salaries grew by 17.4 percent for staff level positions and 14.4 percent for supervisory positions during that same period.

Such increasing costs, when coupled with further reductions in reimbursement, cannot help but affect the ability of laboratories to offer accessible, efficient, high quality laboratory testing.

2. The Need for Structural Change

In view of these increasing costs and reductions in reimbursement, laboratories are hesitant to agree readily to additional cuts in Medicare rates. However, ACLA could accept some cuts, if Congress also enacted other changes in the market. Enactment of a direct billing law would permit laboratories to accept such reductions, because it would result in a more equitable payment structure and, in addition, would ultimately save money for the entire health care system.

To understand the importance of direct billing, it is important to understand how the laboratory market works. Under the present system, physicians can request that laboratories bill them for testing that they order for their non-Medicare patients. Because laboratories cannot order testing themselves, the physician can also request--and receive--discounts from the laboratory providing this testing. The physician can then mark-up these tests when third parties and patients are billed. This system gives the doctor a financial interest in the testing that is ordered, comparable to that which exists in the case of self-referral. As a result, the current system creates incentives that can lead to increased use of laboratory testing. Because of the obvious concerns arising from this arrangement, Medicare requires the laboratory performing the testing to bill the Program directly. Most states, however, permit the laboratory to bill the physician for non-Medicare testing.

The current system results in cost-shifting because it forces laboratories to increase prices to other payors--to Medicare, to the extent possible, to third-party payors and to patients. Medicare has protected itself from such shifting to some extent through the enactment of the fee schedules and national limitation amounts. However, patients and private payors still end up paying increased prices, either because they bear the mark-up tacked on by the test-orderer or because laboratories are forced to offset physician discounts and reductions in Medicare reimbursement when they bill patients and third-party payors.

Reform of this system would allow laboratories to absorb the lower Medicare reimbursement proposed by the Administration because it would eliminate the inequities noted above. Under such a system, the laboratory that performed the testing would usually be required to bill for the testing. Enactment of such a provision would eliminate the incentives that currently lead to increased testing. Furthermore, because laboratories would no longer have to offset the discounts given to test-orderers, laboratories could afford to accept lower reimbursement from Medicare, private payors and patients.

In addition, the enactment of direct billing would result in a substantial savings to the health care system. An independent study sponsored by ACLA demonstrates that such savings could be between $2.4 and $3.2 billion a year. The Center for Health Policy Studies ("CHPS") compared the experience of Medicare and Blue Cross/Blue Shield in direct billing and in non-direct billing states. The CHPS Report, a copy of which is attached as Appendix 3, found that laboratory prices and utilization were dramatically higher in non-direct billing states than in direct billing states. Among the findings of the study were the following:

- Charges for laboratory services were 8.4 to 9.6 percent higher in non-direct billing states than in direct billing states.

- Laboratory utilization per enrollee was higher in non-direct billing states than in direct billing states. For tests reimbursed by Medicare, utilization was 6.5 percent higher and for tests reimbursed by private payors--where incentives for overutilization are greatest--it was 28.3 percent higher.

- Laboratory charges per enrollee under private health insurance programs, a measurement that takes into account both utilization and price differences, were 40.6 percent higher in non-direct billing states.

The report concludes that if a national direct billing law were enacted, savings of between $2.4 and $3.2 billion per year could be achieved in health care expenditures, as a result of reduced utilization and lower prices.

Further, as detailed in the attached health reform proposal, if direct billing were enacted, ACLA would also be willing to accept a cap on non-Medicare reimbursement. Enactment of such a cap would have the effect of substantially lowering laboratory reimbursement in the private sector.

In short, enactment of direct billing would mean that Medicare, private payors and patients would all end up paying fairer prices. Laboratories could also afford to accept lower reimbursement from these payors. Finally, the health care system itself would save at least $12 billion to $16 billion over the next five years because of reduced laboratory utilization and lower prices. This savings figure does not take into account additional reductions in Medicare or the cap on private reimbursement envisioned by our proposals.

3. Response to the Administration's Proposal

With this background in mind, we now turn to a discussion of the Administration's proposal. The Administration has suggested reducing Medicare reimbursement for laboratories from 88 percent to 76 percent of the fee schedule medians, a figure that is derived from an industry report done by the GAO. ACLA believes that there are flaws in that report, and that it is inappropriate to base a major change in policy on its conclusions alone. Based on our review, it appears that the GAO may have substantially overstated the differences between what laboratories earn on Medicare and non-Medicare testing.

Nonetheless, as noted above, if direct billing were enacted, laboratories would be able to accept some additional cuts in reimbursement from Medicare. ACLA wishes to emphasize, however, that it is the efficiencies resulting from the enactment of

direct billing that would permit laboratories to absorb such reductions. Without direct billing, these cuts will simply exacerbate the inequities of the current system and many laboratories, especially smaller laboratories and those serving rural and underserved areas, will be unable to survive.

ACLA also could accept a cap on the update in the fee schedules in connection with direct billing, although we believe some adjustment should continue to be made to reflect rising costs faced by the industry. A failure to have some update would actually constitute an additional cut in laboratory reimbursement.

ACLA must object, however, to the Administration's proposed plan that would permit the Secretary to set rates based on changes in technology and market conditions. In the past, HHS and the Administration have submitted proposed changes in reimbursement to Congress, which then has decided whether or not to enact them. The Administration's proposal would not permit the Congress any involvement in the procedure by which payment levels for laboratory services are set, a dangerous precedent in the view of ACLA. If the Department determines that further changes in payment levels are necessary, it should propose such changes to Congress, just as the agency has always done in the past, and then permit Congress to determine whether, and how, to implement those changes.

ACLA has a number of other recommendations for health care reform in the laboratory industry. These include caps on reimbursement from private payors, limitations on the use of profiles, and the enactment of administrative simplification. These changes are discussed in ACLA's statement on health care reform, which is attached to this testimony.

ACLA appreciates the opportunity to appear before the Committee today and looks forward to working with the Congress and the Administration in creating a fairer market for clinical laboratory services.

STATEMENT OF THE AMERICAN COLLEGE OF RADIATION ONCOLOGY

The American College of Radiation Oncology (ACRO) is a professional association of physicians specializing in radiation oncology -- physicians who provide direct, sustained hands-on care to cancer patients. Founded in 1990, ACRO currently has more than 1,000 members. Although there are many radiology professional and scientific societies, ACRO is the only organization that specifically represents the socioeconomic interests of radiation oncologists. ACRO's membership is comprised of chairmen of leading academic radiation oncology programs, medical directors of some of the nation's best freestanding radiation oncology facilities, and community hospital-based physicians.

ACRO has three concerns that it would like to bring to the attention of the Committee:

- First, ACRO believes that legislation is urgently needed to prohibit referring physicians from having a financial interest in providers of radiation oncology services. At the same time, it is essential to ensure that such legislation does not inadvertently preclude radiation oncologists from owning their own facilities.

- Second, ACRO staunchly opposes incorporating payment for radiation oncology services furnished to Medicare inpatients into the Medicare DRG payments.

- Third, ACRO opposes any reductions in the practice expense component of Medicare payments for radiation oncology services.

Before turning to these specific concerns, however, we would like to describe briefly for the Committee the role of the radiation oncologist in caring for patients with cancer.

THE JOB OF THE RADIATION ONCOLOGIST

Radiation oncology is a unique, hybrid specialty that uses technology to treat patients who have or have had cancer. The radiation oncologist uses radiation as the treatment for cancer rather than surgery or chemotherapy drugs. Depending on the state the cancer is in when the patient is referred, the radiation oncologist's goal is either to cure the cancer or to relieve pain and prolong life. Approximately 60% of all cancer patients require a radiation oncologist's services at some time during the course of their disease.

There are only about 2,400 radiation oncologists in the United States. Radiation oncology services are provided both in hospitals and in freestanding settings.

Radiation oncologists work strictly on a referral basis. After a diagnosis of cancer is made, the patient is sent to a radiation oncologist for examination and the rendering of an opinion as to whether radiation is an appropriate treatment for the patient. If it is determined that radiation would be useful, the treatment of the patient is planned, supervised, and carried out under the immediate direction of the radiation oncologist. During the treatment period, the radiation oncologist generally assumes responsibility for the overall management of the patient's medical needs.

Because radiation oncology is entirely dependent on referrals, radiation oncologists cannot engage in self-referral. Moreover, the number of treatments that can be given to a particular area is narrowly limited by effectiveness of dose on the one hand and tolerance of normal surrounding tissues on the other.

PHYSICIAN SELF-REFERRAL IN RADIATION ONCOLOGY

In the last several years, it has become increasingly common for developers of radiation therapy facilities to offer ownership interests to referring physicians, often at prices well below fair market value. Developers have done so because they know that where a referring physician has a financial interest in a facility, the physician has a strong incentive to refer patients to that facility, regardless of the facility's quality, location, or charges.

ACRO believes that the conflicts of interest inherent in physician self-referral pose a grave danger to patient care and cause the physician-patient relationship to be marred by suspicion and distrust. While the corporate sponsors of joint-ventured radiation therapy facilities have worked aggressively to hide the ball, we believe there can be no serious doubt about the dangers that this phenomenon presents.

Indeed, research has concluded unequivocally that self-referral in radiation therapy results in substantially higher costs as well as lower quality. According to a study of Florida radiation therapy facilities that was published in the November 19, 1992 issue of the New England Journal of Medicine, the frequency and costs of treatment at radiation therapy facilities where referring physicians had an ownership interest were 40 to 60 percent higher than at facilities without referring physician ownership. Moreover,

personnel of joint-ventured radiation therapy facilities spent 18 percent less time in quality control activities than their counterparts at facilities without referring physician ownership. The study also found that no joint-ventured radiation therapy facilities were located in inner-city neighborhoods or rural areas, showing that physician self-referral does not improve access to care in otherwise underserved areas.

The existing Medicare-Medicaid anti-kickback statute has proved inadequate to deter self-referral. Similarly, experience has shown that self-referral cannot be contained through voluntary ethical guidelines. Rather, federal legislation explicitly banning self-referral for radiation therapy services is needed to finally eliminate this serious threat to high-quality, cost-efficient cancer care. ACRO asks the Committee to include in this year's budget reconciliation bill a provision that would prohibit physicians not trained in radiation oncology from referring patients to radiation therapy centers in which they have a financial interest.

Such legislation, however, must be carefully drafted to ensure that it does not inadvertently prohibit radiation oncologists from owning, or having some other financial relationship with, the facilities at which they practice. For example, Representative Stark's H.R. 345, as currently drafted, would likely have such an effect, even though Congressman Stark's staff has assured us that this was not his intent.

H.R. 345 retains the definition of "referral" currently contained in Section 1877(h)(7) of the Social Security Act. This provision purposely defines "referral" very broadly, to include almost every case in which a physician requests an item or service -- even requests for services to be rendered within the physician's own practice or facility. The bill relies on a special exception -- known as the "in-office exception" -- to protect "referrals" made within a physician's own practice or facility. This exception is currently found in Section 1877(b)(2) of the Social Security Act.

Unfortunately, in the case of radiation therapy services, the current language of the "in-office exception" would not achieve its objective. To qualify for this exception, the service in question must be provided at a site at which the referring physician (or another member of his or her group) furnishes services that are "unrelated" to the referred service. This language is fine for, say, clinical laboratories located within physicians' offices, as the physicians who "refer" to such laboratories generally provide a variety of services which are clearly "unrelated" to clinical laboratory tests. Radiation oncologists, however, do not provide any services that are "unrelated" to radiation therapy services. Thus, if H.R. 345 were enacted in its current form, not only would it prevent non-radiation oncologists from having an ownership interest in radiation therapy facilities, it would also prevent radiation oncologists themselves from owning, or having any financial relationship with, such facilities.

It may be possible to replace the current "unrelated" standard with other language more appropriate to the way in which radiation therapy services are actually delivered. However, we believe the best solution would be to adopt the approach taken by Senator Bingaman in his S. 337, which is also aimed at the self-referral issue. While that bill has some technical drafting problems as well, it adopts the straightforward approach of providing an explicit exemption for referrals by a radiation oncologist for radiation therapy services. We believe this is the simplest, most effective solution, with the least potential for unintended, unforeseen consequences, and we urge the Committee to adopt a similar approach.

OPPOSE INCORPORATION OF PAYMENT FOR RADIATION ONCOLOGY SERVICES INTO THE DRG AMOUNT

The President's budget proposal would fold payment for inpatient services furnished by radiologists, anesthesiologists, and pathologists into the Medicare DRG payments. As we understand it, the theory behind this approach is that few patients have a pre-existing relationship with their diagnostic radiologists, pathologists, or anesthesiologists, and, indeed, that patients rarely have any personal relationship with such physicians at all. Rather, it is said, diagnostic radiologists, pathologists, and anesthesiologists simply "come with the hospital." Therefore, it is argued, such physicians should be paid like other hospital employees, rather than being permitted to bill patients directly.

We believe that there are serious flaws with this line of reasoning. But whatever its merits in general, it certainly does not apply to radiation oncologists. Unlike the situation with other RAP physicians, radiation oncologists provide direct, sustained patient care, typically assuming primary responsibility for the patient during the entire treatment period, which may last for six to eight weeks or longer. Indeed, in marked contrast to the situation with, say, anesthesiologists and pathologists, patients often come to a particular radiation therapy program because of a particular radiation oncologist with whom they or their primary care physician are familiar.

Moreover, in many parts of the country radiation oncologists who work in the hospital setting have no formal relationship of any kind with their hospitals. Adoption of the Administration's RAPs proposal would force all radiation oncologists to enter into a formal contractual arrangement with each hospital at which they practice, in order to spell out the terms under which the basic DRG payment would be divided. We see no productive purpose that would be served by forcing radiation oncologists and hospitals to enter such a necessarily adversarial relationship.

We understand it has been suggested that, instead of incorporating inpatient RAP fees into the DRGs, the Committee should reduce all radiology, pathology, and anesthesiology fees in order to achieve a comparable degree of savings. We believe that such a course would be entirely unfair to radiation oncologists.

Radiation oncologists serve very few inpatients. In fact, because patients treated on an inpatient basis tend to have multiple medical complications, making them unusually difficult to treat, such patients tend to receive the shortest possible course of treatment. As such, the amount of savings that would be achieved from the incorporation of radiation oncology payments into the DRGs is minuscule. An across-the-board cut in all radiology, pathology, and anesthesiology payments would thus reduce radiation oncology payments by far more than would occur if the RAPs proposal, for all of its drawbacks, were adopted. We therefore urge the Committee to seek other methods of achieving the necessary savings.

EXEMPT RADIATION ONCOLOGY SERVICES FROM ANY REDUCTIONS IN PRACTICE EXPENSE RVUs

The Administration's budget proposal asks for reductions in the practice expense components of certain services. The Administration has not yet revealed which services it believes should be subject to this reduction. ACRO believes that no radiation oncology services should be so reduced.

In 1991, HCFA increased the RVUs for the practice expense portion of radiation oncology services by over 14%. This adjustment was based on data submitted by ACRO and other radiation oncology groups showing that previous payment levels failed to cover the costs of delivering these expensive services. After scrutinizing this data, HCFA concluded that a 14% increase was necessary to bring radiation oncology practice expense RVUs in line with actual costs. Radiation oncology was the only specialty given such an across-the-board increase.

Given HCFA's conclusion that current payment levels for radiation oncology services reflect actual costs, there can be no basis for alleging that these services are overvalued. Indeed, any reductions in current practice expense RVUs would cause payments to fall below actual costs. We therefore urge the Committee to exclude radiation oncology services from any legislative reductions in the practice expense component of physician payments.

* * * * *

If the Committee would like any additional information concerning these issues or if ACRO can assist the Committee in any way, please contact our Washington counsel, Joel Suldan, at 202/778-8008.

STATEMENT OF THE AMERICAN COLLEGE OF RADIOLOGY

The American College of Radiology appreciates the opportunity to present the following testimony for the record on issues related to the 1994 Medicare Budget.

The Administration's budget for federal fiscal year 1994 contains recommendations for further significant reductions in federal spending for Medicare. The ACR is concerned that these deficit reduction proposals are ill-conceived and fail to address the problems the administration claims are inherent in the Medicare payment system. The budget proposals ignore the tremendous efforts of medical groups, such as the ACR, who have worked in good faith with the Congress to address cost and payment concerns with the Medicare program.

The ACR has a proven track record of working with this subcommittee, the Congress and the Health Care Financing Administration to develop meaningful changes to the physician payment system. We expended tremendous efforts and resources to develop a fee schedule and a methodology for appropriate changes and modifications to it. We are pleased to note that much of our methodology for updating relative values was incorporated by the American Medical Association in its system for reviewing relative values and we are pleased to participate with the rest of medicine in that process.

The Administration now proposes to ignore these sincere efforts on the part of medicine. We believe the budget recommendations would have the effect of canceling our collective efforts to reform the physician payment system. Further, we believe that these recommendations are premature. Based on the most current data on volume performance standards, there seems to be a moderation in increases in physician payments in the Medicare program.

The most egregious proposal in the budget recommendations is that which again recommends bundling payments for radiology, anesthesiology and pathology into single payments based on diagnosis-related groups. We are surprised that the Administration has chosen this failed ill-conceived proposal from the previous Administration to include in its current Medicare budget recommendations.

The Congress has rejected this notion on several occasions including proposals in 1965, 1972 and 1987. After deliberation on the RAPs idea in 1987, the Congress adopted a provision in the law that specifically prohibits implementing such a system. We strongly urge you to reject this proposal for the fourth time.

The Administration claims the justification for the RAPs DRG proposal is over-utilization and increased utilization of radiology services in the in-patient hospital setting and attributes the increase to radiologists. This contention ignores the facts. Data from the Health Care Financing Administration shows that extraordinary increases in volume of services in radiology in the in-patient hospital setting is not attributable to radiologists, but to non-radiologists performing radiology services. Virtually all radiological procedures performed by radiologists are ordered by referring physicians. Secondly, the larger increases in radiology services have taken place in the out-patient and office setting. Further, we note that the increase in utilization of radiology services has occurred because of the incidence of self-referral by non-radiologists for diagnostic testing and treatment.

We are pleased that the budget recommendations address an important facet of the self-referral problem with a provision which would bar physician referrals to outside facilities in which they have ownership interest. For almost a decade, the ACR has raised this issue and we are pleased that recognition of this problem has now garnered almost universal acceptance. The ACR is pleased to have played a role in the AMA's adoption of a policy statement which addressed the abuse of these self-referral arrangements. We hope that 1993 will be the year for passage of legislation addressing joint venture self-referral. But, this is only a part of the problem.

Based on Medicare data and peer-reviewed studies, we find that joint venture self-referral is only a small portion of the self-referral problem. We are submitting these data and studies for the record. The growth of self-referral done directly by non-radiologists has been substantial. We believe that medicine and the Congress must address this utilization problem which would result in significant budget savings. In the Medicare program alone, we estimate scorable savings of $200 million annually.

Where there is inappropriate utilization beyond self-referral, we stand ready to define a system to eliminate it. Work has begun on such a system. To complete this work, we are willing to expend the same efforts and resources as we did in developing a fee schedule for Medicare payment. We believe we are uniquely positioned in the health care delivery system to develop patient care guidelines for diagnostic imaging and therapeutic radiology. Because of our consultative role in medicine, patients are seen on a referral basis and the Inherent conflict of interest in self-referral is avoided.

One way to address this problem is through the development of diagnostic patient care guidelines. These guidelines would identify what procedures are most beneficial to patients and also could identify which procedures are most cost-effective. We believe such guidelines would produce significant savings in the health care system with no impact on the quality of care given patients. We also believe that such a system would not only provide for the most appropriate care by physicians but that the care would be provided by those specifically trained to do procedures. It is essential that the system of patient care guidelines be unambiguous so there can be easy compliance and monitoring.

There must also be meaningful reform of the professional liability environment if guidelines are to work. Many states have adopted changes in the law to reform professional liability and we urge the Congress to do the same. We also urge you to adopt changes in the fraud and abuse laws which will make enforcement of these laws easier and more meaningful.

The ACR believes these initiatives to be realistic recommendations to deal with problems of cost and over-utilization of radiology services. Simply bundling RAP payments does nothing to address the issues of inappropriate utilization of services nor does it provide any safeguards to assure patients have access to the most appropriate care.

Our second major concern with the President's budget proposals is the recommendation to arbitrarily change the updates for Medicare physician payment. The RBRVS fee schedule was adopted to correct perceived inequities in physician payment. We believe it is inappropriate to change the system of updates which would effectively change the basis of a fee schedule that is not fully implemented and is still in the process of refinement.

The Congress the previous administration and the medical community expended considerable time, money and effort working together to develop a payment system for physicians that addressed perceived inequities in payment among physicians and among different localities across the country. Even though this fee schedule is only half way through the process of implementation, several proposals from the administration involve changes which would completely destroy the basis of the fee schedule. It is important to continue this transition to full implementation of physician payment reform including refinement of geographic practice cost differences and study of resource based practice costs.

An additional problem with the Medicare fee schedule is the previous administration's contention of a behavioral offset in response to changes in payments. We recommend fixing this and other problems with the fee schedule rather than throwing it out and starting over.

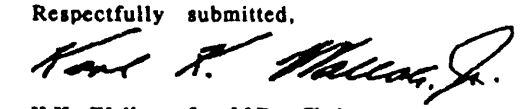
The ACR's third concern with the budget proposal is related to funding for training physicians. We believe it is inappropriate to arbitrarily decide that funding for training specialists should be reduced. The need for specific specialists should be based on need and not perception. Changing the supply of specific specialties is not a panacea for eliminating what some perceive inappropriate utilization of medical services. It is more appropriate to determine need for services and provide sufficient numbers of specialists to meet those needs. This will also allow for provision of the most appropriate care by the best qualified physician.

In addition to the specific problems we have with the Administration's budget proposals, there is a general observation to make regarding Medicare budget considerations. We question the appropriateness of discussing recommendations for policy changes in the Medicare program when the administration has not yet completed its work on the anticipated plan for reform of the health care delivery system. Some of the President's budget proposals raise policy issues that may be incongruent with proposals for health care system reform.

We will be happy to supply data concerning our ideas for your review. Some of this data is attached to our statement for your record. Our proposals will address your deficit reduction goals in a more appropriate way than those submitted by the administration.

As we have in the past, the ACR looks forward to working with the Congress and the administration to address concerns with the health care system.

Respectfully submitted,



K.K. Wallace, Jr., M.D., Chairman
ACR Board of Chancellors

ESTIMATED SAVINGS FROM ADDRESSING RADIOLOGY SELF-REFERRAL PERFORMED DIRECTLY BY NON-RADIOLOGISTS

Tabulations of the BMAD procedure file are the starting point for estimates. The 1991 BMAD procedure file shows approximately $800 million in allowed charges for diagnostic radiology performed by non-radiologist physicians. (Diagnostic radiology is measured here by all diagnostic procedures with CPT-4 codes in the 70,000 series. While most carriers probably think of diagnostic radiology in this fashion, it in fact omits important imaging procedures, particularly certain ultrasound and angiographic procedures. It also omits procedures inherently linked to some imaging, such as the injection and other procedures involved in angiography.)

The 1990 BMAD procedure file shows an essentially similar sum. The absence of growth from 1990 to 1991 is probably the result of an approximately 9% average reduction in the conversion factor applied to radiologic services.

Action on self-referral could affect not only payments to physicians, but also the Part B hospital facility fee (or technical component charge) paid in conjunction with diagnostic radiologic services rendered to hospital outpatients. Tabulation of the 1991 BMAD file shows 64 million relative value units (RVUs) (under the radiology RVS) associated with office radiologic services rendered by non-radiologists, with 25 million of these for the professional component of these services. To estimate hospital facility fees, we apply a similar ratio (64/25) to the $38 million that was paid to nonradiologists for diagnostic radiology in the hospital outpatient hospital setting. This indicates that total Part B allowed charges for these services were approximately $97 million, some $60 million larger than allowed charges for physicians. Thus, the total allowed charges of concern were approximately $800 million plus $60 million, or $860 million in 1991.

This amount must be projected into future years. We assume no growth from 1991 to 1992 because payment level reductions were approximately as large as 1991's 9%. We assume 5% annual growth thereafter through 1996. This is conservative, as reductions under the RBRVS transition rule are averaging approximately 2% annually for the mix of professional and technical component services represented by the activities of nonradiologists. After 1996, we assume 7% growth. Thus, the allowed charges of concern are projected to be:

FY1994	$950 million
FY1995	$1.00 billion
FY1996	$1.05 billion
FY1997	$1.12 billion

One approach to the issue would be not to pay non-radiologists for diagnostic radiology services. A study published in the *New England Journal of Medicine* (attached) found non-radiologists were four times as likely to order imaging services if they self-referred than if they referred patients with the same problems to radiologists for imaging services. Another study, published in the *Journal of the American Medical Association* (attached), examined a different patient population and different medical problems. It found self-referrers 1.7 to 7.7 times as likely to order imaging services as physicians seeing patients for the same conditions but sending their patients to radiologists for imaging work. We have assumed that if non-radiologists were not paid for diagnostic radiology, they would refer half as many patients for imaging studies. This is conservative (i.e., a low number) as it represents picking 2 as the "right number" from one study showing 1.7 to 7.7 as the

appropriate number and another showing 4 as the number. Following our assumption, one would expect half the above-listed amounts of allowed charges to disappear. Savings to Medicare would be only 80% as great because Medicare pays only 80% of allowed charges. Moreover, the Medicare actuary always assumes that "behavioral response" negates half of any savings. Including the actuary's behavioral assumption, the savings to Medicare would be $190 million in 1994 rising to $225 million in 1997, and the four-year total would be $825 million.

Another approach, already being used by one Medicare carrier, is not to pay non-radiologists for the professional component of diagnostic radiology services. Under this approach the allowed charges of concern are the professional component amounts for non-radiologists' hospital diagnostic radiology services (both inpatient and outpatient), which totaled $95 million in 1991, plus the professional component part of their allowed charges for services rendered in offices and centers. We estimate the latter, again based on the division of RVUs, as 25/64 of the $702 million in allowed charges for their non-hospital services, or approximately $275 million. Thus, the total allowed charges of concern were $95 million plus $275 million, or $370 million, in 1991.

Projecting this amount foward, using the same method already described, yields:

FY1994	$410 million
FY1995	$430 million
FY1996	$450 million
FY1997	$480 million

Again Medicare would save only 80% of these amounts because it pays only 80% of allowed charges. Using the Medicare actuary's behavioral assumption, which cuts all savings in half, implies savings would be $165 million in 1994 rising to $190 million in 1997, with a four-year total savings of approximately $700 million.

If non-radiologists, in response to this approach, changed behavior by referring some patients for imaging, then savings would probably be intermediate between those shown for the two approaches.

The financial results shown are for Medicare only. If action were taken in all federal programs, including Medicaid and CHAMPUS, savings obviously would be larger. Federal Medicaid spending (excluding amounts spent on long-term care) is approximately one-third as large as federal Medicare spending, so savings in Medicaid probably would be approximately one-third of those listed for Medicare.

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Rick Pollack, Executive Vice-President for Federal Relations at AHA. I am accompanied by Jim Bentley, Senior Vice-President for Policy. On behalf of AHA's 5,300 institutional members, I am pleased to testify today on the President's FY 1994 budget proposal .

I would like to cover three basic points in my testimony this morning. First, the AHA is very concerned about the impact further Medicare and Medicaid savings will have on the nation's hospitals and the communities they serve. Second, although some short-term budget savings may be necessary, it is imperative that they be linked to the long-term goal of a health care reform package that provides both universal access and a restructuring of the delivery system. Finally, while we work on real reform, we must address the need for fairness and accuracy in the current Medicare program.

As you know, the Administration's FY 1994 budget proposals for Medicare and Medicaid are one part of an economic package that aims to stimulate the economy, create long-term job growth and reduce the federal budget deficit. We support these goals and believe it is in the best interests of the communities we serve that the nation's economy gets back on track. We further recognize that a strong economy generates job growth and health coverage in the private sector. To achieve deficit reduction and economic growth, the President has asked for sacrifices to be made. We understand that hospitals need to participate in the shared sacrifice required of all Americans in the short term to attain our shared long-term goals.

Yet, as we work toward these laudable goals, we must ensure that the sacrifice is fair and that budget decisions lead toward, not away from, a solution to our nation's health care crisis. To accomplish real and fair health care reform, everyone needs to understand how budget decisions made today will affect hospitals and their communities.

In May, when the President presents his comprehensive health care reform plan to the Congress and the American public, we will all be engaged in an important discussion about the future of our nation's health care system. While we look forward to that dialogue and are eager to work with this Committee and the Congress, we must ensure that existing federal programs do not undermine providers' ability to meet the legitimate needs of their patients. Purely budget-driven decisions can exacerbate our nation's health care problems and weaken the infrastructure upon which a reformed system must be built. Consequently, we need to carefully examine President Clinton's FY 1994 budget proposal in terms of its impact on hospitals and the communities they serve.

MEDICARE AND MEDICAID SAVINGS IMPACT

The President's budget proposal calls for nearly $60 billion in savings for Medicare and Medicaid over the next five years. This comes at a time when the Prospective Payment Assessment Commission (ProPAC) estimates that for FY 1992 the aggregate PPS margin--for both urban and rural hospitals--was negative 8.3 percent and AHA estimates that for FY 1993, two-thirds of the nation's hospitals were forced to subsidize the cost of treating Medicare patients. AHA further estimates that four-fifths of all hospitals lost money treating Medicaid patients in FY 1991. Many of these vulnerable hospitals provide the only access to health care services for specific populations such as the poor, elderly and rural Americans. Reductions in Medicare spending have exacerbated shortfalls between payments and costs in ways that hospitals cannot sustain.

UPDATE FACTOR/CAPITAL

The President's budget proposal delays the FY 1994 PPS update by three months until January 1, 1994, limits the growth in these factors for FYs 1994 and 1995, and extends the 10 percent reduction in capital payments. Clearly, these proposals would exacerbate an already difficult situation for those institutions experiencing losses and place increased pressure on their ability to continue providing high quality services to Medicare beneficiaries.

OUTPATIENT PAYMENTS

The proposals offered by the Administration serve only to further fragment outpatient payment policies without taking any steps toward comprehensive reform. Continued tinkering with the numerous payment systems currently used to pay for outpatient services meets short-term budget needs only. While we look forward to examining the Administration's proposal for reform of outpatient payment, we believe that only with systemic reform will these issues be adequately resolved.

GRADUATE MEDICAL EDUCATION

The President's budget proposes significant cuts in payments to hospitals that train physicians. First is a reduction in indirect medical education payments, provided to cover the indirect costs of running teaching programs. It has long been recognized, and deemed appropriate, that these payments also compensate for the additional costs associated with the patients these hospitals treat. In the context of their broader mission of education, teaching hospitals typically care for a greater number of indigent patients and those with higher severity of illness. Care must be taken, before further reducing this adjustment without enacting simultaneous access reforms, to ensure that these patients continue to receive appropriate care.

Second, the budget recommends basing direct medical education payments on a national per-resident amount--using resident salaries only--and further modifying payments by differential weighting depending on choice of specialty. We understand the need to implement incentives to train more primary care physicians, but do not believe that paying hospitals less for training other, non-primary care, physicians is the incentive that will most affect the choices of graduating medical students. Only long-term, comprehensive reform of the delivery and financing of health care will properly align incentives in the direction of primary care.

These cuts in graduate medical education could exacerbate the financial situation of teaching hospitals--many in our nation's inner cities--where residents in training provide a large portion of the care to the medically indigent. The Association of American Medical Colleges will present detailed testimony at this hearing on these issues. We share their commitment to protect those vital hospitals.

PAYMENT FOR INPATIENT RADIOLOGY, ANESTHESIA AND PATHOLOGY

AHA is encouraged by the Administration's apparent commitment to aligning hospital and physician incentives as a method of controlling spending across all sites of care. In fact, a bundled payment is consistent with our vision of reform and the need for integrated payments. However, until these incentives are broad-based and the delivery system is restructured at the local level by collaborative arrangements among hospitals and physicians, hospitals should not be unfairly burdened by a federal requirement imposing a new relationship on hospitals and their medical staffs.

HOSPITAL-BASED HOME HEALTH SERVICES

The President's budget proposes to reduce payments for services provided by hospital-based home health agencies. These reductions could result in access limitations for some beneficiaries. A 1992 General Accounting Office report indicated that add-on payments for hospital-based home health agencies (HHAs) are consistent with Medicare reimbursement principles, recognizing that mandatory Medicare cost-reporting procedures result in approximately 13 percent more overhead costs attributed to hospital-based programs. In commenting on this report, the Department of Health and Human Services also pointed out that "hospital-based HHAs can offer more services to the beneficiaries and offer a continuum of care not available from freestanding HHAs . . . where hospital-based [HHAs] are adversely affected by eliminating the add-on, beneficiary access to certain quality services may be reduced." It logically follows that eliminating payment adjustments that reimburse hospitals for legitimate cost differences and promote access to services are not in the best interest of the communities we serve.

MEDICAID ADMINISTRATIVE MATCH

The President's budget proposal calls for approximately $8.4 billion savings in Medicaid program savings over the next five years. AHA asks that the options for controlling future Medicaid program spending be evaluated in broader terms than simply the dollar amount of budget savings. The Medicaid program serves as the insurer of last resort for the most vulnerable of all Americans--it is the safety net for the poor and medically indigent. Reductions in a program that is already underfunded to the point that it can only pay 82 cents for each dollar of acute care it purchases must be carefully planned so we do not deny access to quality health care to those most in need of public support.

A significant portion of the Medicaid savings called for in the President's budget proposals will be realized through decreases in the federal portion of the administrative expense of operating the Medicaid program at the state level. This comes at a time when states are facing severe fiscal pressures. A closer look at the many different administrative functions performed at the state level shows that program administration focuses on much more than eligibility processing and claims payment. Certain administrative functions are critical to protecting the financial integrity of the program; examples include anti-fraud and abuse units, audit programs, and coordination of payment with other insurers. Limiting these activities may result in higher program costs in the long run if the states are less able to ensure the fiscal integrity of their programs.

There are other costs of reducing administrative expenditures that cannot be measured solely on a dollar basis. These are the human costs of limiting programs designed to assure that Medicaid beneficiaries have access to high quality services. Utilization review is one type of program designed to safeguard the quality of care; facility certification/licensure is another.

AHA'S VISION FOR HEALTH CARE REFORM

These proposed Medicare and Medicaid hospital savings in the President's plan total over $30 billion for FYs 1994-1998. They must be viewed, however, in a broader context. Hospitals have made significant contributions to deficit reduction in past budget bills; Medicare hospital savings alone in the Omnibus Budget Reconciliation Act of 1990, for example, totaled almost $16 billion. And any reductions in the Medicaid program must be subject to the keenest scrutiny to evaluate both their dollar savings and their human costs because adversely affecting the health of the elderly poor, and indigent mothers and children is too high a price to pay for short-term stimulus of the economy.

Despite the magnitude of these savings, this year presents us with an opportunity we have not had in past years. It is imperative that whatever budget savings are ultimately enacted in the short term are accomplished fairly and that we remain focused on the long-term goal of meaningful reform that achieves universal access and a restructured health care delivery system.

Further, we must ensure that these measures do not freeze the current fragmented health care system in place. The solution to our nation's health care crisis is not in tinkering with current flawed payment systems such as Medicare PPS. Indeed, meaningful health reform can only come about through universal access and restructuring both the financing and delivery system to encourage more prudent and appropriate behavior by providers, payers, and consumers at the local level. Only in this way will we achieve universal access to needed services at a cost this country can afford.

The AHA's top priorities are achieving universal access and restructuring health care delivery around Community Care Networks.℠ These networks would be consortia of hospitals and other institutional providers, physicians and other health care professionals, insurers, employers, unions and others groups.

Networks would be expected to provide patients with a broad, coordinated continuum of care, focused on improving the health status of their enrollees. In return, community care networks would be paid on a capitated basis, receiving a fixed annual payment per individual. The allocation of resources among providers within the network, including the method and level of payment to various participating providers, would be determined within each network.

Networks would give providers greater freedom to make decisions without micro-management by government payers and insurers. In exchange, networks must be accountable. Networks might provide regular reports to communities on health status improvement, patient satisfaction, and provider satisfaction with network relationships.

The AHA believes that community care networks hold the best promise for reducing inappropriate competition within our system; improving patient care; and eliminating unnecessary care, duplication of services and excess capacity. Restructuring our health care system into capitated networks will increase the focus on preventive and primary care services.

TRANSITIONAL ISSUES

While we work toward reform, hospitals must continue to operate under Medicare PPS. There are a number of areas where this system could provide more equitable payments to hospitals.

LABOR MARKET AREAS

The movement away from the use of metropolitan statistical areas (MSAs) to define labor areas, and toward a definition more specifically representative of local labor costs is a much needed conceptual improvement. ProPAC has presented a proposal on this subject in its March report. We would expect such a modification to minimize the differences in wage index values between neighboring areas and to prevent the grouping under a single wage index of hospitals separated by several hundred miles, as is currently the case for many rural hospitals.

AHA appreciates the complexity of the task ProPAC has undertaken in trying to identify more appropriate labor markets and feels that they have made excellent progress in this direction. We look forward to additional details on the methods as well as further impact analyses to determine the appropriateness of the significant payment redistributions that such a change would likely entail.

OUTLIER PAYMENT

The AHA continues to support *measured* movement away from day outlier payments, toward a greater emphasis on cost outlier payments. ProPAC's recommendation to completely eliminate day outlier payments within three years, however, would cause severe disruption of payment for a significant number of hospitals. We feel that any such change should be phased in over a longer period.

The suggested increase in the outlier pool to six percent of total PPS payments (from the current 5.1 percent) should be deferred until the effects of eliminating the day outlier payment are better understood and there is real assurance that all currently reserved outlier funds will be fully disbursed.

PPS EQUITY

In discussing equity adjustments to the existing Medicare system, we must not forget the numerous proposals passed by the Congress last year as part of H.R. 11, but vetoed by President Bush. H.R. 11 reauthorized the Essential Access Community Hospital program, provided for separate payment for the interpretation of EKGs, phased in changes in outlier payments, and contained important provisions to assist hospitals to keep their Medicare dependent and rural referral center status until the urban/rural differential is eliminated. AHA fully supports these proposals and, like ProPAC, we continue to support the elimination of the urban-rural differential by October 1, 1994, as mandated by Congress.

AHA commends the members of this Committee for their leadership in helping to pass these provisions last year and we are pleased to see that Sen. Dole has introduced--in S. 176, the Medicare Amendments of 1993, with seven Finance Committee members among the cosponsors--a number of these provisions, including Medicare dependent hospitals, rural referral centers, and payment for interpretation of EKGs. We are also heartened that President Clinton included, in the public investment section of his FY 1994 budget package, a rural health initiative that includes the Medicare dependent rural hospital reauthorization and the rural referral center provision.

We urge the Committee to include all of H.R 11's important Medicare equity proposals in this year's reconciliation package.

CONCLUSION

As America's hospitals prepare for health care reform they must continue to operate under the current system, complete with a flawed and inequitable Medicare program and a Medicaid program that struggles to serve as the current safety net for the medically indigent. Both the members of this Committee and ProPAC have supported important improvements to PPS. We stand ready to work with you to achieve these goals as well as to make the difficult choices required to meet the President's goal of a stronger economy. The President has asked for shared sacrifice from all Americans, including the nation's hospitals--many of which are financially vulnerable because of continued tinkering and past deficit reduction efforts.

We have worked with our members to develop a constructive approach to respond to the nation's health care crisis and look forward to working with you and the Administration in the months ahead. AHA is committed to meaningful health care reform that achieves universal access and a restructured health care delivery system.

STATEMENT OF THE AMERICAN ORTHOTIC AND PROSTHETIC ASSOCIATION

Introduction

The American Orthotic and Prosthetic Association (AOPA) is the national membership organization which represents more than 800 allied health care provider firms who serve the needs of the physically challenged throughout the United States. Orthotic and prosthetic practitioners employed by AOPA member firms design and fit orthoses (braces) and prostheses (artificial limbs) which enable these physically challenged individuals to overcome often serious and crippling injuries and return to productive lives.

These are AOPA's views on the President's budget proposal and proposals to modify Part B of the Medicare program relating to orthotics and prosthetics (O&P). While we discuss the President's budget, we recognize that this budget is also a vehicle used develop and implement public policy.

The Administration's Proposals for Fiscal Year 1994

In introducing his budget this year, President Clinton stressed the need to invest today to build a stronger tomorrow, a tomorrow that does not demand enormous amounts of money and sacrifice to right pervasive problems. Instead, investment made today for prevention and preservation will build a strong future, one not built upon a devastatingly weak foundation. We believe these principles hold true for the successful rehabilitation of patients who suffer muscular, skeletal and limb-loss disability. Specifically, early investment in rehabilitation that provides braces and artificial limbs mainstreams people. Mainstreaming entails restoring people to their optimum level of function, allowing them to pursue employment and other activities, and thus lead productive, independent lives. These independent Americans contribute to society.

Failing to restore individuals to their optimum level of function increases dependency, thus limiting their ability to remain productive, economically independent members of society and increasing their need for added medical, social service and state care, which impose great expenses upon society.

To accomplish the goals of reducing health care expenditures tomorrow by providing assistive technology today, such as quality orthotics and prosthetics, it is crucial that O&P care is:

1. recognized by Medicare as **distinct** and **separate** from the vending and renting of durable medical equipment; and,

2. provided by qualified board certified practitioners.

Separation of O&P from DME and Qualifications of Providers

In the past, confusion has arisen over the definition of orthotics and prosthetics. While in a limited sense the definition of orthotics and prosthetics has been addressed by Congress, the results have been very broad and have included a number of items not characteristic of O&P care. To clarify this confusion, the organized field of O&P is strictly defining orthotics as "braces" and prosthetics as "artificial limbs", and proposes that Congress do the same.

Orthotics and prosthetics are radically different from durable medical equipment in that O&P health care "services" are highly

individualized to specific patient needs, and are as much a professional "service" as a "product". The "product" element of the O&P practice is only part of the total package of treatment provided by an O&P practitioner, and reimbursement for the service element is specifically included in O&P's Medicare reimbursement codes. O&P devices are generally custom-fabricated and custom-fit for each individual patient, unlike DME products, which are reusable and rentable by other individuals.

The approximately 2,700 certified practitioners provide artificial limbs and braces that are designed in response to a physician's perscription and meet the unique needs of individual patients. O&P patient care services include evaluation, consultation, design, individual fabrication, fitting and patient orientation training.

Further, the O&P medical field is completely different from DME in that O&P has a defined body of technical knowledge, a core of certified practitioners, and a well-established post-baccalaureate education program offered at eight major American universities.

It is important to note that these wide differences in O&P and DME were addressed by Congress in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). In practice, though, the statutory separation is in name only, as it has not brought any concrete separation in the treatment of O&P with respect to the Health Care Finance Administration's (HCFA's) philosophical and financial practices.

The past practice of continuing to group O&P with DME, despite the OBRA '90 recognition of separation, has resulted in confused or limited understanding of this small but important component of rehabilitation.

The President's 1994 budget proposal further confuses O&P and DME by again inappropriately placing O&P's highly specialized patient services with a group of apparatus providers who primarily sell or rent products to support certain treatment modalities.

Congressional Proposals Pertaining to O&P and DME

There are several proposals in Congress that address the fraud and abuse which are believed to be rampant in the delivery of DME products. The organized field of O&P supports these efforts to eradicate fraud and abuse, but does not believe these proposals are applicable to the O&P field, because, as previously discussed, the delivery of O&P patient care service is inherently different from the provision of DME.

Conditions of Coverage

The second area that is crucial for helping to reduce health care expenditures is conditions of coverage. To ensure that all Medicare patients enjoy the quality of O&P care, the organized field supports establishing conditions of coverage. While the Medicare billing system was designed to permit fair and equitable reimbursement of O&P devices and services, these codes are used by apparatus providers who do not provide the same product/service combination as O&P practitioners. This has created significant and unintended problems in Medicare reimbursement of O&P services, and may contribute to DME fraud and abuse. Since O&P practitioners are generally not subject to state licensure, O&P provider numbers may be accessed by virtually anyone.

Although O&P practitioners provide health care products and services for which they are highly trained and certified, the Medicare program has no conditions of coverage for O&P services, as it does for similar services, such as those of physical

therapists. Such an omission puts the patient at risk through exposure to unqualified practitioners. To address this, the organized field of O&P recommends that conditions for coverage be established under Medicare for the provision of O&P products and services. This measure would serve to promote the quality control of O&P health services provided to Medicare beneficiaries. A definitional standard similar to the one used by HCFA for physical therapists could easily be incorporated into HCFA administrative policies. This measure could be accomplished in the context of the budget proposal.

Such conditions for coverage also compliment President Clinton's goal of investing today, in this case investing in the recognition of quality care, to ensure less expenditure tomorrow. Further, the creation of conditions of coverage for O&P services under Medicare would greatly benefit the Medicare beneficiary as well as HCFA, thereby establishing high standards for quality care.

Conclusion

It is my hope that this testimony has demonstrated that the organized field of O&P has acted responsibly with respect to the delivery of health care and has not contributed to spiralling health care costs, and more specifically, has not contributed to cost spirals that result from DME fraud and abuse. For example, it is important to note that the O&P field **CAN'T** market artificial limbs and braces through unsolicited telephone calls; **CAN'T** sell unneeded artificial limbs and braces; **CAN'T** engage in carrier shopping; and, **CAN'T** provide unnecessary tests to bilk Medicare. In short, O&P has not used these tactics to gouge Medicare. Therefore, using the typical methods of curbing fraud and abuse in DME inadvertently makes it impossible for legitimate O&P practitioners to recommend devices based on functional necessity rather than just medical necessity. Once again, functional necessity is an investment made today to assure an independent and cost effective future for the physically challenged.

Any attempt to reduce or restrict reimbursement for O&P would adversely impact the profession. To illustrate, increases in reimbursement for O&P practitioners over the last ten years have at times been as low as zero, and never more than five percent. These limited increases in Medicare reimbursement have been difficult to sustain since O&P practitioners have no control over the costs of their components. Should a component increase in cost by 15 percent from manufacturers, the O&P provider can not pass the increase to medicare or the patient, but must cover this increase within the allowed reimbursement amount for the finished product and service.

Finally, because the population that uses these products is so limited, it is impossible to recapture production and research costs through economies of scale, as other products in the marketplace often do. In this regard, O&P has problems similar to orphan drugs.

Quality O&P services, which are investments in rehabilitation/preventive care that save money on expensive treatment in the future, are the next logical step to compliment the American with Disabilities Act (ADA). After all, what good are designated handicapped parking spaces near the food market entrance if an amputee is unable to climb out of the auto and walk to the door?

If the delivery of O&P services is not enhanced, we predict the wisdom of the ADA cannot become a reality. For O&P practitioners to continue providing quality care to its patients, the O&P field must be recognized distinct and separate from DME.

STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

The American Physical Therapy Association (APTA), which represents over 57,000 physical therapists, physical therapist assistants and students of physical therapy, commends the Committee for holding this hearing and appreciates the opportunity to submit this testimony.

Physical therapists are affected by a number of provisions in the President's Budget Proposal and in other health care legislation which will be before the Committee as part of any Reconciliation package. Our comments include:

- support for the provision to ban physician ownership and referral of physical therapy services;
- support for legislation to eliminate Medicare's $750 annual limit on physical therapy services provided by physical therapists in independent practice; and
- modification of language in the Miscellaneous and Technical Medicare Amendments Act of 1993 to allow greater provider participation in the development of pediatric relative value units.

BAN ON SELF REFERRAL FOR PHYSICAL THERAPY SERVICES

The APTA supports President Clinton's inclusion of a physical therapy self referral ban in his Budget Proposal. However, we believe that the provision does not go far enough because it will permit physicians to skirt the law by converting joint venture operations into employer/employee relationships.

The excess cost to our health care system associated with physicians being permitted to own and self refer patients to physical therapists, laboratories, radiological facilities, pharmacies and other services has been well documented.

In 1989, the Florida legislature mandated that State's Health Care Cost Containment Board examine the impact of joint ventures in health care on the cost of services, quality of services and access to services in Florida. Physical therapy services were surveyed in two settings: free-standing physical therapy facilities and comprehensive rehabilitation centers that provide physical therapy services. The findings were dramatic.

Physician-owned physical therapy facilities provided 43% more visits per patient than did non-joint-venture physical therapy facilities, generating approximately 31% more revenue per patient in joint-venture facilities than in non-joint-venture facilities. At comprehensive rehabilitation facilities, 35% more physical therapy visits were provided per patient in joint-venture facilities, generating approximately 10% more revenue per patient than in non-joint-venture facilities.

Equally important, the Florida study found that quality of care in joint-venture facilities was lower than in non-joint-venture facilities, and that joint-venture facilities did not increase access to services. In fact, the non-joint-venture facilities offered increased access to a wider range of clients. (Higher quality of care and increased access to services are often cited as rationales to defend joint ventures.)

Subsequent to the study conducted in the State of Florida, the Center for Health Policy Studies estimated the impact of physician joint ventures on medical care costs in Florida. This was done for three categories of services: imaging services (MRI and CAT Scan tests), clinical laboratory services and physical therapy services. Estimates for 1991 were developed based on findings from an analysis of Medicare claims data, results from the report by the Florida Health Care Cost Containment Board, "Joint Ventures Among Health Care providers in Florida" and from other sources. The estimated 1991 cost impact of physical joint ventures for these services in Florida are:

• Imaging Services (MRI tests and CAT Scans) (74% of MRI costs, 16% of CAT Scan Costs)	$322.9 million
• Clinical Laboratory Tests (16.3% of clinical lab costs)	$167.0 million
• Physical Therapy Services (2.4% of physical therapy costs)	$10.9 million
TOTAL	$500 8 million

The cost estimates for clinical laboratory and physical therapy services likely understate the true figures as only additional costs for users of these services were estimated. The incentives for physicians to refer to joint venture facilities likely also resulted in an increase in the number of users, the cost impact of which is not included in the estimates.

Spurred on by the findings of the Florida study, William M. Mercer, Inc. analyzed spending under California's mammoth Workers' Compensation program which will spend an estimated $3.6 billion for medical care in 1992.

The Mercer study found that if an injured worker received initial treatment from a provider with an ownership interest in physical therapy services, that patient received a referral to physical therapy 66% of the time. If, on the other hand, the injured worker received initial treatment from a provider with no ownership interest in physical therapy, the patient was referred to physical therapy 32% of the time.

The study concludes that the added incentive for investing physicians to refer to physical therapy generates approximately $233 million per year in services delivered for economic rather than clinical reasons.

While the President's proposal is a good first step, it contains a loophole which would allow physicians to skirt the intent of the law. The provision would still allow physicians to convert and continue to own physical therapy clinics where the health care staff are employees. This loophole would allow financial interest to remain in the referral process.

The APTA recommends that legislation be enacted to ban this practice of physician self referral to services to which they control access either as a matter of law or third party reimbursement policy. As the law is currently written, physicians are encouraged to offer through their employees the very services which other nonphysician practitioners are licensed by the States to provide but for which a physician's referral is required.

Consequently, if physicians are prohibited from investing in these services, such as physical therapy, but encouraged to offer them through their employees, a significant part of the problem will still remain. The situation will become that those physical therapists who are unwilling to become employees of referring physicians will simply not receive physician referrals and will, therefore, be precluded from providing the services they are licensed to provide.

We urge that Congress repeal Section 1128B(b)(3)(B) of the Social Security Act. This provision of the law protects these very arrangements from being categorized as fraud and abuse situations.

MEDICARE'S $750 ANNUAL LIMIT ON PHYSICAL THERAPY SERVICES

Legislation will shortly be before this Committee to eliminate Medicare's $750 annual limit on physical therapy services that a beneficiary can receive from a physical therapist in independent practice (PTIP). This arbitrary limit is a redundant and ineffective means of utilization control and cost containment because several Medicare requirements already provide adequate protection and control.

Current Medicare coverage guidelines ensure the medical necessity of treatment by requiring that physical and occupational therapy services provided to a beneficiary:

1) be prescribed by a physician;
2) be furnished under a written plan of treatment approved in writing by the beneficiary's physician (the plan must relate the type, amount, frequency and duration of the therapy services and indicate the anticipated goals of treatment. Any changes in the plan of treatment must be approved by the physician); and
3) the beneficiary's physician must review the plan of treatment and recertify the patient's continuing need for therapy services at least every 30 days.

Additionally, the Health Care Financing Administration (HCFA), under the mandate of the Omnibus Budget Reconciliation Act of 1989 (PL 101-239), has placed the services of PTIPs under the physician fee schedule and volume performance standards. This measure controls payment for therapy services by a fee schedule; and overall volume of services are subject to volume performance standards.

Under current Medicare law, there is no limit to physical therapy services when they are provided either in a physician's office or in other provider settings. Medicare only limits coverage for services provided by PTIPs. When a patient who receives services from a PTIP reaches his or her limit, the patient must either stop treatment, change to a therapist in another provider setting, or pay for these services out-of-pocket. Not only is it a burden for older and disabled Americans to change providers, but for those Medicare patients who live in areas where there is a shortage of health care providers such as rural areas,a physical therapist in another setting may be unavailable. Medical necessity and cost containment are ensured by the provisions mentioned above; not by an arbitrary limit of $750. This limit merely disrupts necessary treatment of Medicare beneficiaries.

In the last Congress, Representative Bill Richardson (D-NM) and Senator John Chafee (R-RI), along with 62 of their colleagues sponsored legislation to eliminate the $750 limit. They are preparing to reintroduce this legislation into their respective bodies in the very near future. The APTA asks the Committee to end this burden on older and disabled Americans by rapidly passing this legislation.

EXPAND PROVIDER INVOLVEMENT IN PEDIATRIC RBRVS DEVELOPMENT

The APTA believes that the wording of Section 206 of the Miscellaneous and Technical Medicare Amendments Act of 1993 (H.R. 21) needs to be modified. Section 206 directs the Secretary of Health and Human Services to explore development of a Resource Based Relative Value System (RBRVS) for pediatric services in consultation "with appropriate organizations representing pediatricians and other physicians."

This provision should be amended to ensure that not only physicians, but all health care groups who would be affected by a pediatric RBRVS system are included in the development of such a system.

The APTA supports the development of pediatric resource based relative value units (RBRVUs) because of the inherent differences in the way services are provided to pediatric and adult populations. Pediatric physical therapists deliver a wide range of services to children in schools, homes, private offices, and other community settings. We can be a major resource in the development of physical therapy RBRVUs.

Our concern about being excluded from this process is well founded. HCFA developed RBRVUs for physical medicine codes in the Medicare physician fee schedule with no input from physical therapists. The research team contracted by HCFA decided to solely rely on physician input. The result was a coding system which satisfied neither HCFA nor physical therapists in independent practice, who are required to bill under the Medicare fee schedule. The RBRVUs which were developed were so inaccurate that they were eventually rejected by HCFA. HCFA and the APTA are currently working to develop a coding system which reflects the full scope of physical therapy services and contains equitable RBRVUs. This could have been avoided if we were initially included in the process.

Because any system of codes and values for pediatric services extends beyond physicians to physical therapists as well as other nonphysician providers, the APTA strongly requests that Section 206 be amended by striking "physicians" in the last sentence (page 45, line 24 of H.R. 21) and replacing it with "health care providers."

The APTA appreciates the opportunity to provide this testimony and we are willing to work with the Committee on these and other issues of mutual concern.

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Mr. Chairman, I am Melvin Sabshin, M.D. I am a psychiatrist, and serve as Medical Director of the American Psychiatric Association (APA), a medical specialty society representing more than 38,000 psychiatric physicians in the United States.

The efforts of the Clinton Administration, and the continuing efforts of the Congress and particularly yourself and members of the Finance Committee to reform the nation's health care system pose a unique opportunity for redressing discrimination against persons with mental illness, and for ensuring -- once and for all -- that those who suffer from these illnesses have access to the care their illnesses require for effective treatment.

Sadly, discrimination against persons with mental illness is an ingrained aspect of American culture. Our acceptance of pejorative terminology for mental illnesses has two main results. First, it desensitizes the public to the reality that persons with mental illnesses are in fact suffering from illnesses, just like millions of Americans who suffer from heart disease, cancer, or diabetes. Second, by dehumanizing the victims and denigrating the illness, it facilitates discrimination in health insurance coverage for persons with mental illness.

More than any other medical doctor, psychiatrists know first hand about the health insurance crisis affecting the United States. As the "primary care" physician for persons with mental illness, we are confronted every day by the fact that many of our patients effectively have no health insurance, particularly if they suffer from "severe" mental illness.

Our insured patients face discrimination in the form of higher coinsurance or different arbitrarily established limits on inpatient or outpatient coverage duration for their mental illness than is otherwise applied to other non-psychiatric medical illnesses. Regrettably, many of our patients because of stigma refuse to use the insurance coverage they have purchased out of fear of being denied health insurance if they ever change jobs.

Even the Federal Government is guilty of "discrimination by diagnosis." More than 30 years after the enactment of the Medicare program, our nation's senior citizens and disabled Medicare beneficiaries must still pay out of their own pockets 50 cents of every dollar for outpatient care by a physician psychiatrist, clinical psychologist, or clinical social worker. This is direct and blatant discrimination by the Federal Government against persons with mental illness. APA has worked for many years to end the 50 percent Medicare outpatient mental health coinsurance requirement, and we urge you to make this a reality this year.

Yet such discrimination is in stark contrast to the scope and prevalence of these illnesses. Mental illness (including substance abuse) affects tens of millions of Americans, knows no geographic boundary, respects no income distinctions, and is unaffected by race, sex, or religion.

- **Some 40 million adults in the United States suffer annually from diagnosable mental disorders, including mental illness and alcohol and drug disorders.**
- **11 million Americans suffer from "severe" mental illnesses such as schizophrenia, bipolar disorder (manic depression), or major depression.**
- **12 million children suffer from some form of mental disorder.**
- **Maternal alcohol abuse is the leading *preventable* cause of mental retardation in children.**

- **One third of the nation's homeless persons suffer from severe mental disorders.**

- **One-fifth to one-quarter of persons with AIDS will develop AIDS-related cognitive dysfunction. Two-thirds of all persons with AIDS will develop neuropsychiatric problems.**

- **Mental illness is a major problem among our nation's elders. At least 50% of elderly nursing residents have a diagnosis of a mental disorder such as major depression. The suicide rate for the elderly is twice that for the general population.**

- **Alzheimer's disease is the fourth leading cause of death among U.S. adults, afflicting an estimated 4 million elderly Americans who, along with persons with other dementias, occupy more than 50% of the nation's nursing facility beds.**

- **30,000 Americans commit suicide each year. Suicide is the third leading cause of death for individuals between the ages of 15 and 24. Among adolescents, suicide has increased by 30 percent since 1950.**

Discriminatory insurance coverage, and the concomitant lack of access to needed treatment, stem from a series of myths -- rooted in ignorance and fear -- about mental illness. The three most pervasive myths about mental illness and its treatment are as follows:

- **Myth Number One: "Diagnostic Criteria are Too Broad for Mental Illness."**

The fact is that mental disorders are at least as clearly definable as "physical" disorders.

According to recent data from the National Institute of Mental Health (NIMH), *the full spectrum of all mental disorders affects about 22 percent of the adult population in a given year;* 7 percent of the population have symptoms which last for a year or longer, and; only 9% of the population report some disability associated with mental disorders. Using similar criteria, *50 percent of the adult population suffer from respiratory disorders, and 20 percent suffer from cardiovascular diseases.*

Mental illnesses are thus clearly and objectively diagnosable, and do not occur in "disproportionate" numbers relative to the incidence of other non-psychiatric medical disease in the population as a whole.

- **Myth Number Two: "Mental Illnesses Cannot Be Effectively Treated."**

The fact is exactly the opposite.

The NIMH data shows that treatment of severe mental illnesses, including bipolar disorder, obsessive compulsive disorder, panic disorder, major depression, and schizophrenia, have success rates of 60 to 80 percent.

In contrast, the success rate for two major forms of cardiovascular treatment -- atherectomy and angioplasty -- have effectiveness ranges of 41 to 52 percent.

Let me repeat that: NIMH data shows that treatment for severe mental illness is up to 100% more effective than a commonly accepted medical treatment for cardiovascular disease.

Health planners should therefore be confident that coverage of treatment for mental illness in health care reform is not an "open ended" proposition -- treatments are defined and effective.

- **Myth Number Three: "We Cannot Afford to Cover Treatment of Mental Illness as Part of Health Care Reform."**

Again, the fact is precisely the opposite: The nation cannot afford to exclude such treatment.

In 1990, the nation's health care bill was approximately $670 billion. Of that, the direct cost of treating all mental disorders was 10 percent, or $67 billion.

Recent data from Rice, et al, which I would be pleased to provide on request shows that the indirect costs of mental illness (i.e., the cost of not providing treatment in terms of lost productivity, etc.) was $75 billion in 1990.

Thus, the total cost (direct and indirect) of mental disorders in 1990 was $148 billion. This compares to the total costs of cardiovascular disease of $159 billion in 1990, according to NIMH data. Health planners do not advocate exclusion of treatments for cardiovascular disease. Why then, should treatment of mental illness be considered for exclusion due to spurious concerns about total direct and indirect costs?

The APA's recommendation for health care reform can be stated quite simply:

- *We urge your strong support for health reforms which end the pervasive pattern of discrimination against persons with mental illness and those who treat them.*

- *Coverage of treatment for mental illness should be included as a uniform health benefit in any health care reform proposal, subject to the same scope and duration as applied to non-psychiatric medical illness.*

- *Persons with mental illness -- and their treating physicians and other health professionals -- should be subject to the same protocols, the same reviews, and the same cost controls as are required of patients with non-psychiatric medical illnesses and the physicians and other health professionals who treat them.*

- *We recommend consideration of the development of a prioritization process for all medical services, including mental health services, based on common criteria for outcome and usefulness to patients.*

- *Patients should have access to a broad array of services offering a full continuum of care, including inpatient, outpatient, partial hospitalization, and home- and community-based services, as the patient's clinical needs require.*

We know that timely interventions, including the use of psychotropic medications in conjunction with appropriate psychotherapy, can make an enormous difference to persons with mental illness, enabling them to resume a full and productive life. We also know that these treatments are clinically effective and cost effective. And we know that providing coverage for treatment of mental illness would save the nation nearly $100 billion in annual indirect costs incurred from our failure to provide access to care today. We thus believe that coverage of treatment for mental illness should be included in whatever health care reform model the Administration ultimately puts forward.

The APA asks simply that psychiatrists and their patients be treated like all other physicians and patients are treated under a reformed health care system. We should be subject to the same cost constraints and the same internal reviews as are other physicians and patients. We should be subject to the same outcomes measurements as are imposed on other medical specialties and their patients. These studies will show what we have known all along: mental illnesses are real, can be clearly diagnosed, and can be treated effectively. The time for differential treatment based on prejudice rooted in fear and ignorance is past.

In addition to determining the scope, duration, level, and type of benefits to be included in health care reform, the Administration, the Congress (and particularly the members of your Subcommittee), will also have to consider a host of related and complicated issues. Let me touch briefly on several of them.

First, and foremost will be the basic structure of the reformed health care delivery system. APA believes that the philosophical objectives of Managed Competition where it permits the continuation of a free market system, e.g., patient freedom of choice of physician, are well worth pursuing, and that a clearly defined, carefully structured Managed Competition system e.g., which requires treatment criteria or protocol to be based upon scientific evidence and not solely cost, offers considerable promise to the nation's health care consumers.

At the same time, APA is concerned about the impact of Managed Competition on those patients with special needs, particularly those suffering from severe mental illnesses who, as potential "high cost outliers" -- such as patients with similar chronic and long-term illnesses such as diabetes, cardio-vascular disease, etc. -- could be at risk under Managed Competition unless special precautions are taken, for example to ensure that academic centers of research, training and patient care excellence for such tertiary care patients are appropriately an integral part of Managed Competition.

Key questions about Managed Competition and its impact on mental illness include:

- Will the "basic benefits" package be permitted to include specified limited coverage of treatment for mental illness (including substance abuse) different from limits on physical illness?

- If coverage is subject to specific day or visit limits, will patients be protected from financial devastation by an effective catastrophic stop loss, or will there be a secondary annual dollar cap on total per capita expenditures on mental health care?

- How will Managed Competition ensure access to needed mental health or other health care in sparsely populated rural areas where there may be insufficient patients or facilities to support multiple competing health care plans?

- How will health care plans under Managed Competition interface with State-run mental health systems?

- Will global health budgets be imposed *on top of* Managed Competition reforms? If so, will separate global budgets be established for mental health services?

- How will Managed Competition affect the delivery of long-term support services to those who require them, such as persons with severe mental illness?

Second, the Administration and the Congress will have to consider the question of whether to impose global budgets. Global budgeting poses particular problems for the mental health community. APA opposes undefined global budgets which would "lock in place" current inequitable coverage and reimbursement for treatment of mental illness (including substance abuse). As noted, such treatment is, under most Federal and private health care programs, subject to artificial and discriminatory limits on scope and duration of coverage. Imposing global budgets on top of a health care system which already discriminates against persons with mental illness and their treating professionals would greatly exacerbate existing inequities, and would create major problems for delivery of mental health services.

APA is particularly concerned about the possibility that undefined global budgets would be appended to Managed Competition reforms of the nation's health care system, particularly if the so-called Standard or Basic Benefits package under Managed Competition reforms sets strict arbitrary limits on coverage of mental health services.

This "double hit" could severely disadvantage mental health care (and treatment for other chronic illnesses) by creating pressures on Accountable Health Plans to reduce access to or payment for mental health services in order to meet global budget targets.

Another major concern for APA is the interaction between global health budgets and the specific physician payment methodology established under national health systems reform. Current Medicare payment for mental health services is, we believe, less than adequate. If Medicare payment methodology is used as the basis for physician payment under Managed Competition, global budgets could severely exacerbate existing payment deficiencies, and further reallocate dollars between various specialties and across geographic boundaries.

How will budget targets be enforced? If enforcement methods include reductions in payments to physicians as "punishment" for exceeding budget targets, will all physicians be lumped under a single regional global budget? Will mental health services be subject to a separate budget? How will patients requiring higher than average levels of care (i.e., "high cost outliers") affect budget targets and hence provider payments?

APA urges Congress to not only carefully and fully consider the impact of global budgeting on access to needed services, and on overall quality of care provided, in addition to the potential cost savings, but also to respond appropriately to the specific impact of poorly defined global budgets on patients requiring treatment for mental illness (including substance abuse) particularly when patients are presently uniquely disadvantaged and in an already unequal position relative to treatment for non-psychiatric illness.

Third, another major issue will inevitably be determination of payment for whatever services are ultimately covered under health care reform. It is possible that use of current Medicare payment methodology may be considered as at least an interim cost containment measure during the transition to the "reformed" health care delivery system.

Use of Medicare's Resource-Based Relative Value Scale (RBRVS) payment methodology for mental health care poses serious problems for psychiatrists, and we believe for non-physician mental health care providers. Since the passage of the Omnibus Budget Reconciliation Act of 1989 and the subsequent release of the HCFA Notice of Proposed Rule Making to implement the Medicare physician fee schedule based on the RBRVS, APA has been working constantly with HCFA to redress major problems in the RBRVS as applicable to psychiatry.

To their credit, HCFA staff have tried very hard to respond to our concerns, but there are major and systemic problems which remain. Time precludes lengthy discussion in today's hearing, but APA would be glad to address these issues with members of the Subcommittee at a later date.

Let me cite one specific example. Briefly, the RBRVS for psychiatric services just does not work very well. A particularly problem is the fact that most psychiatric services are highly time dependent. As a result, psychiatrists, for example by their most used CPT 4 Code (90844), cannot respond to expected reduced payment under the Medicare Fee Schedule (MFS) by increasing volume or intensity of service -- yet this is the basic assumption applied to all physician and non-physician services covered under the Fee Schedule.

Put another way, time may be a relatively inconsequential variable for other procedures, but it is a significant constant for psychotherapy. Unlike other physicians, psychiatrists do not have a multitude of services and CPT 4 procedures to bill for during a typical psychiatric office visit (45 to 50 minutes of psychotherapy). As a result, psychiatrists can't increase intensity by adding services to the psychotherapy session, nor can psychiatrists increase volume by making reductions in the time that they see patients, thereby increasing the number of patients seen in an hour of time. Clearly psychiatrists cannot and will not compensate for their expected loss in reimbursement the way other physicians may be able to.

APA has previously argued in comments to HCFA on the 1992 MFS that the existing MFS Volume Performance Standard (MVPS) methodologies will unfairly result psychiatry having to "pay" for some of the "over utilization" attributable to physicians outside of the practice of psychiatry. This fear had indeed come to pass.

The MVPS for "cognitive" services -- which includes psychiatric services -- was "over shot" in 1991. Because the volume of cognitive services was greater than the target amount, the update that HCFA applied to the conversion factor for cognitive services for 1993 was reduced. In other words, the increase in the '93 conversion factor for cognitive services was lower than what it should have been because the previous year's volume target was exceeded.

Although psychiatry cannot effectively increase volume or intensity of services to compensate for expected losses in reimbursement, psychiatry is penalized -- through a lower conversion factor than that which would have otherwise been provided -- by the volume responses of other physicians. Clearly, this is a significant methodology failing of the MVPS and both HCFA and Congress need to establish some framework within the MFS that protects psychiatric services from the volume excesses of other "cognitive" physicians.

Extension of Medicare payment rates "for all" as an interim cost containment measure would thus, we believe, have a potentially severe impact on delivery of mental health care services and on access to care and would directly and adversely affect reimbursement to non-physician mental health care providers.

Finally, Mr. Chairman, in the interests of comity and most particularly in the interest of ensuring that our patients have access to needed treatment, APA has chosen to emphasize our common purpose with others in the mental health care community and to work for enactment of a broad array of mental health services in health care reform.

As we have said from the beginning, there is room enough and work enough for all licensed and qualified providers of mental health services. We will seek consensus and compromise at every opportunity, and we most sincerely hope to avoid the divisive debates which have too often characterized the various providers of mental health services.

We nevertheless note that some have suggested that the payment issue would be moot because non-physician providers would step in to "fill the gaps" in the system. We suggest otherwise. This assertion assumes that all mental health care providers have the same qualifications, education, training, areas of clinical expertise, and so on, when in fact they do not.

Certainly, there are many areas of overlapping expertise and service capacity, and I stress that APA absolutely supports access to a broad array of qualified and licensed mental health providers. But we caution that it does not follow that all providers are substitutable one for another with regard to appropriate patient care which should, in the end, be the objective of a rational health care system. We look forward to working with you to ensure access to a broad array of services in support of the clinical needs of the patient.

These concerns aside, Mr. Chairman, the APA is heartened by the prospect of reforms to the nation's health care system, and particularly by the prospect that the opportunity for reforming the system as a whole will provide us with an opportunity to end discrimination against persons with mental illness and those who care for them. We hope your Subcommittee and the Congress will seize the opportunity to redress the long-standing and unjustified discrimination against persons with mental illness which have been a feature of our health care system for far too long.

Thank you. I would be pleased to answer any questions.

STATEMENT OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

On behalf of the American Society of Anesthesiologists (ASA), which represents more than 30,000 physicians nationwide we are pleased to submit the following statement for the record on the Administration's Fiscal Year 1994 budget proposals. The issue of the so-called RAP DRGs is the subject of this statement.

For reasons we cannot understand, the Clinton budget has borrowed an unsuccessful page from the FY88 Reagan budget and proposes to bundle payments for inpatient radiology, anesthesiology and pathology services into the Part A hospital DRG payment. This proposal was a bad idea when the Congress rejected it in 1987. Subsequent enactment of the Medicare Fee Schedule makes it a worse idea today. The projected four year savings are $390 million—a relatively modest sum to offer as justification for so radical a proposal; indeed, a proposal at total odds with the underlying concepts of the Medicare Fee Schedule mandated by Congress.

The ASA has worked with this Committee over the past several years to achieve significant budget savings. We certainly never welcomed reimbursement reductions but we have been realistic in our assessment of the need for the Congress to find appropriate savings without adversely affecting the quality of anesthesia care. Given this background, we find the Administration's proposal both inappropriate and insensitive: inappropriate because it comes hard on the heels of implementation of the Medicare Fee Schedule under which the specialty of anesthesiology sustained the largest cut of any specialty, and insensitive to legitimate quality of care concerns and to the nature of anesthesiology practice.

To put the RAP DRG proposal in budgetary context, allow me briefly to review the recent history of Medicare reductions for our specialty:

- OBRA '86 ratified HCFA regulations halving the base units for cataract anesthesia services from 8 units to 4 units. Estimated five year savings were $405 million.
- OBRA '87 mandated base unit reductions for those anesthesiologists (70 percent of anesthesiologists) medically directing nurse anesthetists. Estimated three year savings were $35 million.
- OBRA '89 froze anesthesia reimbursement rates and mandated the use of actual anesthesia time, as opposed to rounding up to the next whole unit. Estimated five year savings were $245 million.
- OBRA '90 cut the average anesthesia conversion factor by 7 percent and extended the base unit reductions for medical direction services. Estimated five year savings were $285 million.
- The Medicare Fee Schedule, effective January 1, 1992, reduced reimbursement for anesthesia operating room services an average 29 percent upon full implementation—the largest cut imposed on any specialty.
- 1993 Fee Schedule reduced all physician services another 2.7 percent to achieve budget neutrality for new and revised codes.

In the aggregate, these are dramatic reductions to be placed on one specialty, but to a great extent they have occurred as a result of active good faith give-and-take between ASA representatives and the health committees of the Congress. In part, at least, our cooperation with otherwise unpleasant reimbursement decisions has stemmed from the continuing commitment of the Congress, including this Subcommittee and the full Committee, to the methodology for anesthesia reimbursement advocated by ASA; that is, the use of a relative value guide in which both the procedural and time units are recognized to determine the value of a specific physician service to specific patient.

MEDICARE FEE SCHEDULE AND ANESTHESIA REIMBURSEMENT

One of the reasons Congress decisively rejected RAP DRGs in 1987 was the anticipation of development and implementation of a Medicare Fee Schedule (MFS) based on the Resource Based Relative Value Scale (RBRVS). Many experts, such as the Physician Payment Review Commission, believed that any problems with RAP services would best be addressed through modification of fee-for-service payment for these services.

In the years since 1987, these modifications have occurred via several legislative and regulatory actions which built upon one another and confirmed the commitment of Congress to reimbursing anesthesia services under the Medicare Fee Schedule, using the ASA Relative Value Guide (RVG), and addressing perceived problems with payment levels.

THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987

OBRA '87, which rejected RAP DRGs, mandated that the Health Care Financing Administration (HCFA) adopt a Uniform Relative Value Guide (URVG) for use by all Medicare carriers. Pursuant to notice and comment in the Federal Register. HCFA adopted the ASA RVG as the URVG, for services provided on or after March 1, 1989. An important corollary to this was the adoption of the CPT–4 anesthesia codes, in lieu of surgical codes previously required on claims. The 4200 surgical codes are successfully complemented by only 248 broad anesthesia codes because the addition of anesthesia time measures the difference—from the anesthetic standpoint—between the many thousand surgical procedures. I must repeat the specific consideration of actual anesthesia time, makes the use of anesthesia codes valid.

OMNIBUS BUDGET RECONCILIATION ACT OF 1989

Prior to the OBRA '89, anesthesia time was counted and reimbursed in terms of 15 or 30 minute units, with the actual time rounded up to the next whole unit. OBRA '89 contained a significant policy change regarding recognition of anesthesia time—a change proposed by the Inspector General as a way to achieve accuracy of reimbursement; ASA supported this sound policy approach. Anesthesia time is now recognized in terms of actual minutes or fractional units. This not only achieved budget savings for the Program, but brought tighter verification to anesthesia time.

Most importantly, OBRA '89 also addressed anesthesia services with regard to their integration into the Medicare Fee Schedule. Section 1848(b)(2)(B) of the Social Security Act therefore states:

> In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustments in the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value.

From our perspective, this statutory requirement for the Department of Health and Human Services to use the Uniform Relative Value Guide for anesthesia services—in essence, the ASA Relative Value Guide utilizing both base and time units—is one of the most critical elements of OBRA '89. ASA and our members are well aware that Members of this Committee were instrumental in persuading HCFA not to eliminate anesthesia time units, which would have been contrary to the expressed will of Congress, when the final Medicare Fee Schedule was put into effect. The conference report on H.R. 11 (vetoed in 1992 for unrelated reasons) reinforced the Congressional commitment to preserving actual anesthesia time.

ASA believes the intent of Congress is both clear and consistent: the Uniform Relative Value Guide, including base units plus actual time, should be the basis for reimbursing anesthesia services under Medicare. With ASA's involvement and support, the Congress over the years has painstakingly crafted its policy on anesthesia reimbursement as part of physician payment reform—and the Administration's DRG proposal is totally contradictory to that policy. (There would, obviously, be no more RVG or anesthesia time under a RAP DRG scheme.)

THE ADMINISTRATION PROPOSAL HAS FLAWED RATIONALE

According to the Department of Health and Human Services (DHHS) budget, RAP DRGs would give "physicians and hospitals incentives to be cost-conscious, provide only medically necessary services and eliminate the provision of marginal services."

This rationale is seriously flawed. First, and I hope this is self-evident to the Subcommittee, there is no such thing as a "marginal" anesthetic. There is no "marginal service" in the pre-operative evaluation of patients and in the selection, from an array of potentially lethal anesthetic agents, of the appropriate anesthesia plan for an individual patient. There is no marginal service intraoperatively, when the anesthesiologist manages the patient in a carefully controlled anesthetized state, at a medically-determined level between consciousness and death, for a period of time dictated by the surgeon, not by us. Nor is there a "marginal service" post-operatively, when we manage restoration of the patient's respiratory and cardiovascular systems to normal.

Second, the Administration's rationale is inconsistent with demonstrated experience with reimbursement for anesthesia services. A recent study analyzed changes in Part B expenditures between 1986 and 1989 and was published in the *Journal of the American Medical Association* (JAMA, Holahan and Berenson, 1992). While

anesthesia accounted for approximately 6 percent of Part B expenditures, it represented only 2.6 percent of the growth in expenditures. Over the same period, the average annual growth in allowed charges for anesthesiologists was 7.7%, against 12.3% for all physicians.

This data shows only the effects of the fee freeze, OBRA '86 and OBRA '87; the significant impact of the OBRA '90/Medicare Fee Schedule combined 38.7 [average] percent reduction is not even measured at this point. This data also underscores the inability of anesthesiologists to increase volume, or introduce "marginal" services, in response to payment reductions per service.

Concerns stated in earlier years about this specialty—particularly concerns with low participation rates and significant balance bills—have been addressed with implementation of the series of reimbursement reductions and imposition of strict balance billing limits. While only one fifth of anesthesiologists accepted Medicare Participating Physician status in 1987 (more than 10 percent below the national average), as of January 1992, nearly one half of anesthesiologists were Participating doctors (less than 3 percent below the national average.) We have every reason to believe that the 1993 participation and assignment rates are even higher. For those who choose not to accept assignment on a given case, the Medicare Fee Schedule allows a balance bill of somewhat less than 10 percent.

Third, to the extent the rationale for RAP DRGs is based on allegedly unnecessary anesthesia procedures, it simply ignores the mechanisms within its own Department which deal with medical necessity issues—mechanisms which neither HCFA nor the Inspector General are reluctant to use.

RAP DRGS WOULD IMPACT QUALITY OF CARE

ASA believes that the RAP DRG proposal will severely interfere with our direct relationship with patients. The administration proposal will place a third party—the hospital or entity within the hospital—between the anesthesiologist and his or her patient. This same concern was cited in a Congressional Research Service paper prepared for the Senate Finance Committee in 1986: "Implementation of a physician DRG system would too closely align the incentives of physicians with hospitals. This might well result in the physician not continuing to be as strong an advocate for needed medical services . . ." These are valid concerns because DRGs do not pay for services actually provided; in fact, they reward the hospital for services not provided. The hospital incentive will be to limit needed care or to avoid very ill patients in need of surgery.

Even if we lay aside our grave quality of care concerns about such a system, we are deeply disturbed by the concept that we would be providing our service not to the patient, but to the hospital. Anesthesiologists have been practicing as fee-for-service physicians since long before the Medicare Program. While some anesthesiologists may practice under a contractual arrangement with one or more hospitals, these are contracts to assure 24-hour provision of quality services, they are not salary contracts.

Further, the proposal can only address inpatient services. Anesthesiologists provide half their care to outpatients—what is the rationale for applying two radically different reimbursement mechanisms to services provided in the same operating rooms, but sometimes to inpatients and other times to ambulatory surgery patients?

DRGS ARE NOT RELEVANT TO PHYSICIAN SERVICES

ASA's opposition to the DRG proposal also stems from our deep concern that hospital DRGs do not describe or measure the anesthesia services provided to patients falling within DRGs. What physician DRGs will inevitably represent is a reimbursement system that seeks to "average" medical care within DRG categories that simply were not constructed to account for that care and which, in any given case, will bear no necessary relationship to the services actually provided to a particular patient by the anesthesiologist or, as far as we are aware, by the radiologist, pathologist or for that matter, by the surgeon.

For example, DRG 110 (vascular procedures) would include anesthesia for procedures that vary widely in anesthetic difficulty, from surgery on vessels in the periphery, to surgery for resection of a thoracic aortic aneurysm. These are very different procedures of great variability in difficulty, complexity and skill—the *resource based inputs.* The RVG assigns a value of 5 to 8 base units to the former procedures and 20 to the latter, reflecting the significant resource based differences. There are examples such as this for virtually every DRG.

ASA commissioned the Battelle Medical Technology Assessment and Policy Research Center to study the correlation, or lack thereof, between hospital DRGs and anesthesia services. Battelle examined data from 6,300 surgical cases at ten hos-

pitals of varying size and type in five states (summary attached). The Battelle study found the potential for systematic bias within DRGs, with some anesthesia procedures being systematically underpaid, while others were overpaid. Any individual anesthesiologist has neither the volume of cases or control of case mix to mitigate such distortions.

CONCLUSION

The anesthesiologist's relationship with their patients is exactly the same as that of the surgeon: there is a pre-operative exam and evaluation, an intense relationship during the surgery itself, and post-operative care. It is simply incredible that the Administration would seek to treat similar disciplines so incongruously and unfairly.

The ASA cannot speak too strongly against this ill-conceived RAP DRG proposal. If implemented, it would cause serious disruption in patient care, dislocation of physicians and access problems. I can guarantee that physicians would neither stay in, nor enter, anesthesiology as a career if RAP DRGs are approved. This is a critical, demanding specialty with overwhelming implications for patient safety; this cannot be compromised.

We do not ask for special treatment—if anything, the history of budget cuts shows anesthesiologists have had far more than their share of special treatment. We ask to be treated like all other physicians. There should be no differential updates; if the Congress considers an across-the-board limited MEI update or freeze for all physicians, then that is the appropriate place for anesthesia services. We ask you to forcefully reject RAP DRGs and we ask for your continued support of anesthesia time.

EXAMINATION OF VARIATIONS IN HOSPITAL ANESTHESIOLOGY SERVICES AND CHARGES: AN EXPLORATION OF POSSIBLE EFFECTS OF A DRG PAYMENT SYSTEM FOR ANESTHESIOLOGISTS

FINAL REPORT

June 23, 1988

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EXECUTIVE SUMMARY

This study was designed to examine variation in anesthesiology services and charges and to identify the potential impact of a physician diagnosis related group (DRG) reimbursement system on anesthesia services in the United States. The primary goal of a DRG-based physician reimbursement system is to reduce Medicare program costs by improving efficiencies in the delivery of hospital-based physician care without compromising quality of care.

Background

Inpatient Hospital Services. There is a growing interest within both Congress and the Department of Health and Human Services (DHHS) in physician payment reform. The current system for reimbursing Medicare physician services is based on customary, prevailing and reasonable (CPR) charges, a system which many believe is responsible for physician payment inflation (Burney, et al., 1984). A possible alternative to the present system is to implement a prospective payment system (PPS) based on DRGs for inpatient physician services. A physician DRG system would combine all physician services delivered in the hospital by DRG and would prospectively set prices for each bundle of services.

Physician DRGs have an intuitive appeal in that the payment unit (i.e., hospitalization) can be easily and objectively defined. Advantages associated with the implementation of a physician DRG system include economic incentives to manage medical resources more efficiently, more integrated care, and more closer alignment of physician incentives with those of hospital administrators under PPS. Potential adverse effects to quality of care connected with having hospitals and physicians share risks may be no more than those that occur in HMOs.

There are several potential problems associated with this approach to physician reimbursement. Probably the most important is that the current DRG system was designed for prospective reimbursement to hospitals based on the patient's length of stay and hospital resources used during the inpatient stay. Physician services were not included in this conceptualization. Thus, if physician time, complexity, and expertise do not correlate well with hospital length of stay, the DRG may be the incorrect case grouping system for a bundled inpatient physician payment system Several studies have found considerable variation in physician charges within individual DRGs. This variation may be due to heterogeneity in the complexity of physician services, patient severity of illness, or some combination of patient and physician specific factors.

The literature on physician DRGs has focused on the variations in approved charges or physician practices within individual DRGs. The two research groups that primarily have studied this question have found comparable results using claims data but have differed in their interpretations of these findings. Both have found greater variation in the medical DRGs compared to surgical DRGs. Mitchell (1985) has focused on the relative variations in charges and concludes that the surgical DRGs are relatively homogeneous. West et al. (1986) have focused on potential clinical heterogeneity and the absolute variations in charges and conclude that the surgical DRGs are not particularly homogeneous.

Hospital-Based Physician Services. Because of potential difficulties associated with administering the system and disbursing payments to a number of different physician specialties delivering hospital services, interest shifted from all physicians that provide services to hospitalized patients to only hospital-based physicians. It is thought that charges for radiologist, anesthesiologist, and pathologist (RAP) services might vary less than the charges for other physicians. According to this view, since many of these physicians practice in hospitals and are primarily involved in delivering inpatient services, they may only experience limited financial risk in a DRG-based system. Under a prospective payment system for hospital-based physician services, Medicare would make one payment that would include reimbursement for all physician services provided during the hospital stay. The expectation is that the RAP DRG system might control costs and increase efficiency by paying a predetermined amount for all physician services during a hospitalization, thereby providing incentives to decrease unnecessary services or to substitute lower cost services. The approach would be conceptually similar to the existing hospital prospective payment system.

There remain significant administrative, technical, and equity issues that need to be resolved before implementation of RAP DRGs. The most obvious concern is that physician resource utilization may not be strongly correlated with hospital length of stay. Also, individual physician practices may be too small or specialized so that a DRG system may provide for inequitable redistribution of payment, overpaying some and underpaying others. Thus, there may be unacceptable financial risk to individual physicians. There may also be inadvertent quality of care and access to care implications as well, if, for example, some cases are consistently underpaid or overpaid relative to the present system of payment.

Anesthesiology Services. The present study examines the effect of a physician DRG system on anesthesiology services. Currently, Medicare payments for anesthesia services are based on a relative value guide (RVG) methodology consisting of three components: (1) basic units, which are intended to reflect the relative complexity and risk of the procedure; (2) time units, which represent the actual time incurred by the anesthesiologist; and, (3) modifier units, which represent additional units relating to the physical status or age of the patient. Thus, the existing Medicare payment system has many features of a resource-based relative value guide. Actual payment is determined by multiplying the resulting total units by a conversion factor which itself is determined through a CPR calculation.

Specific policy questions addressed in this report are:

-- would a DRG system foster more efficient anesthesiology care;

-- would a DRG system be equitable relative to the present payment system; and

-- would a DRG system adversely affect quality of care?

Technical questions center mostly on the nature of charge and time variations.

Methods

The three major objectives of the present study were (1) to describe the extent and nature of variation in anesthesiology services and charges; (2) to simulate the distribution effects of physician DRGs on anesthesiology charges; and (3) to analyze the implications of such a policy change. Data were collected from 16 hospitals selected to represent different geographic regions in the United States, rural versus urban/suburban location, hospital size, and teaching status. Anesthesiology service and hospital utilization data were collected for all Medicare patients hospitalized for any of 27 of the most common surgical DRGs during 1986. Information on patient characteristics (e.g., age, gender) and attributes related to the hospital stay (e.g., length of stay, diagnoses, procedures, total hospital charges) were obtained from hospital billing records. Surgical time was abstracted from the medical records in six hospitals, representing 60% of the sample cases. Data on the procedure, anesthesia time, basic units, modifier units, time units, and charges associated with the hospital stay were collected from anesthesiology billing records. The final sample contained 7,770 merged hospital and anesthesia records for the 16 hospitals.

Approved anesthesia charges were estimated based on the average Medicare carrier-specific reduction in Part B charges for the fourth quarter of 1986. Physician prospective payment system reimbursement for anesthesia services for individual DRGs were estimated using the approved anesthesia charges and Medicare carrier-specific data for the states included in the study sample. Average approved anesthesia charges for each DRG were adjusted for regional price differences for physician services and volume of Medicare Part B claims in each state. The final result was a national, regional cost-adjusted, reimbursable anesthesia payment for each surgical DRG.

Results

Variation in Anesthesia Charges. The findings indicate that there is considerable heterogeneity in anesthesia charges and time within different hospitals, DRGs, and surgical procedures within DRGs. The majority of DRGs exhibit 4-fold or larger variation in approved charges. This variation in charges may represent, in part, geographic or hospital-specific differences in anesthesia practice, surgical practice, or differences in the content of practice within DRGs.

Anesthesia charges are calculated by a combination of units reflecting time, complexity and patient physical status (e.g., time, basic and modifier units) and the use of a multiplicative conversion factor. Anesthesia charges vary with anesthesia time which, in turn, is strongly correlated with the length of surgery. Although DRGs can statistically predict hospital length of stay, they may not be sensitive enough to differences of complexity and time for individual surgical procedures. There exist a number of different possible procedures that may fit into a particular surgical DRG. Often these procedures vary with respect to surgical complexity, anesthesia complexity, and length of operation. Patient age, physical status, severity of illness, and co-

morbidity may also influence the amount of time and technical skill required to successfully complete the surgery.

Variation in Anesthesia and Surgical Time. The findings of this study show that anesthesia time varies 3-fold to 10-fold within individual DRGs. Seventy percent of the DRGs exhibit more than a 4-fold variation in anesthesia time. An important factor in the large variation in anesthesia charges is variation in the amount of time that it takes to complete surgery. Surgical time is important in that it is the surgeon and not the anesthesiologist who determines the length of the surgical procedure. Although there is a strong relationship between surgical services and anesthesia services, greater variation is found in surgical time compared to anesthesia time. The correlation between surgical and anesthesia time is .94 and ranges from .78 to .98 across the procedures we examined. Approximately 91 percent of the variance in anesthesia time can be predicted from surgical time alone. The combination of surgical time, patient characteristics, and hospital characteristics account for almost all of the variation in anesthesia time. Surgical time continued to be the strongest predictor of anesthesia time.

This strong relationship suggests that most of the variation in anesthesia time depends on the length of surgery. If the amount of time that a surgical procedure takes is determined by the surgeon, then anesthesiologists may not be in a position to increase efficiencies in their services to patients. For example, the average amount of time that an anesthesiologist spends with a patient undergoing coronary bypass surgery involving four arteries is 361 minutes. The patient's surgery takes, on the average, 286 minutes. During the remaining time, the anesthesiologist administers the anesthetic to prepare the patient for surgery and monitors the patient's recovery from the anesthetic after the completion of the surgical procedure. The length of time necessary for recovery from the anesthetic is influenced by the anesthetic administered and the age and physical status of the patient.

Comparison of the Study to HHS Report. Variations in anesthesia charge data from this study are comparable to variations in Medicare charges for anesthesia services from eight states. Comparisons of anesthesia charges in the present study and the HHS report (Health and Human Services, 1987) indicate that the present data may be representative of more complete Medicare claims data for anesthesia services. The comparisons suggest that any systematic differences may result in a conservative bias in this study with respect to variation in anesthesia charges. In addition, since there may be less heterogeneity within single physician practices compared to a large number of practices, the present study may provide a conservative estimate of variations in anesthesia services.

Results of the Physician DRG Simulation. The effects of a DRG-based system for reimbursing anesthesia services were studied by constructing a national estimated regional cost-adjusted, reimbursable anesthesia payment for each surgical DRG included in the study. The estimated DRG-based payment was subtracted from the approved anesthesia charge to identify patterns of gains and losses by hospital, hospital location, and teaching status. Anesthesiologists practicing in five of the 16 hospitals would be likely to lose an average of $62 to $234 per case. Their peers working at one of the other

11 hospitals would be likely to gain, on the average, $74 to $206 per case. The results of this analysis suggest that anesthesiologists practicing in rural and nonteaching hospitals would be more likely to gain, while anesthesiologists working in large, suburban or urban, or teaching hospitals would lose in a DRG system. Those physicians practicing in teaching hospitals would lose an average of $73 for each surgical case. Anesthesiologists working in rural community hospitals are estimated to gain approximately $186 per case, while those in urban hospitals would lose $66 per case.

There are also significant gains and losses associated with individual surgical procedures within DRGs. In 57 percent of all procedures, it is estimated that the average difference between the approved charge and DRG-based payment is within $50. Although, this pattern of gains and losses may not seem significant, the implication is that in 43 percent of the surgical cases, anesthesiologists may gain or lose more than $50 per procedure.

When the patterns of gains and losses for individual procedures are examined within DRGs, the findings suggest that it may be difficult for anesthesiologists to manage their practice. Although, for the majority of procedures, there were no significant differences between approved anesthesia charges and DRG-based payments, in at least 41 percent of the procedures significant gains and losses were present. If anesthesia charges were based on DRGs, as estimated in this study, losses would occur in thirty percent of the procedures. Anesthesiologists would be reimbursed more than current approved charges in the remaining procedures. Average losses range from $2 to $473, while gains were between $3 to $108. Unless the anesthesiologist has a very large and varied practice, he or she may not be able to balance these estimated gains and losses in any effective way without additional billing to the patient.

There was an inverse relationship between the length of the operation and the DRG-based reimbursement status for anesthesiologists. Anesthesiologists in long operations are more likely to be undercompensated for their services under a DRG-based system compared to their current approved charges. Seventy-seven percent of the anesthesia services delivered in lengthy operations are likely to be underpaid more than $50, compared to only 33 percent in the shorter operations. Individual analyses by DRG tended to support this interpretation.

Conclusion

This study provides evidence that DRGs may not be an appropriate grouping for equitable payment of anesthesia services. DRGs, originally developed to represent the average utilization of hospital resources for clinically meaningful disease categories, may not be sensitive enough to describe different surgical procedures within individual DRGs. Hospital location and teaching status clearly influence the case mix of surgical procedures in the aggregate and within particular DRGs. There is a wide variation in technical complexity and surgical time associated with different procedures within a single DRG. This variation is exacerbated by patient characteristics, such as age, physical status, and comorbidity. Length of stay,

the dependent variable used to develop the hospital DRG system, is an inadequate predictor of anesthesia service utilization.

The proposed RAP DRG system is likely to benefit anesthesiologists practicing in small or rural community hospitals and penalize those working in large urban and teaching hospitals. Although some kind of adjustment could be made to control for geographic and hospital characteristics, there will remain the problem of significant differences in the complexity and length of surgical procedures within individual DRGs. Differences in the case mix of procedures within DRGs between different types of hospitals is likely to account for most of the gains and losses associated with the implementation of a DRG-based system.

Finally, since the present system for paying anesthesiologists is based on anesthesia time, which is highly correlated with surgical time, case complexity and severity of the patient's condition, there appears to be little or no means by which the incentives of a RAP DRG system would foster more efficient anesthesia care.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

Introduction

The American Society of Internal Medicine, representing 26,000 internists nationwide who provide primary and subspecialty care to Medicare patients, is pleased to submit this statement for the record on President Clinton's recommendations on Medicare Part B budget issues.

ASIM's statement emphasizes the importance of working constructively with Congress and the administration in this time of great change. Internists have great anxiety about how they and their patients will be affected by the changes being contemplated. But they also have a great sense of commitment toward achieving workable solutions for their patients. There will be times when ASIM, on behalf of its members, must and will oppose proposals that we believe to be unfair or unworkable. But we prefer to be able to work with Congress and the administration towards achieving consensus on the changes that are needed.

It is in that spirit that ASIM has considered the President's Medicare proposals. You may be hearing from many others who reject out-of-hand the President's recommended changes in Medicare. ASIM is not among them. Instead, on February 24 ASIM wrote to President Clinton and stated our desire to work with him in a constructive manner on his deficit reduction plan. There are some proposals in the plan that ASIM supports, such as the proposed exemption from cuts for some visit services.

Although ASIM supports appropriate measures to allow for deficit reduction and expanded access, internists are concerned that continued cuts in Medicare will compromise their ability to provide patients with appropriate care. Too many cuts, especially if targeted at the wrong expenditures, could be highly detrimental to Medicare patients. Consequently, ASIM's support of the administration's and Congress's efforts to reduce the rate of increase in Medicare expenditures is predicated on the following principles:

1. **Savings in Medicare should not be allocated solely to deficit reduction, but also to expanding access to health insurance coverage.** Internists will be far more willing to accept limits on Medicare spending increases if they perceive that the savings will be used to expand health insurance coverage for those who are now unprotected, rather than solely to reduce the deficit or to allow for increased spending in areas other than health.

2. **Services that are already underpaid--and that are experiencing access problems as a result--should not be subjected to further Medicare cuts.** Instead, savings should

be achieved from other services that are paid too high, and where there is little risk of access problems being created if payment increases are restrained.

3. **Efforts to limit increases in Medicare spending on physician services should be part of a balanced package that also asks beneficiaries, taxpayers, suppliers, and others in the health industry to also do their part to reduce the deficit and expand access.** Physicians should not be singled out for an unfair proportion of the Medicare savings that will be required to reduce the deficit and expand access to care.

4. **Specific changes in authorizing legislation that are needed to achieve the savings goals must be carefully scrutinized, prior to enactment, to assure that they do not result in further "micromanagement" of physician practices or result in denial of payments for legitimate services.** In 1990, when Congress and the President last reached agreement on a major deficit reduction package, the result was enactment of several provisions that denied payment for legitimate services. A last-minute addition to the OBRA 90 Medicare spending cuts resulted in elimination of payments for EKG interpretation, which has disrupted the ability of physicians and hospitals to arrange for qualified interpretation of this important diagnostic test. OBRA 90 also included unfair limits on payments to new physicians. It is essential that Congress not only correct these mistaken policies, but that care also be taken so that similar mistakes do not occur this time around.

For the most part, ASIM believes that President Clinton's Medicare proposals are consistent with the above principles. The package exempts certain undervalued primary care services from the proposed cuts, targets most of the reductions toward services that have been paid too highly, requires each of those with a stake in Medicare--physicians, hospitals, durable medical equipment (DME) suppliers, and taxpayers--to contribute toward the savings, and generally avoids proposals that would result in micromanagement or denial of reimbursement for legitimate services. It appears, however, that all of the Medicare savings will be devoted to deficit reduction, not expanded access. And ASIM remains concerned that the balance struck in the package may be altered in Congress as other groups oppose cuts that adversely affect their interests.

ASIM's specific views on the President's Part B Medicare proposals follow.

The Medicare Budget and Primary Care

ASIM specifically supports--and commends--the President for proposing that primary care services be exempted from the proposed reduction in next year's fee schedule update. Under the proposal, primary care services (which in the past has been defined in statute as office, nursing home, and home visits) would in 1994 receive the *full* fee schedule inflation update required under current law. All other services would receive the current law update minus two percent. If enacted by Congress, this would represent the first time in three years that some primary care services received an update that is at least equal to inflation. The 1993 update, by comparison, was only .8 percent for visits and other nonsurgical services but 3.1% for surgery.

Exempting primary care from further cuts would be an important first step toward alleviating the growing crisis in access to primary care. ASIM recently released a major new white paper "Rebuilding Primary Care: A Blueprint for the Future." The paper explains why primary care is in trouble, and what can be done about it. A copy of the paper has been sent under separate cover to the members of the Finance Committee.

In reviewing the research literature to prepare the paper, we found that the number and proportion of physicians in primary care has been steadily declining. Even more disturbing, the trend is getting worse. Citing numerous studies, the paper reports that:

- The proportion of physicians who are in the primary care specialties of internal medicine, pediatrics, and family practice has declined from 50 percent in 1963 to only 34 percent today.

- Only 14 percent of medical students surveyed in 1991 intend to go into primary care.

- If current trends continue, within a decade fewer than 20 percent of America's physicians will be in primary care.

- Costs will be lower and care will be better if there is a greater number and proportion of internists and other primary care physicians.

- The principal factors driving physicians away from primary care is a hostile economic and regulatory environment and a training system that encourages overspecialization.

The paper provides 44 specific and detailed recommendations for rebuilding primary care. Because Medicare has a disproportionately larger impact on internists than other payers, 18 of the recommendations are for changes in Medicare's payment and regulatory policies.

One of the key recommendations is that primary care services should be protected from further budget cuts. The paper notes with approval President Clinton's proposal to exempt office, nursing home, and home visits from the reduction in next year's update. But the paper also cautions that as groups raise objections to other Medicare cuts, the higher update for primary care that the President proposes could be at risk of being reduced. This would occur if Congress rejected some of the cuts and made up the lost savings by lowering the primary care update.

You will likely be hearing from other groups that a "more fair" alternative to the administration's proposed cuts would be for Congress to enact an across-the-board limit, freeze, or delay in the 1994 Medicare fee schedule update. ASIM strongly disagrees.

Nothing could be *more unfair* than freezing in place a payment schedule that undervalues primary care and other visits services and that pays too much for many other services, or in delaying the update for primary care services. If, in order to ease the cuts in other areas, office, nursing home, and home visits are not given the full update proposed by the administration, it will be yet one more signal that the federal government is not yet willing to take the steps needed to begin to rebuild primary care. By doing so, the trend away from primary care will be exacerbated.

ASIM believes that the administration was right to recognize that if additional Medicare savings are needed, they should come from non-visit services that are being paid more highly, and for which there is no evidence (unlike primary care) that patients are likely to experience problems in obtaining access to those services even if further payment increases are limited. We urge the committee to uphold this approach by providing a full 1994 fee schedule update for office, nursing home, and home visits, and to reject the calls that will be presented under the guise of "fairness" for an across-the-board freeze or delay in the 1994 fee schedule update.

We do believe that there is one key element of the administration's proposal that requires clarification, however. The administration proposes that primary care receive the "current law" update, and that all other services would receive the "current law" update minus two percent. This has been reported to mean either that primary care would receive the full Medicare economic index (MEI), and other services the MEI minus two percent, or that primary care would receive the MEI plus or minus actual expenditure performance relative to the nonsurgery volume performance standard (VPS), and all other services would receive the MEI plus or minus actual expenditure performance compared to the applicable VPS, minus two percent. Preliminary expenditure data reportedly indicate that expenditures for both surgery and nonsurgery fell under their applicable VPS. If this is the case, the current law update for surgery and nonsurgery would be the MEI plus an (as yet to be released) bonus payment. It has also been reported that expenditures on surgical procedures may have come under the applicable VPS by a larger margin than nonsurgery, which would mean that under current law surgery would receive a larger bonus than nonsurgery.

A higher current law "bonus" for surgery could result in the surgical update being equal to or even higher than the primary care update, even after the two percent reduction for non-primary care services that is proposed by the administration. ASIM would strongly object to an update for surgery that is higher than that for primary care. In establishing the surgery VPS, the administration assumed that a behavioral offset would occur to offset fee reductions under the RBRVS, when preliminary analyses by the PPRC and others suggest that such an offset may not have occurred after all (or at least not to the degree projected by HCFA's actuaries). Consequently, even if surgical expenditures fell below the surgery VPS by a greater margin then nonsurgery, this is likely due to HCFA's erroneous assumption of a behavioral offset in developing the surgical VPS, not because of better performance by surgeons in controlling volume.

We strongly recommend that the committee seek clarification from the administration of its proposal to provide a full update for primary care and the current law update minus two percent for all other services. If the administration's proposal would result in a higher update for surgery than primary care, even after application of the two percent reduction, ASIM recommends that the committee modify the proposal to provide a higher absolute update for primary care than for surgery, which we believe is the real intent behind the administration's proposal. And, under this

scenario, if additional savings are needed because other proposed Medicare cuts are rejected by the committee, they should come out of the surgery update, not primary care. If Congress is to begin to rebuild primary care, it is essential that primary care receive higher updates than surgery, especially given the fact that the update last year for primary care was significantly lower than for surgery.

Finally, the payment inequities that were created last year by the separate VPSs for surgery and nonsurgery, and that could occur again in 1994, point out the urgent need to modify the VPS mandate to create incentives for primary care visits and other E/M services.

Modifying the Volume Performance Standards

The administration also proposes to lower the "default" volume performance standards (VPS). ASIM supports the need to amend the VPS formula established by OBRA 89 and 90. As the committee may be aware, ASIM urged Congress last year to amend the formula to preclude the separate and higher update for surgery--and the lower update for all nonsurgery, including primary care--that occurred in 1993 based on the existing statute. Unfortunately, Congress adjourned without taking any action to prevent the higher default update for surgery from going into effect. The result is that unless Congress acts to correct the problem, surgery will permanently have a higher conversion factor than nonsurgical services, including primary care visits and other evaluation and management (E/M) services.

The administration's proposal provides an opportunity to correct this flaw. Instead of lowering the default VPS equally for surgery, nonsurgery, and all services, as the administration's proposal apparently would do, ASIM instead urges that the committee either support a single VPS for all services, or that it work toward establishment of a separate and higher VPS for E/M services and a higher default update for office, nursing home, and home visits. Specifically, if separate VPSs are to be maintained, Congress should:

- Amend OBRA 89 and 90 to establish a separate and higher VPS for evaluation and management services, including primary care visits. For E/M services only, the VPS should be based not only on historical expenditure trends, demographics, changes in law, and an "intensity" factor, but also on an explicit factor that is designed to allow for investment of additional spending on E/M services.

- Amend OBRA 89 and 90 to raise the default "floor" on the fee schedule update for office, nursing home, and home visits ("primary care" services) only. The current floor (minimum update) for all services is the Medicare economic index minus 2 percent. For the specified visit services, the floor could be raised to the MEI, or the MEI minus .5 percent, thus assuring that primary care would be protected even if spending exceeded the VPS for those services.

- If necessary to allow for a higher default VPS and update for E/M and primary care services and still maintain the savings expected under the President's proposal, the default VPS and update for all other services should be set at an even lower level than the administration proposes.

In its upcoming report to Congress, the Physician Payment Review Commission (PPRC) is expected to propose similarly that if separate VPSs are to be maintained, E/M services should be given improved treatment by being placed under a separate VPS.

Implementation of Resource-Based Practice Cost RVUs

The administration proposes to begin phasing in resource-based relative value units (RVUs) for services paid under the Medicare fee schedule. ASIM has been on record for several years as favoring a change in the OBRA 89 methodology for determining the practice expense RVUs under the Medicare physician fee schedule. The existing method, by basing practice expenses on historical charges instead of resource costs, perpetuates inequitably high payments for surgery and other services done primarily in the hospital setting, and unfairly low payments for E/M services. We are pleased that the Physician Payment Review Commission in its upcoming report will be recommending that Congress mandate implementation of a resource based practice cost methodology.

Although the administration's proposal also would begin moving toward a resource based methodology, it apparently would do so in a manner that would lower the practice expense RVUs for some overpriced services, without raising them for other services--especially E/M services--that the PPRC believes are underpaid under the current formula. Under the administration's proposal, by obtaining savings from interim reductions in the RVUs for overpriced services, but without increasing them for undervalued ones, there would be little or no money available to raise the practice expense RVUs for E/M services when a full resource based methodology is implemented in later years. ASIM believes that it would be highly unfortunate for a resource based practice cost methodology to be used only as a budget-cutting tool, rather than one that also results in more equitable payment for undervalued E/M services as intended by the PPRC, ASIM, and others that have supported this concept.

ASIM believes that Congress and the administration should consider an alternative that would allow for interim increases in the practice expense RVUs for E/M services, while also obtaining some short-term budget savings. The administration proposes to reduce the practice expense RVUs for all services whose current practice expense RVUs exceed their work RVUs. The practice expense RVUs would be reduced each year by 25 percent of the difference between the current work RVU and the practice expense RVU, subject to a floor (maximum reduction) of 110 percent of the work RVU. The alternative that we believe should be considered would accelerate the reduction in the practice expense RVUs for overpriced services, and lower the floor on the maximum reduction that would be permissible, with all of the additional savings being used to raise the practice expense RVUs for undervalued E/M services, especially office visits.

ASIM believes the recommendations made by the Physician Payment Review Commission for determining which services are overvalued offer advantages over the administration's methodology, by avoiding the danger of cutting the practice expense RVUs for some services--such as office-based diagnostic procedures--by more than is merited.

Another option the committee could consider would be to begin phasing in higher practice expense RVUs for office and other visits, and paying for this by lowering any "bonus" update for surgical procedures that might occur under current law (even after the administration's proposed two percent reduction), as discussed earlier. This might eliminate the need to accelerate the reductions in overpriced practice expense RVUs and to lower the floor on the maximum reductions that could occur.

Regardless of which alternative is selected, ASIM urges the committee to instruct the administration to begin phasing in a resource based practice expense methodology in a manner that provides for increases in the practice cost RVUs for undervalued E/M services, while maintaining the proposed budget savings if necessary.

Laboratory Fee Schedule Reductions

The proposed cuts in the Medicare laboratory fee schedule are of concern to internists, many of whom are struggling to keep open their office laboratories at a time when their costs are increasing due to the requirements of the Clinical Laboratory Improvements Act (CLIA). We believe that the administration and Congress should reassess the impact of those cuts on the ability of primary care physicians to provide their patients with quality laboratory testing. If it turns out that many physicians are in fact being forced to close their laboratories due to the high costs of complying with CLIA and lower Medicare payments, Congress should consider modifying the administration's proposal to allow for payments that are sufficient to cover the costs that physicians incur in providing their Medicare patients with the convenience of an in-office lab. To allow for Congress to make an informed judgement, ASIM recommends that Congress require HHS to study and report annually to Congress on changes in the number of labs operated by physicians and the impact on beneficiary access to those services, including an assessment of the impact of costs of complying with CLIA and reduced laboratory reimbursement on availability of in-office laboratory testing.

Self-referral Legislation

The administration also proposes to extend the ban on physician "self-referrals" to facilities other than laboratory services. ASIM supports further restrictions on potentially abusive self-referrals, provided that "shared" laboratories are exempted (shared laboratories are office laboratories that are shared by several physicians to provide testing for their own respective patients, usually located in space contiguous to their offices, but who do not otherwise meet the definition of a group practice), since such shared arrangements are often the only way that many physicians can afford to maintain a lab for their patients. Such an exemption was contained last year in H.R. 11,

which was vetoed by President Bush, and has been re-introduced as part of H.R. 21, introduced by Rep. Dan Rostenkowski (D-IL). Since the Department of Health and Human Services (HHS) does not believe that it has the authority to grant a regulatory exemption for shared labs, it is essential that Congress promptly enact H.R. 21. New self-referral legislation should also continue the current exemption for in-office diagnostic procedures, such as office X-rays, that are an essential part of a physician's practice.

Electronic Claims Processing

ASIM supports the goal of converting to electronic claims processing. Physicians should not be penalized, however, if they are unable to convert to electronic claims processing because of a lack of administrative and technical assistance from Medicare or for other legitimate reasons, such as excessive costs. ASIM strongly believes that the administration must assure that sufficient technical expertise is provided to physicians to facilitate conversion by 1996. Congress should reexamine prior to implementation the administration's proposal to begin charging $1.00 per paper claim, starting in 1996, if it appears that physicians have not been provided with sufficient assistance in making conversion to electronic billing, or costs and other factors have precluded a substantial number of primary care physicians from making the conversion by 1996. HHS should be required to report to Congress, no later than June, 1995 on the technical assistance that has been provided to physicians, and the number of physicians who have--and have not--converted to electronic claims processing. The $1.00 per claim "penalty" should be postponed if this report shows that a significant number of physicians have been unable to convert to electronic claims processing.

Other Part B Cuts

Our statement has focused on those Medicare proposals in the President's plan that will have a direct impact on internists and their patients. We recognize that other organizations will express strong objections to some of the proposed cuts. There may in fact be legitimate reasons for some of their objections. The committee has a responsibility to consider legitimate concerns about the President's proposals, and to consider modifications if necessary. But if some of other proposed Medicare cuts are rejected or modified, it is essential that the "lost" savings not be made up by lowering the update for office visits, nursing home, and home visits. ASIM will strongly oppose any effort to provide for a lesser update for office, nursing home, or home visits ("primary care services"), in order to allow for proposed cuts in other areas to be restored.

Conclusion

Even with the proposed full update for office, nursing home, and home visits, the President's proposals will require sacrifice from internists. Many of their other services will receive a less-than-inflation update, payments for laboratory services will be curbed, and payments for some services may even be reduced as a resource based practice expense method is phased in. Nevertheless, ASIM is willing to work constructively with the President and Congress on restraining increases in Medicare expenditures, as part of a balanced and fair package to reduce the deficit and expand access to care. We believe that our suggestions for modifying the volume performance standard (VPS) and default update, and for changes in the administration's proposal to implement a resource based practice expense methodology, would further the goal of rebuilding primary care while still allowing for savings.

ASIM has also suggested that some of the other proposed cuts be reexamined based on further data. We have suggested that HHS be required to report on changes in the number of physicians who offer in-office laboratory services, and if the data show that physicians are unable to maintain their office labs under the proposed laboratory fee schedule cuts and given the costs of complying with CLIA, reexamination by Congress of those cuts would then be in order. Similarly, the proposal to begin in 1996 charging $1.00 per paper claim should be reexamined prior to implementation if physicians have been given insufficient technical assistance or other legitimate factors have precluded large number from converting to electronic claims processing.
ASIM also urges Congress to require that some of the Medicare savings be used to expand access, rather than solely for deficit reduction.

As long as the proposed package remains true to the principles outlined at the beginning of this statement, ASIM will not oppose further savings in Medicare. To recap, ASIM believes that Medicare savings must be used not only to reduce the deficit, but to expand access; that primary care and other undervalued services must be protected from cuts; that the package must require a fair and balanced contribution from all players, as the administration's proposal appears to

require (rather than physicians being singled out for disproportionate cuts); and the savings must not be achieved through policies that would micromanage physicians practices or result in denial of payment for legitimate services. By and large, and notwithstanding ASIM's recommendations for modifying specific administration proposals, the President's package is consistent with these principles. We urge the committee to act to assure that the final package that is enacted by Congress does not depart from them.

Finally, ASIM urges the committee to consider other legislative changes to assure adequate access to services by internists, especially primary care internists. Exempting primary care from further budget cuts will not, by itself, encourage physicians to enter and remain in primary care (although further cuts would certainly *discourage* them from doing so). ASIM urges the committee to consider the other proposals in "Rebuilding Primary Care: A Blueprint for the Future," many of which fall under the committee's jurisdiction. Protecting primary care from further cuts is a step in the right direction. But much more must be done to alter an economic, regulatory and training environment that is hostile to primary care.

STATEMENT OF THE ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

The Association of Freestanding Radiation Oncology Centers ("AFROC") is delighted to have the opportunity to submit this testimony with respect to the Medicare Part B provisions of the federal government's FY 1994 budget. AFROC is an association of over 150 freestanding radiation oncology centers located throughout the country. Freestanding radiation oncology centers are health care facilities organized and operated to provide high quality, cost-efficient radiation oncology services to patients in their communities outside the hospital setting. It is estimated that there are approximately 300 to 350 freestanding radiation oncology centers located throughout the country, most of which are owned by the radiation oncologists who provide professional services in the facilities. Freestanding radiation oncology centers are heavily dependent on Medicare reimbursement, since approximately 55 to 65% of patients treated by such centers are covered under the Medicare program.

AFROC's comments relate specifically to proposed reductions in Medicare payment for practice expenses and proposed restrictions on physician "self-referral" for radiation oncology services. Each of these issues is discussed separately below.

I. PROPOSED REDUCTIONS IN MEDICARE PAYMENT FOR PHYSICIANS' "PRACTICE EXPENSES."

The provision of radiation oncology services outside the hospital setting requires significant capital investment, and the ongoing operation of such centers entails high expenditures for specialized staff, equipment, equipment maintenance, and other "facility" costs. In effect, such costs are comparable to the "facility costs" incurred by hospital outpatient departments that provide the same services.

Such "facility" costs are not directly reimbursed by the Medicare program; rather, these "facility" costs are currently reimbursed as the "technical" component of radiation oncologists' fees, under Medicare's physician fee schedule. When the Health Care Financing Administration ("HCFA") implemented the physician fee schedule, it closely analyzed the technical component RVUs provided for radiation oncology services, at the request of AFROC and other concerned radiation oncology organizations. Specifically, HCFA analyzed two cost studies that were submitted by the industry (one of which was performed by AFROC) and concluded that, in fact, freestanding radiation

oncology centers had been underreimbursed for the substantial "facility" costs involved in providing radiation oncology services in freestanding settings. As the result of its analysis, HCFA decided to adjust the technical component RVUs provided for radiation oncology services to more accurately represent the costs incurred by "efficiently operated" facilities. Thus, the technical component RVUs for radiation oncology services are among the only technical component RVUs that are specifically based upon the resource costs involved.

In its proposed budget, the Administration has suggested that practice expense RVUs for certain services be reduced to more accurately reflect the resource costs involved. AFROC respectfully requests that radiation oncology technical component services be exempt from any such reductions, since the technical component RVUs for these services have already been adjusted by HCFA to reflect the substantial resource costs involved in providing radiation oncology services in freestanding settings.

II. PHYSICIAN "SELF-REFERRAL."

The President's budget proposal also proposes to extend the current restrictions on clinical laboratory "self-referral" to a number of other services, including radiation therapy services. AFROC strongly believes that where referring physicians, such as medical oncologists and surgeons, have a financial interest in a radiation therapy facility, this financial interest presents a serious conflict of interest which may interfere with the referring physician's judgment concerning the most appropriate center for the provision of radiation oncology services. For this reason, AFROC strongly supports the extension of physician "self-referral" restrictions to providers of radiation therapy services.

However, great care should be taken to ensure that such legislation does not inadvertently preclude radiation oncologists from owning their own facilities. For example, some of the bills introduced to extend restrictions on physician "self-referral" to radiation oncology and other "designated health services," fail to make conforming changes in the physicians' office exception included in the legislation. If the physician "self-referral" restrictions currently applicable to clinical laboratories were to be extended to radiation oncology services without appropriate changes in the exception language, the legislation could be read to preclude radiation oncologists from owning their own office. AFROC does not believe that radiation oncologists' ownership of their own facilities raises the types of conflicts of interest issues raised by medical oncologist or surgeon ownership of these facilities, nor do we believe that the "self-referral" legislation was originally intended to preclude radiation oncologists from owning their own facilities. Accordingly, we request that any physician "self-referral" legislation include a specific exception for radiation oncologist-owned centers.

If you have any questions regarding this testimony or any other questions concerning AFROC, please do not hesitate to call AFROC's Washington counsel, Diane S. Millman, at (202) 778-8021.

STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists appreciates the opportunity to share with the Committee on Finance pathologists' perspective on Medicare Part B budget proposals. The College represents more than 13,000 physicians who practice laboratory medicine in community hospitals, academic medical centers, independent medical laboratories, and other settings in which Medicare patients are provided necessary medical services.

At the outset, we would like to acknowledge that physicians should be involved in and contribute to the effort to control federal spending for health care services. The College of American Pathologists is willing to work with the Committee in that regard. We are not asking to be exempt from those efforts. We do ask that pathologists' share of the efforts to control health care spending be appropriately structured, that it not be disproportionately large given the size of the specialty, and that it not be crafted in such a way that the future of pathology and the quality of laboratory medicine will be endangered.

In the budget proposals under consideration, there are several items that would affect pathologists. The College statement focuses on six of those items.

I. BUNDLING INPATIENT PATHOLOGY, RADIOLOGY, AND ANESTHESIA PAYMENTS

Once again an Administration has proposed bundling Medicare payments for pathology, radiology, and anesthesia services provided in the hospital setting into a fixed payment per discharge. The payment would be made not to the physicians who provide the services but to the hospital or the medical staff. In 1987, after extensive study and debate, the Congress rejected a virtually identical proposal. Since then, the Congress has adopted a resource-based fee schedule for pathology and other physician services. We urge the Committee to oppose the bundling proposal.

The Administration's proposal asserts that the bundling proposal would give physicians and hospitals the incentives to be cost-conscious, provide only medically necessary services, and eliminate the provision of marginal services. We can think of no manner in which the bundling proposal would accomplish this. Instead, hospitals and physicians would be unfairly burdened by federal requirements imposing new relationships among them, a burden which would be destructive to development of voluntary collaborative arrangements at the local level that could serve to contain the growth in health care costs while preserving the quality of and access to health care services.

The college believes that the interests of the government, of patients, and of physicians as patient advocates are best met when payment for physician services is made to the physician who provides the service without mandated intervention of another party, such as a hospital or medical staff. The College also believes that decisions about the relationships between hospitals and pathologists and pathologists and other physicians are best handled at the local level, so they can respond to local health care needs and local market conditions. Micro-management of local relationships between health care providers by the federal government will only harm physician-to-hospital, physician-to-physician, and physician-to-patient relationships and over time erode the quality of health care.

Pathologists, and all other specialties, are already very actively engaged in development of innovative collaborations and networks of health care service delivery that only a few years ago had not been contemplated. Those efforts vary in structure and size from region to region, of necessity having been structured to meet the needs of the local area. We urge the Committee to allow those types of voluntary and very competitive efforts to continue and not to dampen such efforts by imposing a new federal structure for payment of pathology services.

II. RVS FEE SCHEDULE UPDATE FOR 1994

The Administration's proposal would give a Medicare relative value scale fee schedule update for 1994 of approximately two percentage points less than the full update that would otherwise be allowed, with a full update only for primary care services.

The College is willing to work with the Committee and Congress to discuss a reduced RVS fee schedule update for 1994 as physicians' contribution to attempts to reduce health care spending and to reduce the budget deficit. There is no sound basis for subjecting pathology to a more onerous reduction than is applied to physicians in general. Instead of imposing a bundling initiative for pathology services, we urge the Congress to include pathology in whatever update or reduction is generally applied to physicians for 1994 using the payment system that is currently in place.

III. RVS PRACTICE EXPENSE COMPONENT REDUCTIONS

The Administration's proposal also includes a reduction in 1994 through 1996 of the practice expense relative value component in the Medicare RVS. Our understanding is that the basis for this proposal is the Physician Payment Review Commission recommendation that the Health Care Financing Administration conduct studies to allow resource-based practice expense relative value units to be phased-in beginning in 1997.

The College is not opposed to resource-based practice expense components. In fact, the College has been proactive in the development of resource-based components by funding an external study of the practice expenses incurred by pathologists in the provision of services subject to the Medicare relative value scale. Those data now form the basis of the pathology technical component values.

We do oppose arbitrary changes in the Medicare practice expense relative values prior to completion of studies suggested by the PPRC. The Medicare RVS is only in its second year of implementation. Confusion, misunderstanding, mistakes, and other implementation problems are still in the process of being resolved. Yet another change in a fundamental part of the RVS fee schedule, the practice expense components, would be unfair to physicians and confusing to all involved. The College urges you to allow the relative value practice expense components to go unchanged until a time when more accurate data on what they should be are available.

IV. REDUCTIONS IN PAYMENT FOR CLINICAL LABORATORY SERVICES

The budget proposal includes a provision to reduce national caps on the Medicare clinical laboratory fee schedule from 88% to 76% of the national median of the carrier-specific fee schedules. Apparently there would be some potential for differential adjustments.

Since its beginning in 1984, the Medicare clinical laboratory fee schedule has been a favorite target for budget reduction efforts. Attached is a summary of the reductions and other changes in the fee schedule over the past nine years (Attachment A—retained in Committee files). This history alone should give pause to any proposals for additional reductions for these services. The current proposal is additionally troublesome because of its size—reduction from 88% to 76% is a dramatic reduction that the College must oppose, because it would drive many small laboratories out of the market and reduce local access to these services.

However, it has been sometime since the clinical laboratory fee schedule has been looked at other than as a budget saver. The College would appreciate the opportunity to work with you to resolve some glaring inequities in payment for certain services subject to the clinical laboratory fee schedule. We are also willing to discuss reductions in payment under the fee schedule.

In particular, the Medicare payment policy for Pap smear testing of women is totally contrary to federal attempts to ensure the quality of Pap smears and to encourage Medicare beneficiaries to avail themselves of this benefit. In 1988, the Congress passed the Clinical Laratory Improvement Amendments which established stringent new requirements and restrictions on the provision of cytology services, especially Pap smears. Personnel requirements, workload restrictions, proficiency testing quality assurance mandates, and other CLIA '88 requirements have greatly increased the cost of Pap smear screening. The following year, in 1989, the Congress recognized the importance of the Pap smear as a preventive health care service and added to Medicare benefits a provision for reimbursement of a screening Pap smear every three years or more often for women at high risk of developing cervical cancer. The 1989 provision explicitly provided for coverage of both the screening by a technologist and a physicians' interpretation when medically necessary.

Nevertheless, Medicare payment for the technologists' screening service under the clinical laboratory fee schedule was capped nationwide in 1992 at $7.89, well below the cost of this service. Information from cytology laboratories indicates that the cost of the screening Pap smear is somewhere between $10 and $20.

In addition, with implementation of the Medicare relative value scale, the Health Care Financing Administration arbitrarily and without opportunity for public comment eliminated separate payment for physician interpretation of outpatient Pap smears. Pathologists are required under CLIA to review and diagnose all abnormal Pap smears. Prior to 1992, the Medicare program made separate payment for these interpretations. The pathologists' Pap smear interpretation was studied by Harvard during the relative value studies and a relative value has been established for the service on that basis. Were the Medicare relative value scale fully implemented, and using the current $31 conversion factor, the average payment nationwide for a pathologists interpretation of a Pap smear would be about $25.

The Administration's policy regarding Pap smear interpretations is that payment for the interpretation is included in payment for the technologists' review under the clinical laboratory fee schedule, beginning January 1, 1992. However, the clinical laboratory fee schedule payment was not increased to include payment for these interpretations. Instead, beginning last year the $7.89 cap, already well below the cost of Pap smear screening, was merely deemed to now include payment for a pathologists' interpretation.

Clearly this is a problem from several perspectives. First, the payment for the technologists' review is inadequate for the services that it has been intending to cover since 1984. If indeed there ever was any payment in the clinical lab fee schedule for pathologists' interpretations it was not on the basis of resources as those data were not available until the Harvard studies were completed. The Medicare relative value for the interpretation of a Pap smear is the federal statement of the resources involved in pathologists' interpretation of Pap smears, not the Medicare clinical laboratory fee schedule. In addition, pathologists in hospital practices generally do not receive the clinical laboratory fee schedule amount at all; that payment goes to the hospital. As discussed above in another context, we strongly believe that it is in the best interest of the government, physicians, and patients for Medicare payment for physician services to be made to those who provide the services not to another party.

The College is willing to work with the Congress and the Administration to discuss reductions in national caps for clinical laboratory fee schedule services, including differential adjustments, with the provision that problems with the payment policy for Pap smears be corrected.

V. GRADUATE MEDICAL EDUCATION PAYMENTS

The Administration's budget proposal would change Medicare payment policy for direct Graduate Medical Education such that payment would be based on a national average per resident amount and would give greater weight to primary care residencies.

The College of American Pathologists appreciates the need to ensure adequate access to primary care services through incentives for medical students to enter those areas of medical practice. We want to make you aware, however, of a growing problem in recruitment and retention of pathology residents, and of the implications of that problem for an adequate supply of pathologists in the near future. Any differential weighing of specialty residency programs should be based on a study of the need for residencies in each specialty, not an across-the-board reduction in non-primary care funding.

Pathology is not a large specialty, despite the fact that pathologists' services are required in almost every hospital setting and are considered an essential component of medical care in all communities. The American Medical Association listed fewer than 1000 pathologists in 1940, the first year that such data are available. As with other specialties, in the years following World War II pathology experienced a growth in the number of medical students entering the specialty. Even so, the proportion of physicians who are pathologists reached a peak of only 3.1% in 1970 and has declined since then. Likewise, the number of pathology training programs in Graduate Medical Education has steadily declined since the late 1960's from over 600 to 200.

We are now in the period during which pathologists who trained and entered practice following World War II are leaving practice. Pathologists currently practice 25 to 30 years. Average age at completion of residency training is 34 years; average age at retirement is 62; and there is an average of 6.86 deaths per 1000 pathologists per year. We anticipate that one third of the pathologists who entered practice between 1940 and 1965 will have reached retirement age by 1994. The specialty is losing an average of 1.87 pathologists per day.

In contrast, problems in recruitment and retention of pathology residents are producing an average of only 0.96 newly trained pathologists per day. Attrition is a significant problem in pathology—approximately 30–40 percent of pathology residents fail to finish training. When the 25% of pathologists who pursue careers in academic pathology, the military service, forensic and government jurisdictions, and industry are eliminated, this leaves less than 400 new pathologists a year to fill the anticipated 600 openings in community pathology practice.

We do not know of the exact number of pathologists that is needed in the United States; we know of no data that will give one this number. We do believe that the decline in physicians entering pathology practice, combined with the graying of practicing pathologists, produces a situation that will likely produce a shortage of

pathologists by the year 2000. Literature, supporting our concern is attached (Attachment B—retaind in Committee files).

As consideration of reforms in payment for Graduate Medical Education proceed, we strongly encourage the Congress not to adopt a restructuring of the federal payment for Graduate Medical Education that either gives incentives for pathology residencies to be reduced in number or quality, or creates additional disincentives for medical students to enter pathology practice. These disincentives are already in place and working, too well in our estimation.

VI. PHYSICIAN OWNERSHIP, REFERRAL, AND DIRECT BILLING

The Administrations' proposal includes an extension of the current Medicare prohibition on ownership and referral arrangements for clinical laboratory services to additional services. Self-referral and direct billing issues are also addressed in the "Ethics in Referral and Billing Act" (S. 337) introduced earlier this year by Senators Jeff Bingaman and Howard Metzenbaum.

Consistent with American Medical Association policy, the College of American Pathologists supports limitations on self-referral. The College believes, however, that prohibitions on physician ownership and referral arrangements must, in order to be equitable and effective, create a level playing field. That is, there should not be exemptions for certain types of services that will produce distortions in the market and adversely affect the quality of those exempt services.

The current Medicare prohibition on self-referrals went into effect on January 1, 1992, and applies to all clinical laboratory services, including tissue pathology and Pap smears. We are concerned about proposed exemptions to the prohibitions on self referral in S. 337 for interpretation of tissue pathology, Pap smear slides, and the provision of other cytology services. Prohibitions on self referral should include tissue pathology and cytology services as well, to assure that there is a level playing field in arrangements for these services. The College urges that the current Medicare prohibition on self-referrals for clinical laboratory services, including tissue pathology and Pap smears, be retained and included in proposals to expand self-referral prohibitions to all payers.

In addition, the College firmly believes that a direct billing requirement goes hand-in-hand with prohibitions on self referral. Since 1984 there has been a direct billing requirement for services under the Medicare clinical laboratory fee schedule (clinical diagnostic laboratory testing). Payment can be made only to the entity that provides the services, with an exception for referrals between laboratories that are independent of a physicians' office. Physician pathology services subject to the Medicare relative value fee schedule are not subject to this requirement. For those services, an ordering/referring physician can purchase the service from pathologists and bill the Medicare program themselves, although they have not provided the service.

The College urges the Congress to expand the direct billing requirement for Medicare to pathology services subject to the Medicare relative value scale, and in any legislation that expands self referral prohibitions beyond Medicare to include a direct billing requirement for anatomic and clinical laboratory services.

CONCLUSION

The College of American Pathologists understands that physicians will be expected to contribute to the effort to reduce federal health care spending and the budget deficit. Pathologists want to be involved in how that contribution is configured and to ensure that pathology does not bear a disproportionate share of the load. Pathology and laboratory medicine has already undergone a series of reform initiatives over the last decade. We should not be singled out for additional reductions and changes beyond what all physicians in general will bear.

In summary, bundling of pathology services into a payment made to another entity is a totally unsound idea that has been rejected by the Congress previously and should be so again. Reductions in practice expense relative value components without adequate data in that regard are not an intermediate step to a resource-based system but are just a budget reduction mechanism. We urge you not to confuse the two with adoption of this intermediate proposal.

We are willing to work with the Congress to address pathologists' and laboratory medicine's contribution to health care spending reductions, both with regard to the RVS fee schedule and to the clinical laboratory fee schedule.

Thank you for the opportunity to present pathologists' perspective on Medicare Part B budget issues to the Committee on Finance.

STATEMENT OF THE TRADE ASSOCIATION HEALTHCARE COALITION

The Trade Association Healthcare Coalition (TAHC) was formed after a number of Associations found that last year's health reform proposals included provisions that could eliminate their unique industry specialized group health insurance programs.

We appreciate this opportunity to submit testimony at this early date, since we are aware that the Finance Committee is waiting for the White House Task Force to send up its recommendations. TAHC is also aware that you will be hearing from the many interests with vital stakes in the health reform debate—doctors, insurance companies, tort lawyers, unions, pharmaceutical companies, consumer organizations, the AARP, large and small employers, and more.

There is much that is inefficient, expensive or just wrong headed about our health care delivery system. There are also some things that work quite well, and one of these is employer health insurance offered by bona fide associations such as those represented by the Trade Association Healthcare Coalition.

We represent trade associations who have been providing group health insurance coverage for many years to small businesses, as one of many services to members. We operate through master group policies or trusts, very similar to that of large employer plans. Thus, we are able to aggregate various occupational risks with particular employer based professions, and use this leverage to negotiate for our employees.

As we visited Congressional offices last year on behalf of Association health insurance plans, we were advised to limit ourselves to this issue only, and not align ourselves with efforts of insurance companies, artificial groups and associations, or anyone else with a larger or different agenda.

It also became clear that we needed to address the concerns of bona fide associations and not those whose main purpose is to provide insurance. We draw a distinction between our trade and industry associations and other affinity groups which are not employment related or industry specific. Quite often, these are the brainchild of insurance brokers seeking to find a way to market essentially individually underwritten policies to a group and who pick and choose only profitable accounts.

The easiest way to explain the membership of TAHC is that we were formed for reasons other than providing group health insurance, and insurance was not the motivating factor for businesses to join. The provision of health insurance is one of numerous services made available to our members. For many of our small business members, health insurance has become a very important service, but not the main reason for membership.

We are enclosing as a part of this testimony, a letter from Paul Wilson, a health insurance professional and a member of the TAHC Steering Committee, to the White House Task Force. We believe that the Task Force will recognize our existing association operations as similar in purpose to the purchasing groups under consideration and large employers.

We hope that in your deliberations, the Finance Committee will insure that functional association group health plans remain a viable part of the future health care delivery system.

Attachment.

NORTH AMERICAN EQUIPMENT DEALERS ASSOCIATION,
St. Louis, MO, March 2, 1993.

THE FIRST LADY,
The White House,
1600 Pennsylvania Avenue, N.W.,
Washington, D.C. 20500

Dear Ms. Clinton: By way of introduction, I am General Manager and Secretary/Treasurer for North American Benefit Administrators, Inc., the employee benefits subsidiary of North American Equipment Dealers Association (NAEDA). NAEDA is a member of the Trade Association Healthcare coalition and I serve on the steering committee of that Coalition. As a 29 year benefits professional and an association employee, I have the responsibility for administering managed-care group health programs for approximately 1,000 small to intermediate size employers who are members of NAEDA.

NAEDA and its 24 affiliated state or regional associations have been providing health insurance programs for over 45 years and now cover approximately 90,000 employee and dependent lives in 50 states through four insurance carriers. We operate our health plans much the same as large employer plans through one master group policy or trust. Our recent estimates are that approximately 4 to 6 million Americans are covered under genuine trade association programs like ours.

As you and the President's Task Force on healthcare reform continue your deliberations, I would like to bring to your attention an issue of vital importance to numerous genuine industry-wide trade associations, such as the members of the Trade Association Healthcare Coalition, which provide employment based group health programs to their trade association members.

NAEDA and its affiliated associations have provided a broad array of services, dedicated to the specific needs of America's farm, construction, and outdoor power equipment dealers for over a century. Throughout its existence, NAEDA's principal purpose has been, and remains, to assist dealers in operating their small businesses and serving their mostly rural-based customers. Providing health insurance programs, pooling the risks of large numbers of dealers has become an important service.

Our concern is that the President's Task Force could propose a program which might jeopardize or eliminate association health insurance programs, however unintentionally. We support federal reform, but have found that many even in the healthcare field are totally unaware of the value of legitimate association health insurance programs. Even worse, reformers often confuse us with the bad publicity generated by undesirable practices of our imitators. We should not be mistaken for entrepreneurial sales schemes which limit membership to low-risk employers, or which, unfortunately, defraud insureds.

As you can imagine, equipment dealerships involve working around powerful equipment, both in the shop and on-site in farmers' fields and construction sites. While farm and industrial equipment dealers have an enviable safety record, it is true that their employees are exposed to potential hazards eve day. In sum, NAEDA's healthcare programs, by definition, are not limited to a select group of low-risk individuals who are not likely to need healthcare.

By providing group health insurance, NAEDA, its affiliated regional associations, and other members of the Trade Association healthcare Coalition have enabled small businesses to form legitimate pools and to benefit from good group rates and administration costs that are less than half that which is proclaimed by many urging administrative reforms. The result has been to provide quality healthcare coverage to a large number of employees who might otherwise have gone uninsured because of the prohibitive cost of obtaining insurance for individual small businesses.

Unlike many of the healthcare programs that have been formed as entrepreneurial ventures by insurance company agents and brokers, genuine trade association plans such as NAEDA, firmly believe that while federal healthcare reform should expand coverage for those currently uninsured, it must also protect the viability of genuine trade associations such as NAEDA to continue to provide comprehensive, affordable coverage to its membership.

We are proud of the fact that our program, and numerous similar programs throughout the country, have long histories of providing managed healthcare to members. We negotiate with insurers for the lowest possible rates and for the best plans available. We monitor healthcare costs and actually interact with healthcare providers. We promote safety within dealerships in order to reduce not only the healthcare costs to the employers, but also to reduce risks of injury or poor health to their employees. We offer our programs to those who are otherwise eligible for membership in our associations.

I would like to accept the offer to meet with you and members of the Task Force on behalf of NAEDA and the Trade Association Healthcare Coalition to explain our concerns and the important role which our trade associations play in providing healthcare coverage.

Sincerely,

PAUL WILSON, *CPCU, CEBS, General Manager/Secretary-Treasurer, North American Benefit Administrators.*

STATEMENT OF THE UNITED MINE WORKERS OF AMERICA
HEALTH AND RETIREMENT FUNDS

United Mine Workers of America Health and Retirement Funds
3540 Wilshire Boulevard — 12th Floor
Los Angeles, CA 90010

November 30, 1992

1950 & 1974 Pension Trusts
1950 & 1974 Benefit Trusts

Dear Doctor:

The UMWA Health and Retirement Funds (Funds) is modifying its reimbursement criteria for diagnostic imaging services performed on or after January 1, 1993. The enclosed literature details revised policies and procedures pertaining to these services.

Designed to enhance the clinical efficacy and cost effectiveness of diagnostic imaging, the modifications are a consequence of an extensive study conducted by Bruce J. Hillman, M.D., and Funds' staff. Their findings were recently published in the *October 21, 1992* issue of the Journal of the American Medical Association under the title, *"Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population."*

Using methodologies developed in Dr. Hillman's previous work, the study presented a comparative analysis of diverse clinical presentations, evaluating: 1) mean imaging frequency; 2) mean imaging charges per episode of care; and 3) mean imaging charges for diagnostic imaging attributable to self-referral versus radiologist-referral. Dr. Hillman and his associates concluded that within all physician specialties, self-referral uniformly led to significantly greater utilization of and higher charges for diagnostic imaging than radiologist-referral. Additional research has also identified related qualitative concerns regarding diagnostic imaging results generated by nonradiologist physicians.

Please review the enclosed information regarding revisions in Funds' criteria for diagnostic imaging services. The Funds appreciates your cooperation with our health care cost management initiatives.

Sincerely,

Marvin J. Shapiro, M.D., D.A.B.R.
Medical Director

enc.

Radiology Credentials

In order to receive payment for the professional component, individual radiologists, clinics and groups with staff radiologists must provide the Funds with the current radiology certification information requested on the enclosed form and return it to the following address:

UMWA Health and Retirement Funds
Radiology
P. O. Box 10140
Van Nuys, CA 91410

Verification of radiology credentials is an integral part of the Funds' health quality and cost management initiatives, and the Funds appreciates your cooperation with these measures.

Please direct any questions you might have concerning Funds' policies and procedures for diagnostic imaging to:

Marvin J. Shapiro, M. D., D.A.B.R.
UMWA Health and Retirement Funds
3540 Wilshire Boulevard
Los Angeles, CA 90010

Diagnostic Imaging Services

Policies and Procedures

Criteria for Reimbursement

Following is a review of the UMWA Health and Retirement Funds (Funds) criteria, effective January 1, 1993, for the payment of radiology claims:

❑ Radiologists, Clinics and Groups

Radiologists, clinics and groups with radiologists on staff, may submit claims for the type and level of services performed. For the purposes of payment, radiologists are defined as physicians who are are certified by the American Board of Radiology or have completed an accredited residency program in radiology.

❑ Nonradiologists

For the purposes of payment, the interpretations of nonradiologists constitute extensions of the providers' clinical evaluations of patients, and are not considered to be the same service available through radiologists who have comprehensive training in diagnostic image interpretation.

Nonradiologists (*self-referring physicians*) who perform diagnostic imaging services will be paid only for the technical component of an imaging examination. **Claims from nonradiologists for the professional component will not be paid, and claims for global services will be paid at the same rate as the technical component. The Funds will not reimburse nonradiologists for interpreting images exposed by radiologists or outpatient hospitals.**

Nonradiologists using imaging equipment may contract with radiologists to interpret the images they produce, but the radiologist must bill the Funds directly for these professional services.

Claims Submission

All claims for radiology services must contain a modifier identifying the component of the diagnostic imaging service that is being billed. Each claim must contain one of the following standard Medicare modifiers in order to be processed for payment:

00 - Global Service
TC or 25 - Technical Component
PC or 26 - Professional Component

Any claim submitted without the required modifier will be denied.

Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population

Bruce J. Hillman, MD; George T. Olson, MRP; Patricia E. Griffith, MPhil; Jonathan H. Sunshine, PhD; Catherine A. Joseph; Stephen D. Kennedy, PhD; William R. Nelson, MA; Lee B. Bernhardt

Objectives and Rationale.—For 10 common clinical presentations, we assessed differences in physicians' utilization of and charges for diagnostic imaging, depending on whether they performed imaging examinations in their offices (self-referral) or referred their patients to radiologists (radiologist-referral).

Methods.—Using previously developed methodologies, we generated episodes of medical care from an insurance claims database. Within each episode, we determined whether diagnostic imaging had been performed, and if so, whether by a self-referring physician or a radiologist. For each of the 10 clinical presentations, we compared the mean imaging frequency, mean imaging charges per episode of care, and mean imaging charges for diagnostic imaging attributable to self- and radiologist-referral.

Results.—Depending on the clinical presentation, self-referral resulted in 1.7 to 7.7 times more frequent performance of imaging examinations than radiologist-referral ($P<.01$, all presentations). Within all physician specialties, self-referral uniformly led to significantly greater utilization of diagnostic imaging than radiologist-referral. Mean imaging charges per episode of medical care (calculated as the product of the frequency of utilization and mean imaging charges) were 1.6 to 6.2 times greater for self-referral than for radiologist-referral ($P<.01$, all presentations). When imaging examinations were performed—including those performed in both physicians' offices and hospital outpatient departments—mean imaging charges were significantly greater for radiologists than for self-referring physicians in seven of the clinical presentations ($P<.01$). This result is related to the high technical charges of hospital outpatient departments; in office practice, radiologists' mean charges for imaging examinations were significantly less than those of self-referring physicians for seven clinical presentations ($P<.01$).

Conclusions.—Nonradiologist physicians who operate diagnostic imaging equipment in their offices perform imaging examinations more frequently, resulting in higher imaging charges per episode of medical care. These results extend our previous research on this subject by their focus on a broader range of clinical presentations; a mostly elderly, retired population; and the inclusion of higher-technology imaging examinations.

(*JAMA*. 1992;268:2050-2054)

From the Department of Radiology, the University of Virginia School of Medicine, Charlottesville (Dr Hillman); Aka Health Strategies, Inc, Los Angeles, Calif (Messrs Olson and Nelson and Ms Griffith); Research Department, The American College of Radiology, Reston, Va (Dr Sunshine); Health Research Area, Abt Associates, Cambridge, Mass (Ms Joseph and Dr Kennedy); and Benefits Department, United Mine Workers of America Health and Retirement Funds, Washington, DC (Mr Bernhardt).

Reprint requests to Department of Radiology, University of Virginia Health Sciences Center, Box 170, Charlottesville, VA 22908 (Dr Hillman).

DURING the last decade, direct payments for physicians' services tripled, from $41.9 billion to $125.7 billion.[1] In large part, this has been due to an increase in the number of services provided to patients.[2,3] One phenomenon promoting greater intensity of care is physicians increasingly adopting more and more complex technologies into their office practices.[2] Physicians then can "self-refer" their patients to these technologies. Self-referral has been shown to be associated with higher-technology utilization than when physicians refer their patients to specialists employing these same technologies.[4-7]

See also p 2055.

Previously, we demonstrated that, for each of four common clinical presentations, self-referring physicians employed diagnostic imaging at least four times as frequently as their colleagues who referred imaging examinations to radiologists. Self-referring physicians also charged significantly more for performing and interpreting imaging studies in their offices than did radiologists.[7] This investigation employs similar methodology to expand upon our previous work assessing physicians' utilization of and charges for diagnostic imaging by studying a mostly elderly, chronically ill patient population that is of particular interest with regard to Medicare reimbursement; evaluating a broader array of imaging technologies and clinical presentations; more extensively portraying imaging charges; and assessing

patients with 10 common clinical presentations, including three of the four presentations investigated in our previous research.

METHODS

Insurance Claims Database and Clinical Presentations

Access to the insurance claims database used in this investigation was provided without charge by the United Mine Workers of America Health and Retirement Funds (Funds). Reimbursement for physicians' claims and the claims database are administered for the Funds by Alta Health Strategies, Inc (Alta). We investigated the portion of the database representing all physicians' claims for all Funds beneficiaries, regardless of age, rendered during the 2-year period January 1, 1988, through December 31, 1989. The claims history file records the billed charge for all line items for each claim.

Funds beneficiaries and their dependents receive full reimbursement, with no copayments, for outpatient diagnostic imaging examinations. The Funds administers both the Medicare and supplemental insurance components of physician reimbursements for Funds beneficiaries (84% of Funds beneficiaries are covered by Medicare Part B).

The Funds database details the health insurance coverage for their approximately 119 000 beneficiaries. Of these, 79% are 65 years or older. Thirty-four percent are male. Eighty percent live in the Appalachian coal-mining region.

Using this database, we compared the frequency of imaging and the imaging charges accrued during episodes of acute care of self-referring physicians with those of radiologist-referring physicians for 10 clinical presentations. The clinical presentations and their associated imaging examinations were chosen to obtain a broad distribution of anatomic locations, variety of imaging examinations, and sophistication of imaging technology, as well as for their frequency of appearance in the Funds' claims database and the imaging costs they represented to the Funds.

The 10 clinical presentations selected included three of the four clinical presentations investigated in our earlier research,[1] including (with the associated imaging examinations) acute upper respiratory tract symptoms (plain films, fluoroscopy), men with trouble urinating (excretory urography, cystourethrography, sonography, sonography), and low-back pain (plain films, myelography, diskography, computed tomography [CT], magnetic resonance [MR]). Additional clinical presentations investigated in this study were headache (CT, MR), transient cerebral ischemia (CT, MR, sonography including Doppler studies, angiography), upper gastrointestinal bleeding (plain films, barium studies), knee pain (plain films, arthrography, CT, MR), urinary tract infection (plain films, excretory urography, cystourethrography, sonography, CT, MR), chest pain (plain films, barium studies, radionuclide studies), and congestive heart failure (plain films, echocardiography, real-time and Doppler sonography, angiography, radionuclide studies). A complete list of the radiologic procedure (*CPT-4*) codes[2] counted and the analysis for each clinical presentation can be obtained from the National Auxiliary Publications Service (NAPS).

Development of Episodes of Medical Care

We previously have detailed the methods employed to define episodes of outpatient care.[1] Briefly, for each of the 10 clinical presentations, we defined all diagnostic (*ICD-9*) codes[3] that physicians reasonably might enter on their claims for services to these patients. The *ICD-9* codes selected for each clinical presentation (index *ICD-9* codes) can be obtained from NAPS. Each of the 10 clinical presentations was analyzed separately.

We applied to the database a version of the computerized algorithm we employed in our earlier work.[1] Briefly, an episode was initiated by a physician's claim for a service related to an index *ICD-9* code. The date of this service represented the starting date of the episode; the episode concluded after a fixed period of time, the amount of time depending on the clinical presentation. All claims from physicians with specialties relevant to the clinical presentation (see NAPS deposit), for office and hospital outpatient services, encountered between the beginning and end dates for the episode were eligible for inclusion in the episode. A lag period was observed immediately following each episode, during which neither an index *ICD-9* code nor index *CPT-4* code either counted as part of the previous episode or initiated a new episode. This restriction prevented the misclassification of a follow-up service as the initiation of a new episode. The durations of episodes and lag periods for each clinical presentation can be obtained from NAPS. The appropriateness of the durations of episodes and lag periods was established and tested by the same methods we have previously described.[1]

Episodes were eligible for inclusion in the analysis if they were triggered by an appropriate index *ICD-9* code, with a service date on or after January 1, 1988, and were completed by December 31, 1989. Because we were unable to determine which of two or more physicians decides whether to perform an imaging examination, we excluded episodes where multiple nonradiologist physicians cared for the patient or where services other than laboratory or radiology were provided in a hospital outpatient department (10% of episodes). Since we could not reliably categorize imaging services as self- or radiologist-referral when multispecialty group practices provided both radiologic and other services, we excluded episodes occurring in clinics and when a provider was involved in numbers of episodes greater than 2 SD from the mean. Following these exclusions, the episode files included 50% to 75% of the original episodes for the 10 clinical presentations.

Individual claims within valid episodes were excluded if the services were unrelated to the clinical indication or provided in nondesignated settings or if there was no charge for the claim.

Designation of Physicians as Self-referring or Radiologist-Referring

Each nonradiologist provider (defined by their primary specialty code and/or having less than 75% of their claims being for imaging procedures) was designated individually as "self-referring," "radiologist-referring," or "unknown," separately, for each clinical presentation in which he or she participated. A self-referring physician was one who at least once during the 2-year period submitted a claim for performing an index imaging study, even if he or she also referred a patient to a radiologist. A radiologist-referring physician never submitted a claim for an index imaging study and at least once participated in a valid episode in which the patient was referred to a radiologist for imaging. An unknown physician did not participate in a valid episode during which either he or a radiologist performed an index imaging examination.

Classification of Episodes and Estimation of the Frequency of Imaging

We classified the episodes of self- and radiologist-referring physicians on the basis of whether imaging was performed. This provided us with the observed frequencies of imaging for these two groups. These observed frequencies overestimate the actual imaging rates of self- and radiologist-referring physicians, since they do not account for physicians who were not involved in episodes where imaging occurred (the "unknown"

Table 1.—Primary Estimates of Imaging Frequency for Self-referring and Radiologist-Referring Physicians*

Clinical Presentation	Imaging Frequencies†		Ratio (95% Confidence Interval)
	Self-referring Physicians (No. of Episodes)	Radiologist-Referring Physicians (No. of Episodes)	
Chest pain	0.31 (4369)	0.16 (12 842)	1.9 (1.8-2.1)
Congestive heart failure	0.25 (13 568)	0.09 (24 840)	2.7 (2.5-2.8)
Difficulty urinating	0.11 (1111)	0.05 (5990)	2.2 (1.5-2.9)
Gastrointestinal bleeding	0.23 (1159)	0.13 (12 074)	1.7 (1.5-2.0)
Headache	0.30 (275)	0.07 (6874)	4.3 (3.3-5.4)
Knee pain	0.40 (2898)	0.05 (5191)	7.7 (6.6-8.7)
Low-back pain	0.21 (7381)	0.06 (21 179)	3.6 (3.4-3.9)
Transient cerebral ischemia	0.60 (334)	0.13 (2531)	4.7 (3.9-6.4)
Upper respiratory tract infection	0.30 (10 781)	0.13 (21 552)	2.3 (2.2-2.4)
Urinary tract infection	0.11 (1731)	0.05 (18 280)	2.4 (1.9-2.8)

*Estimates were rounded to the nearest percentage. All differences between self- and radiologist-referring physicians are statistically significant, $P<.01$.
†Imaging frequency is the number of episodes containing one or more imaging claims divided by the total number of episodes.

group). To correct for this deficiency, we employed the same method of maximum likelihood estimation as in our previous study[1] (detailed in the NAPS deposit) to estimate the imaging frequencies for all self-referring and radiologist-referring physicians, including those in the unknown group, as the proportion of episodes for each physician group in which imaging was performed. Our method of maximum likelihood estimation is based on the expectation that, within physician designations as self- or radiologist-referring, physicians' imaging practices are uniform. However, this may not strictly be the case. Thus, as in our previous study,[1] we performed upward and downward biased estimates to represent "worse case" scenarios, embodying the maximum departures from the primary estimate that could result if there were no similarities among the practices of self-referring or radiologist-referring physicians (described in the NAPS deposit).

Comparison of Physicians' Charges and Correction for the Complexity of Imaging Examinations

Our analysis of charges for imaging examinations included all global, professional, and technical charges in both the office and hospital outpatient settings.

We compared the total charges for imaging for all episodes in the database, whether or not imaging occurred. The result, termed "mean imaging charges per episode," is calculated as the product of the mean charges for diagnostic imaging claimed during episodes in which imaging occurred and the frequency of imaging.

To assess the influence of differences in the complexity of examinations on differences in mean imaging charges per episode, we assigned to each imaging service its relative value (in relative value units [RVU]), according to the relative value scale used through 1991 for payment for imaging services provided to Medicare patients. Dividing the mean charge by the mean RVU provided the measurement "mean charge per RVU," which we used to compare the charges of self- and radiologist-referring physicians for comparable work. Because hospitals apply high technical charges to imaging performed in their hospital outpatient departments and because financial incentives to perform imaging examinations usually differ in office and hospital outpatient practice, we performed this analysis separately for episodes involving imaging solely in physicians' offices.

Analysis

Differences between self- and radiologist-referring physicians' estimated frequency of imaging and imaging charges were tested for statistical significance by unpaired t tests of the difference in means between the two groups. Differences were considered statistically significant at $P<.01$.

We also conducted an analysis of imaging utilization for selected individual physician specialties, investigating the imaging practices of a specialty for a clinical presentation if the number of episodes was large enough that the error of the estimate of the frequency of imaging for all physicians of that specialty was less than one fourth the magnitude of the estimate and there were at least 25 self-referring and 25 radiologist-referring physicians in the sample for each such analysis.

RESULTS

The claims database yielded 174 800 episodes for the 10 clinical presentations (Table 1).

The Frequency of Diagnostic Imaging

The primary estimates of imaging frequencies for self-referring physicians were significantly greater than the imaging frequencies of radiologist-referring physicians for all 10 clinical presentations (all presentations, $P<.01$). The ratios of the frequency of imaging varied considerably with the clinical presentation. Self-referring physicians employed imaging 7.7 times as frequently as radiologist-referring physicians for knee pain but only 1.7 times as often for gastrointestinal bleeding (Table 1).

Upward biased estimates sustained the essential result of significantly greater imaging by self-referring physicians for all clinical presentations ($P<.01$). However, in three clinical presentations, the downward biased estimate resulted in differences between self- and radiologist-referral that were not statistically significant (difficulty urinating, gastrointestinal bleeding, and transient cerebral ischemia). In two other clinical presentations, the downward biased estimates indicated imaging utilization by radiologist-referring physicians significantly greater than that of self-referring physicians (headache and urinary tract infection). A table of biased estimates is available from NAPS.

Twenty-one clinical presentation–physician specialty combinations met the screening criteria for investigation of specialty-related imaging practices. Six clinical presentations were represented in general practice, four each in internal medicine and family practice, two in general surgery, cardiology, and orthopedic surgery, and one in pulmonology. In all cases, the primary estimates indicated that self-referring physicians employed imaging significantly more frequently than radiologist-referring physicians (all specialty–clinical presentation pairs, $P<.01$) (Table 2). The ratio of the frequencies of imaging (self-referring/radiologist-referring) ranged from 1.5:1 to 4.8:1 for different clinical presentations and specialties. The finding that self-referring physicians employ imaging significantly more frequently than radiologist-referring physicians was sustained

Table 2.—Primary Estimates of Imaging Frequency by Selected Physician Specialties*

Physician Specialty and Clinical Presentation	Imaging Frequencies†		
	Self-referring Physicians (No. of Episodes)	Radiologist-Referring Physicians (No. of Episodes)	Ratio (95% Confidence Interval)
Cardiology			
Chest pain	0.38 (380)	0.19 (1327)	2.0 (1.6-2.4)
Congestive failure	0.30 (2185)	0.13 (1314)	2.4 (2.0-2.5)
Family practice			
Chest pain	0.30 (784)	0.16 (2442)	1.8 (1.5-2.1)
Congestive failure	0.30 (2477)	0.10 (5036)	2.1 (1.9-2.3)
Low-back pain	0.30 (1388)	0.05 (4475)	3.6 (3.1-4.6)
Upper respiratory tract infection	0.31 (2834)	0.13 (4216)	2.3 (2.1-2.5)
General practice			
Chest pain	0.30 (2025)	0.16 (5058)	1.8 (1.7-2.1)
Congestive failure	0.25 (4985)	0.09 (10 458)	2.7 (2.5-3.0)
Gastrointestinal bleeding	0.20 (618)	0.13 (4081)	1.5 (1.2-1.8)
Knee pain	0.25 (981)	0.05 (1946)	4.8 (3.5-6.1)
Low-back pain	0.19 (2542)	0.05 (8446)	3.5 (3.0-4.0)
Upper respiratory tract infection	0.26 (36	0.11 (8721)	2.4 (2.2-2.7)
General surgery			
Low-back pain	0.23 (545)	0.07 (1350)	3.1 (2.3-3.9)
Upper respiratory tract infection	0.30 (726)	0.15 (1660)	1.9 (1.6-2.5)
Internal medicine			
Chest pain	0.33 (990)	0.14 (3633)	2.3 (2.0-2.6)
Congestive failure	0.25 (3715)	0.09 (7866)	2.8 (2.6-3.1)
Low-back pain	0.16 (1274)	0.05 (5693)	2.9 (2.3-3.5)
Upper respiratory tract infection	0.33 (2030)	0.16 (4561)	2.0 (1.8-2.2)
Orthopedic surgery			
Low-back pain	0.28 (1666)	0.12 (511)	2.3 (1.6-3.0)
Knee pain	0.56 (1307)	0.30 (135)	1.9 (1.3-2.5)
Pulmonology			
Upper respiratory tract infection	0.34 (360)	0.20 (184)	1.7 (1.1-2.4)

*Estimates were rounded to the nearest percentage. All differences between self- and radiologist-referring physicians are statistically significant, $P<.01$.
†Imaging frequency is the number of episodes containing one or more imaging claims divided by the total number of episodes.

in all 21 upward biased estimates and 19 of 21 downward biased estimates ($P<.01$). In two cases—general practitioners seeing patients for gastrointestinal bleeding and internists for patients with low-back pain—the differences in the downward biased estimates were not significantly different.

Imaging Charges

Mean imaging charges per episode—for all episodes, including both office and hospital outpatient department settings and regardless of whether an imaging examination occurred—are detailed in Table 3. For all 10 clinical presentations, mean imaging charges per episode were 1.6 to 6.2 times greater for self-referral than for radiologist-referral ($P<.01$, all clinical presentations).

When all episodes with imaging were considered—including office and hospital outpatient examinations—charges per RVU for self-referral were 0.8 to 1.0 of the charges per RVU referable to radiologist-referral, depending on the clinical presentation. However, the comparison of charge per RVU for examinations performed in office practice indicates that these differences are attributable to the technical charges billed by hospitals and the fact that almost all imaging examinations in hospital outpatient departments are performed by radiologists. For examinations performed in office practice, self-referral results in charges per RVU 0.9 to 1.3 times the charges per RVU of radiologists.

Table 3.—Imaging Charges per Episode of Care*

Clinical Presentation	Charges per Episode, $†		Ratio
	Self-referral	Radiologist-Referral	
Chest pain	29	19	1.6
Congestive heart failure	41	7	6.2
Difficulty urinating	19	8	2.3
Gastrointestinal bleeding	36	24	1.6
Headache	117	36	3.3
Knee pain	31	5	6.2
Low-back pain	34	13	2.5
Transient cerebral ischemia	242	65	3.7
Upper respiratory tract infection	19	9	2.2
Urinary tract infection	32	13	2.4

*Charges were rounded to the nearest dollar.
†Charges were calculated as the product of the percentage of episodes in which imaging occurred (ie, imaging frequency) and the mean imaging charge in episodes with imaging.

COMMENT

This investigation both extends and confirms our previous research into how physicians' ownership of diagnostic imaging technology in their office practices affects imaging utilization and charges. The major differences between our previous and current research include the nature of the patient and physician

populations. Also, the present investigation evaluates a broader range of clinical presentations and assesses utilization of both conventional and more advanced imaging technologies. Finally, we were able to extend our evaluation of charges for imaging examinations to include the hospital outpatient setting. Despite these differences, the essential result remains unchanged: physicians who own imaging technology employ diagnostic imaging in the evaluation of their patients significantly more often and, as a result, generate 1.6 to 6.2 times higher average imaging charges per episode of care than do physicians who refer imaging examinations to radiologists. This result is reinforced by the consistent result of significantly greater utilization associated with self-referral in our specialty-based analysis.

In this study, differences in imaging utilization between self- and radiologist-referring physicians were more varied with respect to clinical presentation than in our previous research. Almost certainly, this is attributable to characteristics of the patient population. The Funds' beneficiaries are, overwhelmingly, elderly and, because of their work histories, prone to a variety of chronic ailments. As such, they are very different from the generally healthy, younger, working individuals we evaluated in our initial research.

The large differences between self- and radiologist-referring physicians' mean imaging charges per episode are almost entirely attributable to differences in utilization. Differences in charges for imaging examinations and the complexity of examinations are largely referable to the setting in which the examinations were performed. Examinations performed by radiologists in hospital outpatient departments usually generate higher overall charges because of the high technical charges filed by hospitals. Medicare, on average, pays 58% of these charges.[11] In office practice, self-referring physicians generally charge higher fees than radiologists for comparable examinations.

In recent years, physicians' referral of their patients to medical technologies in which they have a financial interest has gained increasing attention as a significant problem promoting increasing health care costs. Investigations demonstrating that self-referral promotes greater frequency of technology utilization,[4-7] studies indicating that a financial incentive may motivate the higher frequency of self-referral,[12-15] and articles in the lay press discussing these findings have negatively affected public perceptions about the medical profession (*Wall Street Journal*. March 1, 1989; *Christian Science Monitor*. December 8, 1988). Although it is difficult to determine what proportion of the higher utilization associated with self-referral might be inappropriate, it has not been shown that more frequent application of office-based ancillary technologies provides a consonant benefit in improving patients' health.

These considerations motivated the United Mine Workers of America Health and Retirement Funds to participate in our continuing research into the costs associated with self-referral for diagnostic imaging. The Funds face a difficult financial future. While the cost of health care for the Funds' beneficiaries continues to increase, contributions to the Funds' financial base from the participating coal companies are declining. Thus, the Funds must identify means of controlling their expenditures that still sustain the high quality of care their beneficiaries receive. This research has provided information that may guide the Funds and other payers in developing new policies with respect to payment for self-referred imaging. One possible policy would be to deny payment for self-referred imaging, or to deny payment to specific specialties or individual physicians shown to utilize imaging technology at significantly higher rates than other specialties or their peers. The Funds could choose to reduce financial incentives for self-referral by reimbursing self-referred imaging at a lower level than it pays for referred examinations or bundling payment for imaging as part of the reimbursement for an office visit. Alternatively, the Funds might develop standards for image quality and physician training for different examinations, much as standards have been developed for reimbursing claims for mammography under Medicare. Nonqualified practices would become ineligible for reimbursement of their claims.

Each of these alternatives is accompanied by potential political consequences and might potentially affect patient care. The activation of policies regarding self-referral by a payer such as the Funds may provide a demonstration for government and other payers of the effects of restricting self-referral on patient access to diagnostic imaging, the quality of care patients receive, and imaging-related expenditures.

Our research was funded by the United Mine Workers of America Health and Retirement Funds, Alta Health Strategies, Inc, and The American College of Radiology

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SPECIAL ARTICLE

FREQUENCY AND COSTS OF DIAGNOSTIC IMAGING IN OFFICE PRACTICE — A COMPARISON OF SELF-REFERRING AND RADIOLOGIST-REFERRING PHYSICIANS

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Abstract *Background.* To assess possible differences in physicians' practices with respect to diagnostic imaging, we compared the frequency and costs of imaging examinations as performed by primary physicians who used imaging equipment in their offices (self-referring) and as ordered by physicians who always referred patients to radiologists (radiologist-referring).

Methods. Using a large, private insurance-claims data base, we analyzed 65,517 episodes of outpatient care by 6419 physicians for acute upper respiratory symptoms, pregnancy, low back pain, or (in men) difficulty urinating. The respective imaging procedures studied were chest radiography, obstetrical ultrasonography, radiography of the lumbar spine, and excretory urography, cystography, or ultrasonography.

Results. For all four clinical presentations, the self-referring physicians obtained imaging examinations 4.0 to 4.5 times more often than the radiologist-referring physicians ($P<0.0001$ for all four). For chest radiography, obstetrical ultrasonography, and lumbar spine radiography, the self-referring physicians charged significantly more than the radiologists for imaging examinations of similar complexity ($P<0.0001$ for all three). The combination of more frequent imaging and higher charges resulted in mean imaging charges per episode of care that were 4.4 to 7.5 times higher for the self-referring physicians ($P<0.0001$). These results were confirmed in a separate analysis that controlled for the specialty of the physician.

Conclusions. Physicians who do not refer their patients to radiologists for medical imaging use imaging examinations more frequently than do physicians who refer their patients to radiologists, and the charges are usually higher when the imaging is done by the self-referring physician. From our results it is not possible to determine which group of physicians uses imaging more appropriately. (N Engl J Med 1990; 323:1604-8.)

THE potential for conflicts of interest and higher costs for health care arising from the ownership by physicians of the diagnostic facilities to which they refer patients has attracted considerable attention recently in the medical literature[1-5] and lay press[6,7] and has been the subject of government study and legislation.[8-10] The ownership of imaging centers by physicians has received much of the media attention. However, most self-referral for medical imaging — in which physicians perform and interpret diagnostic imaging examinations of their own patients rather than refer them to imaging specialists — takes place in the physician's office.

The few previous studies investigating the effect of self-referral on the use and costs of imaging have been limited by methodologic flaws, small study populations, and lack of controls. To overcome these limitations, we analyzed a large data base of private insurance claims and evaluated the imaging done in physicians' offices during episodes of outpatient medical care. After controlling for differences in patients' clinical presentations and physicians' specialties, we compared the frequencies with which the patients underwent imaging examinations during episodes of medical care for acute conditions, according to whether their physicians could perform those imaging examinations themselves. We also compared the resultant charges for the imaging examinations.

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Supported by the American College of Radiology.

METHODS

Selection of Data Base and Clinical Presentations

We purchased access to a data base (Medstat Systems, Ann Arbor, Mich.) comprising all the health insurance claims of 403,458 employees and dependents of several large American corporations. The insurance programs provided comprehensive coverage, including outpatient imaging services, with no copayments required. The data base was selected for its uniformity and completeness. Seventy-nine percent of the study population lived in the north central United States, 6 percent in the Northeast, 11 percent in the South, and 4 percent in the West. Fifty-one percent were female, and 49 percent male. Fifty-five percent were 0 to 34 years old, 33 percent were 35 to 54 years old, and 12 percent were 55 or older. Ninety-three percent of the physicians making claims for care provided to these patients practiced in metropolitan areas.

Using this data base, we compared the frequency of imaging and the charges for imaging among self-referring physicians and among physicians who instead referred patients to radiologists (radiologist-referring physicians) for four clinical presentations, selected for their variety and the volume of associated imaging procedures. The presentations, with the associated diagnostic inquiry, were as follows: acute upper respiratory symptoms (Was chest radiography performed?), pregnancy (Was obstetrical ultrasonography performed to assess fetal size and gestational age?), low back pain (Was radiography of the lumbar spine performed?), and (in men) difficulty urinating (Was excretory urography, cystography, or ultrasonography performed?).

Definition and Initiation of Episodes

We surveyed the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM),[11] selecting all codes that might reasonably represent diagnoses that would be entered by physicians

Reprinted from the *New England Journal of Medicine*
323:1604-1608 (December 6), 1990

whose patients presented with symptoms related to any of the four clinical presentations. A detailed tabulation of the codes is available elsewhere.*

We developed and applied to the claims data base a computer algorithm, modeled on previous methods, for defining episodes of outpatient medical care occurring in physicians' offices.[15] The date of a claim for an index ICD-9-CM code in an office setting was used to define the starting date of an episode. Episodes were considered to have ended after specified periods — four weeks for upper respiratory infection, nine months for pregnancy, six weeks for low back pain, and six weeks for difficulty urinating. Claims made between the initiation and termination dates of an episode were eligible for inclusion in that episode. Depending on the clinical presentation, a lag period of two to eight weeks followed the termination of each episode, so that follow-up visits for the original episode would not be counted as new episodes of care. The length of the episodes and lag periods was initially proposed on the basis of medical experience. We ensured that these durations were appropriate by evaluating the completeness of 600 randomly selected episodes and determining that the use of alternate durations for the episodes of up to two-thirds longer affected the number of episodes by only 1 to 6 percent in the case of the clinical presentations studied.

To be included in the study, episodes of care had to begin after January 1, 1986, and end before June 1, 1988. Episodes were excluded if the only physician involved in the episode was a radiologist or if the specialty of any physician involved was unknown. Within valid episodes, we deleted any claims for which no charge or payment was made, any claims for supplemental payments, and any claims for which the age or sex of the patient or the physician's identification number was unknown. We also excluded claims that were unrelated in terms of ICD-9-CM coding to the clinical presentations under investigation and claims made by physicians whose specialty codes indicated practices unrelated to the clinical presentations under study. A list of the specialties of the physicians included in the analysis is available elsewhere.*

Categorization of Physicians and Classification of Episodes

The physicians who filed the claims included in the episodes studied were distinguished by their physician identification numbers; these numbers were coded to protect confidentiality. With regard to each clinical presentation, the physicians were grouped, according to their involvement in episodes for which they were the only nonradiologist physician to file a claim (one-physician episodes), into the following categories: self-referring physicians, who charged at least once for an index imaging examination; radiologist-referring physicians, who never charged for an index imaging examination and who were involved in at least one one-physician episode in which a radiologist performed such an examination; and physicians whose patients had no imaging in any one-physician episodes. One-physician episodes comprised 92 percent of all valid episodes.

We considered the possibility that some physicians categorized as radiologist-referring might actually be self-referring physicians who happened not to have performed any imaging in the episodes in our sample. We performed a correction to account for this possibility (details available elsewhere*). Since this correction did not alter the results, we report only our unadjusted data here.

The categorization of the physicians who participated in the one-physician episodes was used to develop six categories of similar and dissimilar pairs of physicians for the 7 percent of valid episodes in which two different physicians, neither a radiologist, cared for the patient (two-physician episodes). The 471 valid episodes (0.7 percent) in which more than two nonradiologist physicians were involved were not included in the analysis. We performed separate classifications of the one-physician and two-physician episodes on the basis of the categorization of the physicians and whether a claim for a related imaging examination was filed during the episode, as evidenced by the encountering of an appropriate diagnostic-imaging-procedure code (CPT-4 code; the table of index codes is available elsewhere*).

Estimation of the Frequency of Imaging

For the one-physician episodes, our estimates of the frequency of imaging by the self-referring physicians and the radiologist-referring physicians were based on the observed frequencies for these two categories of physicians. Applying maximum-likelihood methods to the information we derived from our data about the imaging practices of self-referring and radiologist-referring physicians, we adjusted these observed frequencies to account for the episodes attributable to the physicians who had performed no imaging. This adjustment was based on the assumption that the imaging practices of the physicians within each category were homogeneous. However, this was almost certainly not the case. As a result, the correct adjustment of the observed frequencies is uncertain. For this reason, we report here the most likely estimates of the imaging frequencies for the self-referring and the radiologist-referring physicians. In addition, to account for heterogeneity in the physicians' imaging practices, we developed estimates biased upward and downward that show that our results are not affected qualitatively by the choice of the adjustment for the episodes involving the physicians who performed no imaging over the entire range of possible adjustments. The methods we employed, the initial categorization of the physicians and classification of episodes, and the upward- and downward-biased estimations of imaging frequencies are available elsewhere.*

Statistical Analysis

For the analyses of both the one-physician and the two-physician episodes, we assessed the differences between self-referring and radiologist-referring physicians in terms of the proportion of episodes that involved imaging, the charges for imaging performed, and the average imaging charges per episode. To calculate the results for the group, we weighted the results for individual physicians according to the number of episodes in which they were involved. The significance of the differences between self-referring and radiologist-referring physicians was determined by the usual t-statistic for the difference in means between the two groups. We conducted a similar analysis based on the specialties of the physicians involved in the episodes, to compare differences within specialties. The null hypothesis of no difference was rejected at a P level of <0.05.

Complexity of Imaging Procedures

For each clinical presentation, we compared the complexity of the imaging examinations performed by the self-referring physicians with that of the examinations performed by the radiologists by calculating the mean (±SD) relative values of their procedures (i.e., a measure of the complexity of the procedure).[15]

Results

One-Physician Episodes

The data base generated 62,880 one-physician episodes for the four study groups. After exclusions (see Methods), there were 60,829 valid episodes involving 6419 physicians. One-physician episodes represented 92 percent of all valid episodes. These were distributed as follows: upper respiratory symptoms, 47,794 episodes involving 3452 physicians; normal pregnancy, 1377 episodes involving 468 physicians; back pain, 9634 episodes involving 2001

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physicians; men with difficulty urinating, 2024 episodes involving 498 physicians.

Table 1 shows the frequencies with which imaging was used during the episodes, the charges for imaging, and the charges for imaging per episode for self-referring and radiologist-referring physicians. The mean imaging charges of the self-referring physicians were significantly higher (P for all comparisons, <0.0001) than those of the radiologists for all clinical presentations except difficulty urinating. Depending on the clinical presentation, the episodes involving self-referring physicians resulted in imaging 4.0 to 4.5 times as frequently, with average imaging charges per episode 4.4 to 7.5 times higher than those for the episodes involving radiologist-referring physicians (P<0.0001 for each clinical presentation, for both frequency of imaging and average imaging charges per episode).

Two-Physician Episodes

There were 4682 valid two-physician episodes, or 7 percent of all episodes. The results for these episodes support the findings in the one-physician episodes. Depending on the clinical presentation, the episodes involving two self-referring physicians were 1.7 to 3.7 times as likely to result in imaging as episodes involving two radiologist-referring physicians (P<0.01 for each presentation). Complete results for all six categories of physician pairs are available elsewhere.*

Table 1. Categories of Physicians and Episodes, Frequencies of Imaging, and Imaging Costs in One-Physician Episodes.*

Variable	Self-Referral	Radiologist-Referral	Self/Radiology Referral Ratio	P Value†
Upper respiratory symptoms				
Physicians (%)	38	62	0.6	—
Episodes (%)	57	43	1.3	—
Episodes with imaging (%)	46	11	4.2	0.0001
Mean charges ($)	54	40	1.4	0.0001
Mean charges per episode ($)	25	4	6.2	0.0001
Pregnancy				
Physicians (%)	48	52	0.9	—
Episodes (%)	56	44	1.3	—
Episodes with imaging (%)	59	13	4.5	0.0001
Mean charges ($)	304	185	1.6	0.0001
Mean charges per episode ($)	180	24	7.5	0.0001
Low back pain				
Physicians (%)	49	51	1.0	—
Episodes (%)	66	34	1.9	—
Episodes with imaging (%)	54	12	4.5	0.0001
Mean charges ($)	70	63	1.1	0.0001
Mean charges per episode ($)	38	8	4.8	0.0001
Difficulty urinating (men)				
Physicians (%)	38	62	0.6	—
Episodes (%)	46	54	0.8	—
Episodes with imaging (%)	32	8	4.0	0.0001
Mean charges ($)	264	241	1.1	0.14
Mean charges per episode ($)	84	19	4.4	0.0001

*Mean charges shown are for episodes with imaging. Mean charges per episode were calculated as the fraction of episodes with imaging times the mean imaging charges in episodes with imaging.

†P values are for the difference in values between self-referring and radiologist-referring physicians.

Differences among Specialties

For each specialty and each clinical presentation, the self-referring physicians performed imaging 2.4 to 11.1 times as often as the radiologist-referring physicians, and at a cost per episode for imaging that was 3.0 to 17.1 times higher, depending on the specialty and clinical presentation (Table 2) (P<0.01 for each specialty studied with regard to each clinical presentation).

Complexity of Imaging Examinations

The mean (±SD) complexity score for chest films was 3.02±0.14 for self-referring physicians, and 3.00±0.20 for radiologist-referring physicians. For obstetrical ultrasonography, the comparison was 11.24±1.14 versus 11.35±0.96; for lumbar spine films, 3.98±0.63 versus 4.14±0.52; and for the combination of urography, cystography, and ultrasonography, 8.46±0.70 versus 8.35±0.43. Thus, the differences in complexity ranged from 1 to 4 percent and do not account for the differences identified in the charges for imaging.

Discussion

For the clinical presentations we studied, patients with similar sets of symptoms were at least four times as likely to have diagnostic imaging performed as part of their evaluation if they sought care from a physician who performed imaging examinations in the office rather than from one who referred patients to a radiologist. Because self-referring physicians performed imaging studies more frequently and generally charged more than radiologists for similar imaging procedures, patients seeking care from self-referring physicians incurred considerably higher charges for diagnostic imaging than patients whose physicians referred them to radiologists. These effects cannot be attributed to differences in the mix of patients, the specialties of the physicians, or the complexity of the imaging examinations performed.

Previously, Childs and Hunter[14] found that physicians other than radiologists who provided imaging services used imaging more frequently than their peers in caring for elderly patients in Northern California. In a 1978 survey of 5447 physicians, Radecki and Steele[15] determined that nonradiologist physicians with imaging facilities either in their offices or at the same site have higher rates of use than physicians without such facilities. A similar study of the effect of

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Table 2. Frequency of Imaging and Costs per Episode in One-Physician Episodes, According to the Specialty of the Physician.*

Variable	Upper Respiratory Symptoms		Pregnancy		Low Back Pain		Difficulty Urinating (Men)	
	Self-Referral	Radiologist-Referral	Self-Referral	Radiologist-Referral	Self-Referral	Radiologist-Referral	Self-Referral	Radiologist-Referral
General and family practice								
No. of episodes	14,913	5104	30	113	2919	1251	95	258
% with imaging	47	14	92	11	58	11	83	7
Mean charge ($)	26	5	260	16	40	6	217	16
Internal medicine								
No. of episodes	5,351	3464		NA	1533	1043	57	155
% with imaging	58	24		NA	50	13	89	8
Mean charge ($)	30	10		NA	38	9	239	14
General surgery								
No. of episodes	2,335	340		NA	353	84		NA
% with imaging	44	15		NA	67	13		NA
Mean charge ($)	22	4		NA	50	8		NA
Pediatrics								
No. of episodes	3,660	8458		NA		NA		NA
% with imaging	18	2		NA		NA		NA
Mean charge ($)	10	1		NA		NA		NA
Obstetrics/gynecology								
No. of episodes		NA	724	475		NA		NA
% with imaging		NA	58	14		NA		NA
Mean charge ($)		NA	178	25		NA		NA
Orthopedics								
No. of episodes		NA		NA	1024	124		NA
% with imaging		NA		NA	46	15		NA
Mean charge ($)		NA		NA	30	10		NA
Urology								
No. of episodes		NA		NA		NA	709	683
% with imaging		NA		NA		NA	25	8
Mean charge ($)		NA		NA		NA	65	19

*P<0.01 for all differences between self-referring and radiologist-referring physicians. NA denotes insufficient number of episodes for analysis

the site of imaging facilities used by family practitioners produced a similar result.[16]

The differences between our study and those performed previously include the relatively large number of patients and physicians we studied and the emphasis on specific clinical situations and episodes of medical care. Analyzing episodes of care permitted us to focus directly on the issue that seemed most pertinent — whether individual patients with specific symptoms were more likely to receive imaging examinations when their physicians operated imaging equipment. As compared with the global measures used in previous studies, this method controls better for other variables — physicians' specialization, the complexity of examinations, differences in the types of patients seen by physicians, and the number of patient–physician encounters that might occur during the course of a patient's medical care. Finally, the focus on episodes as the unit of analysis allows a more accurate assessment of the activities and costs of medical care, the chief focus of our study.[12]

We have attempted to account for what we perceive to be the major possible biases of our study. After assessing the effect of correcting our results to account for the small percentage of physicians who had probably been miscategorized, and evaluating alternative probabilistic models for assigning the episodes involving physicians whom we could not categorize definitively, we found that these considerations did not affect the results qualitatively (details of these assessments and the adjusted results are available elsewhere*). Our population of patients did not represent the American population, geographically or according to age. However, the geographic concentration tended to lessen the effects of regional differences in practice patterns, and it seems implausible that the large differences we identified in the use of imaging would be related to age. Although there is no assurance that the clinical presentations we studied represent the imaging practices of physicians in other clinical settings, the dimensions and consistency of our findings with regard to four very different clinical presentations and types of imaging examinations suggest that this practice pattern may be widespread.

We based our methods on those used by previous investigators,[12,17,18] but with adaptations to account for the large number of physicians and patients in our data base. Doubtless, the initial visits to physicians that triggered episodes of outpatient care occurred in

an undefined context of patients' seeing their personal physicians, being referred by one physician to another, and seeking the specialist they believed to be appropriate. Although the manner in which the patients ended up seeing the physicians they did might potentially have affected the results, it is important to note that the results were uniformly sustained in our analysis of individual specialties. Also, with regard to our means of defining the index symptoms, determining the start of episodes, and including claims in episodes, there is nothing to suggest that our choices unequally biased the probability of imaging or the imaging charges in favor of either self-referring or radiologist-referring physicians. We believe that the differences between these two groups of physicians are so considerable that such issues have little relevance to the results.

Our findings of increased use of imaging and increased costs attributable to nonradiologist physicians who operate their own imaging equipment should be of interest to regulatory and reimbursement agencies. It is impossible to determine from our results whether the imaging practices of the self-referring physicians or those of the radiologist-referring physicians represent the more appropriate care. Nor is it possible to determine the extent to which financial incentives are responsible for the higher levels of use and charges among the self-referring physicians. These physicians may perform imaging more frequently because they have financial incentives to do so, because imaging is more convenient when performed in a physician's office, or because physicians who perform imaging more often are more likely to acquire imaging equipment. Nonetheless, the differences between the self-referring and radiologist-referring physicians in the use of imaging are so large that some concern over the role of financial incentives must be invoked. Schroeder and Showstack[19] have detailed the potent financial incentives for a physician to incorporate imaging into an office practice. More recently, Hemenway et al.[20] validated this concern by showing an increase in the use of imaging when a group of ambulatory clinics changed to a method of compensation that used the frequency with which physicians ordered imaging examinations as the basis for paying them.

The American Medical Association has stated that the referral of patients to facilities in which physicians have an ownership interest is permissible, provided that patients are apprised of this relation and have other choices, and provided that physicians always act in their patients' best interests.[21] With respect to diagnostic imaging, however, it is unlikely that patients, even if so apprised, will be able to assess the appropriateness of such referrals accurately or seek imaging elsewhere. Particularly in the office setting, patients cannot be said to have a meaningful choice when their physicians advise them to undergo imaging. The potential to self-refer patients for imaging must surely complicate physicians' decisions and perhaps jeopardize their obligation to place their patients' interests above their own.

We are indebted to Medstat Systems, Inc., for assistance in providing access to the insurance-claims data base and help in developing the algorithm used to identify episodes of outpatient care; to Dr. Barbara J. McNeil for reviewing the penultimate version of the manuscript and making suggestions for its improvement; and to Ms. Janet Wallace for her help and patience during numerous revisions of the manuscript.

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