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MEDICARE PHYSICIAN PAYMENT REFORM REGULATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

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CONTENTS

OPENING STATEMENTS

COMMITTEE PRESS RELEASE

ADMINISTRATION WITNESS

PUBLIC WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

COMMUNICATIONS

MEDICARE PHYSICIAN PAYMENT REFORM REGULATIONS

FRIDAY, JULY 19, 1991

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:12 a.m., in Room SD-215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Also present: Senators Bentsen, Baucus, Daschle, Durenberger, Grassley, and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H-30, July 12, 1991]

SUBCOMMITTEE TO DISCUSS PHYSICIAN PAYMENT REFORM REGULATIONS, ROCKEFELLER WANTS TO EXAMINE ADMINISTRATION PROPOSAL

WASHINGTON, DC—Senator John D. Rockefeller IV, Chairman of the Finance Subcommittee on Medicare and Long-Term Care, Friday announced a hearing on the Health Care Financing Administration's (HCFA) rulemaking proposal on Medicare physician payment reform.

The hearing will be at *10 a.m. Friday, July 19* in Room SD-215 of the Dirksen Senate Office Building.

On June 5, 1991, HCFA proposed rules on Medicare physician payment reform based on legislation enacted in 1989.

The 1989 law provides for replacement of the current "reasonable charge" system with one that uses a resource-based relative value scale to determine payments. In addition, the law provides for increased outcomes research and the development of practice guidelines, better protections against out-of-pocket costs to Medicare beneficiaries and a system of Medicare volume performance standards.

HCFA has proposed to reduce the conversion factor by 16 percent in order to offset anticipated increases in program expenditures due to transitional payment rules and projected behavioral responses by physicians to the new payment system.

"The goal of the physician payment reform legislation was to develop a fairer and more equitable payment method for physicians' services under Medicare," said Rockefeller (D., West Virginia). "HCFA recently issued proposed rules for implementing the law that falls short of Congressional intent. This hearing will provide an opportunity to examine more closely the Administration's proposal, as well as the concerns that have been raised about it," said Rockefeller.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA, CHAIRMAN OF THE SUBCOMMITTEE

Senator ROCKEFELLER. This hearing will come to order. I want to thank everybody for coming this morning.

In 1989, Congress passed and President Bush signed what was really landmark legislation. And that legislation changed, or was

meant to change how physicians were going to be paid for treating Medicare beneficiaries, and the effect of that would wash over on the rest of the payment schedule eventually. This law represents the most significant change in physician payment since the enactment of Medicare in 1965.

In fact, some of the provisions of the 1989 law have already gone into effect, such as requiring physicians to file Medicare claims on behalf of their beneficiaries, and the phasing in of balance billing limits. However, the major features of the law are scheduled to be implemented beginning January 1st, 1992.

From the beginning, Congressional intent regarding this law has been very precise. This law was intended to establish a logical, rational method for reimbursing physicians based on the resources required to carry out that service.

Certain procedures, particularly high-tech, invasive ones have traditionally been over-valued, while others that require the investment of time and are, perhaps, more cognitive in nature, are under-valued. Congress clearly wanted a new payment system that understood these differences and would correct the distortions.

In addition, we know that there is real need in this country to increase the number of primary care physicians, not only generally, but particularly in the inner cities, and in our rural areas.

One of the reasons cited for physicians not going into primary care or making the choice when they are in medical school is that the reimbursement rates for primary care services are generally much lower than for other specialties.

The resource-based fee schedule was viewed as a way to remove those financial disincentives facing the medical student when he or she is making his or her decision about a long term career.

I am happy to say that when this legislation was enacted, Congress, the administration, physicians, and beneficiaries all agreed to these goals. So, even though there is a considerable controversy today on how we go about achieving those goals, I believe we are still united in this pledge.

On June 5th, the proposed final rules were published. Since I was a major architect of the law, I was shocked and I was surprised when I read them. Many of the intentions have not been realized. In fact, in some instances, the opposite is being proposed. In all, we are very short of our initial goals.

The majority of the controversy revolves around the setting of the conversion factor, which translates relative values into dollar amounts. Never in our discussions before or after the passage was the fee schedule envisioned to be the mechanism to reduce physician payments.

Was there concern about Medicare expenditures on physician services and the effect a new resource-base fee schedule might have on overall physician spending when we considered physician payment reform legislation? You bet.

Did we anticipate there might be a change in physician behavior as a result of the new fee schedule, when some doctors would see their reimbursement rates rise, and others would see a net decrease? Sure.

Did we include a mechanism in our reform legislation to deal with these very serious concerns? You bet. It is called the Medicare Volume Performance Standard.

I remain committed, as ever, to figuring out ways to hold down the cost of health care, and not just in Medicare. But the resource-based fee schedule was not meant to be a way to hold down cost increases. That was not its intent. The Medicare volume performance standard is, and was, meant to be the tool to hold down Medicare spending for physician services.

I am pleased to say that, although this is a very difficult issue, everyone seemed genuinely concerned, and everybody seems to want to work together to work the situation out the best possible way. I feel a certain confidence that we can return to our original goals.

Senator Bentsen.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. Thank you very much, Senator Rockefeller. I think that this hearing is particularly important and timely, because it comes in that comment period for the June 5th rule on physician payment reform. I think it is also important so we can better understand the problems associated with the June 5th rule, and try to work toward some possible solutions.

I, like most of my colleagues, am concerned about the reductions to the conversion factor that are reflected in this rule. And, of course, the immediate concern is the budgetary treatment of the six percent reduction on the transition problem.

I think most of us would agree this reduction was an effect that none of us anticipated and none of us intended. Neither the CBO, nor the OMB attributed any budgetary savings to the transition at the time that the law was passed.

I hope the administration would agree that the problem can be corrected in the final rule without the need for offsetting cuts in the Medicare program, or an increase in taxes, which I am sure would not be looked forward to in this committee. And that was not the intent. Now that the dimensions of this problem are better understood—we realize we are looking at a lot of moveable parts here in a very arcane process, and I think that was part of the problem in trying to put a fix on this thing and understand its impact.

I hope we can begin a process today where the affected parties—the administration, the Congress, the physicians, and the consumers—can work together for a solution and try to bring this back to its original intent.

I am very appreciative of the witnesses who have agreed to be here today and, of course, having Dr. Wilensky speak to the issue.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Bentsen. Senator Durenberger.

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

Senator DURENBERGER. Mr. Chairman, thank you for holding this morning's hearing. You know only too well, and everybody in the audience does, that when we passed the physician payment reform legislation in 1989 we did not expect the implementation process to be free of problems.

On the other hand, no one—least of all this Senator—expected the magnitude of problems encountered to jeopardize the underpinnings of what we were trying to accomplish with this legislation.

Mr. Chairman, I am deeply concerned about the contents of the notice of proposed rulemaking issued on June 5th. I am particularly disturbed about the manner in which the conversion factor has been calculated, and the ramifications of limiting budget neutrality to the first year of the transition.

As you and other members of the subcommittee may recall, Mr. Chairman, the Senate version of the Physician Payment Reform legislation required budget neutrality for all 5 years of the transition. As I recollect, we recognized it would impossible to predict the effects of the asymmetrical transition. We did not know if we would end up with a deficit or a surplus. I mean, when we were trying to take one set of fees up faster than we were reducing the other ones, it was difficult to be exact. We wanted to avoid at all costs the problem that we now face.

So, Mr. Chairman, the physicians in Minnesota and around the country right now feel—and it may be expressed more strongly than feelings—betrayed by the Congress and by the Administration. And we have got to be included in that.

I think that is particularly true, because we all lived through the 1983 and 1985 experience of promising one thing and doing another. It is pretty clear that when we did hospital DRGs and said the nation is going to move toward prospectively pricing medical services, we promised that the savings were not going to be used for any purpose other than the rationalization, if you will, of the health care delivery system. But by 1985, we began using it for budget savings and we never seemed to give up on it.

In 1989, we entered into an agreement with the physicians in this country—I know the people at this table felt that it was a partnership; I think the associations of physicians felt it was a partnership—to rationalize the manner in which physicians are reimbursed for their services by Medicare. We all wanted to create a fair payment system.

Mr. Chairman, fair is hardly the first adjective that comes to the mind of physicians or this Senator when examining the effects of the new fee schedule.

Rather than engage in a litany of problems with the proposed fee schedule—I guess the hearing is designed to come to grips with that—let me instead describe what I would like to do to correct these problems if the administration cannot come up with a solution.

And I must say that both at this hearing and at a previous hearing last week, Gail Wilensky has said that she is going to do her

best to see that the administration does come up with that solution.

First of all, it seems clear to everyone—and the Chair has already mentioned this—that Congress never intended to reduce the base of payments to physicians through this reform. I think Jay made that clear.

Therefore, the conversion factor must be recalculated to reflect budget neutrality in each of the 5 years of the transition. Second, it seems inherently inequitable that one- third of the procedures will be reimbursed at a rate six percent lower than they would otherwise be to offset the two percent deficit created by the transition rules.

To eliminate this inequity, I am contemplating a 2 percent across the board reduction in payment for all physician services in 1992. While it seems fair to me, I really am anxious to receive—as we all are—input from all of the physician groups represented here today to see if that makes any sense at all.

Third, I would plan to address the behavioral offset, but I do not have really the foggiest idea of the best way to do it. One approach is to eliminate the offset in 1992 and impose one that is empirically driven in future years when we can measure, at least to some extent, the actual volume response to fee changes.

Another is to eliminate the behavioral offset and create some kind of a withholding mechanism, much the way they do it in some large HMOs where you could establish yearly updates for projected outlays without behavioral offset, then withhold a percentage from all physicians Medicare payments for the year. If they do not increase the volume of services, then they get the money. You can think about that one, if you like.

But I want to stress that personally I am far from reaching a conclusion on what is a very sensitive matter.

While fixing the conversion factor is of the highest priority, there are other aspects of physician payment reform I think we need to address in legislation.

Since 1989, this Senator, at least, has been worried about subjecting Minnesota physicians to a national volume performance standard, and now to a national behavioral offset.

Why, I ask myself, should the physicians in Minnesota and other states where medicine is practiced in a conservative, efficient, low-cost, high-quality manner, be punished for the sins of other less prudent doctors? And we asked that question here 2 years ago, and we were told, "We do not have the data."

I believe the data exists. Whether we recommend demonstrations, or something else, I believe that a number of States in this country ought to be permitted to demonstrate that the physician community can contain the demands of the volume performance standard.

So, Mr. Chairman, I thank you for allowing me the time to put those thoughts on the table, and they are strictly suggestions. We have got 72 days left, I think, to try to do something with this. And I guess the sooner we get to it, the better.

Thank you.

Senator ROCKEFELLER. Thank you, Senator Durenberger. Senator Grassley.

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

Senator GRASSLEY. Mr. Chairman, the people of Iowa thank you for holding this hearing. It is very important to all of us, not only in the country as a whole, but particularly in the rural areas of America. I have consistently supported Physician Payment Reform; the Iowa medical community did also. For us, a lot is riding on it.

We supported Physician Payment Reform because we thought it was a good idea strictly on the merits. We also thought it was a very good idea for rural areas of America—that includes my State of Iowa—because it was going to help us to recruit and to keep primary care physicians of the kind that we need in our rural communities across the State, but have a very hard time finding.

At the present time, 170 communities in Iowa are seeking more than 200 doctors. I am also hearing from Medicare beneficiaries in the eastern part of my State that they are having trouble finding doctors who will add them to their case load. This seems to reflect increasing frustration with the hassles of the Medicare program on the part of physicians.

Part of our problem lies in our low Medicare reimbursement levels. Of the 240 Medicare payment areas around the country, the eight in Iowa rank 196th and lower in reimbursement.

Iowa is also a State with a great many Medicare beneficiaries, so any doctor who practices in Iowa is likely to be very dependent upon the Medicare program.

We believed, with everyone else, that the Medicare Physician Payment Reform was going to re-allocate money towards primary care practitioners, and was going to more equitably allocate Medicare reimbursement around the country as well.

This, we thought, would help us considerably in finding and keeping doctors for our smaller communities. Now, unfortunately, it does not look like the recently published rule is going to help us at all.

It is true that Iowa does relatively well compared to other States according to the averages that were released by HCFA. However, in year five of the reform, Iowa will be losing four percent in charges per service compared to current law, and two percent in outlays.

It appears that the gains which will be made by Iowa doctors compared to current law will be so modest, that they will really not change our overall situation very much as far as the distribution of medical practitioners is concerned.

From this Senator's perspective, this is just not acceptable. I sincerely hope that we can work with the Health Care Financing Administration to make this payment reform a success.

If Physician Payment Reform is widely seen by doctors as being prevented from fulfilling the purposes for which we created it, the problems that we are currently experiencing with Medicare could be seriously compounded.

Thank you, Mr. Chairman.

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

Senator ROCKEFELLER. Thank you, Senator Grassley. Senator Daschle.

Senator DASCHLE. I have no comment, Mr. Chairman.

Senator ROCKEFELLER. All right. Dr. Wilensky, we are glad to see you. You are dressed in bright red, and ready, as always. And in a good mood. So we welcome your testimony.

STATEMENT OF HON. GAIL R. WILENSKY, Ph.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. WILENSKY. Thank you. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss the proposed physician fee schedule, one of the three pieces of the Physician Payment Reform enacted in OBRA in 1989.

The development of the physician fee schedule proposed rule has involved a great deal of work by HCFA, and a large amount of input from outside groups. Let me emphasize that the proposed rule was published to invite public comment. We encourage groups to submit comments by the August 5th deadline.

The development of a national fee schedule is a large undertaking. Physician payment is much more complicated than hospital payment. Physicians are paid for some 7,000 different services; there are some 500,000 physicians, and we pay almost a half a billion physician bills.

I believe that the proposed fee schedule has accomplished the goal of Physician Payment Reform; it has corrected the historical imbalance of Medicare physician fees. That is, it sets the right relative prices for services. The fee schedule will help the physicians it was designed to help. It redistributes Medicare fees toward primary care services in low-priced geographic areas, and away from surgical and diagnostic procedures in high-priced areas. Fees for medical visits in 1992 will increase over eight percent before the fee update, compared to the 1991 fees under the old system.

The default physician update is estimated to be 2.2 percent, although Congress can set the update at any other level it wishes. With this update, fees for medical visits would average 10.7 percent more than 1991 levels. In addition, a 10 percent add-on to the fee schedule is provided for physicians who provide services in rural or health manpower shortage areas.

While the fee schedule restructures fees, Medicare outlays for physician services will continue to grow rapidly. During the fee schedule phase-in, Medicare physician spending will grow 63 percent, from $27 billion to $47 billion; a hefty 10.3 percent per year.

Let me turn to the issues of the fee schedule transition and behavioral adjustments, which you all have mentioned in your statements. You know that the transition results in the 1996 Medicare outlays that are six percent, or $3 billion lower than what would have happened under the old system. It is true, as best we can estimate, that that is the effect. It occurs because of the transition rules and the budget neutrality requirements.

We believe that the statute requires that the fee schedule be budget neutral in 1992. That is, we spend no more or no less than we would have spent under the old system.

We also believe the statute requires a five-year phase-in. For 1992, historical payment amounts will increase or decrease no more than 15 percent of the fee schedule. If the historic amounts are within 15 percent of the fee schedule, they are paid at the fee schedule.

The nature of the transition is asymmetric, because the low fees come up faster than the high fees come down. Physicians come up or down 15 percent from where they are going; not where they are coming from.

For example, a service which the historical amount is $100 and the fee schedule is $50, would be reduced by $7.50 in 1992. That is, 15 percent of the $50.

On the other hand, a service for which the historical amount is $50 and the fee schedule is $100, would be increased by $15 in 1992; that is, 15 percent of $100. The transition eases the reduction for physicians with high fees, and helps physicians with low fees get to the fee schedule more quickly. This was a very deliberate move.

When the transition rules are applied, however, expenditures are 2 percent greater than the budget neutrality. To restore budget neutrality, we have adjusted fees in a way that is consistent with the transition rule and also with budget neutrality.

We do not believe that we can reduce all fees by 2 percent because we think that is inconsistent with the transition rules that are laid out in the statute. The way to restore budget neutrality and to meet the transition rules is to adjust the conversion factor.

Because the fee schedule conversion factor only applies to one-third of the fees in 1992—those that were within 15 percent of the fee schedule—the 2 percent figure multiplies into a six percent conversion factor reduction.

It was not our intention for the transition to reduce Medicare spending in this way, but we believe that the proposed rule is based on the correct interpretation of the law. We have looked for other interpretations of the statute and, to date, have found none that we thought did not violate either the transition rules of the statute, or the requirement for budget neutrality in 1992.

We welcome, however, suggestions of alternative approaches that allow us to fulfill both of these statutory requirements, and we also will look to find other interpretations.

We believe that physicians and beneficiaries will respond to fee changes, policy standardizations, and changes in beneficiary out-of-pocket spending that occur under the fee schedule. We are not accusing physicians or the elderly of generating unnecessary services.

Prior experience with payment changes has taught us to anticipate aggregate changes in volume and intensity of services. The literature also indicates behavioral responses to fee changes.

In its 1991 annual report to Congress, the Physician Payment Review Commission indicated that the results of several studies, including one by PPRC staff and another by CBO, suggested the volume of service is affected by fee changes.

We observed a volume response to the Medicare physician fee freeze. The response was complicated by other factors, particularly the implementation of hospital PPS. However, when the data are adjusted for a sharp decline in PPS hospital admissions, increases

in physician volume and intensity reached historical highs in 1985 and 1986.

We believe it would be imprudent to ignore this evidence and to assume no behavioral response will occur. Failure to account for behavioral changes would result in a conversion factor set too high, and consequently, greater Part B spending than anticipated. The volume performance standard is not an adequate mechanism to correct for a conversion factor set initially too high.

When all is said and done, we estimate that there will be a three percent increase in volume and intensity in 1992 as a result of the new Physician Payment Reform. A 3 percent reduction in all fees is, therefore, necessary to restore budget neutrality. Again, since the fee schedule affects only some of the services in 1992, a 3 percent increase in volume has translated into a 10 percent conversion factor reduction.

The statute does not require budget neutrality for the transition rules 1993 through 1995. And we have not proposed any behavioral adjustments for those years. However, had a behavioral adjustment been made in those years, the 1996 conversion factor would have been reduced by a 10 percent amount.

Finally, I would like to note that the behavioral adjustment is included in legislative savings estimates and thus increases the volume performance standard that we provide every year.

We should keep in perspective that projected increases in Medicare physician spending will top 10 percent per year, or, as I said earlier, 63 percent over the five-year transition.

Attention is focused on the $6.9 billion reduction in physician spending over the five-year transition. We also need to keep in perspective that this reduction is relative to where spending would have been under the old system; not a drop in the absolute level of physician spending. It only slows the rate of growth between 1991 and 1996 from 11.7 percent to 10.3 percent.

We should also keep in mind that past growth and physician expenditures have far exceeded spending growth in other programs of national priority.

While physician expenditures increased at a compounded annual rate of growth of 13.2 percent from 1981 to 1990, spending increased for health research at 8.6 percent; supplementary security income grew at 6.6 percent; and spending on primary and secondary education kept pace with inflation at 3.8 percent.

Medicare physician spending will increase from $27 billion to $45 billion between 1991 and 1996. Without the effects of the transition, Medicare spending would have increased to almost $48 billion.

Although the magnitude of increases under the fee schedule does not meet physicians' expectations, the growth in overall Medicare physician expenditures will continue to put substantial pressure on the Federal budget.

Let us remember that the fee schedule still preserves all of the perverse incentives inherent in fee-for-service medicine. Although the volume performance standard is intended to moderate increases in physician expenditure growth, it, in fact, provides weak incentives for individual physicians to hold down the volume of services that they provide.

More direct incentives for physicians to control the volume and intensity of services delivered will still be needed. It is one of the reasons I have been so interested in bringing more of the elderly into coordinated care plans. I believe it is the best way to moderate the growth in Medicare spending, while leaving the practice of medicine in the hands of physicians.

We are in the process of formally responding to the letters of interest from many of the people regarding proposed regulation. I would be happy to respond to any of the questions that you may have here today, and I look forward to working with you and physician groups as we move forward to the successful implementation of the fee schedule in January.

Thank you.

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

Senator ROCKEFELLER. Thank you, Dr. Wilensky. And thank you, also, for the several points in that testimony where you talked about desire to work with physicians, and Congress, and others to try to make this work, and I appreciate that very much.

I call upon Chairman Bentsen.

The CHAIRMAN. Thank you very much, Senator. Dr. Wilensky, you know, 14 Senators on the Finance Committee wrote Dr. Sullivan back, I believe it was about June 28th, asking how HCFA's analysis of the transition problem evolved, the magnitude of the problem, and why we were not advised sooner.

Now, in that letter, we asked a number of detailed questions, but let me make a point to you, Dr. Wilensky. We are in no way questioning your good faith, or talking about the agency trying to hide this issue from us. We are just trying to understand how it happened, and the magnitude of the difference in the estimates.

Certainly, I do not believe HCFA understood the magnitude of the problem back in September when you published your model fee schedule and made the comment in there that the impact could be minimal.

In fact, I think HCFA seems to have been genuinely surprised earlier this year when the preliminary estimates of the Physician Payment Reform Review Commission were that the reduction would likely be as much as six percent. I am also told that the commission exceeded its full computer-budget allocation by just reviewing this to try to see what happened; to try to be sure that they were correct; double-checking it--in part because your agency was that skeptical.

And, of course, HCFA's own estimates of the impact of the transition problem have changed substantially since the regulation was issued on June 5th. It started at $3 billion over 5 years, but has risen to $6.9 billion.

And finally, the mid-session review of the budget which was just issued by OMB, includes a technical adjustment to reflect, and I quote, "reduced spending for physician services due to lower residual payments and the implementation of the conversion factor adjustment in the proposed physician fee schedule."

Now, all of that suggests to me that you did not know the dimensions of the problem until fairly recently, which I think is under-

standable when I look at the complexity of this new payment system.

But when I look at our responsibilities on the Finance Committee, then I look to the fact, of course, that the Gramm- Rudman Hollings law locks in the economic and the technical assumptions of the President's budget on February the 4th.

In light of all of that, I find it hard to believe that this six percent reduction could have been reflected in that document. The point I am getting to is I do not think that six percent reduction was in our baseline, which has a very material effect on what our obligations are in this committee—whether, in order to fix the problem, we would have to make offsetting cuts in Medicare or raise taxes, which I look forward to with no enthusiasm at all.

Now, I understand that in previous testimony you have indicated that there is likely to be a budgetary cost if we want to correct that transition problem. I want you to explain to me how that could be true.

Dr. WILENSKY. You have made a number of points. Let me try to briefly respond.

The CHAIRMAN. They all get down to the problem there——

Dr. WILENSKY. Yes, I understand.

The CHAIRMAN.—that we are faced with in this committee.

Dr. WILENSKY. I am, of course, prepared to respond to the questions you addressed to Secretary Sullivan, and we will be responding in writing as well.

It is certainly true that at the time that this legislation was passed, there was no clear sense about what the effects would be, although it was one of the reasons, as Senator Durenberger indicated, that the Senate believed—we also believed—that budget neutrality authority in each year was so important because of the potential for transition effects.

I would also like to point out that PPRC, both in its 1990 and 1991 reports to Congress, indicated that they believed that it was likely that the conversion factor would result in payments lower than budget-neutral.

I can give you, for the record, both the section in the 1990 and 1991 PPRE reports, as well as the CBO report in April 1990, indicating that at that point the Physician Payment Reform transition would reduce 1996 Medicare payments by 3.9 percent.

[The follwing information was subsequently received for record:]

The effects of the transition provision were reported by both the Physician Payment Review Commission and the Congressional Budget Office.

- The PPRC reported in both their *1990 Annual Report to Congress* (pp. 24-25) and *1991 Annual Report to Congress* (chapter 6) that the conversion factor would be reduced.
- The CBO reported in their April 1990 report *Physician Payment Reform Under Medicare* (chapter 5) that the transition would reduce Medicare payments in 1996.

In the letter that you sent to the Secretary, you included the last sentence in the paragraph of the model fee schedule which said that there was a possibility that the budget impact would be minimal. In fact, in the paragraph itself, we actually indicated that program savings are likely to be derived in years after 1992 when the prior year of payments are blended in with the full fee schedule

mechanism, and that this is a result of the implementation mechanism prescribed by the legislation.

I say that only because starting in March and April of 1990 with PPRC and CBO—CBO actually having a 3.9 percent figure—and then with our model fee schedule, where we did not include an amount, the likelihood that there would be a reduction was something that we all put on the books.

Let me now respond to, as best I can, the question about how this affects the baseline estimates.

Let me say most importantly that the Health Care Financing Administration and, indeed, the Department of Health and Human Services, does not set scoring for the Administration. That is something that is done by the Office of Management and Budget.

I will tell you what my understanding is. I have been trying to teach myself the arcane rules of scoring over the past several months, but ultimately it is OMB that will determine what does and what does not count for the administration, and not HCFA, or HHS.

It is my understanding that the interpretation of what is and is not in the baseline is according to current law, and not technically what we included in the estimate as of the January baseline estimate.

If there was an error at that point, it would be fixed by a technical correction as, in fact, I believe is what happened with the mid-year estimate; that it is explicitly in the mid-year estimate.

If we continue to interpret current law as requiring this transition effect, then it is in the baseline. What we are trying to do——

The CHAIRMAN. It is very clear under Gramm-Rudman that what is current is what was in the January budget. That is what we are talking about. What I am trying to find out, Dr. Wilensky, is what you knew then insofar as the——

Dr. WILENSKY. Well, again, it is my understanding—I am not challenging you, and I am only telling you my understanding of the Administration's position. First, the baseline is determined by OMB, not by us. And second, it is whatever current law is. If it should have been in the January estimate but technically was not because we did not have the precise amount, that would not impact what the baseline was. It would be fixed with a technical correction. I can only tell you that is my understanding of the OMB position.

The CHAIRMAN. But I do not think it is nominal or minimal when you are talking about $6.9 billion. I have not been here that long. I think that is a bunch.

Dr. WILENSKY. Scoring is something that occurs at OMB; it is not something that Health and Human Services or HCFA determines. A definitive answer will need to be provided in consultation with them.

What we are looking to do, however, is to see whether or not current law requires this interpretation. The other way around the issue, Senator, is if, in fact, there is a legitimate interpretation of current law that does not require this transition effect. Then, even according to the interpretation of scoring that I have given you, the transition effect would not be in there, or not need to be in there.

So, at least from HHS's and HCFA's point of view, what we are struggling with right now is finding alternative interpretations of statute to determine whether there is some other legitimate way to read the statute that would not require the transition effect.

We believe the proposed rule contains the correct interpretation of the statute. We have asked our counsel to review this issue to see whether there is any other option available to the Secretary, because we do recognize that it was not Congressional intent.

The CHAIRMAN. Well, sometimes it is difficult to understand the purpose of the proposed rule.

Dr. WILENSKY. Well, the purpose of the proposed rule is precisely to try to respond to these issues and to give us a second round. I think, in this case in particular, it would have been very unfortunate had we only come out with final rule from which there was no attempt to try to respond to comments. Again, this is something that we believed, since March of 1990 was in the neighborhood of four percent, given the CBO report. We had a clear understanding that the likely effect was a savings, although there was some confusion about how much.

You indicated that there was some confusion between whether it was $3 billion or $6 billion between the time we put out the rule and now. I gave an incorrect response to a question I had received on the telephone from the Finance Committee, and gave them the 1996 number ($3 billion), as opposed to the cumulative number ($6.9 billion). Our estimates have not changed since the spring.

The CHAIRMAN. Well, let me get to another point then. HCFA has always come to us for correction on technical problems; both when there were ambiguities in the law, and when they were clear errors.

In fact, in at least three cases in the past 2 years, your agency and OMB have asked for, and they have received, a letter from the relevant committees to enable you to implement the law in a manner that disregards errors in the statute. And, of course, we subsequently corrected those errors through legislation.

A good example of that is the over-valued procedures, reductions in the 1989 budget bill, which, by the way, is the same legislation. It contained physician payment reform.

In cases such as this, the committees have provided you with the protection against litigation; assured that anticipated budgetary savings were achieved. Now, what is the difference between cases like that and the transition problem?

Dr. WILENSKY. Senator, there are really two points. The first is that we needed to have budget neutrality authority each and every year. You had tried to give us the authority, but were unable to. I mean, we were aware that the Senate attempted to do that. That would have fixed this problem.

So, it was our presumption that having tried and not been able to do that, that this was not something that would be accepted as a technical fix. In other words the issue is not a drafting error, but an unintended consequence.

The second problem is, we believe, that had a "technical fix" been made last fall, it really presents the same problem that exists now, which is that it would have cost money. Therefore, it was not something that could have been done.

Again, unless we can find a different interpretation of the statute, which we are looking for very hard, the technical fix is not something that could have been done without having to put money on the table.

Therefore, this is not something that you could have helped us with without having to face precisely the problem that is being faced now, which is how you fix this without putting out the money.

The CHAIRMAN. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Dr. Wilensky, the AMA has gotten an outside, independent legal opinion of your interpretation of the law. Have you seen this?

Dr. WILENSKY. Yes, they have sent it to us.

Senator ROCKEFELLER. How do you respond to, or characterize their interpretation?

Dr. WILENSKY. Well, we received the opinion early this week. We have given it to our General Counsel, as we have assured the AMA we would do as soon as we had gotten it. We are waiting for our counsel to give us advice as to whether or not there are legitimate alternative interpretations.

Senator ROCKEFELLER. All right. One of the problems is that if there had been a five-year budget neutrality equation, we would not be running into a lot of these concerns.

And there was a worry, on the part of Congress, particularly on the House side, that OMB's approach to health policy, would be to constantly, year by year by year, erode the funding base.

In fact, it is my understanding that the administration did not support a five-year budget neutrality provision in 1989 when we were considering all of this. Would you support it now?

Dr. WILENSKY. I was asking whether we did or did not support the budget neutrality. I am sorry. I did not hear the last part of your question.

Senator ROCKEFELLER. Would you support it now?

Dr. WILENSKY. As far as I am aware. I have not specifically been asked, in terms of the administration, to give a response. Again, the difficulty, as I understand it right now, is that changing the law now will cost something unless we can find a different interpretation in the law. But neutrality in all the years, we think, would have been useful. It clearly would have gotten us out of the particular problem we are in now. But I am not really prepared to speak for the administration. Although I believe that budget neutrality authority would be helpful.

Senator ROCKEFELLER. That is important. The reason I suggest that is because in our own conversations in my office—and here today, I get a kind of a general sense of frustration that we have done something that we really did not mean to do.

Dr. WILENSKY. Correct.

Senator ROCKEFELLER. Or, on the other hand, that what we have done is being interpreted in a way that leads to vastly different results. Let's not quibble about that for the moment. But if we want to make this work, if we want to change the ambitions of students in medical schools so they go into primary care—and most specifically in under-served areas—we must fix this. We must press on to see what we can do to make that happen:

It seems to me that what you are saying is that the law says this, and therefore, that's what we have to do. And yet, I have the sense that you do not necessarily, want to have physician payment reform as a vehicle for saving $13 or $14 billion on Medicare. You know, many of the physicians in my State feel that they were betrayed, and I share that sense of betrayal. I do not know particularly who to blame. Certainly I am not going to blame you. A more likely target would be OMB, but that is just habitual. [Laughter.]

Senator ROCKEFELLER. But on the other hand, none of that makes any difference. The point is, this law was passed with clear intent, and if that intent is not being accomplished, do we not all need to get together and see what we have to do in order to accomplish that intent?

Now, if the possibility of corrective legislation is raised everybody gets concerned, including the administration, because nobody wants to have to open this whole issue up to debate and deal with the question of Medicare volume performance standards again, and I understand that. But the concept of making it work is important to you, is it not, Dr. Wilensky?

Dr. WILENSKY. Absolutely.

Senator ROCKEFELLER. And you understand what Congressional intention was on this issue, don't you.

Dr. WILENSKY. Yes.

Senator ROCKEFELLER. And you are being held up not by Congressional intention, but by several things within the law which preclude you from doing, in your opinion, what you would like to be able to do, or what you think professionally you ought to be able to do.

Dr. WILENSKY. Again, it is important to distinguish now between the two effects, and since you have raised the number of $14 billion, I am afraid you may be putting them together. We think there are two different issues that are causing concern.

Senator ROCKEFELLER. I understand.

Dr. WILENSKY. One has to do with the transition, the other with behavior. The transition does take money out of the system, relative to the old CPR system. We are looking to see whether there is another reasonable interpretation.

We would, as I think everybody I have ever heard discuss this issue, like to see whether there are administrative solutions to try to make this better. I suspect there are no administrative solutions that will fix all things for all people, but we may find one that will defuse some of the frustration and the sense of betrayal that has occurred. The behavioral offset, however, as we have discussed, is more complicated. As it now stands, we believe the volume performance standard does not serve as a mechanism to effectively recoup in the future money that gets spent early on. There will be a growing expenditure base that we could not ever fully recover. We are looking to see whether this can be fixed administratively or whether in fact, it would require additional legislation.

Senator ROCKEFELLER. Yes. I understand. I understand that I was lumping the two together. If we go then, to behavioral offset—and one thing that is terribly clear is that the legislation said not one single word with respect to behavioral offset. I mean, not one single

word. And you apply it in the calculation of the 1992 conversion factor.

Now, in West Virginia, if we use the proposed conversion in 1992, Medicare payment for some rural and primary care services will increase and HCFA assumes no volume decrease due to these fee increases. Is this correct?

Dr. WILENSKY. HCFA assumes no volume declines as a result of fee increases. If you had an offsetting effect, which is, I think, what you are getting at, we expect that when fees drop on average, when there is a reduction in net Medicare income, there will be a response. We do not have a response in for physicians who have higher fees. What we would expect them to do, if there was a response, would be to do less; to see fewer patients, to spend more time with patients, to take more leisure time. And we have not put in an offsetting response for the winners.

Senator ROCKEFELLER. For those with the higher fee schedules now?

Dr. WILENSKY. Yes.

Senator ROCKEFELLER. Because I was just prepared to say that there are studies that show that those physicians who perform, under-valued services would, in fact, decrease their volume of services when their reimbursement was raised. And I was going to ask if that is included in your behavioral offset.

Dr. WILENSKY. No. I mean, it is included technically as a zero value. That is, we have not assumed an offsetting response from those with higher fees. There is—as I know you know—one study out that was done that suggested a response for those who had higher fees. Our concern was two-fold. The first is that there seems some general agreement that the study was pretty flawed. The second was the overall sentiment that because primary care physicians are in such short supply, the likelihood of them being able to see fewer patients or to spend a lot more time with them, or to take more leisure time—which is what that offsetting effect means in behavioral terms—did not seem to make much sense given how strapped all of these primary care physicians are because of all the people who try to see them.

So, when we try to think through whether an offsetting behavioral response was conceptually reasonable given the short supply of primary care physicians, especially in rural areas, it did not seem so. And the empirical evidence in that direction is much shakier than it is elsewhere.

Senator ROCKEFELLER. Let me ask a generic question, just flat out. Do you think it is fair to reduce payment for rural and primary care services in order to offset the expected volume responses to fee cuts for other services?

Dr. WILENSKY. I do not think it is fair, no. But I think if you do not want to spend more money, it is the only way we have to control expenditures. We only know one way to control expenditures now, and that is by price. Expenditures are price times quantity. Controlling expenditures is something that we face. It is something that in all of your health care reform bills you face, and you almost always look to fees to do it.

Unfortunately, the problem that we have, is that we have not been able to figure out how to control volume effectively in the fee

for service system. And frankly, a fee-for-service system—which is what this is based on—gives you all the incentives in the wrong direction, because the more you do, the more you get.

But is it fair? No, it is not fair.

Senator ROCKEFELLER. And the behavioral offset was not in the legislation.

Dr. WILENSKY. We are not directed and we never are——

Senator ROCKEFELLER. Well, let me finish my question.

Dr. WILENSKY. We are not directed, as we never are by the Congress, to assume a particular behavior, but we always do, as does CBO.

Senator ROCKEFELLER. All right. Now, can you cite for me by what authority you include behavioral offset in the calculations of the conversion factor, after all, it is the major part of the reduction, isn't it?

Dr. WILENSKY. The budget neutrality requirement means that we not spend more than we would have otherwise spent. The budget neutrality assumption, as of 1991, with the update for 1992 means that you have to try to figure out the effects of the fee schedule, and the effect of the OBRA 1990 changes in law. What would it take to be budget-neutral in order to start this off? We thought that was what you were instructing us to do.

If we believe that the elderly will respond because they have lower out-of-pocket payments, and more protection on their own liability, and that physicians respond by changing their billing practices, the number of tests they order, or other referral practices, we will, in fact, end up spending more. We had to ask the actuaries to price out all these effects. This is what we do every time we come to you with an estimate for anything.

Senator ROCKEFELLER. I will come back to that subject, but my time is up. You will say, however, I hope, that you are willing to try to find a way that their concerns can be worked out?

Dr. WILENSKY. The answer is yes, I am certainly willing to look. Senator Durenberger ticked off a couple of interesting ideas, such as withholds, all of which are very complicated, have a lot of operational implications and, unfortunately, require legislation. That also would allow for getting money back after the fact in case you overspend

Our concern now is that as the MVPS exists, if you miss that first year, you will never get it back. It is the reason why employers or other people like to use bonuses instead of increasing wages. Every time, if your base goes up, anything you do thereafter carries forward what you did the last year or two.

Senator ROCKEFELLER. I understand, Gail. Before I call on Senator Durenberger, Senator Bentsen has a comment.

The CHAIRMAN. Mr. Chairman, I regret I have another commitment and have to leave. But I would like to leave some written questions, one in particular about the elimination of billing for actual time by anesthesiologists, as opposed to average. I would like to submit that for the record.

[The questions and answers appear in the appendix.]

Dr. WILENSKY. Certainly.

The CHAIRMAN. I would also, Dr. Wilensky, like to have an answer from you as soon as possible insofar as when we can get a

written response to that letter that I wrote to Dr. Sullivan that we discussed earlier. Thank you.

Senator ROCKEFELLER. Thank you, Senator. Senator Durenberger.

Senator DURENBERGER. Gail, I would like to make three, or four, or five observations quickly, and them move from the very good questions that you were asked by my colleagues regarding the budget implications to some other related questions.

The first observation, as I sit here and listen to these very good questions and the way in which they are asked, and I look at every face in this room—you cannot see them—is that everybody here wants you to succeed in this effort.

Dr. WILENSKY. I guess that is comforting.

Senator DURENBERGER. Yes. And that includes some of the losers in this room. That is, those who represent financial losers. Excuse me. I did not mean that as a——

[Laughter.]

Senator DURENBERGER. I meant folks that come down a little bit. Second observation is that probably in this room are the only people who understand what we are talking about. The third is that they are, unfortunately, not the only ones who care, and there is a lot riding on this. Some of the issues have been mentioned, and some have not.

In the latter category is the issue of reduced access in rural areas. I mean, I am below Iowa by a long way, and if physician payment reform does not work, the result will be reduced access in rural areas. But worse than that, I think, is more unnecessary practice in urban areas, particularly along the coast where we are observing plenty of unnecessary practice now. There are a whole lot of things being done in this country by doctors who do not have to go on, and that is another, I think, serious consequence. The other is the fact that our policy is trapped in this awful vice of reconciliation, and I think it drives us up here crazy. This is the sixth, or seventh straight year.

The next observation is that we have got only 72 days, and we are caught in the fact that you were required to do all of this 1 year short of what you wanted to do it, and we should all recognize, that we were told not to push it too fast. And we pushed, and so you are a year ahead of it.

We should also recognize that in your interpretations—and you have responded to the Chairmens' question—the General Counsel at HCFA—and this is not our first experience—is responsible for interpreting what we intended. And I just caution you about the fact that that is beginning to get under our skin a little bit, but I know there is not a lot you can do about that. Believe me, I have got experience with lawyers. [Laughter.]

Senator DURENBERGER. OMB, somebody has already—I guess visceral was a word that our Chairman used. OBRA 1990 CBO baselines. I mean, this is no way to provide assurances that we are going to have adequate doctor services in America. But it is a fact, and we cannot change that in the next 72 days. We need to learn to deal with it.

And the Chairman has told this to you in private—and I will just say it publicly so everybody understands it—that everybody here is going to do everything they can—that includes the Chairman of

the Finance Committee, as you can easily tell from his questions—to make this thing work, work right, despite the General Counsel; despite OMB; despite CBO. Big talk. But at least we are going to give it our best shot.

I would like to ask you about things like assumptions, decision rules, certain caveats in the fee schedule analysis. And I know that one of the organizations that I did not mention in my list is the one that we have set up between—in effect—you and your rule and us, and that is the Physician Payment Review Commission.

And to some degree, we rely on as many experts as we can get to help us with information. But it really is important to us, besides listening to the lawyers, to listen to the folks that can understand some of the assumptions, some of the gives, some of the caveats. I do not know what you call all of these things that go into converting the information and the methodology and the underlying data into a fee schedule; conversion factor; geographic adjusters; and all the rest of that sort of thing.

To the best of my knowledge, we do not have all the information we would like to have on assumptions, decision rules, caveats, and so forth.

To the best of my knowledge, PPRC does not have all of the assumptions, all of the caveats, all of the decision rules. And I will just give you one example. It may not be the best one, it happens to be the only one I can remember.

It has to do with cleaning of data, which is a term I am sure you understand. I am not quite sure that I do. But I understand that HCFA made a decision to eliminate all payments outside of two standard deviations from the mean for given procedures.

Now, when you look at that from Iowa and Minnesota, it means that there was a systematic elimination of very high charges and the effect of that seems to be that the final conversion factor is going to come out lower by some percentage than it was.

Dr. WILENSKY. That is not correct.

Senator DURENBERGER. Maybe you can just cue off of that and answer some of the other questions that I tried to lay on you in terms of the background that we need to know how you made the decisions you made.

Dr. WILENSKY. Let me take that one, and then I will answer more generally. It is true that we did make a decision to eliminate all values that were greater or lesser than two standard deviations from the mean. That is not uncommon. It is done so that you do not have very high or low outliers skewing the results. It is not something that is locked in stone. It, again, is something that we can respond to in the final rule, and that we would reconsider at a technical level of comment.

However, there is, we believe, a misunderstanding. We have gone back to look at it and from our preliminary analysis, is we believe it raised the conversion factor; it did not lower the conversion factor. We did not do it, however, to raise the conversion factor, and we did not do it to lower it.

Senator DURENBERGER. No, I know that.

Dr. WILENSKY. We did it because we believed it was a reasonable way, technically, to clean the data.

Let me answer more generally, and that is to say that this is a very complicated process. We have tried to be as open as we know how. We have made information available about the relative value units; the GPCIs, the geographic practice cost adjustments; the malpractice relative values; and we have had endless hours of debates about the new visit codes with PPRC and with other groups, and with the AMA, the CPT-coding group.

We make our assumptions known, in general, through the very large model fee schedule and then the proposed rule. We make our assumptions known in the specific and in detail when anybody asks us about them, and we make our data tapes available for other people to use to see whether or not they can calculate the same kinds of things that we can calculate.

And as a practice, when we make our data tapes available and people who have some other interests cannot duplicate our results, we invite them to come in and sit down with our actuaries and to go step-by-step through what they did, so that our actuaries and our technical people can explain to them where they made some assumptions that we did not, or we did something that they did not understand.

It is not in our interests, or in our intentions, to operate in a "black box." We really feel like we go to great lengths to share this information, both with the technical community, and more generally, in frequent meetings with the medical groups and the medical specialty associations at every step in the last couple of years, as has Bill Hsiao. We try to make sure that they understand this incredibly complicated rule.

Senator DURENBERGER. Was some of Dr. Hsiao's Phase III work incorporated into the NPRM?

Dr. WILENSKY. Well, some of it, but not most of it. And there is a problem that we have now in the proposed rule: We have provided values for services representing the vast number of dollars, 85 percent of the total. We had a good portion of the dollars accounted for with the 1,400 codes we had with the model fee schedule, representing the majority of dollars. We are now up to 85 percent in terms of the money. Some values came in after the proposed rule, but there are some other codes that have not come in. Our intention is, as indicated in the proposed rule, we will put the interim relative values in the Federal Register final rule and ask for comment on them. We will publish a Federal Register notice to respond to the comments.

Senator DURENBERGER. I have some other questions, but I had better defer to my colleagues. Thank you.

Senator ROCKEFELLER. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman. I have had a chance to look at the 1991 report of the Physician Payment Review Commission. In that report, it suggested that the volume of services is affected by changes in fee charges.

But the Commission seems to think that your assumptions about volume changes are too pessimistic. Your assumption about volume increase is fully three times larger than the commission's.

So, my question to you is how is it that you choose such a large adjustment factor compared to what the commission recommended?

Dr. WILENSKY. The commission has recommended an adjustment that is consistent with the offsetting effects that I was discussing with Senator Rockefeller. That is, they have a position that is consistent with what could be regarded as a 50 percent change for the losers, and a 35 percent change for the winners.

They found it either technically more believable, or what I believe, having discussed the issue, politically more palatable to assume something more than no response from the winners. Their estimate is consistent with an adjustment for not only those with a net loss, but also some reduction in services for those who were going to have higher fees. It is their 1 percent versus our 3 percent.

Now, the reason our three percent blows up into a bigger number is what we believe has been the need to use the conversion factor and to only hit those fees at the fee schedule and that leverages or triples all of the effects. As I have tried to indicate several times, we are going back to see if in the statute there is anything that allows us not to use the conversion factor, that is, to spread things over all fees. Because it obviously magnifies any effect, for both the transition and the behavioral offset.

Senator GRASSLEY. Well, but you also suggested that theirs is a political decision, and yours was a non-political decision, is that——

Dr. WILENSKY. Ours was absolutely a non-political decision. That may have been a bad move. It was the actuaries' assessment as to what it would take to get budget neutrality. I pushed hard to see whether I could not get another number——

Senator GRASSLEY. Oh. Well, are you saying that their motives or their goal was not budget neutrality? They were not taking that into consideration?

Dr. WILENSKY. Well, they will speak for themselves. I think that what I have heard them say is they are willing to run a little more risk and try to recoup it after the fact. My understanding is CBO and PPRC—but again, PPRC will speak for themselves—do not believe the actuarial assumption is incorrect; it is a question of how you go about implementing this and where you spread some of the risk for under or over-payments. It is my understanding that CBO, for example, does agree with our actuarial assumption. Now, that does not mean you cannot use, for whatever reasons, some other assumption, but this is our best actuarial assumption, and I believe CBO would support it.

Senator GRASSLEY. All right.

Dr. WILENSKY. And PPRC will speak for themselves.

Senator GRASSLEY. On the subject of increased volume, what was the magnitude of the increases which you noted accompanying the physician fee freeze during the middle 1980s, and how does it compare to the assumptions that you have made in the rule between fee reductions and volume increase for right now?

Dr. WILENSKY. We have done some analysis about what happened during the fee freeze. The reason I say that is because during the fee freeze, we had the hospital PPS going on. The reason that is important is that there was a big change in hospital admissions.

What we found is that the physician non-hospital volume and intensity increases, in 1985 and 1986, were 20 percent and 17 percent.

And this is why the overall change looks as it does. In 1985, there was a big reduction in inpatient hospital days. There was a big response to PPS, and physician hospital volume and intensity, went down 8 percent. In the next year, when you did not see such a significant drop in hospital days there was still a positive response of 3.7 percent.

If you look in toto, what you see in 1986 versus 1985 is the 3.3 percent increase in 1985, and a 10 percent in 1986. But the 3.3 percent in 1985 is masked by this very big decline of what was going on in the hospital and that, in fact, there were very substantial increases in volume occurring during these periods.

These 2 years had very substantial increases in physician volume when you adjust for the fact that there were changes in admission rates.

I would also—I know the time is gone—say that the volume performance standard that we calculated for 1990, assuming that only half of the changes that were made in statute in 1989 would actually occur, estimated that expenditures would go up in 1990 9.1 percent. Had we not assumed a behavioral response we would have had an expenditure goal for 1990 of 7.4 percent. What we found was that expenditures actually went up in 1990 10.6 percent. I raise that for two points.

The first is this 50 percent behavioral offset—that is, half the savings go away—is something that you have routinely seen from us—even though you are not aware of it—as you routinely get it from CBO—although you are not aware of it.

The second is that if we had tried to recoup after the fact what happened in 1990, had we not accounted for behavior we would have been in the position of trying to get back 3 percent. But, of course, the statute only allows us to ding updates by 2 percent early on. Furthermore, we would have had a bigger base. In other words, we would have had a 7.4 percent goal, but we observed a 10.6 percent increase.

Senator ROCKEFELLER. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. Dr. Wilensky, I would like to go over some ground that you have covered already with many of my colleagues, because I am equally as intrigued with this behavioral offset. You made the statement that this is a very complicated issue, and it certainly is.

Dr. WILENSKY. The regulation.

Senator DASCHLE. We have all been trying to better understand it.

Dr. WILENSKY. Yes.

Senator DASCHLE. I think you have made it more complicated, frankly, and I am not so sure that the added complication is necessary. I am still trying to understand, and maybe if you could just explain it one more time why there is an offset for the losers, but no offset for the winners? PPRC disagrees with you; as I understand it, most budgetary analysts who look at behavioral considerations will take into account both winners and losers.

Now, you say this was not a political consideration. It seems to me that you have made a budgetary consideration. In so doing you tried to acquire the greatest amount of savings—3 percent versus 1 percent—to attain the budget neutrality that you seem to seek.

But tell me again why it is you do not favor providing some offset for winners, as well as losers.

Dr. WILENSKY. I will try to explain. Let me say, however, unlike our inability to recoup if spending goes up from the volume performance standard, if spending does not go up as much as we think it will, we can, in fact, through updates, give back any amount of money that was not taken out. This effect of not being able to get money back because of the growing base only works when it grows bigger. It is not a problem on the other side. Having said that——

Senator DASCHLE. So, what you have just said is you are speculating as to what is going to happen, and you are affecting the lives, I must say—and I do not mean to interrupt, but I know my time is limited—you are affecting the lives and incomes, and well-being of a lot of people by what you have just admitted is an estimate. But go ahead.

Dr. WILENSKY. There is no question that we are put in a position of trying to figure out the most reasonable way to spend no more in 1992 than we would otherwise spend. We turned to our actuaries to give us their estimates of what kind of adjustments it would take in order to do that. I will tell you that I do not know of too many examples when we have over-estimated spending. What our problem has traditionally been, is that as much as we think we account for behavioral changes and other effects, we never quite do enough. We traditionally under-estimate; we do not over-estimate spending.

Senator DASCHLE. Well, PPRC disagrees with you on that very point. You are asking physicians to take a double hit. First of all, you are reducing the payment outright, and then secondly, you are saying, because you think the services will be over-utilized you are going to reduce the conversion factor even more.

But, on the other hand, you have got the so-called winners who will benefit from the initial payment revision, but then are not in any way accounted for as you try to offset what you expect will be a reduced level of services provided by these individuals.

Dr. WILENSKY. Senator Daschle, this is, as I have said, a proposed rule. We are aware of one study that was done. We have discussed as to how we thought it impacted our thinking. It is definitely an area that we have asked for comment from other people, although we obviously tried to have as much discussion with the technical community as we could about the various studies that have been done, and what they show. It is the only study that we have come up with that suggests this positive offsetting effect, but we will certainly take it, as well as every other piece of advice that comes in.

I am intrigued with the notions that Senator Durenberger has raised, which is if we have more spending than we anticipate, is there a way that we are more protected than we are under the present system. We are also trying to solve that problem, because we think that is a risk that exists and we are concerned about it.

But we are very mindful of the impact that the fee schedule is going to have, both on physicians and the elderly, and obviously the——

Senator DASCHLE. Are you talking about the mid-1970s study? Is that what your estimates on behavioral offset is based upon?

Dr. WILENSKY. No. That is the only study that I am aware of that was done in Colorado that shows a positive offset for the winners.

Senator DASCHLE. I see.

Dr. WILENSKY. There are a series of other works, as well as whatever it is our actuaries do to estimate spending that were also used. It happens to be an area in which I have also done research, and I am particularly knowledgeable about the research.

Senator DASCHLE. Do you disagree with Dr. John Eisenberg, a member of the commission, whose article in the June 19th issue of Journal of American Medical Association indicates that, "there is no conclusive evidence in all the studies that have been done that would lead one to conclude on any confident basis that there are behavioral reactions to payments being made."

Dr. WILENSKY. Yes. I would disagree with that. I think he is a fine physician, but I think there are economists who would argue with that statement. I think that the committee might want to look at one of the recent CBO volumes that was put out on rising health care costs, causes, implications, and strategies. There is a whole section in Chapter Two on page 21 on Physician-Induced Demand for Services.

This is something we economists worry a lot about, and believe that, in fact, there are clear responses to fee changes, although we work in a world in which nothing is hardly ever conclusive. But we still have to go ahead and try to make estimates as best we can.

Senator DASCHLE. Thank you, Dr. Wilensky.

Senator ROCKEFELLER. Dr. Wilensky, I just want to say that a lot of the members of this committee have questions that they would like to submit to you in writing, and we will do that, but I did want to just ask one final question and make one final point, which I hope you will see as being helpful.

The proposed rulemaking says that MVPS is inadequate for correcting inappropriate volume responses to fee schedules because of the two-year lag between when the volume change is observed and when the corresponding adjustment in the update is applied.

Now, you are aware that Congress considered and rejected prospective correction for estimated volume responses to fee reform.

Dr. WILENSKY. I have been told that.

Senator ROCKEFELLER. Since Congress clearly considered, and since Congress clearly rejected a prospective volume offset to fees; rather, we explicitly enacted and then the President signed the MVPS with a two-year cycle. Given that and given thata behavioral offset is mentioned nowhere in the law, what authority does HCFA cite—I know I asked this in a different way, before—for applying behavioral offset to the conversion factor?

Dr. WILENSKY. I would like to provide an answer in writing to that. But it basically has to do with the budget neutrality directives that are in the statute, and how one goes about achieving budget neutrality.

Senator ROCKEFELLER. You will reply in writing?

Dr. WILENSKY. Yes.

[The following information was subsequently received for record:]

The Health Care Financing Administration actuaries consistently use a behavioral offset in estimating Medicare spending due to price or policy changes. The statute did not prohibit us from making our usual technical assumptions (i.e., behavioral

offset) in estimating program expenditures due to implementation of the physician fee schedule.

The budget neutrality requirement is specified in Section 1848(d)(1)(B) "Special Provision for 1992" of the Social Security Act, which stated:

> the conversion factor specified in this subparagraph is a conversion factor (determined by the Secretary) which, if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.

Because the statute requires budget neutrality in 1992, our actuaries included in their spending estimates, as they always do, estimates for behavioral response. Therefore, we believe the budget neutrality directive gives us the authority to use a behavioral offset.

Senator ROCKEFELLER. Are you aware that in the Labor/HHS Appropriations Bill report language, there is language threatening to withhold administrative funds needed to implement the new system if HCFA does not correct the problem by September 15th?

Dr. WILENSKY. I have been told that. I assume that the appropriators are aware that they will create savings that even OMB never dreamed of, since after January 1st, we are not able to pay physicians any other way.

Senator ROCKEFELLER. And you are aware that the Finance Committee was successful in convincing the appropriations people to take that out of the statutory language and just keep that in the report language? All I am saying is that, during our private conversations, we have expressed a mutual concern about being able to get this done in time. Senator Durenberger kept referring to 72 days, I think Senator Daschle would say we have something like 35 or 40 more legislative days. So, time is short, and you have expressed concern about implementing these no matter what.

Dr. WILENSKY. Yes. Right.

Senator ROCKEFELLER. You are concerned about our timing aren't you?

Dr. WILENSKY. If you are going to legislate, we would like you to do it fast.

Senator ROCKEFELLER. Yes. So, I mean, there are genuine concerns, and all of these could be interpreted as adding up to a system that really is not ready to be implemented. We have a behavioral offset in a way which was not contemplated and, in fact, none of these reductions in payment were really contemplated. It was not the intention of the Congress. And this is not directed at you, because I consider you an ally. I am really talking to Dick Darman downtown. The Labor/HHS hits the floor next week, or perhaps the week afterwards. The Labor/HHS subcommittee is Chaired by Senator Harkin, who is not timid on these matters. And I would just say to you that the Senate Finance Committee would have no jurisdictional basis for contesting what Senator Harkin, or members of his Appropriations Subcommittee might choose to do. So, this is serious stuff.

Dave and I, and a lot of other people, when Physician Payment Reform passed, felt good; we felt that we made a contribution to physician payment, and increased the opportunities for medical care in rural and urban areas. We felt that we based all of these changes on fairness as a theme.

What has come out is something that is wholly unacceptable, and it seems to be not your fault. We seem to be caught in some kind of a trap. And so, I just want to remind you and others who hopefully would be listening, that there is this authority, and it is a very drastic authority; but there is this authority.

Dr. Wilensky, I repeat to you my enormous appreciation for your willingness to try to work this out. I understand that very strongly. It is a very difficult problem; a very important problem, and I very much appreciate as I always do your testimony.

Dr. WILENSKY. Thank you. We are, as I have said, working very hard. Staff at HCFA has worked days, nights, and weekends for many months to try to get this far.

We are looking to see whether there are ways that we do not have to confine ourselves only to those fees that are inside the fee schedule which has the leveraging effect; we are looking to see whether there are other legitimate interpretations of the statute that do not give us the transition effect that we have included in the proposed rule.

We have more concerns about the behavioral offset, because we do believe, at least under present law, that we are vulnerable for not recouping lost Medicare funds even with the MVPS there. It is not just the two-year lag, it is the bigger base, and also the fact that it becomes current law, and therefore, the baseline on the five-year moving average.

But we are looking to try to find ways, preferably administratively, and if not, legislatively, that would fix the problem. It is a little difficult for me to respond in a helpful way with regard to language in the appropriations bill.

We will not have fixed this in two weeks, I will guarantee you that. Our comment period will not even be closed, and it would be inappropriate to make final decisions about what we ought to do to fix this before we have allowed the public to respond.

And I was not jesting when I said that, to the best of my knowledge, we do not have to implement this, but we have no authority to pay physicians under any other mechanism come January 1st.

So, I assume the good Senator will take that into account, as well. But I assure you that with or without that hanging over our head, we are regarding this as very serious.

We are concerned about the impact that it has been having. I have spent the last year and a half doing everything I can to try to improve working relationships between the physician community and the Health Care Financing Administration, and I am none too pleased to have it all go down the drain.

So, we are regarding this as a very serious matter. But we do feel that whatever we do, we cannot cavalierly say, well, we knew what you meant, even if it is not what you wrote. We do feel confined to the fact that what we do is something that legal counsel believes is consistent with the statute as it is written.

They have promised to spend serious time looking to see whether or not there may be more flexibility than we realized at first, and we are pursuing that with very seriousness.

Senator ROCKEFELLER. Thank you, Dr. Wilensky, very much. Dr. William Curreri is on PPRC, Commissioner from Mobile, Alabama

is our next witness. We welcome you, sir, and apologize for making you wait so long. Please proceed.

STATEMENT OF P. WILLIAM CURRERI, M.D., COMMISSIONER, PHYSICIAN PAYMENT REVIEW COMMISSION, MOBILE, AL

Dr. CURRERI. Thank you, Mr. Chairman. I appreciate the opportunity to be able to come and testify on behalf of the PPRC on this very important matter with regard to the notice for proposed rulemaking.

On my right is Dr. Lauren LeRoy, who is Deputy Director of the Commission, and she will be accompanying me during this testimony.

The PPRC considered in great depth the NPRM at its June meeting, and has concluded that, although there is much merit in the proposal, there are very, very significant problems, many of which you referred to earlier today. And if these problems are not corrected, the success of the payment reform, we believe, could be jeopardized.

The most serious of these problems you also identified earlier today, and that is that the conversion factor is far too low; we believe much lower than we intended it to be, and we believe far lower than Congress intended it to be.

In addition, there are serious distortions in the relative value scale itself, and these need to be corrected before implementation. However, we think that if there is sufficient commitment by HCFA, many of these issues can be addressed in an administrative manner, and through rulemaking, and, perhaps, will not require new legislation.

Now, in my testimony today, I wish to review the key issues; others will be covered in my full statement. The commission has prepared a report for Congress critiquing the proposal which will be submitted to you on July 31st.

Now, with regard to the conversion factor, you have already identified many of the major problems. One of them is the interpretation of how to achieve budget neutrality under the asymmetric transition; we have problems with the assumptions that HCFA has made in determining a behavioral offset; there are assumptions HCFA has made that give us difficulty regarding the utilization of new visit codes, which account for about 35 percent of expenditures under the Medicare system. It anticipated a too great a use of high-cost codes. And finally, as Senator Durenberger pointed out this morning, we have some problems with the way they trimmed the data, or cleaned up their data, which we believe also has reduced the conversion factor.

Now, with regard to the asymmetric transition, the language in the bill clearly is not very clear, even to us. But we do not think that the 6 percent reduction in the base, which you have identified will occur by 1996 and thereafter, was the intention of Congress.

And we would recommend that this be revised by HCFA to achieve budget neutrality each year. In our written testimony, we have given you several options as to how this really could occur.

With regard to the behavioral offset, we believe that HCFA's assumption is far too large. We recognize that there is a paucity of

research in this area, and what research is available, can lead you to almost any conclusion you want. But it is clear that HCFA has accepted the worst case assumption, and as a result, it winds up with a 10 percent reduction, and we do not believe that this is just.

We also think it is unwise, because in the OBRA 1989 legislation, you created the MVPS, and it is my understanding that there is not any limit in the reduction of the MVPS if Congress takes action and does not rely on the default mechanism. So all corrections could be made in the future by the utilization of the volume performance standard.

Now, it is true the commission did recommend a 1 percent reduction after a lot of consideration and disagreement, frankly, among the Commissioners. But we felt a 1 percent reduction was not unreasonable; it was probably more practical and was probably more fair than the 10 percent reduction that HCFA has recommended.

In regard to utilization of the new visit codes, our examination of the assumptions underlying the crosswalks that HCFA made suggests that when we look at survey data, we get very different results and come to different conclusions.

We believe that the expenditures under these new visit codes might be 13 percent less than HCFA projected, which could result in an increase in the conversion factor of about 5 percent, and still maintain budget neutrality.

And we disagree with HCFA that the cleaning or trimming of the data increased, in fact, the conversion factor. It is our preliminary understanding that it may have decreased the conversion factor by up to a factor of 2 percent.

Now, with regard to the scale of relative work, there are problems that we have known about for some time, and the Hsiao studies have not achieved the accuracy that we had hoped, but we think that the values can be improved so that they are accurate.

The problems have been identified in the past, but so far, they have not been successfully resolved by HCFA. And I think that the distortions are readily apparent to all physicians, they are very clear, and they result from a number of different problems: problems with the vignettes, problems with the physicians who were chosen to judge those vignettes.

And we are concerned, because if the relative value scale is not accurate, it is going to be difficult to get physicians to accept it as a good and fair way for payment.

Now, to correct these, we do not need to do more research, we do not believe. We think that properly structured panels of experts, including beneficiaries, physicians, payors and others, could easily make fixes in the codes that we think are not truly accurate. And a final step of review by physicians in each specialty in a budget-neutral process could fix the values relatively quickly, and they would be acceptable to be introduced in 1992.

Now, there are some problems also with the calculation of practice expense. I will not dwell long on these, but simply say that under the notice, there are site of service differentials. We applaud the concept, but the adjustments and assumptions that HCFA has made are fairly crude, and perhaps their use should be delayed until we get better resource costs for practice expense at the different sites.

I should also point out that the statute specifies that charge data for 1991 should be utilized to calculate practice expenses, and that is going to unnecessarily penalize over-valued procedures, radiology, anesthesiology, and pathology, that had significant reductions before 1991 as a result of OBRA 1986, 1987, 1989, and 1990. Practice expenses are going to have to be looked at in the future, and adjusted to reflect true resource cost, which is the long-term goal of the PPRC.

With regard to geographic payment areas, we recommended very strongly—and this is not in the notice, of course—that we use state-wide payment areas in all but the 15 States that have the most intrastate variation.

This would simplify the whole process by reducing the number of localities from 237 down to 94. And that should provide for better communication between beneficiaries, payors, and physicians.

Regarding the coding for EM services which has been adopted by HCFA in the notice, we think that the overhaul of coding for evaluation and management services is clearly needed, but we cannot endorse the system that is proposed in the NPRM; we think it is too complex, and we think it is going to be sending mixed messages to physicians. So far, we have seen no evidence that this new system of coding is going to be an improvement over the current.

We also would like to recommend that actual time continue to be used for the payment of anesthesia. This is truly resource-based when time is utilized. We do recognize that there could be a better operational definition of time and more vigorous validation.

So, in summary, the NPRM raises a number of issues that deserve Congressional scrutiny, and many of these changes need to be made if payment reform is to meet the goals that have been set for it.

Thank you very much.

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

Senator ROCKEFELLER. Thank you very much, Doctor. A large component of the decrease in the conversion factor comes from the behavioral offset assumptions made by the administration; you have referred to that fast in your testimony.

PPRC suggested a 1 percent offset; therefore, there must be some concern about volume response, but would you try to help me understand how PPRC can look at the same evidence that HCFA does, the same history that HCFA does, and come out with 1 percent and they come out with 3 percent? Why the difference?

Dr. CURRERI. Well, I think that HCFA has used their actuarial experience, or the assessments by their actuaries to come to the estimate of this behavioral offset. And, as Dr. Wilensky testified, they have assumed that the so-called "winners" will not have any decrease in volume, and she said that because she was really relating to the family practitioner in the rural area who, perhaps, cannot respond with a decrease in volume. But that negates all of the people in urban areas where, in fact, there have been studies that show that the winners do decrease their volume.

We do not know, frankly, what is going to happen. It would be all right, I am sure, with the PPRC, to the volume performance standard simply take care of this problem in future years. We recognize, though, that there is likely to be some volume response, but

we think the offset should be minimal. That is, 1 percent, not necessarily 1 percent multiplied three times.

Senator ROCKEFELLER. You said very clearly in your testimony that there are alternative approaches that could be taken to this whole question of budget neutrality.

Could you please review your suggestions regarding what HCFA, and/or Congress would have to do, in order to implement some of those alternatives?

Dr. CURRERI. Well, I think that interpretation of the law could say that it would be possible to apply the 2 percent reduction across the board in a budget-neutral way. That is, to apply it both to historical charges, as well as to the conversion factor, and not just to the conversion factor alone; that would get rid of the asymmetry.

An alternative would be to take a 3 percent reduction in the historical base of those procedures that were more than 15 percent above, or more than 15 percent below the fee schedule value.

And, in essence, since the historical fee will disappear over the four-year period of time, that will disappear as you adjust it each year to maintain budget neutrality without decreasing the base.

Senator ROCKEFELLER. Got another one? [Laughter.]

Dr. CURRERI. Those are the two that I think we would suggest most strongly.

Senator ROCKEFELLER. What is your assumption as you hear the bind that HCFA is under in terms of implementing these rules in time? I did not really get Dr. Wilensky on the record the way I wanted to, on the fact that she is very concerned about, just literally being able to get this implemented, accommodating any changes that might have to be made, either legislatively or otherwise, in time for January 1, 1992, much less before we go out of session.

Do you, and PPRC, have a sense of real concern that we could be heading into something here which we did not intend, and which could have on a net basis a substantially negative effect on physicians and their practice of medicine?

Dr. CURRERI. I think that the PPRC is, of course, very dedicated to this legislation. Since we suggested it very strongly to the Congress, we want to see it implemented.

But I think we want to see it implemented correctly, and if there is a problem that cannot be solved relatively quickly by administrative maneuvers within HCFA itself, then I think that the PPRC would consider the implications of waiting an appropriate amount of time until we could be convinced that the relative values scales were as accurate as could possibly be made, and that the system will work in terms of controlling long-term costs.

Senator ROCKEFELLER. Senator Durenberger.

Senator DURENBERGER. Dr. Curreri, I just have a couple of questions that relate to the specifics of the NPRM, and I just want to set it in a context for you as a physician. As everybody in this room and a lot of other people know, one of the popular things as you approach an even-numbered year that has a President up for reelection is health care reform. That is particularly true this coming year, and my colleagues on my right have a proposal.

In fact, they have a couple of proposals to solve the universal access problem. I guess a couple of my colleagues on my left pro-

pose to have something just like that. I am not one of them, because I feel fairly strongly that we are not going to solve this problem unless we can be bipartisan about it.

I have said before and I will just say it again, that the folks on this side of the aisle have tried to be bipartisan; they ended up, because we would not cooperate with them, coming up with something that looks partisan.

And I think most folks here probably believe that while we may lay political solutions on the table, the answers to some of these problems are going to have to be bipartisan, because there is nothing inherently political about what we are doing.

It just happens to be my belief that we are not going to solve the universal access problem if it is a financial problem until we change the way medicine is practiced in America. And I cannot tell you that I have a lot of faith that RBRVS is the solution to the problem. It is just another regulatory approach to try to rationalize the system.

If our problem is universal access, and if one of the problems behind that is changing the way medicine is practiced in America, I frankly do not believe that RBRVS is going to solve the problem. It does rationalize a lot of the things that are done, and that is very important.

A lot of other things are very important, too: the effort to get to total quality management and practice guidelines, and all the rest of these things that are new to our lexicon. Those are very important.

But I will say it again, and I will continue to say it, and I will exaggerate the percentages. But I believe that 10 percent of the physicians in this country practice very appropriate and very efficient medicine; that 80 percent of the physicians in this country would love to, they just do not know how to; and 10 percent are creating problems for us.

To the extent that any of this is posited as a solution, I do not believe it is a solution, but it makes a big difference. I mean, it is going to make a big impact out there in America.

So, as we struggle here as policymakers, I am reminded of something that the Director of OMB told us Republicans about a week or so ago when he was meeting with us. And he said, before you decide what "it" is, you ought to have some vision for what "it" is going to do to this system, referring to the so-called "Republican package," or something like that.

And I think that is what the Chairman of this subcommittee—as in my experience with him—and the Chairman of the full committee, and a lot of other people on this committee are doing; they are trying to formulate a vision for the future and then we all put our "its," whether "it" is RBRVS, or "it" is Pepper Commission, or whatever, into that particular vision.

But one of the problems that I have, or one of the suggestions that I made in my opening statement is that we try to take advantage of the 10 percent of the physicians out there, and the 80 percent of the physicians who would like to be like the 10 percent. And I really find it difficult instinctively to buy national hammers on behavior. I mean, you know that my State benefits the most

from RBRVS, in terms of overall dollar increases. What does that tell you? That is, that we are currently paid the least.

And yet, we are the home of some of the best multi-specialty group practice organizations in America. I think we are the home of a lot of the 10 percent that do it right. But I cannot tell them I can get everybody else up to speed with them with this system. I cannot tell them this system is going to reward them for being in the 10 percent. Am I wrong?

Dr. CURRERI. No, I do not think you are wrong at all. Let me just in response to you say this, that the PPRC has never envisioned the fee schedule to create any reduction in expenses.

The only thing that will create reduction in expenses would, from the Government's standpoint, in fact, be if the volume performance standards work, and physicians get together and actually decrease the amount of volume that is either excessive or, in fact, as you suggested, inappropriate because they do not know how to use efficiencies in practice.

Now, you ask then, well, how can you excite people in Minnesota to respond to some sort of national MVPS, particularly when they do not control all of these people? Well, the legislation already goes somewhat in this direction by splitting into two groups: surgical procedures on the one hand, and medical services on the other.

Now, you suggested this morning, I think, that maybe we ought to go down to State MVPSs. We have looked at that in some detail, and the problem that we have with that is the variability in expenditures at the State level. They go up and down, and up and down so rapidly, that you would be like on a yo-yo if you then had to upgrade depending on volume predictions.

So, we do not think that the State level is feasible at all. Now, we think we should look at, perhaps, national levels, but divided into tighter specialty groups, rather than just surgery on one side and medicine on the other side.

Because in general, peer pressure and education, which are the things that are going to reduce volume, come from the national specialty societies. And that may be a way that you can get interest of the people in Minnesota, because the surgeons at the Mayo Clinic and the cardiologists at the Mayo Clinic responded in very positive manner to their American College of Cardiology, or the American College of Surgeons, and so forth.

But we do not believe that you can get to the State level, because we think that the variability in expenditures is just too great to use the VPS mechanism to update fees each year.

Senator DURENBERGER. Well, I appreciate the response, and it is certainly not persuasive. But we can explore that. I do appreciate the other suggestion, which I think is appropriate.

What is your impression about paying new physicians a lower payment rate than more experienced physicians? This comes up in various settings, but I think the last time I got it as a question was in a—and I have been in a couple of them lately—in a multi-specialty, group practice situation.

Dr. CURRERI. Yes. As you know, that is in the current law, and there is a four-year phase in for new physicians until they reach 100 percent. We do not think that new physicians have any less ex-

pensive practice costs, and we do not think that new physicians are necessarily less efficient.

In fact, you could argue that they may be even more efficient, since this has become a subject of interest within medical schools and teaching centers now. And we believe that all of the physicians should be rewarded in exactly the same manner for the same work.

Senator DURENBERGER. Thank you very much, Doctor.

Senator ROCKEFELLER. Dr. Curreri, thank you very much. I have to say, because I never have and I always feel that PPRC is an enormous factor in what is happening in medicine, and what ought to happen, and as it is intended to be, it is a wonderful balance; it is very wise; it is very comforting to those of us who are trying to work on these problems, because we have great respect for PPRC and the work that you do. Thank you very much.

Dr. CURRERI. Thank you very much.

Senator ROCKEFELLER. Our next panel consists of Dr. Clifton Cleaveland, who is Chairman of the Health and Public Policy Committee of the American College of Physicians; Dr. Robert Graham, of the American Academy of Family Physicians; Dr. John Seward, Member of the Board of Trustees, American Medical Association; and Dr. Seward comes from Rockford, Illinois.

Dr. Cleaveland, I will start at the top of my list with you, sir, if you are ready. We welcome you very much and, again, apologize for the long wait, but the stakes are high.

STATEMENT OF CLIFTON R. CLEAVELAND, M.D., CHAIRMAN OF THE HEALTH AND PUBLIC POLICY COMMITTEE, AMERICAN COLLEGE OF PHYSICIANS, CHATTANOOGA, TN

Dr. CLEAVELAND. Mr. Chairman, thank you so much for convening this hearing. The American College of Physicians appreciates this opportunity to present the views of internists and subspecialists in internal medicine on the critical issue of physician payment reform.

I am Cliff Cleaveland, an internist in full-time private practice in Chattanooga. I am a Regent of the College, and Chair of the Health and Public Policy Committee. Accompanying me is Howard B. Shapiro, Ph.D., Director of Public Policy.

Mr. Chairman, my Medicare patients—who comprise 40 percent of my clinical practice—are the most complex patients I see. Typically, they are beset by multiple chronic illnesses and degenerative conditions. They require lengthy, intense, and expert care. This work carries with it considerable financial, physical, and emotional overhead.

RBRVS represented hope for us in the primary care community that finally a just payment scale would be enacted which would recognize and appropriately reward our efforts. Because our work is so demanding and the present fee schedule so low, the number of medical students opting for careers in primary care specialties has substantially decreased for several years.

In the most recent residency match just concluded, only 57 percent of first-year internal medicine residencies were filled with graduates of U.S. medical schools. Other primary care specialties report similar experiences.

A gap in the supply of primary care physicians, once it is created, will take years to correct. Our ranks in my community are progressively thinning, and my colleagues and I struggle to accommodate new patients in an aging society.

I truly despair that in the years just ahead there will simply not be enough competent, U.S.-trained graduates in primary care to look after an ever-increasing number of Medicare patients.

It is only with a just payment schedule for primary care services that we can ensure an adequate number of highly-trained primary care physicians. The regulations, as advanced by HCFA, gut our morale in many ways.

The American College of Physicians remains committed to the full and fair implementation of the 1989 Medicare Payment Reform legislation. If payment reform fails because of budget-related interpretations of the legislation, the wave of cynicism will last for years.

There are three major problems related to budget neutrality that must be resolved. We believe that they can best be addressed by HCFA in a revised regulation, and this is the preferable outcome.

First, Congress created a transition rule to move primary care services toward the full fee schedule amount quickly. The net cost of this transition formula should not be included in the budget neutrality calculation. The AMA's legal opinion makes clear Congress' intent in this matter. We think that HCFA has made a serious mistake in interpreting the statute.

Second, on an interpretation of ambiguous language in Section 1848(d)(1)(b) can be used to justify applying budget neutrality adjustments to the conversion factor alone, producing the tripling effect of any cuts. Adjustments should be made across both the RBRVS and the historical charge components of 1992 fees.

Third, we oppose any reduction in the conversion factor to offset anticipated changes in volume. Congress deliberately chose to use MVPS to correct for volume fluctuations. This would be analogous to spanking a child before he went to school, in the event that he misbehaved that day.

Additional statutory changes will be necessary to bring about consistency of approach to services and payment calculations under the fee schedule.

Among these, Congress should restore payments for EKG interpretation at the correct relative value level, and should mandate a resource-based approach to the measurement of practice costs.

Congress, the administration, physicians, and the Physician Payment, Review Commission put together a powerful partnership to undertake payment reform in the first place. It is of extreme importance to the future of Medicare that the partnership continue and that we work out the serious difficulties raised by HCFA's interpretation of this legislation.

Thank you.

Senator ROCKEFELLER. Thank you, sir, very much. Am I missing a name plate? Oh. It just arrived. Would you proceed, please, sir?

STATEMENT OF P. JOHN SEWARD, M.D., MEMBER OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ROCKFORD, IL

Dr. SEWARD. Thank you, Mr. Chairman. I am P. John Seward, a family physician from Rockford, Illinois, and a Member of the AMA's Board of Trustees. With me today is Janet Horan, of the association's Division of Federal Legislation.

The American Medical Association acknowledges the committee's longstanding interest and involvement in Medicare physician payment reform. We appreciate the extraordinary letter dated June 28th, 1991 to the Department of Health and Human Services signed by two-thirds of the committee. We share your concerns, and appreciate your direct involvement in resolving this issue.

Over the past few weeks, there has been much discussion of the options under the law available to the Health Care Financing Administration in resolving the conversion factor problem. All agree that there are ambiguities in the law that need interpretation.

To assist HHS, HCFA, and others, the AMA requested a letter of opinion from the respected law firm of Sidley & Austin concerning the issues. This letter of opinion indicates that the 16 percent reduction is not inevitable and, in fact, contravenes the statute. We strongly concur.

A copy of this letter of opinion is attached as Appendix I of our written statement, for your reference, Mr. Chairman.

As you have no doubt heard, physicians throughout America are angry at the payment levels in the June 5th, 1991 proposed rule to implement Medicare physician payment reform. This is understandable, because the proposal reflects an unwarranted, devastating, and immediate 16 percent reduction in the schedule's initiation conversion factor, contrary to the intent of Congress.

It breaks faith with American doctors, but even more important, physicians are worried. We are worried that the proposed schedule of payments for the drastic cuts for many services will mean that some Medicare patients may not have access to the full range of services that they need.

To put it clearly, some doctors in my specialty of family medicine, for instance, may not be able to see new Medicare patients, pay their overhead costs, and stay in their current practice location if the 16 percent reduction in Medicare payments is finalized.

More and more we hear of physicians who are questioning their ability to maintain their practices due to continued Medicare payment cuts and administrative hassles.

Do we want to create a Medicare program with access problems equal to, or worse than those in the Medicaid system? The proposed 16 percent reduction in the conversion factor will do just this, if it is uncorrected in the final rules. We are requesting Congressional assistance.

This proposed 16 percent reduction in the conversion factor results from a misinterpretation by HCFA of the mandate for budget neutrality contained in OBRA 1989, as well as from inappropriate and demeaning assumptions about anticipated physician behavior in response to payment reform.

HCFA has interpreted this provision as requiring two reductions in the conversion factor: one to offset volume increases that a projection will occur as a behavioral response to payment reductions, and one, to offset spending projected to result from the payment system's transition formula for 1992.

Finally, HCFA has applied all of these cuts to the conversion factor, thereby tripling the effect of the conversion factor.

The AMA remains committed to physician payment reform; we simply want to make it work. The AMA believes that the decisions that are causing the radical reduction in the conversion factor could be, and should be dealt with administratively.

We believe these matters can be and will be best handled by modification to the proposed rules. Our approach includes the following elements: clarification that HCFA's conclusions regarding the so-called "transition asymmetry" are incorrect, in that OBRA 1989 neither requires, nor allows HCFA to make this cut.

And second, a Congressional directive that HCFA uses no behavioral offset which has no clear analytic or statutory basis. Instead, Congress enacted the MVPS to retrospectively respond to potential inappropriate increases in volume.

In conclusion, Mr. Chairman, Congress, as much as anyone, has a major stake in seeing a smooth transition to physician payment reform. Fair relative values linked to an absurd conversion factor do not produce fair payment levels.

Access may become a real concern. For example, data from a limited PPRC survey of national Medicaid patients indicates that for some services, Medicare rates will be near or below the Medicaid rate in many States.

Furthermore, anticipated increases in rural areas will be substantially reduced or reversed, with 40 States suffering losses in Medicare payments in 1992, and 49 States suffering losses in the next 5 years. Out of the 240 Medicare payment localities in the nation, only 14 will see a payment increase in 1991.

We certainly thank you for calling this hearing and inviting the AMA to testify. Your interest reflects our strong view that we all have invested too much time and effort on payment reform to see it destroyed. I certainly thank you for your attention and would be pleased to answer any of your questions, Mr. Chairman.

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

Senator ROCKEFELLER. Thank you, Dr. Seward, very much. Dr. Graham.

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE-PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS, KANSAS CITY, MO

Dr. GRAHAM. Mr. Chairman, Senator Durenberger, I appreciate the opportunity to appear before the subcommittee again and continue our discussions about the implementations of RVS.

I think it should be noted that we would not be here today were it not for the very strong support that this subcommittee and committee had for the implementation of the Act in 1989, which we continue to appreciate very much.

You have my full statement before you, and I think it perhaps would serve the best purposes of this hearing for me to try to summarize our feelings about some of the major questions which have been raised already today in previous comments of witnesses.

Item No. 1: Behavioral offset. I believe the committee is on the right track in questioning the legitimacy and the logic of the behavioral offset proposed by HCFA over and above the questionable assumption as to whether or not there is a statutory base. I believe that to assume that physician behavior will alter because of a change in payment if it comes down, but will not alter if a change in payment goes up, has no internal logic to it. And even Dr. Wilensky said they tend to underestimate. Well, perhaps they underestimate the degree to which physician behavior would change if payments go up.

The whole issue of the science behind behavioral offsets, I think, is so cloudy, it does not form a basis for sound public policy. HCFA should be encouraged, both because of the questionable statutory basis, and because of the questionable science behind it, not to pursue the behavioral offset.

Again, Dr. Wilensky said several times, we have to do it this way because the MVPS does not allow us to recoup; we can only take back 2 percent a year. That is not what the law says. The law says the Congress can do whatever is necessary. The 2 percent is the limitation that is provided for the default provision for the Secretary.

Senator ROCKEFELLER. And so, how would we encourage them to do that?

Dr. GRAHAM. I believe, if you cannot do it administratively—and with the conversations that you are already having with HCFA, it may well take legislative action, sir, and I know that is difficult.

Senator ROCKEFELLER. And opening up potential MVPS again would not worry you?

Dr. GRAHAM. It would not worry me. Other members of the panel may have different feelings about it. As you are aware, in our conversations in 1989, we were willing to accept MVPS as a legitimate assurance to the Congress that there would not be major changes in physician behavior nor major impact on the budget as part of the RVS package. So, re-addressing that, no, would not concern the Academy, in particular.

Issue No. 2, which has been discussed, is any changes that need to be taken in the conversion factor to provide for budget neutrality should apply to all fees, not simply those fees in the first part of the year.

Now, there it does sound that HCFA and Dr. Wilensky are trying very hard to find a legislative basis to allow them to do that. That may be an area which can be worked out administratively and through conversations of goodwill.

A third area that I would identify that has not been talked about by a prior witness that is of substantial concern to us is the need for an ongoing review of the geographic adjustment factor. Many of our physicians, as I know physicians in the States represented by the two of you, do practice in rural areas. We believe that the current geographic adjustment factor does not treat rural physicians properly.

This is not an issue that I bring before you for resolution prior to 1992, but it is an issue where we think the way the implementation is going right now needs to be carefully re-examined, because there is an implicit assumption that rural practice is less expensive and rural overheads are less expensive.

And we do not believe that is right, so we would encourage the committee, and PPRC, and HCFA to continue to look at that.

Let me close with two comments about process. What happens if we are not successful in addressing these issues in bringing about a change in HCFA's proposal? What if physician payment reform is implemented just the way the NPRM reads right now?

We have substantial concerns that there will be major disillusionment and disaffection within the practicing physician community. It will be perceived that once again the Federal sector promised one thing, and granted another.

I do not believe that will mean that current physicians will abandon their Medicare patients, because physicians care about their patients, and they have relationships with them.

But the implication that I see is for Medicare patients five and ten and twenty years in the future, as we try to encourage individuals to go into family medicine, general internal medicine, general surgery, providing services to the patients where they exist. And they look at the fee schedule for Medicare and say, "I cannot do it."

You have heard Dr. Seward and Dr. Cleaveland refer to this already. The long-term effects of the implementation of RVS, as proposed by HCFA right now, concern me a great deal.

And if I can, I will make a closing comment. Without delay, I would urge you and members of the subcommittee to do everything possible to bring about a resolution of these issues so that the fee schedule can be implemented as of 1992. Allowing administrative bureaucratic concerns to push that back, I think, would not serve any of our interests at all.

I think you are on the right track, perhaps, through the Appropriations Committee, trying to find some leverage. I have a little concern with the proposal that funds would be withheld to implement, because, as you identified Dr. Wilensky, I think she is an ally of the subcommittee and an ally of this process. I think you are shooting the messenger. If attention——

Senator ROCKEFELLER. But I indicated that is what I was doing.

Dr. GRAHAM. If the attention of the administration needs to be captured, perhaps the target should be something closer to their heart.

Senator ROCKEFELLER. No, I agree with you. I simply wanted to rattle the situation sufficiently to express that you can sit here and discuss these things and throw all of these acronyms around, and the process just keeps moving. And, as Senator Daschle indicated, we have only got 35 legislative days left.

The assumption is that maybe there is someplace that Congress can be helpful if everything cannot be done. If Gail Wilensky cannot prevail over OMB, then that means maybe we have to do something.

We are only going to be here for a certain amount of time, so moving the process along has a very high priority, which is why I

decided to sort of drop that small little item in there. It was not intended for her, it was intended for Dick Darman. And it is frustrating.

Dave has indicated. I believe him when he talks about Minnesota. Physicians and the fact that there are a lot of low-cost practices there because people are doing what they are meant to do, and they are doing it very well. And I think that is sort of commensurate with the way Minnesota and Wisconsin and some other States operate.

In West Virginia, we had anticipated a 30 percent increase for primary care. I mean, we anticipated it. We were very happy about it. We were looking forward to it. We saw people getting into areas where they were not going before. And we now are going to see less than half of what was anticipated. if what currently is on track actually takes place.

And, in fact, on an overall basis, West Virginia physicians will see no change in total payments in 1992, and a 6 percent decrease in total payments by 1996.

Is that what was intended with RBRVS and our physician payment reform? Absolutely not; absolutely not!. You have indicated that most family physicians moved to the fee schedule in 1992, Dr. Graham. Why is that, and why does that disadvantage family physicians in comparison to physicians who move to the fee schedule later on?

Dr. GRAHAM. The reason why most move to the fee schedule in 1992 is most family physician fees turn out to be within that 15 percent band above or below the fee schedule; most below. And the reason why that is a disadvantage is the entire change in fees—due to the tripling effect, and budget neutrality—is applied only to the RBRVS conversion factor, and only in 1992.

So, family physicians who move to the fee schedule in 1992 feel the full brunt of that reduction in the conversion factor right away, and then permanently for the rest of the time.

If, indeed, as you have mentioned before, there was the requirement for budget neutrality in every year, then that particular problem would be alleviated for family physicians.

Senator ROCKEFELLER. In other words, budget neutrality each year?

Dr. GRAHAM. Year-by-year, that is correct.

Senator ROCKEFELLER. Which we should have done, shouldn't we have?

Dr. GRAHAM. You tried.

Senator ROCKEFELLER. Dr. Cleaveland, if I could ask you a question, sir. First of all, I want to say that your expression of continued support for physician payment reform—in spite of what is going on—is welcome.

I would like to focus on something that you raised in your written testimony, specifically the payment for EKGs and calculation of practice costs.

First, would you please elaborate on your proposal for covering the reading of routine EKGs, and what you mean by "you will ask HCFA to narrow the visit categories that should be adjusted for EKG interpretation."

Would this narrowing of codes allow for the recovery of sufficient funds to cover payment of EKG interpretation as a separate service?

Dr. CLEAVELAND. Dr. Shapiro will respond to that, Senator Rockefeller.

Dr. SHAPIRO. Senator, HCFA has tried within the constraints of the law to provide some payment for EKG interpretation. What they did was propose adding a very small increment to all visit fees in order to recognize the value of EKG interpretation. The problem is that that goes to surgical visits, visits in which an EKG is not performed, in addition to those visits performed by internists, cardiologists, and others, where the EKG is actually done.

So, its impact is certainly negligible as the increment is spread out through the entire series of visits for all specialties. What we would suggest to HCFA is that it narrow that to the visits or the specialties in which EKGs are most often performed.

Senator ROCKEFELLER. You want to add to that?

Dr. CLEAVELAND. I have nothing to add to that.

Senator ROCKEFELLER. All right. That is fine. Why is it that you think——

Dr. SHAPIRO. Senator, if I may, though, I am sorry to interrupt you. Just to add that that may be a solution within the confines of the legislation and the regulation, but it is our position—and I think all physician organizations—that the Congress must re-open this particular issue and allow payment for EKG provision, albeit at the correct relative value under the Hsaio research.

Senator ROCKEFELLER. Yes. All right. I understand. My next question is, why do you think the PPRC's recommendations for calculating direct and indirect practice costs is more appropriate, and how will that help primary care physicians?

Dr. CLEAVELAND. The calculation of overhead for primary care physicians is an extraordinarily difficult moving target. In my office, as we try to get a handle, for instance, on overhead, we have seen it move from 40 percent to 60 percent, trying to be very frugal. Overhead costs must be based on careful use of resources. This cannot be broken down geographically.

For instance, in my community we will compete against large metropolitan areas for a dwindling supply of X-ray technicians, laboratory technicians, and such.

The calculations of overhead must look far enough in the future to accommodate rapidly shifting availabilities of the very skilled paramedical people that we require to run our offices.

Senator ROCKEFELLER. I am not sure I understood that.

Dr. CLEAVELAND. Overhead requires the use of people resources, rental resources, a variety of factors in running an office that——

Senator ROCKEFELLER. I understand that. But you are saying that those costs have to be projected much farther out in terms of what they might become in order to apply them to a formula?

Dr. CLEAVELAND. That is correct, because a shortage in laboratory personnel, for instance, 3 years down the pike, would be very difficult to encompass in a year-by-year budgetary formulation of overhead that is based on resource use.

So, unless you look at where the shortages are going to be—and we see it, quite frankly, in paraprofessional people—then resource formulations become, at best, guesses.

Senator ROCKEFELLER. All right. Dr. Seward, I will come back to you, sir. But I will turn to Senator Durenberger.

Senator DURENBERGER. Gentlemen, thank you.

I want to pick up on the exchange that Dr. Graham and the Chairman had relative to the tripling effect of adjusting to the asymmetrical transition and make sure we all understand it again. This is where the folks that are going to go up do so faster than the folks that are going to come down. And we knew we were going to be lucky if we could make it and end up budget-neutral. We knew it had to be a loser or a gainer, and it ended up being a loser.

So, I said in my opening statement that one of the ways to solve this problem is to take the 2 percent and spread it across everybody, rather than putting 6 percent on one-third.

Do you have views on that solution that you want to share with us? We will begin with Dr. Graham.

Dr. GRAHAM. We agree heartily.

Senator DURENBERGER. Thank you. Dr. Seward.

Dr. SEWARD. Senator, the AMA believes that putting all of the reduction on the conversion factor is not appropriate.

The AMA is in favor of budget neutrality. A reduction on the applied adjusted historical payment basis would be more appropriate, rather than putting it all on the conversion factor.

Senator DURENBERGER. How do you do that?

Dr. SEWARD. You apply the reduction over that entire adjusted historical payment basis versus just to the conversion factor.

Senator DURENBERGER. You mean, in the calculation of the formula base, is that——

Dr. SEWARD. Yes, sir.

Senator DURENBERGER. All right. Dr. Cleaveland?

Dr. CLEAVELAND. Well, the question is somewhat moot, in that it really gets down to whether or not a behavioral offset is required. If one is——

Senator DURENBERGER. No, I am not talking about behavioral offsets. I am talking about the fact that when we decided that the procedures that were going to benefit would benefit more quickly than the procedures that would lose money, and one moves faster than the other, we would be awful lucky to come out at zero. We came out at a minus 2 percent, in effect, in dollars.

And now the question is simply should the one-third of the physicians in the first year who do not go right to where they are supposed to be, should they carry the whole load for picking that up, or should we——

Dr. CLEAVELAND. Absolutely not.

Senator DURENBERGER. Pardon me?

Dr. CLEAVELAND. Absolutely not. The adjustment should be spread across both RBRVS and the historical charge components. All physicians and all fees should be affected.

Dr. SEWARD. Senator, can I add one thing. I would ask the committee to look at whether or not the asymetry assumptions are really valid.

Senator DURENBERGER. Yes. I have tried that at the staff level, and I will continue to try that. They say, no, you cannot do it, but we will take your advice and keep working at it. But right now, AMA is not recommending that we spread it across the board?

Dr. SEWARD. Yes, we are.

Senator DURENBERGER. Oh, you are?

Dr. SEWARD. Well, on the adjusted historical payment basis, Senator.

Senator DURENBERGER. Oh, yes. All right.

Dr. SHAPIRO. I think the point is that there may be nothing to spread.

Senator DURENBERGER. I understand.

Dr. SHAPIRO.That is why Dr. Cleaveland started to say that the point may be moot. If you are not going to do a behavioral offset and you are not going to reduce spending for a transition effect, because the law does not require you to do so, in fact, the law requires the opposite; that you first calculate a budget-neutral conversion factor and then you apply the transition formula. You, in effect, have no spending to take out of the total payment levels, either of conversion factor or of historical payment basis.

Senator DURENBERGER. That is it.

Senator ROCKEFELLER. All right. Dr. Seward, just one question for you. In your written testimony, you talk about balanced billing limits, and obviously the purpose of them is to protect Medicare beneficiaries from what we, in Congress, consider excessive charges.

Now, I am committed to working out the problems with the proposed fee schedule in an administrative way, but I am willing to go to legislation if that is the only way to get at it. But it is not my intention to resolve this matter at the expense of Medicare beneficiaries by either increasing their costs, or by decreasing their access to care.

And, therefore, my question really is in two parts. First, explain how you think higher billing limits will help physicians who live in rural areas where folks just cannot pay that much in additional out-of-pocket expense? And secondly, would not higher bounds billing limits create equally real barriers to care in the case of many beneficiaries?

Dr. SEWARD. Senator, I certainly agree with your concern on this area. I think one of the things that we need to look at is that there is data to indicate that a significant percentage of physicians are not now billing at the usual and customary rate, and especially in the rural areas.

I think under the new RBRVS we will continue to see physicians concern with their patients' financial situation.

Will the physician, because of a fee increase bill at a higher level? Yes, but the assignment level remains high. This will not be a problem to those patients.

Senator ROCKEFELLER. Do you have anything more, Senator Durenberger?

Senator DURENBERGER. No.

Senator ROCKEFELLER. I think that is all I really wanted to try to get at with you all. I know you have waited a long time, and I apologize for that. But I thank you very much.

Dr. CLEAVELAND. Thank you.

Dr. SEWARD. Thank you.

Senator ROCKEFELLER. And I assume there may be other questions which will be coming to you in written form.

Our final panel consists of Dr. Richard Field, Jr., of the American College of Surgeons, and he is accompanied by Dr. Paul Ebert, Director of the American College of Surgeons out of Chicago; Dr. James M. Moorefield, Chairman of the Board of Chancellors at the American College of Radiology, from Sacramento; and Dr. Betty Stephenson, who is President of the American Society of Anesthesiology from Houston, Texas.

Dr. Stephenson, you are in the middle, so if you are ready, why do you not begin?

STATEMENT OF BETTY P. STEPHENSON, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGY, HOUSTON, TX

Dr. STEPHENSON. Thank you very much. I appreciate the opportunity to testify. I am President of the American Society of Anesthesiologists, which represents 28,000 physicians.

In common with the other medical societies, we have been shocked at the totally unanticipated level of reductions in physician fees proposed by HCFA. They appear to aggregate, for our specialty, a 50 percent cut by the time the fee schedule takes full effect.

As detailed in my written statement, we share with all of medicine extreme concern with the behavioral offset and the transition formula. We, like our colleagues in radiology and surgery, have taken cuts of 7 percent this year that were intended to be counted toward our fee schedule reductions.

Beyond these shared concerns, I would like to focus on HCFA's decision, totally without statutory foundation, to eliminate time units from the calculation of relative values for anesthesia procedures. This decision is directly at odds with OBRA 1989, which required that in establishing the fee schedule for anesthesia services, HCFA shall use, to the extent practicable, the uniform relative value guide already mandated for use by Medicare carriers.

This directive from the Congress was no accident. It was, to the contrary, the product of a very carefully developed partnership between Congress and organized anesthesiology, designed to refine the reimbursement method for our services to make it as fair and accurate as possible.

As this subcommittee is aware, Medicare has reimbursed anesthesiologists using a resource-based relative value guide since the inception of the program in 1966.

The RVG method defines base units which measure the skill, risk, and complexity of the anesthesia procedure, and time units, equally resource-based, which measure the time that the anesthesiologist delivers hands-on care to the patient. Base units plus time units, multiplied by a conversion factor determine the fee.

Mr. Chairman, the 1987 Budget Act included a provision supported by the ASA mandating that Medicare adopt a uniform relative value guide for use by its carriers. HCFA subsequently mandated that the carriers use the ASA RVG.

A critical corollary to this step was the adoption of an uncomplicated set of 250 anesthesia codes to replace the 4,200 surgical codes previously used for anesthesia reimbursement.

Inclusion of time units in the RVG has allowed for simplification of the 250 procedural descriptors. For example, the anesthesia code for lower abdominal procedures covers about 160 surgical codes.

Two years after OBRA 1987, following a study by the Inspector General, the Congress, with ASA's full cooperation and support, instituted the use of actual minutes for calculating anesthesia time, instead of HCFA's previous method of rounding up to the nearest full unit.

When OBRA 1989 directed HCFA to utilize the Medicare uniform relative value guide, it did so with the deliberate knowledge that this guide involved time units. Congress had already mandated actual time in that very same 1989 law.

Now HCFA has, with no substantive justification, proposed to eliminate the separate calculation of time units and to require the use of average time. ASA suggests that HCFA's action is not only in flat contravention to the directive from Congress, but will also lead to significant distortions.

The variations in surgical time, case mix, and case load, over which we have little or no control, point to the impossibility of fairness resulting from the averaging of time among anesthesiologists.

HCFA admits this drastic change is budget-neutral. That means winners and losers within our specialty. The losers will be those treating the sickest patients in inner city, tertiary care, and teaching hospitals.

As you have heard from Dr. Curreri, the Physician Payment Review Commission supports the retention of separate time units in the reimbursement of anesthesia services.

We urge Congress to reinforce its original budget-neutral mandate to HCFA that actual anesthesia time, as well as base relative value units, be included in the Medicare fee schedule.

As a specialty which has pioneered the use of relative values, we are distressed at the approach HCFA has taken, and the apparent undermining of OBRA 1989. If reform is to work and have the support of both patients and physicians, we need Congress to get the train back on the track.

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

Senator ROCKEFELLER. All right. Dr. Field.

STATEMENT OF RICHARD FIELD, JR., M.D., MEMBER OF THE BOARD OF REGENTS, AMERICAN COLLEGE OF SURGEONS, CENTREVILLE, MS

Dr. FIELD. Senator Rockefeller, members of the subcommittee, I am Dr. Richard Field from Centreville, Mississippi, and I am a general surgeon. I am accompanied by Dr. Paul Ebert, who is Director of the American College of Surgeons.

Now, there have been several references this morning to rural medicine, spoken, maybe, from somewhat afar. As you noted from my address, I can assure you that I come from way down deep in the pine trees of Mississippi, and I hope that what I have to say

will have some import, because I am one of those out there practicing surgery.

I might say, too, in preface to my remarks, that it is very heartening to see the real concern shown by you, Senator Rockefeller, and the other fellows on the committee. You really are concerned about the quality of care provided to our patients, and what we can do to stay out there and take care of them. I am pleased to have an opportunity to represent the American College of Surgeons on these points.

We believe it essential that the relative values that will be used for Medicare payment purposes beginning in January 1992 are as accurate as possible. In our judgment, this will require a great deal more effort between now and January 1, as we have already seen here today.

We believe that there is considerable evidence that the relative values being proposed by HCFA for many surgical procedures are flawed. For example, many vignettes developed by the Harvard study described the typical patient, not the typical elderly, Medicare patient.

The amount of care that is required by the average elderly or Medicare patient for at least some surgical procedure would be greater than the physician's time and effort that are required by the average younger, or non-Medicare patients.

If my gallbladder, or Senator Bentsen's gallbladder, is removed, we present a greater risk and a greater problem than, say, a 35 to 40-year-old white male. To the extent that the process for setting relative values does not reflect fully the resource inputs that are associated with the care of elderly Medicare patients, thus, the premise upon which the entire system is based is theoretically being violated. In addition, the College is bothered by the double-standard that is being applied to many physician services under the proposed fee schedules. The services of assistants at surgery, for example, would be paid for in a manner that is not based on a resource-based system.

Similarly, the services that are provided by newly practicing physicians—and you asked that question awhile ago—would be paid at lower amounts than other physicians, even though there is no evidence that the resource inputs for newly practicing physicians are any different from those of the other physicians. Thus, the College's position is that these new, young physicians should be paid on the same scale as those of us who are older.

The College is also bothered by the double-standard that relates to pre-operative services. Special documentation—now, listen to this—will be required by surgeons who stabilize patients prior to operations. Special documentation will be required for us to do it.

Senator ROCKEFELLER. Dr. Field, am I missing something? You are making fundamental complaints about the RBRVS system as it was brought to HCFA?

Dr. FIELD. That is right.

Senator ROCKEFELLER. Yes.

Dr. FIELD. That is right. We are making fundamental observations which we have been concerned with.

Senator ROCKEFELLER. Well, sir, I welcome those observations, but I am just suggesting it is a little bit late.

Dr. FIELD. I understand. Would Dr. Ebert want to respond to that in any way?

Dr. EBERT. Well, it is only late, I think, in the sense that you are using an RBRVS for part of the new reimbursement system, and you are not using it in other parts. And we are somewhat concerned that people will want to play the game on one table, or or one playing field, and yet, That is not the way it is being played, and we say assistants at surgery are paid in a manner that is unrelated to the RBRVS system.

I think the information that you put forth on new physicians was clearly in the old system; it had nothing to do with RBRVS. When the RBRVS came in play, it should have eliminated all that. And yet, this policy is still in the Medicare regulations as they are stated today.

Senator ROCKEFELLER. All right. Well, actually, I am not——

Dr. EBERT. So, we are complaining about the way——

Senator ROCKEFELLER. Sure. And that is entirely fair. And I withdraw my statement. Please go ahead, Doctor.

Dr. FIELD. Thank you. Special documentation would be required, as I was saying, by surgeons who stabilized patients prior to operation. However, if these patients are stabilized by other fellows on the staff—internists, for example—no special documentation would be required.

The inference is that for some reason when we stabilize our own patient—which we are perfectly capable of doing—we have to document it, which seems strange.

There are also problems with the relative values that are assigned to certain global surgical services. The resource-based relative values developed in the Harvard project did not include preoperative visits within 30 days of operation. Yet, HCFA proposes to include these visits as part of the surgical fee. We think that this is not consistent with what was written, and we think that it is wrong.

Now, this has already been spoken about so much today, I will not spend much time on it. But the College adds its voice to the chorus of strong opposition to the behavioral offset that has been proposed. Among other things that have been said, I would note that HCFA has not even given sufficient information to judge reasonably the conversion factor itself before any offsets are applied.

Now, we were the original supports of the Medicare Volume Performance Standards concept, if you remember. And the College believes that that is why it is in there, to control the volume and intensity. The College believes that the use of the surgical and nonsurgical MVPS——

Senator ROCKEFELLER. Doctor, I am just trying to be clear on that.

Dr. FIELD. Right.

Senator ROCKEFELLER. I do not remember that the College was supportive of the MVPS. Am I wrong?

Dr. FIELD. Yes, I believe you are wrong. We supported that from the beginning.

Senator ROCKEFELLER. All right.

Dr. FIELD. And we were particularly enthusiastic about——

Senator ROCKEFELLER. That is right. That is right. The familiar face behind you is nodding.

Dr. FIELD. We have been particularly interested in this, and the reason we wanted it was because it would, indeed, control volume and intensity.

Senator ROCKEFELLER. Once again, I am not going to speak at all while you finish your testimony. I will guarantee it. [Laughter.]

Dr. FIELD. That is all right. Since you are from West Virginia and I am from Mississippi, we speak similar language, I think.

Anyway, we believe that using the surgical and non-surgical MVPSs on a more timely basis is the best way to address this problem. We have talked to HCFA about providing their data every 120 days so that information can be brought to the physician community and how the data are being used; what the volume increases are; and where timely changes can be made.

We think there is inadequate evidence to support behavioral offset. I will not go any further about that, I think we have all agreed—and you all, too. We also want to remind the subcommittee that many surgical services have experienced substantial payment reductions under past budget reconciliation acts. HCFA's fee schedule impact analysis overlooks these past reductions and then projects additional reductions of as much as 35 percent. Our surgeons have already been hit hard, and then they are coming back and hitting us again.

In addition, a preliminary analysis shows that some of the proposed Medicare fee schedule amounts that were published on June 5th are lower than Medicaid payments that were made in 1989. We believe that this creates a real problem.

And speaking as a rural surgeon, our livelihood depends in the main on Medicaid and Medicare Federal reimbursement, and we are beginning to feel real problems out there.

With malpractice insurance going up, I am not sure we can stay. And if these things go down, it will create a real problem in your State, and in Senator Durenberger's. And I do not know how long surgeons can stay out there.

We think that much remains to be done, and we hope, in American College of Surgeons, that we can stand by and help you all and any other agencies involved as much as possible. Thank you very much.

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

Senator ROCKEFELLER. Thank you, Dr. Field, very much. Dr. Moorefield.

STATEMENT OF JAMES M. MOOREFIELD, M.D., CHAIRMAN OF THE BOARD OF CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY, SACRAMENTO, CA

Dr. MOOREFIELD. Thank you, Mr. Chairman. My name is James Moorefield. I am a radiologist in Sacramento, and I serve as Chairman of the Board of Chancellors of the American College of Radiology. I am pleased to present our views on the Bush Administration's proposed Medicare fee schedule for 1992.

We believe that the proposed fee schedule is a violation of the intent and spirit of physician payment reform. It ignores the fact

that radiology procedures—among others—have been subjected to reductions over the last 4 years.

These reductions were made under legislation aimed at reform of Medicare payments to physicians. For radiologists, these prior reductions amount to 18 percent, and they have been ignored.

The Physician Payment Review Commission has previously projected radiology to be over-valued by 21 percent. This was the basis of discussion on the extent of over-value in radiology in the Finance Committee report accompanying the Budget Reconciliation Bill passed by this subcommittee last year.

In that report, the subcommittee discussed the remaining overvaluedness in radiology. At that point—which was only last fall—HCFA believed radiology to be over-valued by 15 percent. The subcommittee elected to use 13 percent as a benchmark for over-value in radiology.

The 13 percent benchmark was used to begin to adjust radiology conversion factors for any of this remaining over-valuedness. Nine percent of that adjustment has taken place in 1991.

The remaining four percent, along with additional adjustments for geographic practice cost differences, was to be phased in through a transition for radiology outlined by this committee.

Even with specific language for a transition in the law, the administration has converted the radiology values in a manner that causes dramatic additional reductions.

We believe that the administration has misinterpreted the law. This misinterpretation, coupled with the ill-conceived transitional and behavioral offsets compound to a total additional reduction in radiology professional work values of 38 percent.

We, too, are concerned over the behavioral offset concept. To our knowledge, HCFA has never published data or analysis for public review and comment which justifies their contention of a 50 percent volume response to payment cuts.

All previous evidence they have given exist in circumstances that are not like the present circumstances; they were not in a fee schedule setting, but were rather in the usual, customary, and reasonable setting. And even at that, there is considerable doubt as to their validity.

In fact, Medicare actuarial data show that volume growth has been slightly slower from 1984 to the present than for the period before 1984. Obviously, from 1984 to 1991, Medicare fees have been significantly constrained. This data contradicts the volume response contention.

We have found further evidence of contradiction in the behavioral response concept. By examining 1989 HCFA data, we have evidence that reduced payments to radiologists under our fee schedule did not generate a volume increase response.

In fact, during that first year of the radiology fee schedule, the rate of increase in volume of services actually dropped. While HCFA has used its best guess in determining a behavioral response under the fee schedule, there is evidence in radiology from their own data that the behavioral response assumptions are incorrect.

Since radiology is a referral-based specialty, we are not quite certain of the broader implications of our findings to the Medicare fee schedule. However, the fact that there is concrete evidence that ra-

diology is different and that the data shows no behavioral response, focuses the need for further study.

In light of these conflicting findings regarding behavioral response, we believe that before a behavioral offset is used, there should be a formal and thorough study of the behavioral response that offers data and analysis.

This study should be subjected to scrutiny by Congress and the public before implementation. We urge the Congress to request such a study for HCFA before they are allowed to implement the behavioral offset.

In 1987, the American College of Radiology asked for the opportunity to work with Congress and HCFA to devise a fee schedule for radiology services that was fair to Medicare patients, the government, and radiologists. The Congress agreed, and we have spent the last 3 years making a fee schedule work. We have worked in concert with Congress and with HCFA. It has required a great deal of effort and sacrifice.

We agreed to work with you because we sincerely believed we could develop a payment schedule that was fair and equitable. Until June 5th, 1991, we believed we were doing just that.

We, too, appreciate the letter that this committee sent to the Secretary of HHS outlining many of the problems and difficulties, and demanding answers.

The Bush Administration's proposed fee schedule is an outrageous violation of our mutual goals. We ask for your support and assistance in putting this payment reform package back on the proper track it belongs on.

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

Senator ROCKEFELLER. Doctor, thank you. I am going to follow-up with questions, but Senator Durenberger is going to start.

Senator DURENBERGER. Mr. Chairman, thank you very much. I am going to ask each of you—as I did the previous panel—to respond to some questions on the behavioral issues. But I just premise that with a couple of observations, which is my belief. And I would like not to be right, but this is what I believe.

I believe that RBRVS, because it is an averaging process much like DRGs and other things we have been through, inherently lacks any incentives for the efficiencies that we need in medicine, and that it has built into it incentives for inappropriate use of services.

And having said that, as one of the inventors, one of the architects, let me say it has a variety of other advantages, and especially has opportunities for physicians in this country. But that is just sort of an economics observation that it is an averaging process; there is no question about that.

And, as such, you have got to really work hard to find the incentives for efficiency, and we can debate forever the issue of incentives for inappropriate use of services.

But my second belief is that volume will increase. My third is that we need to try to deal with that. The fourth is that one of the efforts ought to be across specialties, as we talked about earlier, although I recognize there are some that are at the so-called mercy of others, so to speak.

And that one of those efforts ought to be within some kind of sub-national communities of physicians. I do not know what that might be. I have suggested States, and I do not know if there is something else. But I do believe that the physicians in this country are the ones who can best get us over the big hurdle we face of the high cost of health care in this country.

I do not believe that RBRVS is the right incentive for them to do it, but by the same token, it is the only thing we have got right now. It is better than what we have had; it corrects a lot of the inequities in the system; it does rationalizing in the system, and that is why we support it so strongly.

But on the whole business of do I, or do I not believe that a bunch of doctors in America are going to respond to reductions in income by inappropriate medical services, however you identify that. I believe they are going to do it, and I believe that we need some help. If you do not like the behavioral offset that has been proposed, then we need some help in designing a better one.

One of the suggestions I laid on the table earlier is do not build it in right away, but let us do an empirical analysis of some kind that will help us do it right, for example, by the time we get to 1993, I think, when we have to do the volume performance standard.

But this is an important issue, and I think everyone here recognizes that. And so, the responses to the questions that you are going to get from the Chairman, and from the Chairman of the committee and from this Senator are really very important.

And that is that we, at least, believe there is going to be a volume effect. Some people here believe it is going to be greater than the one that HCFA is predicting; some say it is going to be less.

But there are plenty of people here that believe it is going to be greater than HCFA is predicting. So, it is really important that the medical associations help us deal with that one appropriately.

My question that I need a response to is the same I asked the others, and that is the issue of the built-in 2 percent that we need to recover in the first year across the board because this asymmetrical change just cannot come out to zero, so it happened to come out to a different figure.

One of my suggestions was that rather than hit one-third of the profession in the first year with a 6 percent decrease or cut—which then becomes a base that gets translated all the way out—that we start with a 2 percent reduction in fees across the board for all Medicare payment, and then reduce that each year out until you reach zero in the fifth year.

And I am wondering if the three associations here have a reaction to that. It looks like Dr. Field was grabbing the mike first.

Dr. FIELD. Well, I am going to ask Paul Ebert to answer that for me, if he would.

Dr. EBERT. I think that we would agree with that approach. We think it is more reasonable than the one that has been proposed so far, certainly. I think the Senate recognized, though, that any time you implement any new program it rarely saves money at the implementation. So, I think there is a cost built into it, and the question is how much that cost should be. But we would prefer it be

shared the way you described than in the way the administration has proposed. Thank you.

Senator DURENBERGER. Dr. Stephenson.

Dr. STEPHENSON. Basically, we are opposed to an approach that—we are already double-digit losers—would chop more off from us. This would be terribly unfair. But the ASA has continually worked for this system and for this reform. And I think that we would certainly take this into——

Senator DURENBERGER. Yes. Suppose for the traditional over-priced procedures—and I hate to use the word, because it is not necessarily always received well—but it is radiologists, anesthesiologists, and pathologists.

Suppose we could correct some of the problems that we all know are inherent in the 1989-1990 OBRA approaches to the over-priced procedures which has gotten your base to the point where you become big losers, and you have all testified to that, and PPRC testified to that.

Suppose we could correct that problem in some way so that you are not being penalized for the hits you have already taken. Would that make any difference to either the radiologist or the anesthesiologist as to whether or not they would support a 2 percent across the board, rather than a six percent on the one-third?

Dr. STEPHENSON. We thought the reductions that have already been done in anesthesiology reimbursement would go into count for the reduction that we knew we were going to get with RBRVS, and instead, we are appalled at what has been proposed in our fees for implementation in January of 1992.

Senator DURENBERGER. Dr. Moorefield.

Dr. MOOREFIELD. Senator, were you proposing that as an either/ or?

Senator DURENBERGER. Well, no. This is just the way we do things here after 12:00 o'clock and we try to figure out answers to some of these problems. [Laughter.]

Dr. MOOREFIELD. Well, clearly, the magnitude of the penalty we have taken by having no recognition of our previous cuts is much greater than the 2 percent.

Senator DURENBERGER. I see.

Dr. MOOREFIELD. So, clearly, that is much more of a significant problem. However, we also think that we have gone through most of our transition because we have been on a fee schedule for a longer period of time. A lot of this geographic redistribution for radiology has already taken place. And so, that being saddled with the problems of a new group of physicians just coming on the fee schedule is very much problematic to us.

Senator DURENBERGER. Maybe one thing I just heard you say then is that if everybody else is for 2 percent across the board declining, then we almost have to do something for the so-called over-priced procedures; I mean, the base off of which you are operating, because it would be unfair to hit you twice, in effect. Would that be fair?

Dr. MOOREFIELD. Well, I think that is correct.

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

Senator ROCKEFELLER. Thank you, Senator Durenberger. Let me just ask a generic question, which I probably should have put to

the panel before you, and this goes back to what Senator Durenberger brought out earlier.

In other words, that let us say 10 percent of physicians are doing what they ought to, so to speak; the 80 percent want to do what they ought to, but are not quite sure how to get there; and then 10 percent might not be. There are 500,000 physicians out there, I think, or something like that. I mean, it is an enormous number of people and a lot of specialties.

And then you have this thing called RBRVS, which sort of assumes that everybody is attuned to national cost problems and all kinds of things which may or may not be true. Then you have HCFA coming up with the feeling it is necessary to come up with a behavioral offset.

Now, I disagree with what they have done, but the question as to how is it, if there exists a precedent and empirical data—as is evidently the case over recent years—that a behavioral offset is necessary.

Then you get to the question of how, in fact, does the physician community accept responsibility for a fee schedule which is appropriate and necessary, and procedures which are appropriate and necessary, even as I understand the threat of malpractice and all the rest of it causing defensive medicine for clearly understandable reasons?

I mean, if we were not dealing with laws here, but were dealing with human nature; not with HCFA and regulations, but with human nature, how would we go about this? What would the physician community need to do in order to "get its own house under control," even as I understand there are many houses within the physician community?

Dr. FIELD. Senator Rockefeller, I might respond to that in this way. It is shocking to me that HCFA feels that something needs to be done about this behavioral response, but soberly, I must say that there will be at least 10 percent, no doubt, that will try to increase the work they are doing. I have a little trouble wondering how surgeons can possibly do that.

But the thing that has not been mentioned here that I think is real important is that the Joint Commission for Hospital Accreditation and our own credentialling committees and utilization groups in our hospitals have really gotten strict about this. I am harassed every day up and down the halls by some nurse that has got some rule that we have got to live by. And I think it is really being controlled at a local level real well, and I am not sure that we need this behavior index laid on top of us already. I think we have got enough people back home that are watching over this very carefully.

Senator ROCKEFELLER. But on the other hand, Dr. Field, it is true that the cost of health care, of which the physicians are a part, is just absolutely going out of sight, and I always have to make this point when I talk to doctors.

What we are trying to do here—at least, what Dave and I are trying to do—is to reform the system so that it maintains its present privateness, its present ability for physicians to practice in the way that they want and not to have a single payor system, and all the rest of it.

But if we cannot get this thing worked out in the next decade, or 12 years, we are going to get our heads handed to us on a silver platter in the form of national health insurance, which the Congress cannot afford to implement, but which we may be forced to implement.

In other words, to say that we are doing everything that we can and that surgeons are performing as exactly they should, probably is not a sufficient answer. Dr. Ebert.

Dr. EBERT. Well, last year we talked about our support of the MVPS, which, at that time, had a different name. We said the most important aspect was peer pressure. We have put together a proposal—we are meeting with HCFA next week—to try to look at volume. The experience with the Canadian system was put in was that operations did not increase, so there was not a behavioral offset issue.

I think it will end up being a specialty-based any changes in volume, but it has to rely on peer pressure. Dr. Field is correct that in the hospitals there are many barriers put forth that help limit unnecessary or inappropriate operations. It is much more difficult in an office-level aspect, because the patient has a great influence on that, as well as the doctor.

But I believe our ability to help will depend an awfull lot on how helpful HCFA can be in providing timely data on changes within volume of practice. Right now, as you know, there is quite a lag period. If the data can be brought down to on-line with the new common working file, then I think the profession will have a much better opportunity to look at volume changes, both geographically and nationally. Right now it is very difficult.

And as you note in our proposal, we feel that if you are going to have to make financial adjustments based on increased volume—as anticipated by many in Congress and the Senate—I think a more timely updates will be needed. Dr. Field mentioned 120 days—maybe it should be 6 months. But waiting for 2 years to analyze—that first no one is going to pay any attention to it within the physician community after that much lag time.

Senator ROCKEFELLER. Could any of the four of you—and Dr. Field, you gave me one example—but when you say that it is being handled by peer pressure, give me examples of that, how that works within the physician community.

Dr. FIELD. If I may respond to that, Paul. We have monthly meetings. We have utilization review committees in our hospital, and I am sure these other folks do, too. And it is amazing to me after having done surgery for 36 years now that the rules—and I chafe under it sometimes, and I am sure all the guys my age do—the rules have gotten so discreet and careful, and I must admit it is making us practice better medicine. Not that I was in any way dishonest, but it has made me stop and think before I do anything in the hospital. And I think if they do it in our small, 70-bed hospital in Mississippi, I am sure it is intensified in other hospitals.

Senator ROCKEFELLER. Well, what might be a question that somebody would raise, for example, that would cause you to stop and think, or whatever?

Dr. FIELD. Well, one is admissions. We have a protocol now as to when we can admit cases. I will tell you, in days gone by, that we

were prompted by administrators to keep our beds full, because that is what cost him money: an empty bed. Now, we have a protocol that we cannot admit cases unless it answers this, this, and this.

Frequently, we would say—and I will admit this—that if they wanted to keep grandmother in the hospital an extra couple of days because they were going mountain climbing, I would say, ten years ago, well, okay. But now, I would not consider that, because I know the utilization committee would be down on me in a second. And I am sure the rest of these people——

Senator ROCKEFELLER. Is that within your particular hospital? Is this within the county, or the State?

Dr. FIELD. Oh, this was in my particular hospital. But I think it is prevalent throughout the country today. I think they are very careful about this.

Dr. STEPHENSON. That is part of the PRO system.

Senator ROCKEFELLER. Right.

Dr. STEPHENSON. I would just like to make a comment about volume for anesthesiologists. We have very little opportunity to increase volume. We respond by taking care of——

Senator ROCKEFELLER. No, I understand. Right.

Dr. STEPHENSON.—Dr. Field when he schedules a patient.

Senator ROCKEFELLER. Somebody else schedules something first.

Dr. STEPHENSON. That is right.

Senator ROCKEFELLER. Right.

Dr. STEPHENSON. The only thing that we have where we could control volume or costs, for instance, is with our practice standards. We have said that this is a standard that you will use a pulse oximeter. But we also have stated—and it is in the relative value guide—that this is part of the base unit for the fee. There will not be an extra charge for using or interpreting that information.

Senator ROCKEFELLER. Dr. Moorefield.

Dr. MOOREFIELD. I would just like to say that all of medicine is groping with this now in terms of trying to establish guidelines for appropriate practice. The AMA is leading a task force inviting all specialty societies to do this.

However, guidelines are missing a couple of elements that play a role here. We are talking about volume because volume means money. The only reason volume would go up if it is to go up is because of money.

Professional societies have no control over that incentive as a direct incentive, so some measure has to be taken to control some of the perverse financial incentives that are out there, such as some of the self-referral issues that radiology has been very concerned about, where physicians can ratchet up services by, as an example, in an out-patient setting, as Dr. Ebert alluded to, either by patient demand or by volition on the part of the physician. He can decide that more people need to have procedures done to them: chest X-rays, or more laboratory work, et cetera.

Since the professional societies can decry that, that it takes place outside their control without any regulatory, without any financial control; unless some steps are taken in that direction, you still have some problem among a small percent.

I think everybody is recognizing that, whether it is 10 percent, or whatever.

It is not the body en masse in physicians that do this. But where people are bent on doing that, they will do it for the financial incentive, and that has to be attacked. And we do not have control over that. It sounds like a cop-out, but you can only appeal to those type of people so much by professional ethics and peer review.

Senator ROCKEFELLER. All right. I have questions for each of you which I will send to you, but it is after 1:00 o'clock, and you have been more than patient. It is amazing how important this subject is, and it is amazing how little people generally understand about it. And I am really in a sense heartened by the sense of the response by HCFA—I think that HCFA is guided unwillingly on this issue.

I mean, I really think that Gail Wilensky wants to do the right thing. I know she wants to do the right thing, but she has got OMB, which is a higher force. And I think that you all being here this morning, the various panels being here, is really important.

And the fact that the American Medical Association and others are organizing to make sure that Congressmen and Senators who may not understand this precisely, that you are really eating into not only the purpose of physician payment reform, but eating into proper health care in rural areas, and inner city areas, and in general.

And potentially affecting quality of care, so that your concern is entirely valid. Our concern is entirely real. And what we have just got to do is find a way to put this back together again so that it works.

Thank you very much. This hearing is adjourned.

[Whereupon, the hearing was adjourned at 1:20 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE

Thank you Mr. Chairman. I commend you for convening today's hearing on the implementation of physician payment reform. When Congress enacted the resource-based relative value scale for reimbursement of physician services under Medicare, we envisioned that the system would more appropriately reimburse physicians for the services they rendered Medicare patients.

We felt that physicians were reimbursed inadequately for some services, while for others they were reimbursed at levels which were too generous. In addition, our system of reimbursement did not, in all cases, encourage physicians to provide the most appropriate treatment. By eliminating these adverse incentives we hoped to encourage the highest quality and most appropriate care while reimbursing physicians services at a level which more accurately reflected the actual value of the services they provided.

When this new resource-based payment system was enacted, Congress intended that it be budget neutral. Under the proposed regulations, however, a reduction as much as sixteen percent is expected over the previous method of reimbursement. I am concerned about this and hope that Dr. Wilensky and Dr. Sullivan will work with us to correct this and other potential problems related to implementation.

I would also like to address some specific concerns about the impact of physician payment reform regulations on Rhode Island physicians. For years, Rhode Island physicians have been reimbursed at a level that is well below not only the nationwide average, but also neighboring states such as Connecticut and Massachusetts. This has occurred in spite of the fact that practice costs are comparable. It is therefore imperative that calculations be made on the most current available data.

In addition, Rhode Island's small size and the mobility of patients cause our physicians to compete with providers in southern Massachusetts and eastern Connecticut who are often reimbursed by Medicare at a significantly higher rate. I therefore have concerns about treating Rhode Island as a separate locality under the new fee schedule.

I look forward to hearing today's testimony, and am hopeful that we will be able to work out problems with the proposed regulations prior to implementation. Thank you Mr. Chairman.

PREPARED STATEMENT OF CLIFTON R. CLEAVELAND

THE RBRVS-BASED MEDICARE FEE SCHEDULE

The American College of Physicians appreciates this opportunity to present the views of internists and subspecialists in internal medicine on the critical question of physician payment reform. I am Dr. Clifton R. Cleaveland, an internist in private practice in Chattanooga, Tennessee. I am a member of the Health and Public Policy Committee of the College. Accompanying me is Howard B. Shapiro, PhD, Director of Public Policy.

Mr. Chairman, we've got to work together—all of us—HCFA, the Congress, and the physician community—to make the Medicare Fee Schedule work. We have come too far to let it slip from our grasp at the point of implementation. Enactment of the Resource-based Relative Value Scale (RBRVS) was the result of collaborative work, which the College continuously supported, over a period of several years. We all cooperated and compromised in 1989 to achieve a balanced package of reforms.

You and members of this Committee were leaders in that effort, and we thank you again for your efforts. The College and, we think, all of the medical community, remains committed to the full and fair implementation of that legislation. We want to work with you and with HCFA to realize its promise.

In many areas, HCFA has done a good job in developing a complex regulation, with the able support of Dr. Hsiao and his team at Harvard and of the Physician Payment Review Commission, under the strong guidance of Dr. Lee and Dr. Ginsburg. We congratulate Dr. Wilensky and her staff. With the exception of three issues, albeit critical ones, addressed in our statement today, our differences with the proposals in the regulation are relatively small. We will respond to HCFA on those issues during the comment period.

What we find in examining the proposed regulation is that the RBRVS narrowly defmed—that is, as a relative re-valuation of physician work—operated as we expected it to. You were not wrong in passing the payment reform legislation. That is, undervalued evaluation and management (E/M) services rise in relative value, overvalued procedures fall, and the wide geographic variation tied to historical charges is flattened out. Analysis of the proposed regulation supports this conclusion, as follows:

—relative to changes for other specialties, payments per service for internal medicine grow by 16% by 1996, compared to the national average;
—the ratios of payments for E/M services compared to many procedures decrease significantly when compared to current payment differentials;
—projections show that internal medicine as a whole would gain 15% without the proposed reduction in the conversion factor; and
—most payments across geographic areas vary by no more than 10% from the national average, and virtually all are within 20%.

What is so frustrating to our members is to see many of these gains essentially wiped out by budget-related calculations and interpretations of the legislation. HCFA estimates that the fee schedule, as proposed, will result in a zero gain for internal medicine in 1992, and a cut of 3% in payments per service by 1996. Our members are angry that what had been promised as a long-awaited recognition of the value of their services as thoughtful clinicians who spend time with their patients, looks like it will turn out to be little more than a budget-cutting exercise.

Make no mistake that this will produce a cynicism that will have very real, deleterious effects on the Medicare program over time. Medicare may begin to look more like Medicaid in the eyes of the practitioner—a third-rate program that provides inadequate care for the population it is supposed to serve.

Most physicians will continue to take care of their Medicare patients, given their professional duty and personal commitments to these individuals. Nonetheless, access to care is a serious concern. Substantial problems may appear with the next generation of care-givers in five or ten years. Medical students are not selecting careers in internal medicine. In the current year, only 57 percent of first-year internal medicine residency slots were filled by graduates of U.S. medical schools. Those numbers have decreased for five consecutive years, and similar experience is reported by family practice and pediatrics.

The College has viewed the RBRVS-based fee schedule as one component of a strategy to attract physicians to the specialty that provides the largest portion of care for Medicare patients. Absent reasonable payment levels, and in light of other trends in medical care, the success of those efforts is very much in question. For this reason, correction of the deficiencies in the HCFA proposed regulation is an urgent matter affecting patient care.

Mr. Chairman, we are not questioning anyone's motives, or blaming anyone. We believe that all parties are disturbed that the gains of RBRVS are negated by the calculations of the conversion factor. Accordingly, we need to sit down together and craft a solution, be it legislative, regulatory, or a combination of both. The remainder of our statement outlines those areas which need to be fixed.

THE ASYMMETRICAL TRANSITION

Congress explicitly recognized the need for primary care services to reap the benefits of RBRVS reform promptly. Thus, you decided to move primary care services towards the full fee schedule amount quickly, and created a transition rule to do so. The same provision also has the effect of cushioning the reduction in payments to services above the fee schedule amounts. The effect is a net cost in 1992, although no net cost across the full transition period.

We do not believe that the benefits which Congress intended to give primary care with the transition provision, it intended to take away with the requirement for

budget neutrality in 1992. Although this direction is not explicit, language in section 1848(a)(2)(A) would appear to express the intent that the transition provision not be included in the budget neutrality calculation (specifically, the language "without regard to this paragraph"). We urge the Committee to state its intent to HCFA that the transition language be allowed to have its intended effect. Absent a change in HCFA's implementation of budget neutrality, we urge the Committee to amend the law to mandate that the budget neutrality calculation not include the projected net cost of the transition provision.

We believe that this change is essential to achieve one of the central goals of payment reform: setting appropriate payments for evaluation and management services. The change would restore a 2% cut in fees or, with the tripling utilized by HCFA, it would restore a 6% cut in the conversion factor.

THE TRIPLING EFFECT OF THE CONVERSION FACTOR

It is not at all clear to us that the law requires that budget neutrality adjustments be applied to the conversion factor alone. There is no explicit direction to do so, and only an interpretation of ambiguous language in section 1848(d)(1)(B) can be used to justify this approach. Because RBRVS amounts apply only to about a third of total payments in 1992, HCFA's interpretation requires a tripling of any adjustments for budget neutrality when calculating the conversion factor. Thus HCFA's proposed 2% adjustment for the asymmetrical transition and 3.3% adjustment for projected increases in volume (more about that later!) become, respectively, 6% and 10.5% cuts, for a whopping 16.5% cut in the conversion factor.

It makes sense to us that any adjustments for budget neutrality be made across both components of the physician fee in 1992--the RBRVS fee schedule component and the historical charge component. This would spread the correction equitably across all fees and all physicians. Budget neutrality is a comparison of total payments in 1991 under historical charges to total payments under a blended system. To make a correction for any difference utilizing the smaller component of the blended payment has little logic to it. We will urge HCFA to eliminate the tripling effect by correction for budget neutrality across the total payment. Again, we hope that Congress will take this position with HCFA and, if necessary, amend the law.

BEHAVIORAL OFFSET

Physicians, as everyone else, respond to financial incentives. Indeed, the premise of the RBRVS is that setting appropriate payment levels will lead to a more balanced practice of medicine. This augments primary care, and results in more appropriate care and fewer unnecessary services. This embodies the clear benefit of the RBRVS to patients. We wanted to pay the physician for time spent with patients in the hope that physicians would do just that. Conversely, we did not want to drive physicians to overutilize procedures because the time and resources used for those procedures were disproportionately compensated.

We have four objections to the way in which HCFA proposes to reduce fees to take into account anticipated increases in volume under the fee schedule—the so-called behavioral offset. First, as pointed out by PPRC in its 1991 Report, there are no conclusive studies that show a relationship between fee cuts and volume increases. In fact, we were struck by 1984-88 data presented by PPRC in its recent report to Congress on the Medicare Volume Performance Standard and fee update. The data showed that during that period of Medicare fee freezes and reductions, growth in volume remained essentially flat.

Second, we strongly object to HCFA's refusal to anticipate possible *reductions* in volume in response to increases in fees. Both PPRC and the Congressional Budget Office adjust their calculations on this side of the equation, so that the net offset they endorse is more modest. HCFA should do the same.

In this regard, we would note that never before have changes of the complexity of the Medicare fee schedule been undertaken. Thus, even the stronger studies have to be in part discounted. Not only are there fee increases at the same time there are reductions—and, of course, both shifts occurring in most practices—there are also major changes in coding of services, balance billing, beneficiary out-of-pocket costs, and so on. All of this prompts us to question seriously the very conservative assumptions that HCFA used in its calculation of the behavioral offset.

Third, we object to an approach which lumps all physicians together and penalizes all regardless of their record of utilization of services. (For the same reason, we objected to the MVPS.) In this regard, many have suggested that physicians will in particular increase evaluation and management services, because it is easy to schedule a patient for additional visits. But it is the E/M services which would receive

increases under the RBRVS, so the incentive to offset cuts is not operative. Also, data from PPRC show the volume of these services to have increased very little over the last number of years.

Finally, we have to ask how much of the volume problem stems not from an increase in services, but an increase in billings that occurs from disaggregating elements of care and billing for each item separately. This practice of so-called unbundling should be investigated by HCFA and plans laid to stop this gaming of the system.

Given inconclusive support for the theory of the behavioral offset, particularly in light of the complex changes initiated by the fee schedule, we will oppose any fee reduction to correct for anticipated changes in utilization. We urge the Committee to take the same position.

OTHER ISSUES: EKGS, PRACTICE COSTS, CODING REFORM

We will mention briefly three other issues of substantial concern. We continue to object strongly to the mandated elimination of payment for a unique professional service—the physician's interpretation of an EKG. The statement implied in doing so—that Congress does not value this skill—remains deeply troubling to physicians in and of itself, and as a precedent for other services.

We believe that Congress should repeal this provision of the 1990 Reconciliation Act. In the proposed regulation, HCFA has made a small adjustment to all visit fees, but this is inadequate and spread far too thinly across all visits. We will propose some narrowing of the visit categories that should be adjusted for EKG interpretation. But the correct solution is to recognize interpretation as a separate service with its own relative value, as is supported by the Harvard research.

The treatment of practice costs is an anachronism in the payment reform legislation. Rather than measuring resources used, consistent with the RBRVS, practice costs are tied to historical charges. The PPRC has done excellent work in this area, and proposed a direct accounting of practice costs by site of service. Further work remains to be done to develop the data, but we urge Congress to amend the law at the first opportunity to mandate a resource-based approach to measuring practice costs.

Coding reform is a major element of implementing the fee schedule for E/M services. We have supported the use of new codes that would take into account the content of services, complexity of the case, and the typical time involved. Both PPRC and AMA's CPT Editorial Panel have contributed significantly to development of a new system that HCFA appears prepared to accept, but has not yet endorsed. We have some concerns about how HCFA will crosswalk from old codes to new codes—an important issue—and we will address those in our regulatory response.

CONCLUSION

Mr. Chairman, we would prefer a regulatory solution to these problems. Perhaps with the help of Congress in clarifying the intent of the law, we can convince HCFA and the Administration to revise the proposed regulations as necessary.

We recognize that there is no great desire to legislate on this or other elements of Medicare this year, and it is unlikely that there will be a reconciliation bill. We also recognize that if the Committee attempts to make some of these changes, it runs into the straightjacket of the pay-as-you-go provisions of the 1990 budget agreement.

Nonetheless, we all have a stake in the success of the RBRVS. The College believes that the entire payment reform package enacted in 1989 can promote fundamental changes in the practice of medicine in very desirable ways. It is not hyperbole to say that the importance of RBRVS reform goes well beyond Medicare and will play a central role in any significant improvement in our health care system. Given that premise, it is incumbent on all of us to find solutions to the problems we have outlined. We are willing to work with this Subcommittee to identify those solutions.

The point is, if we all give first priority to the realization of the promise of RBRVS in 1992, then we can work together to remove obstacles to crafting the solutions that we need. The American College of Physicians is committed to doing so.

Mr. Chairman, thank you for holding this hearing and considering our views.

Attachment.

AMERICAN COLLEGE OF PHYSICIANS,
Washington, DC, September 4, 1991.

Hon. LLOYD BENTSEN, *Chairman,*
Senate Committee on Finance,

205 Dirksen Senate Office Building,
Washington, DC.

Dear Mr. Chairman: This responds to your question submitted to Dr. Clifton Cleaveland, of the American College of Physicians, in a letter dated August 2, 1991. Your question was a follow-up to the hearing held on July 19 on HCFA's proposed Medicare fee schedule for physician payment.

The concept of budget neutrality appears in Section 1848(d)(1)(B) of the legislation. In that section, budget neutrality applies *only* to the calculation of the conversion factor, which must be set so that spending under the fee schedule is at the same level as 1991 spending under current payment rules.

This calculation of the budget neutral conversion factor and fee schedule amounts is separate from the calculation of actual payment levels, as follows. Once the fee schedule amounts are calculated, the Secretary is directed to compare those amounts to the adjusted historical payment basis, and apply the special transition rule in Section 1848(a)(2)(A). That rule determines actual payment levels for services for which the adjusted historical payment basis is less than or greater than 15 percent of the fee schedule amounts calculated—on a budget neutral basis—without regard to the paragraphs in section 1848(a)(2)(A). Because of the clear distinction between the two sections, and the absence of a budget neutrality mandate for the transition rule calculations, we conclude that payments are allowed to rise to cover the net cost of the transition formula.

Thank you again for inviting the American College of Physicians to testify at this hearing. We appreciate your efforts on this issue, and look forward to working together towards a successful outcome.

Sincerely,

HOWARD B. SHAPIRO, PHD, *Director of Public Policy.*

PREPARED STATEMENT OF P. WILLIAM CURRERI

Mr. Chairman, I appreciate the opportunity to testily this morning on behalf of the Physician Payment Review Commission concerning implementation of the Medicare Fee Schedule. The Commission reviewed the Health Care Financing Administration's (HCFA) Notice of Proposed Rulemaking (NPRM) at its June meeting.

Some of the issues that I will bring before you today may appear technical or arcane. But the level of the conversion factor, the accuracy and validity of the scale of relative work, the definition of payment areas, and other such concerns have major implications for physicians in different specialties and geographic areas and for beneficiary access to care. Because Congress enacted this legislation with the support of the affected parties, it now has a responsibility to ensure that implementation is consistent with its intent.

My testimony will focus primarily on the conversion factor and the scale of relative work. The Commission also has concerns related to practice expense, geographic payment areas, visit coding, and payment for anesthesia, electrocardiograms and to new physicians that I will mention briefly. The Commission expressed its views on several other issues, such as payment to nonphysician practitioners and assistants-at-surgery in its March report.[1] I have attached a more detailed summary of the Commission's views that I will submit for the record. The Commission plans to submit a report to Congress in response to the NPRM later this month.

CONVERSION FACTOR

The Secretary has proposed implementing physician payment reform in a manner that would reduce fee levels by at least 16 percent by 1996 and, perhaps, considerably more. Coming on the heels of substantial fee reductions directed by budget reconciliation legislation in recent years, the proposed conversion factor could pose serious risks to beneficiary access. Medicare fee levels would be below Medicaid rates in many states.

Five issues are involved in the level of the conversion factor:

• the mechanism by which budget neutrality is achieved under an asymmetric transition to the fee schedule;

[1] In comments to the Congress on the President's Budget for fiscal year 1992 (dated June 24), the Commission discusses the proposal for payment for injectable drugs.

- the assumption concerning how physicians will respond to changes in Medicare payments;
- the assumption concerning physician billing for visits under a new set of codes;
- the assumption concerning how often physicians will bill less than the fee schedule amount;
- inappropriate "trimming", of baseline data files by HCFA.

Asymmetrical Transition

Under the transition specified in OBRA89, fees for undervalued services will increase more rapidly than fees for overvalued services will decline. The net impact of this asymmetry in 1992 is a 2 percent increase in total outlays. To achieve budget neutrality, this 2 percent must be recovered.

This adjustment is complicated by two factors. First, HCFA has interpreted the statute as specifying that any such adjustments be made on that portion of payment based on the fee schedule as opposed to that based on historical rates. In other words, the adjustment must be made entirely on the conversion factor. Second, only about one-third of services will be paid at the fee schedule amount in 1992.[2] This means that in order to reduce outlays by 2 percent, the conversion factor actually has to be reduced by 6 percent. While this adjustment achieves budget neutrality in 1992, it actually lowers payments in the out years as the fee schedule conversion factor plays a larger role in payment. That is, when the asymmetry reverses in later years, the reduction in the conversion factor is not reversed. As a result, the conversion factor will be substantially lower by 1996 than it would have been if the fee schedule had been implemented in one step.

Some have questioned whether HCFA has correctly interpreted the transition and budget neutrality provisions of OBRA89. In any case, however, the Commission believes that a 6 percent budget reduction from the method of transition to the fee schedule was not intended by those who came together to agree on physician payment reform and is not sound policy. It recommends that the method of achieving budget neutrality be revised so that adjusting for the asymmetric transition achieves budget neutrality in each year of the transition.

The Commission has discussed several methods to attain this objective. For example, the adjustment for budget neutrality could be applied to the adjusted historical payment base rather than to the conversion factor. A reduction of 3 percent in the base for all services for which the historical base is more than 15 percent higher or lower than the fee schedule would offset the asymmetry without distorting the conversion factor. The Congress could consider a larger reduction for highly overvalued services than for highly undervalued services or an exemption of undervalued primary care services, especially those provided in rural areas. Alternatively, the 2 percent reduction could be applied to all services in 1992, with provision for phasing this reduction out as the transition progresses.

Behavioral Offset

The Secretary has proposed reducing the conversion factor by 10.5 percent to offset changes in physician behavior in response to fee changes. This figure assumes that 50 percent of fee reductions will be offset by increases in volume and changes in billing practices but that none of the fee increases will be offset. Due to the leveraging effect mentioned earlier, projection of a net volume increase in excess of 3 percent results in a 10.5 percent reduction in the conversion factor.

The Commission believes that this offset is far too large and advises that a 1 percent reduction in fees is more appropriate. In a situation of great uncertainty concerning behavioral response, the Secretary has made a worst-case assumption. In a sense, physicians are being slapped on the hand for misbehaving before they have had a chance to show how they will behave. Such an extreme assumption is particularly unwise when the Medicare Volume Performance Standard (VPS) mechanism is available to offset in the future any differences between actual and projected behavior. If the Congress feels that the VPS default mechanisms cannot fully address such differences, its might consider revising aspects of the default rules (for example, the maximum reduction from the Medicare Economic Index), at least for the update for 1994.

The Commission is also concerned about the impact of leveraging that triples the magnitude of the adjustment to offset changes in behavior. It recommends that the adjustment be applied to payments for all services rather than just to the conversion factor.

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[2] For services that are more than 15 percent higher or lower than the fee schedule, conversion factor adjustments affect payment slightly.

With the opportunities for correction that are available, the decision on the behavioral offset assumption is really one of whether physicians or taxpayers should bear the risk of induced changes in physician behavior. I see the Commission's recommendation as a compromise in which both parties share this risk.

New Visit Codes

HCFA's budget neutrality calculations required a projection of the proportion of evaluation and management services that will be billed under each of the newly revised visit and consultation codes (often referred to as "the crosswalk"). Since these services will comprise more than 35 percent of Medicare outlays under resource-based fees, the assumptions on which these projections are based can have a large impact on the conversion factor. Regrettably, HCFA had little data to guide it.

To demonstrate the sensitivity of the conversion factor to this assumption, the Commission simulated an alternative series of assumptions. Basing the assumption on data from various log-diary surveys of physicians results in 13 percent lower projected outlays for visits (and thus a conversion factor 5 percent higher) than predicted by HCFA. This result is suggestive of a high degree of uncertainty in projecting billing patterns for new codes.

The Congress may want to create a process to adjust future conversion factors based on actual billing experience. In contrast to some other assumptions, these projections are relatively easy to verify because physicians' billing patterns for visits have been relatively stable over time. The Congress could direct HCFA to revise the conversion factor in the future if the pattern of visits differs appreciably from the projection.

Bills Lower than Fee Schedule Amounts

Currently, a significant minority of claims are billed for amounts less than prevailing charge screens. While the additional information available to physicians on the level of Medicare fees may reduce the frequency with which physicians bill less than the fee screen, it is unlikely to eliminate these instances. HCFA assumes, however, that under the fee schedule, all bills will be for the fee schedule amount or more. This unrealistic assumption leads to the conversion factor being set too low. As in the case of visit projections, the Congress could direct HCFA to revise the conversion factor in the future to reflect differences between projected and actual experience.

Numerous other assumptions were necessary to calculate the conversion factor (or in some cases, relative values) but are not elaborated in the NPRM. These include, for example, the savings generated by no longer paying additional amounts for after-hours service or unusual travel. We are requesting that HCFA provide supporting information so that we may evaluate these assumptions.

PREPARATION OF BASELINE DATA FILES

In order to calculate the budget neutral conversion factor, one must calculate an average allowed charge for each service in each locality. To prepare the claims data for this calculation, HCFA removed all average allowed charges for that were more than two standard deviations above or below the mean for the service. Since the distributions of average allowed charges are skewed, this resulted in elimination of more high charges than low charges. Most analysts see little reason to trim aggregated data in this way. This inappropriate procedure appears to have reduced the conversion factor by almost 2 percent.

Many other assumptions and techniques for calculating the conversion factor are not revealed in the NPRM. HCFA has an obligation to the Congress and the public to provide a more complete accounting of its methods.

RELATIVE WORK VALUES UNDER THE MEDICARE FEE SCHEDULE

Although much of the initial attention on the NPRM has focused on the conversion factor, distortions in the scale of relative work also threaten the success of physician payment reform.

The medical community generally has accepted the payment reform, even with decreases in relative payments for many services. There was an expectation by all parties, however, that payment would be based on an accurate scale of relative work. We now find ourselves in the position of being six months away from implementation of the Medicare Fee Schedule with many of the values for physician services not accurately reflecting the work involved in providing them.

The Commission has just completed an evaluation of the proposed scale of relative work. In addition to assessing the methodology of the Hsiao study and comparing its results with other relevant research, the Commission sought and received comments

from numerous specialty societies and convened a panel of physicians representing 41 specialties to review outstanding issues and methods for resolving them. This meeting was extremely helpful in assisting the Commission to develop timely approaches for refining relative work values for the Medicare Fee Schedule.

Last month, the Commission heard testimony from organizations representing clinicians and beneficiaries. In addition to strong criticism of the way the conversion factor was calculated, many expressed concerns about distortions in relative work values. These distortions affect relative work values for a broad range of services (particularly invasive and evaluation and management services) and are readily apparent to practicing physicians. Unless they are corrected, physicians will face inappropriate financial incentives and be paid inequitably. We have to be concerned that such an outcome could undermine physician acceptance of payment reform.

Fortunately, the problems underlying the scale of relative work are amenable to solution. In the Commission's July report on the NPRM, we will include recommendations for specific refinements in payment policies, codes, and relative work values. I would like to take this opportunity to highlight the reasons these refinements are needed and the types of problems they address.

Invasive Services. Invasive services are paid in one of two ways: as surgical global services or as nonglobal procedures. The important difference between the two is that a surgical global fee includes payment for most services provided within several months of the operation that are related to the underlying condition for which surgery is performed, while a nonglobal procedure fee covers only those services directly related to the performance of the procedure itself. For nonglobal procedures, physicians are allowed to bill separately for services related to management of the underlying condition.

In order to assure equitable payment under the Medicare Fee Schedule, HCFA must establish a clear policy that specifies which invasive services should be categorized as global and which should be nonglobal. The NPRM does not include such a policy.

Invasive services must be categorized properly, both to set equitable payment rates and to ensure consistency and clarity in billing. Payment will be inequitable if services that are usually performed on patients with substantially different underlying conditions are categorized as surgical global services rather than as nonglobal procedures. In such cases, the work included in the global fee can vary considerably, yet the payment is fixed. For example, the NPRM treats needle biopsy of the lung as a surgical global service. Thus, a physician who performs this procedure on an unstable patient with AIDS and expends considerable work managing his or her underlying disease for the following 90 days (including possible hospitalization and complex treatment) will receive the same payment as a physician who performs a needle biopsy on a patient with a benign, asymptomatic lung nodule who requires no further treatment. If these types of invasive services were classified as nonglobal procedures rather than as surgical global services, payment could more accurately reflect the work involved.

In the fee schedule, closely related services should be categorized similarly. Otherwise, physicians will have difficulty interpreting relative work values and will be confused about appropriate billing. For example, in the NPRM a burr hole for evacuating a hematoma is categorized as a surgical global service while a burr hole for implanting a ventricular catheter is a nonglobal procedure. The four-fold difference in relative work values for these services results from their differing classifications, but it appears irrational if one is not cognizant of the differences in the services included in each fee.

Relative work values for invasive services included in the NPRM also require further refinement but because HCFA did not define the components of its global and nonglobal payment policies in time for Professor Hsiao to use them in assigning work values to invasive services. HCFA has defined these policies in the NPRM (specifying what services before, during and after the procedure will be included in the payment), but the Hsiao work values included in the NPRM are not necessarily consistent with these policies. Because of this problem, all nonglobal procedures (other than endoscopies) are substantially undervalued in the NPRM. The relative work values for these services reflect only the work involved in performing the procedure itself, whereas the payment is intended to cover all services directly related to the procedure that are performed within 30 days.

Evaluation and Management Services. The relative work values for evaluation and management services in the NPRM result in a pattern of payments that does not account for differences in the effort (work per unit of time) involved in providing different types of visits. This implies, for example, that the same effort is involved in performing a consultation on a patient the physician has never seen

before and in a routine office visit with an established patient. Such a fee structure intuitively does not seem accurate to physicians. Moreover, it undervalues shorter visits, resulting in underpayment of both surgeons and family physicians. Family physicians, in particular, are questioning how a reform that was to place greater value on evaluation and management services could result in decreases in payments for lower level visits. The Commission is also concerned that the payment structure included in the NPRM could create incentives for upcoding and inappropriate use of services.

The Commission has concluded that available empirical data on relative work values for evaluation and management services cannot by themselves provide an adequate basis for payment under the Medicare Fee Schedule. Separate studies by Professor Hsiao and the Commission each provide results that lack face validity. Nonetheless, they suggest the form of a reasonable policy. Because of the importance of getting the values right for EM services—which will account for over 35 percent of physician expenditures under the Medicare Fee Schedule and will affect those physicians slated to benefit most from payment reform—HCFA should place a high priority on taking the additional steps to design an appropriate fee structure before the fee schedule is implemented. Additional research is not required. In its July report on the NPRM, the Commission will specify the elements of a policy that would result in appropriate payments for these services.

Medicare Adjuster. Considerably more work is involved in providing certain services to elderly or disabled patients than to patients in the general population. For example, the global service for removal of an ovarian cyst entails twice as many postoperative hospital visits, on average, for an elderly Medicare patient than for a 25 year-old patient (the "typical" patient described in the Hsiao study). Because of these differences, refinements will be required to tailor the Hsiao study scale of relative work to the Medicare population. The Commission recommends that a Medicare adjuster be developed that would increase the relative work value for the services to which it is applied by a fixed percentage. This adjuster would be applied to services in which: (1) the typical patient is not a Medicare patient; and (2) substantially more work is required to provide the service to a Medicare patient than to the typical patient.

The problems I have described thus far affect broad categories of services. Some of the other inaccuracies in relative work values that appear in the NPRM come from problems specific to individual services.

Vignettes and Fitness-to-Rate. The Commission has identified a number of services whose relative work values are inaccurate because they are based on vignettes (clinical scenarios) from the Hsiao study that are not representative of the typical service provided under a given procedure code. Others are inaccurate because they are based on estimates of work by physicians who rarely, if ever, perform the service. These problems are not uncommon, affecting as many as 10 percent of the services provided by some specialties.

CPT Codes. Refinements in the scale of relative work will require not only changes in work values, but also changes in some of the codes that are used to describe physician services. Under the Medicare Fee Schedule, payment will no longer vary to accommodate regional and specialty differences in the use of codes. Thus, CPT codes that are ambiguous or that encompass a broad range of services entailing substantially different amounts of work will need to be revised if they are to provide a sound basis for equitable payment.[3]

Fortunately, the problems underlying the scale of relative work are amenable to solution. The lack of clear payment policies and limitations of the coding system precluded the assignment of accurate RWVs to many services. HCFA could resolve these problems by developing and refining payment policies, by adjusting RWVs in the NPRM to make them consistent with these policies, and by establishing clear policy goals to ensure that coding refinements are adopted that meet the needs of the new payment system.

Distortions in RWVs due to methodologic problems in Phases I and II of the Hsiao study may be corrected in Phase III. This is uncertain, however, because the protocols the researchers are using have not been made available for review and the small-group process approach has not yet been evaluated or shown to be sound.

Many distortions in RWVs can be corrected without further research. Much could be accomplished by properly structured panels of experts (including clinicians,

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[3] For example, the code for excision of a supratentorial brain tumor encompasses operations lasting from two to ten hours. But all physicians who use this code do not provide the same mix of services. Some physicians only use the code to bill for operations only at the low or high end of the range of work.

payers, beneficiaries, and health services researchers) that are provided with available data. Face validity could be assured if, as a final step, physicians in each specialty were given the opportunity to review the reasonableness of relative work values assigned to their services and to suggest refinements in a budget neutral process designed to minimize any potential for gaming.

A number of the refinements in the scale of relative work could be ready in time for initial implementation of the fee schedule. Modifications made after publication of the final rule should be incorporated into the scale of relative work by January 1993. Decisions about methods to be used to update relative work values should not be made until more is known about what approach works best in refinement. The NPRM describes several alternative processes for revising relative work values. Even more important than who does the updating is how it is done. HCFA will need to develop a clear policy on the methods to be used in updating work values.

OTHER ISSUES

The Notice of Proposed Rulemaking outlines the direction HCFA will be taking on other important policy issues such as practice expense, geographic payment areas, visit coding, anesthesia payment issues, payment for electrocardiograms and to new physicians. The Commission commented on most of these issues in its most recent annual report and I will touch on them only briefly here. I will also submit for the record the Commission's views on other fee schedule issues. The Commission recognizes that, in some cases, its preferred policy would require legislation and such alternatives were appropriately not addressed in the NPRM. We raise these issues here, however, to highlight future directions for reform.

Practice Expense

OBRA89 specifies that the practice expense component of the relative value scale be based on an estimate of 1991 national average allowed charges. But for some services, 1991 charges already reflect the implementation of policies to alter fees in the direction of the resource-based fee schedule. The result is relative values that will be systematically too low for overvalued procedures, radiology, anesthesiology, and pathology services.[4] The solution is either to use data on charges from an earlier year or to have an explicit adjustment for these earlier reductions in charges.

In the NPRM, HCFA proposed a site-of-service differential that reduces payment by 50 percent of the practice expense component when a service is provided outside the office setting. While the Commission is supportive of HCFA's efforts to apply a resource-based approach to its determination of practice costs, this proposal ignores the substantial variation in direct costs across services. The Commission has estimated that while the mean differential is 61 percent, the differential ranges from 8 to 97 percent. Until HCFA is prepared to apply service-specific differentials (or differentials specific to categories of services), a smaller differential would be more appropriate. The Commission also believes that the differential should be applied by both increasing payment for services provided in the office and decreasing payment for services provided in other settings.

Geographic Payment Areas

The NPRM makes clear HCFA's intention to maintain the current payment localities under the Medicare Fee Schedule, with the exception of the creation of statewide areas for Oklahoma and Nebraska. In its 1991 report, the Commission recommended using statewide payment areas in all states except the 15 with the highest degree of within-state variation in input prices.[5] This would result in 94 payment areas in the continental United States compared with 237 current localities.

The Commission recommends this policy because it captures input price variation across counties as well as current payment localities, but does so with far fewer boundaries. It avoids large payment differentials at state borders by allowing intrastate variation in states with the highest price variation. Moreover, unlike the cur-

[4] As an example, consider a service with a $100 average allowed (and prevailing) charge in 1988 that is provided by a specialty with a practice cost percentage of 50 percent. This service was judged to be overvalued by 30 percent in Phase I of Hsiao (assuming no changes from Phases II or III). Under OBRA89, the prevailing charge was reduced to $90 in 1990. It was further reduced by OBRA to $80 in 1991. Under the fee schedule, the payment will be $70. But using 1991 charge data for the base leads to a lower fee. Instead of a $50 practice cost component, it gets a $40 component, so that it is paid $60 under the fee schedule.

[5] In each of these 15 states, up to five payment areas would be created by metropolitan statistical area (MSA) categories: more than 3 million; 1 to 3 million; 250,000 to 1 million; fewer than 250,000; and nonmetropolitan. The 29 MSAs that cross state borders will be considered to fall entirely within the state that includes the largest percentage of the MSA's total population.

rent locality boundaries, the recommended areas do not divide counties. This and the smaller number of areas substantially ease the development of accurate data to measure the Geographic Adjustment Factor. Because it is based on familiar geographic units, it also has the advantage of conceptual and administrative simplicity.'

Coding for Evaluation and Management Services

Although the changes in the codes physicians use to report evaluation and management services are clearly needed, the Commission cannot endorse the revised visit coding system that HCFA has proposed in the NPRM. In the Commission's view, the complexity of this system might send mixed messages to physicians, compromising the goals of coding reform. The results of HCFA's pilot study have not alleviated these concerns. The data do not suggest that the new system will be used more uniformly than the current visit codes.

The assumptions made by HCFA concerning use of the new codes suggest that it does not believe that physicians will use them according to the typical times in the levels of service. This suggests either that HCFA projects substantial upcoding or that the content descriptor and the typical time in each code are not congruent. If either is true, the relative work values assigned to the new codes (which are based on the relationship between work and time) will not be accurate or equitable.

Anesthesia Payment Issues

HCFA has proposed eliminating the use of anesthesia time units. This reflects the agency's concern that start and end times for anesthesia services are difficult to determine and that payment for actual time is inconsistent with the way Medicare pays other physicians.

In its 1991 report, the Commission recommended continuing the use of actual time after finding other alternatives, including that described in the NPRM, either inequitable or not operational. Development of a better operational definition of anesthesia time and more rigorous procedures to validate time would best address criticisms of current policy.

Payment for Electrocardiograms

Under OBRA'90, Medicare will no longer pay for interpretation of electrocardiograms when performed in conjunction with a physician visit. To implement this provision in 1992, HCFA has proposed increasing payments for some visits to compensate physicians for the work involved in interpretation. Since most EKGs are done by a few specialties, this approach would be inequitable. A bundling method that is more consistent with the principles of a resource-based fee schedule is needed. The Commission plans to examine alternative methods of bundling EKG, laboratory, and procedural services with visits to determine whether a satisfactory method can be derived.

While equitable methods for bundling are being developed and assessed, the Congress should modify OBRA'90 and pay for EKGs separately from visits at the final resource-based price for both the professional and technical components. To avoid reducing payments for other services by paying for all EKGs (albeit at a lower price), the transition to final fee schedule values should be accelerated for procedures that are substantially overvalued and which have not already been reduced through the overvalued procedure provisions of OBRA'89 and OBRA'90. To address overutilization of EKGs, HCFA should foster development of practice guidelines for the test and should profile physicians' practice patterns and provide educational feedback.

Payment to New Physicians

Under the Medicare Fee Schedule, new physicians will continue to be paid less than their colleagues already in practice. The Commission has long stood by the principle that physicians should be paid the same when providing the same service. Provisions that pay new physicians a discounted fee clearly violate this principle and the Commission has consistently opposed their adoption.

Attachments.

PHYSICIAN PAYMENT REVIEW COMMISSION ADDITIONAL COMMENTS ON IMPLEMENTATION OF THE MEDICARE FEE SCHEDULE

The Commission commented on many of the issues raised in the Notice of Proposed Rulemaking in its 1991 Annual Report to Confess. A summary of the Commission's views is provided here and relevant chapters of the 1991 Report are noted.

Payment Policy for Surgical Global Services and Nonglobal Procedures (Chapter 2)

The surgical global service policy proposed by HCFA in the NPRM is broader than that proposed by the Commission. It has a longer preoperative timeframe (30 days) and, unlike the Commission's policy, includes surgical services related to complications which do not require return trips to the operating room.

The latter provision may compromise access to care for seriously ill patients. Many complications are not under the surgeon's control, but are due to the patient's underlying problem(s). Thus, the work involved in providing services related to complications should be accounted for in the surgical global fee.

The Commission recommends that HCFA not include these services in the surgical global service. If it does so, equitable payment will require the development of a "complications modifier," which would increase payment for all operations to which it is applied by a fixed percentage.

The Commission supports the intent of the nonglobal procedure policy proposed in the NPRM—all pre/post services directly related to the procedure are included in the procedure fee, but physicians can bill for services related to management of the underlying condition separately. The Commission is concerned, however, that HCFA would implement this policy by denying payment for all visits provided within 30 days of the procedure unless a documented, separately identifiable service is furnished.

Most visits provided 15 to 30 days after a procedure are related to management of the underlying condition rather than to the procedure itself. Therefore, a policy that requires physicians to submit additional documentation to be paid for visits in this timeframe would be unnecessarily burdensome (if physicians provide the necessary documentation) or inequitable (if they decide it is too much of a "hassle" to submit the documentation or if they submit it but payment is denied). Moreover, it could discourage physicians from providing visits that are important for medical care. The Commission recommends that HCFA's policy be revised so that the timeframe is 15 days rather than 30 days.

Practice Expense (Chapter 3)

While HCFA has proposed practice expense relative values based on historical charges as specified in OBRA'89, the Commission continues to support basing the practice expense component of the relative value scale on estimates of resources. It has developed and tested the feasibility of a resource-based method and will refine it based on additional analysis and discussion with interested parties.

The method tested by the Commission divides practice expenses into two categories, direct and indirect, as does common accounting practice. Direct costs are those that are clearly identified with the delivery of a service, such as the time a nurse spends assisting the physician during an intermediate office visit or the medical supplies used in setting a fracture. Indirect costs, such as rent, utilities, and management costs, are those that cannot be traced directly to any particular service. Data from national surveys of physicians have been used to split practice expenses into direct and indirect shares.

The Commission will issue a report later this year that includes a more detailed discussion of the methodology used, the data collected, and simulations of changes in the pattern of Medicare payment. It expects the report to stimulate discussion on the limitations of the OBRA'89 method and on refinement and elaboration of the resource-based approach.

Malpractice Expense (Chapter 4)

As with practice expense, the OBRA'89 method of calculating the malpractice expense component of the relative value scale is not resource-based and has several deficiencies that lead the Commission to call for its revision. Under the OBRA'89 method, payment for a given service will be the fraction of the 1991 national average allowed charge that corresponds to the fraction of physician revenue used to pay for liability insurance.

Since the same malpractice expense fraction is used for every service provided by physicians in a given specialty, the OBRA'89 method does not differentiate among services that expose physicians to different levels of risk. Moreover, averaging across specialties will result in systematic underpayment to physicians who perform high-risk procedures.

The Commission supports basing the malpractice expense component of the relative value scale on estimates of the risk of service (ROS). It has developed and tested the feasibility of such a method and will refine it based on discussion with interested parties.

The ROS method bases payments on differences in the service's risk and the overall premium confronting the average physician. As a result, relatively more premium dollars are assigned to higher risk services than to lower risk services. The additional premium dollars paid by physicians in higher risk classes would be spread over the higher risk services they provide—the same services that place these physicians in higher risk classes.

The ROS method would reduce the payment distortions that will occur under the OBRA89 method. It is also easier to update, an important advantage since malpractice premiums often change substantially.

Paying Nonphysician Practitioners Under the Medicare Fee Schedule (Chapter 10)

Under current law, payment for most services provided by nonphysician practitioners (NPPs) is limited to a percentage of what physicians are paid for the service. Under the proposed rules, these percentage differentials will continue. The Commission also recommended continuing the present policy of differential payment. The differentials should, however, be based on estimates of differences in the resource costs required to provide the service. Separate differentials should be calculated for each category of NPP.

For the work component, the differential should reflect differences in investments in human capital: tuition expense and foregone earnings. For example, the work component for physician assistants would be valued at 87 or 75 percent of the physician level, depending, respectively, on whether the high rates of return that physicians receive on their training are applied to NPP training as well or whether rates of return that other professionals with postgraduate training receive are applied.

The Commission recommends no differentials for practice expense since it is assumed that NPPs and physicians face similar rent, supply, and personnel costs when providing a given service. The differential for the malpractice component should reflect premium differences.

HCFA has proposed that modifiers to CPT codes be used to identify services provided by NPPs billing independently. It is the Commission's view, however, that specialty-specific modifiers should be used to identify all services provided by NPPs.

The Commission also has concerns about HCFA's intention to continue payment at the physician rate for services provided by nonphysicians under the "incident to" provision. The Commission has recommended that when physicians bill for evaluation and management services provided by NPP employees, these services should be paid at the NPP, rather than the physician, level.

Finally, the NPRM notes HCFA's intention to pay nurse practitioners and physician assistants at the lower of the specified fee schedule percentage or the reasonable charge as determined under the customary, prevailing and reasonable methodology. This system will be burdensome to carriers and difficult for practitioners and beneficiaries to understand. The Commission therefore recommends that payment be based solely on the fee schedule percentage.

Payment to the Anesthesia Care Team (Chapter 11)

HCFA has noted problems with the phase-in of a provision of OBRA90 that was intended to raise payment to nonmedically directed certified registered nurse anesthetists (CRNAs) to the physician rate by 1996. Because the law specified specific dollar amounts for the CRNA conversion factors and the overall conversion factor is now lower than anticipated, current law will result in higher payments to CRNAs than to physicians. It also will result in distorted relative payments between nonmedically directed and medically directed CRNAs. The Commission recommended changes that would mitigate these distortions in its 1991 report.

The Commission is pleased to note that HCFA intends to change the current policy that creates a disincentive for anesthesiologists to supervise CRNAs. The new policy establishes a consistent medical direction payment policy regardless of whether the anesthesiologist supervises a resident or a CRNA.

Payment to Assistants-at-Surgery (Chapter 12)

Under OBRA90, the Medicare payment to physicians who serve as assistants-at-surgery was reduced from the traditional 20 percent of the principal surgeon's payment to 16 percent. Results from Phase II of the Hsiao study, however, suggest that the 16 percent rate is lower than estimates of the resource costs. When combined with the recent and anticipated reductions in payments for surgical procedures, the 16 percent rule may make it difficult for surgeons to recruit assistants.

The Commission recommends basing payments to assistants-at-surgery on resource costs. Until resource-based relative values are developed for more procedures, it would be appropriate to return payments to assistants-at-surgery for all procedures to 20 percent of the surgical payment under the Medicare Fee Schedule.

RESPONSES OF DR. WILLIAM CURRERI TO QUESTIONS SUBMITTED BY SENATOR BENTSEN

Question. Dr. Curreri, can you tell me a little about the manner in which the Commission arrived at its recommendation regarding the so-called behavioraloffset—the considerations that were involved in your deliberations?

Answer. The Commission began its deliberations by reviewing the available evidence on the relationship between Medicare fees and the volume of Medicare services.

The Commission's first conclusion was that there is not much good evidence available on the linkage from fees to volume in the Medicare program. Only a handful of studies, published or unpublished, have dealt with the linkage from fees to volume of service in the Medicare program

There is little evidence on this subject largely because there have been few opportunities to study it. Until very recently. Medicare fee reductions were nearly uniform across all services When all fees fall at the same rate, there is no easy way to contrast areas with large fee cuts to areas without such cuts to see how volume responds to those cuts Evidence on the impact of large fee increases is similarly difficult to obtain.

On balance, the evidence suggested that there is likely to be some increase in volume as fees are cut. This is based on a handful of studies of the effects of fee freezes. the effects of the restructuring of Colorado payment areas in the 1970s, and the impact of the OBRA87 overvalued procedure fee cuts during 1988. The volume impact of a fee increase was addressed by only one study by CB0 based on Colorado data, so it is difficult to draw any particular conclusion there.

The Commission's second conclusion was that even if the historical record were clear there still would be no way to obtain an accurate prediction of what will happen in 1992. The situation in 1992 will be very different from what we have seen in the past, with much larger fee changes and with widespread and substantial fee increases in some areas

In assessing this literature, the Commission decided that a volume increase was more likely than a volume decrease, but that given the huge uncertainty, assuming a net impact of one percent was most prudent. Some members of the Commission took comfort from the fact that simulation of the recent CBO analysis of the Colorado experience suggest the same offset. The Commission also looked at the volume offset issue in terms of who bears the short-run financial risks during the transition to the fee schedule. In the long run, the Congress can establish fee updates that will offset whatever volume growth occurs However, in the first years of the transition, either physicians or the taxpayer will be put at risk for an incorrect forecast of volume growth If no volume offset is built into the payment rates but volume growth turns out to be substantial the taxpayer loses. Conversely, if a large volume offset is built into the rates but this volume growth fails to materialize, physicians lose.

From this perspective, the Commission concluded that a small volume offset was a reasonable way to share the financial risks between physicians and taxpayers.

Question. Did you have a preference as to whether this issue should be addressed legislatively or through the normal regulatory process—and did you assume that there would be any budgetary costs?

Answer. The Commission does not have a position on whether regulatory or legislative approaches would be a better means of addressing the shortcomings in the proposed rules. Concerning the budget impacts, the Commission was informed by its staff that the budgetary implications were not dear. It focused its attention on what is the best policy independent of the budgetary implications.

Question. In your testimony, you have indicated that the Commission sees the level of behavioral offset as an issue of who bears the risk of a miscalculation—physicians or the Federal Government.

Given that so many changes will be occurring simultaneously in 1992, will it ever be possible for Congress to judge whether actual behavior conforms to the projections? Has the Commission given any thought to how we can sort the various factors out and ensure that there is some accountability?

Answer. The short answer to this question is that there is no easy way to get an estimate of the actual 1992 volume response. However, statistical analysis of the data after 1992 can probably provide a fairly narrow range of estimates for the actual 1992 volume response.

It is clear that one cannot just look at the aggregate or average volume growth number for 1992 and know what the volume response was. Volume growth fluctuates quite a bit from year to year. Typically, volume of services per beneficiary has grown between 6 and 7 percent per year. However, during the 1980s there was one

year with almost no volume growth and one year with almost 10 percent volume growth. With variation like that, simply comparing 1992 volume growth to the recent trends may provide & very poor estimate of the actual volume response that was caused by the changes in fees.

However, the volume response may be estimated by looking beyond the average volume growth. The 1992 fee changes are not across-the-board; their impact differs across areas, specialties, and individual physicians. A reasonable estimate of the volume offset can be obtained by contrasting volume growth in areas with different changes in fees. (Chapter 6 of the Commission's 1991 Report to Congress used this approach to analyze the impact of the OBRA87 overvalued procedure fee cuts.) Recent HCFA research has shown that individual physicians may be identified in historical Medicare data, and with sufficient resources HCFA could perform such an analysis basal on the volume of services provided by individual physicians.

As in any statistical analysis, there will always be some uncertainty about the results. This probably will lead, at best, to some narrow range of estimates for the true 1992 volume response. At the least, however, if there is a very large volume response this analysis should indicate that.

Question. Dr. Curreri, in your testimony, you identify a number of different legislative options for lessening or eliminating the transition problem. Do you have any idea whether they would have budgetary costs under current budget scoring rules?

Answer. The Commission and its staff do not have the necessary expertise in budget scoring to answer this question adequately.

RESPONSES OF DR. WILLIAM CURRERI TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question. Can you please discuss further your concern regarding the preparation of the baseline data and the effect the trimming of the ends of the distribution had on calculating the base and the conversion factor.

Answer. The NPRM made a significant number of technical assumptions in determining the "baseline" level for the conversion factor, that is, the conversion factor prior to the application of the transition rules. These assumptions are discussed fully in the Commission's Report to Congress on the Notice of Proposed Rule Making. (No. 91-6, August 1, 1991)

Briefly, HCFA must make a number of assumptions in developing its baseline (or pre-transition) conversion factor. In effect, HCFA must make the historical Medicare charge and volume data comparable to the Medicare Fee Schedule. The preparation of this historical data, and the adjustment of that data to reflect changes in the payment rules between 1991 and 1992 may both affect the level of the initial conversion factor.

It is impossible to say what the "correct" assumptions should be for many of the issues involved in the calculation of the baseline conversion factor. Consequently, the Commission has relatively few specific recommendations on these issues. In general, however, the Commission emphasizes the need for HCFA to provide more information about methods and assumptions used in its calculations. Some of the specific issues are noted below.

Recent conversations with HCFA staff have confirmed that the Part B Medicare Annual Data (BMAD) files used to calculate the NPRM conversion factor were subject to some statistical edits before use. In particular, HCFA staff "trimmed" the data, removing records on which the average charge for a procedure was more than two standard deviations above or less than two standard deviations below the national mean.

Commission staff have estimated that this data-editing technique may have resulted in changes in the baseline conversion factor relative to the original unedited data. While the approach used by HCFA is a standard technique often used to remove obviously erroneous data, in this case, it has the disadvantage of disproportionately removing high-charge records due to the skewed shape of the distribution of charges, thereby reducing the average charge per service.

In the NPRM, HCFA was careful to compare the BMAD data against other data sources and suggested that extracts from the Common Working File will be used in the calculation of the actual 1992 conversion factor. This may make such data trimming unnecessary. Should similar data validity checks be used, however, HCFA should be urged to adopt an alternative approach, such as comparing charges on billing records to maximum charges in the prevailing charge file.

The crosswalk from old to new visit codes is another major area of concern in the baseline conversion factor. HCFA's budget neutrality calculations required a projection of the proportion of evaluation and management (EM) services that will be

billed under each of the newly revised visit and consultation codes. To demonstrate the sensitivity of the conversion factor to this assumption, the Commission conducted a simulation with an alternative assumption based on data from various logdiary surveys of physicians. This simulation projected outlays for visits 13 percent lower (and thus a conversion factor 5 percent higher) than predicted by HCFA. This result is suggestive of a high degree of uncertainty in projecting billing patterns for new codes.

A similar issue arises in the redefinition of the surgical global service package. Many surgical services bundle pre- and post-surgical care by the surgeon with payment for the surgery itself. Currently, the amount of care that is bundled into the payment varies across carriers. Current payment levels therefore presumably reflect the greater or smaller number of post-surgical visits included in the surgical global package by the various carriers. In 1992, however, the surgical global service definition will be standardized across carriers. To the extent that the new uniform HCFA policy will differ from the average of the old carrier policies in this area, payment rates will need to be adjusted to maintain budget neutrality.

A different issue is raised by bills paid at the billed charge. In setting the baseline conversion factor, HCFA appears to have assumed that physicians will never bill less than the fee schedule amount. To the extent that bills are paid at less than the fee schedule, the conversion factor could be increased and still maintain budget neutrality. Thus, HCFA has made the most pessimistic assumption regarding billing under the fee schedule, resulting in the lowest possible baseline conversion factor.

There are many other instances of bills that will be paid below the full fee schedule. These include payments to non-participating physicians (who are paid 5 percent below the fee schedule amount), and payments to new physicians (who are paid between 5 and 20 percent below the fee schedule amount). All such instances must be recognized in an accurate calculation of the fee schedule conversion factor, and HCFA should provide sufficient information to allow their calculations in this area to be reviewed.

A final issue arises for bills with payment modifiers. For example, bilateral hip replacement (both left and right hip joints) is paid substantially more than surgery for a single hip joint. Current payment rates for these modified services reflect individual carrier policy. In 1992, however, payments will reflect standard HCFA policy. Thus, adjustments may be required to make the historical data match the payment differentials that will exist under the fee schedule. As with surgical global services, the issue here is the comparison between what currently is done, on average across carriers, and what will be done under the fee schedule. To the extent that HCFA's national policy on payment modifiers is more stringent than the average of current carrier policies, the conversion factor should be increased to maintain budget neutrality.

Question. PPRC's concerns regarding the calculation of the values for physicians services is very disturbing, since the entire basis for proposing physician payment reform was to move to a system that paid physicians based on the work put into a service. Although you find many remaining problems, I take it that you are optimistic that enough time remains to make substantial improvements in the methodology before the fee schedule goes into effect. Please elaborate on both the problem and how the distortions can be corrected.

Answer. As you noted, the Commission has found that many of the relative work values (RWVs) for included in the Notice of Proposed Rulemaking (NPRM) do not accurately reflect the work involved in providing them. Luckily, the problems underlying the scale of relative work are amenable to solution. HCFA could resolve some by developing and refining payment policies, adjusting RWVs to reflect these policies, and establishing policy goals to ensure that codes meet the needs of the new payment system. Distortions due to methodologic problems in Phases I and II of the Hsiao study may be corrected in Phase II. We cannot yet assess this, however, because the research protocols are not available and the small-group approach has not yet been evaluated.

The Commission also believes that further research is not needed. Much could be accomplished quickly by panels with broad representation of experts (clinicians, payers, beneficiaries, and researchers) that are provided with available data. Face validity could be assured if physicians in each specialty review relative work values assigned to their services and can suggest refinements in a budget-neutral process designed to minimize any potential for gaming. Many of these refinements could be ready by January 1992. Refinements made after the final rule is published should be incorporated in the scale of relative work in January 1993.

INVASIVE SERVICES

Many of the RWVs for invasive services appear inaccurate and inequitable. To a large extent, this occurred because HCFA policy decisions affecting assignment of work values have not been made or were not made in time to be used by Dr. Hsiao. The Commission has identified three types of problems. First, some invasive services are not categorized properly. Second, other services were assigned RWVs that do not reflect all their components. Third, work values may also be distorted because problems in Phases I and II of the Hsiao study have not been resolved.

Categorization of Invasive Services

Invasive services are divided into two categories—surgical global services and nonglobal procedures—that are paid in different ways. Surgical global fees include payment for most services provided within several months of the operation related to the underlying condition for which surgery is performed. By contrast, nonglobal procedure fees cover only services directly related to the procedure itself; physicians may bill separately for management of the underlying condition.

HCFA does not have a clear policy for categorizing services and did not propose one in the NPRM. Thus, closely related services are not necessarily categorized in the same way. Large differences in RWVs for closely related services can simply result from their differing classifications

Lacking a classification scheme, it is difficult to assign equitable values to invasive services. In the NPRM, services that are usually performed on patients with substantially different underlying conditions are sometimes categorized as surgical global services rather than as nonglobal procedures. In such cases, the work included in the global fee can vary considerably even though the payment will be fixed. If these types of services were classified as nonglobal procedures, payment could more accurately reflect the work involved. To resolve these problems, HCFA should develop a consistent categorization policy with input from all affected parties (practitioners, payers, patients, and researchers). This policy should be made available for comment before it is adopted.

Refining RWVs for Invasive Services to Improve Consistency with Payment Policies

HCFA has specified the components included in fees for surgical global services and nonglobal procedures. But since these policies were not developed in time for use in the Hsaio study, RWVs in the NPRM do not necessarily reflect all the component services included in each type of fee.

Surgical Global Services. Relative work values for surgical global services in the NPRM are based on the Hsiao study and reflect the services included in the Commission's global service policy. The NPRM global service policy, however, has a longer preoperative timeframe (30 days) and, unlike the Commission's policy, includes surgical services related to complications that do not require return trips to the operating room. The two policies also differ in payment adjustments for multiple staged bilateral surgery.

Preoperative Visits. Certain operations may routinely involve more extensive preoperative services than included in the global policy. The Commission recommends that HCFA ask specialty societies to identify these operations so that appropriate adjustments can be made.

Complications. Although HCFA's proposed surgical global service policy includes procedures related to complications, this work is not currently reflected in the published RWVs. The Commission recommends that HCFA allow surgeons to submit separate bills for such services. Otherwise, RWVs will have to be modified to reflect the work involved in managing complications, or a complications modifier could be developed to increase payment by a fixed percentage.

Multiple Surgery. The Commission supports the concept of adjusting global fees for multiple operations as proposed in the NPRM. But it is concerned that the proposed method may overstate the resource cost savings that result when multiple operations are performed or when postoperative care is provided concurrently. More work is needed to calibrate such a modifier equitably. Unique payment policies may be needed for special surgeries such as trauma, transplant, and burn surgery.

Nonglobal Procedures. Currently, all nonglobal procedures other than endoscopies are undervalued in the NPRM. This is because the Hsiao team assigned RWVs to nonglobal procedures other than endoscopies that reflect only the work involved in performing the procedure itself; it was assumed that physicians would bill for pre/post services related to these procedures separately as a visit. But HCFA's pro-

posed nonglobal procedure policy includes all pre/post services directly related to the procedure performed the day of the procedure and for 30 days thereafter. Because of these differences, refinements will be required to account for the pre/post services associated with these nonglobal procedures. Using a panel of physicians, estimates of pre/post work could be developed for a representative sample of procedures and then extrapolated to all nonglobal procedures.

Refining RWVs for Global Services to Reflect Intraservice and Pre/Post Work

At the completion of Phase II, the Commission expressed concern that RWVs for surgical global services did not account for all pre- and postincisional work involved in performing certain operations and did not accurately reflect the pre/post time and intensity of perioperative visits included in surgical global fees. Hsiao has informed the Commission that Phase III is attempting to address these issues.

Pre- and Postincisional Operating Room Work. The principal surgeon typically performs a substantial amount of pre-and postincisional work for certain operations, such as patient positioning prior to an operation. This work was apparently not included in either Phase I or Phase II RWVs

Abt Associates Inc. resurveyed cardiovascular and thoracic surgery, in part, to address this issue. While the Abt study has demonstrated that this is a serious issue, estimating pre- and postincisional work remains difficult. The Abt study appears to overestimate the intensity of this work and the Abt researchers are currently working on refinements Refinements are also being made by Hsiao in Phase III. The Commission anticipates that these efforts will result in improved RWVs. If further work is needed, HCFA could ask specialty societies for additional assistance.

Correcting Estimates of Pre/Post Time and Intensity for Perioperative Visits. Earlier Commission analyses showed that Phase II estimates of time involved in providing pre- and postoperative visits were 14 percent higher, on average, than those in the Commission's global service project, and 23 percent higher, on average, than those in the Abt survey The Commission understands that pre/post times in Phase III are lower than those in Phase II and agree more closely with data in the Commission's study

Pre post work values assigned to surgical global services depend not only on the time involved in providing perioperative visits but also on their intensity (work per unit of time) The Commission's analysis suggests that intensities assigned to perioperative visits in the Hsiao study may need to be adjusted upward. This is because RWVs in the Hsiao study appear to understate the intensity of shorter visits and do not reflect differences in intensity between different classes of visits

REFINEMENTS TO CORRECT PROBLEMS SPECIFIC TO INDIVIDUAL SERVICES

Refinements are also needed to correct RWVs for specific services Some RWVs in the NPRM are inaccurate because they reflect unrepresentative vignettes or work estimates by physicians who rarely perform the service In other cases, codes that are ambiguous or that encompass a broad range of work precluded assignment of accurate RWVs

Problems Related to Vignettes and Fitness-to-Rate

Phases I and II of the Hsiao study used vignettes to describe the typical service that physicians would bill under each code At the completion of Phase II, the Commission expressed concern about some of these vignettes that were either unrepresentative of the code's typical service or ambiguous. This may have introduced bias and measurement error into the estimate of work. Fitness-to-rate (whether the physicians who estimated work for a given service actually perform it) may also be a problem for individual services. While this is not a general problem, for particular specialties and services, the impact could be substantial. For example, intraservice work values for 11 percent of orthopedic surgery vignettes would change by more than 10 percent.

The Hsiao study provides only limited data for substantiating or correcting such problems. While codes with suspected problems may be resurveyed in Phase III, the small group process may not be suited to resolution of these issues. Other approaches, such as having specialty societies propose budget-neutral refinements, should be explored.

Problems Related to CPT Codes for Non-EM Services

Refinements in RWVs will also require changes in some of codes used to describe physician services. The Commission has identified three types of coding problems. First, some codes encompass a broad range of services entailing substantially different amounts of work, and not all physicians who use these codes provide the same

mix of services. Some use them to bill for services that are only at the low or high end of the range of work. The second problem concerns closely related codes. In cases where the distinctions between these codes are ambiguous, different physicians use different codes to bill for the same service and the range of work of adjacent codes is overlapping. Finally, some commonly performed services do not have CPT codes. Physicians use less than optimal combinations of codes for billing and differ in the mu: of codes chosen.

Coding changes to address these problems most likely cannot be made before the fee schedule is implemented. Coding refinements can be integrated into the process of updating the relative value scale. As codes are refined, it will be important to ensure that they meet the needs of the new payment system. HCFA should establish clear policy goals that provide a framework for coding decisions. The Commission recommends that these goals be developed with input from all parties using codes and that they be reflected in HCFA's contract with CPT.

Question. Can you explain further how the current, somewhat flawed, relative work values for evaluation and management services result in the undervaluing of "short" visits and how does this distortion affect primary care physicians?

Answer. The RWVs for evaluation and management (EM) services in the NPRM undervalue short visits because the relationship between work and time used to assign values to these services does not account for differences in effort (work per unit of time) between different types of visits. This implies, for example, that a consultation on a patient the physician has never seen before involves the same effort as a routine office visit with an established patient.

Such a fee structure will result in underpayment to family physicians and to surgeons whose short perioperative visits are reflected in surgical global fees. It could also create incentives for upcoding and inappropriate use of services. Moreover, it is not supported by survey data and is inconsistent with physicians' perceptions of clinical practice.

Empirical data on the relationship between total work and encounter time for visits of different durations is conflicting. Data from the Commission's Visit Survey and the Commission's analysis of individual physician responses from the Hsiao study suggest that total work per unit of encounter time *decreases* as visits become longer. By contrast, mean responses from the Hsiao study, which formed the basis for the Phase II RWVs, indicate that total work per unit of encounter time *increases* as visits become longer. Finally, Phase III RWVs describe a relationship in which total work per unit of encounter time *does not vary* according to visit duration.

Neither the relationship in the NPRM nor that from the Visit Survey provides an appropriate fee structure for visits. The relationship in the NPRM undervalues shorter visits while that in the Visit Survey undervalues longer ones. Following the advice from physicians on its interspecialty panel, the Commission recommends that the fee structure for EM services incorporate three elements:

- The pattern of work for visits of different durations should be revised so that total work per unit of encounter time decreases to a limited extent as visits become longer
- The pattern of work across classes of visits should be revised so that total work per unit of encounter time is greater for new patient visits than established patient visits, for initial hospital visits than subsequent hospital visits, and for consultations than for nonconsultative visits.
- EM payment should be increased by a fixed percentage (through a special modifier) for visits with patients who have communication barriers, disabling cognitive or physical impairment, or an unusual need for counseling or coordination of care.

These three elements are designed to take advantage of the beneficial effects of a downsloping relationship between work and time while mitigating its potential negative consequences. A gentle downward slope (for example, if total work per unit of encounter tune were 10-15 percent lower for a 60-minute visit than for a 5-minute visit) would increase current NPRM RWVs for shorter visits and provide incentives for more appropriate utilization of EM services. Recognizing differences in effort across classes and incorporating a modifier for visits with patients with special characteristics and needs would prevent underpayment of physicians who care for patients who require longer visits.

Distortions in the pattern of work for EM services are compounded by the revised codes proposed in the NPRM. This new coding system will make it difficult to assign accurate and equitable RWVs to visits. The complexity of the system may also send mixed messages to physicians. Results from HCFA's pilot study have not alleviated these concerns. Moreover, the data do not suggest that the new system will be used more uniformly than current visit codes.

HCFA's projection of how the new codes will be used suggests that physicians will not use them according to the typical times in the levels of service. HCFA either assumes that substantial upcoding will occur or that the content descriptor and the typical time in each code are not congruent. If either is true, many physicians will receive inappropriate EM payment.

Because EM codes are so important in assigning RWVs and calculating the conversion factor, and due to the tremendous uncertainty about how these codes will be used, it might be advisable for HCFA to delay implementation of EM coding reform for one or two years. During that period, HCFA's proposed visit codes could be simplified and refined to ensure that time and content are congruent for each level of service. A pilot test could be conducted correlating the use of refined codes to current codes and to the actual duration of visits. These data could be used to assess whether the new coding system would be used more uniformly by physicians and to project the crosswalk from current codes to new codes with confidence.

If coding reform were delayed, interim RWVs could be assigned to current CPT codes using Phase II of the Hsiao study—assigning a time to each level of service and basing the RWV on the relationship between work and time for the class of the visit. No adjustments to the 1992 conversion factor would be necessary because billing patterns for visits under current CPT codes have been relatively stable.

Question. Do you have any estimate of the amount of additional work involved in caring for a Medicare patient or the magnitude of the "Medicare Adjuster" you propose to compensate for differences in the patient population used in Dr. Hsiao's study and the typical Medicare beneficiary?

Answer. The relative work values (RWVs) assigned to services in the Medicare Fee Schedule reflect the relative amount of work involved in providing a service to the typical patient who receives it. Vignettes developed by Hsiao and his colleagues included patients of a variety of ages as typical patients. The Medicare Fee Schedule, however, will apply to a selected population: patients who are 65 years of age or older and patients who are eligible for Medicare on the basis of disability. The Commission believes that, for certain services, the RWVs developed by Hsiao will need to be refined before they can be used as the basis for Medicare payment.

The purpose of a Medicare adjuster would be to increase the RWV, and thus the payment, for services that consistently entail more work when they are provided to Medicare patients. Services for which Medicare patients are the typical patient would not be adjusted because the RWVs developed by Hsiao ostensibly account for the care provided to these patients. The Commission believes that a Medicare adjuster would be needed primarily for invasive services (surgery and procedures). It would probably not be needed for services such a interpretation of laboratory tests or imaging studies. Addition of a special patient characteristic/needs modifier to a new coding system for visit and consultation services would help to ensure equitable payment for services provided to Medicare patients. The Commission supports including a modifier that could achieve this objective in the revised coding system. The Health Care Financing Administration's (HCFA) proposed rules, however, do not include such a modifier.

The Commission recommends that a Medicare adjuster be developed to increase the RWV by a fixed percentage for services to which it is applied. While the Commission is not prepared to make recommendations concerning which services should be adjusted and what the magnitude of the adjustment might be, it is prepared to propose a basic plan to accomplish these tasks.

Medicare adjusters could be developed using empirical data, such as data from the Commission's surgical global service project and Phase HI of the Hsiao study, and input from physicians. Physicians, through their specialty societies, could identity services they believe should be adjusted. HCFA would need to develop criteria to guide physicians in the selection of codes. Available empirical data could then be used to compare the physician work involved in providing the services to Medicare patients and non-Medicare patients. Length-of-stay and outpatient data could assist in this effort. Finally, HCFA could convene a panel representing all involved interest groups that could calibrate the Medicare adjuster and make recommendations about the list of services to which it should apply using the results from data analysis as well as clinical judgment and expertise.

Prelimmary analysis from the Commission's surgical global project reveal that, on average, length of stay in the hospital for Medicare patients undergoing surgery is 18 percent longer than non-Medicare patients. This would translate, therefore, into an adjuster for the hospital visit portion of the total RWV of roughly 18 percent. This estimate accounts only for a difference in days in the hospital. It does not account for differences in the durations of visits provided to Medicare and non-Medicare patients or whether a special patient characteristic/needs modifier would be

applied to some visits provided to Medicare patients. Preliminary analysis of data on the number of office visits provided to Medicare and non-Medicare patients within 90 days of surgery (the surgical global timeframe) show that a similar adjustment is not warranted for the office visit portion of the total RWV.

The Commission plans to conduct additional analysis on this topic in the upcoming months.

Question. If the behavioral offset factor is adjusted downward, is the VPS sufficient to protect against excessive, unanticipated volume increases? If not, what changes in the current system should we be considering?

Answer. In considering the MVPS, the distinction must be made between the default VPS and Congressional action. The default VPS target for expenditure growth and the default fee update are significant only if the Congress fails to act. The Commission believes that Congress intended to play an active role in establishing each year both the VPS target and the annual fee update.

Excessive volume growth will not be handled very well by the default formulas, a point with the HCFA Administrator has stressed. The default VPS target rate of growth of outlays is based on a five-year historical average of volume growth per beneficiary, to which is added projected growth in beneficiaries and fees. The default fee update is simply the Medicare Economic Index less the amount by which outlay growth exceeded the two-years-prior VPS target.

There are three problems with these defaults from the standpoint of the volume offset. First, the default VPS is based on historical rates of volume growth. Excessive volume growth in 1992 will eventually raise the default targets. Second, the default fee update is subject to a maximum reduction of 2.5 percent in 1994. Volume growth that is above the VPS target in 1992 by more than 2.5 percent would not be fully offset under the defaults in 1994. Finally, the defaults cannot recover the excess outlays that would occur between 1992, when the VPS target is set, and 1994, when that VPS target has an impact on the fee update.

However, the VPS is not governed by the defaults, but by Congressional action based on recommendations by both the Secretary of HHS and the Commission. Those recommendations may explicitly take into account unanticipated physician and beneficiary responses to the new fee schedule. Congress may fully offset any outlay growth it considers excessive, and may even recover past outlay overruns by incremental reductions in the fee update.

The question, then, is really one of what should be done to modify the default formulas, under the assumption that the defaults might govern the VPS targets and fee updates. The maximum reduction of the fee update could be removed or modified, to allow fees to reflect the full extent by which outlay growth exceeds the target.

Question. According to HCFA's testimony, work units were increased in other categories to cover EKGs. Do you think these extra units could be extracted and EKGs paid on a relative value basis separately?

Answer. The Commission strongly agrees that EKGs should be paid separately at resource-based prices, but current law (OBRA90 Section 4109(a)) must be changed to permit this. In its *Annual Report to Congress, 1991* the Commission recommended this be done in a way that does not reduce the conversion factor.

By adding EKG interpretation to payment for visits, HCFA has in fact reduced the conversion factor to maintain budget neutrality. In effect, payments for all services have been reduced to allow EKG payments to be added to visits. OBRA90 Section 4109(a) could now simply be repealed without budget consequences, but at the price of maintaining the lower conversion factor.

The Commission's proposal would allow separate payment for EKGs without lowering the conversion factor. The Commission recommended that both the professional and technical components of EKGs be paid separately in 1992 at their full resource-based prices. Also, the transition to final fee schedule prices should be accelerated for those overvalued procedures not already reduced in OBRA89 and OBRA90. This will achieve separate payment for EKGs and ameliorate one of the "hidden" reductions that occurred in the calculation of HCFA's proposed conversion factor.

Question. I am shocked to hear in some locations, the new fee for certain procedures will be at or below Medicaid reimbursement levels. Is this true? And if so, what effect do you think the proposed fee schedule will have on beneficiary access to health care?

Answer. The Commission recently published the results of its survey of 1989 Medicaid fees *(Physician Payment under Medicaid,* Report No. 91-4, July 1, 1991). In that year, five states had higher Medicaid fees than Medicare fees on average. If the Medicare Fee Schedule had been fully implemented in that year with the conver-

sion factor proposed in the NPRM, nine states would have had higher Medicaid fees than Medicare fees on average. Of course, with changes in relative values and the geographic pattern of payment. Medicaid fees for particular services in particular geographic areas may be lower than Medicare in these states and higher than Medicare in other states.

The impact of low fees on beneficiary access to care is uncertain. This is because access will be affected by behavioral responses to the fee schedule on the part of both beneficiaries and physicians. These include changes in physician decisions regarding participation and balance billing as well as changes in willingness to care for Medicare beneficiaries. Changes in co-insurance and balance billing amounts will affect beneficiaries' financial burden and could result in their utilizing more, fewer or a different mix of services than they do currently.

Medicare beneficiaries may have difficulty obtaining care if fees do not keep pace with those in the private sector The Commission's work on Medicaid physician payment indicates that access problems for Medicaid beneficiaries partially reflect physicians' decisions to either limit their Medicaid caseload or to not participate in the program in response to low fee levels. It is unclear, however, whether physicians who currently see a high proportion of Medicare patients will take similar steps.

In the short term, the mechanism to address these concerns about access is to make changes that would increase the proposed conversion factor. Over the long term, both the Commission and HCFA intend to monitor beneficiary access to necessary services with special attention to vulnerable populations.

PREPARED STATEMENT OF RICHARD J. FIELD

Mr. Chairman and Members of the Subcommittee, I am Richard J. Field, Jr., MD, FACS. I am a general surgeon from Centreville, Mississippi. I also am a member of the American College of Surgeons' Board of Regents. Accompanying me is Paul A. Ebert, MD, FACS, who is the Director of the College. On behalf of the more than 51,000 Fellows of the College, we appreciate this opportunity to provide the College's preliminary views with regard to the proposed regulations to implement the Medicare physician payment reform plan that was enacted in 1989.

As you know, the College has been supportive of a major element of the payment reform plan; specifically, the Medicare volume performance standards (MVPS), including a separate MVPS for surgical services. On the other hand, the College has had longstanding reservations about the methodology that was used in the Harvard project to determine the relative value of physicians' services. Our concern is that the methodology ignores several factors that are considered to be almost universally important in determining the value of goods and services in this country. In particular, the methodology ignores the value of services to the patient. With this background, I would like to offer the following comments about various aspects of the proposed regulations that were published on June 5, 1991 by the Health Care Financing Administration (HCFA).

RESOURCE-BASED RELATIVE VALUES

Despite our reservations about the use of resource inputs as the sole determinant of the relative value of physicians' services, we believe it is essential that the relative values that will be used for Medicare payment purposes beginning in January 1992 are as accurate as possible. In our judgment, this will require a great deal more effort between now and January 1. We believe there is considerable evidence that the relative values that are presently proposed by HCFA for many surgical services are flawed.

With respect to thoracic surgery, for example, the values that are reported in the Abt study are significantly different than those reported in the Harvard project. We believe the Abt study results must be considered when setting relative values for these services.

As another example of flawed relative values, the vignettes that were used to collect estimates of time and intensity for general surgery services often did not describe the average Medicare case reported by a particular CPT code. In other words, the vignette that was used to determine the relative value for a particular CPT code reflected an amount of work at the low end of the range, rather than the average amount of work. If this problem is left uncorrected, the result would be a systematic undervaluation of the codes in question.

Let me give you two specific examples. The vignette that was used in the Harvard project to collect resource input data for CPT code 32020 was, "Chest tube insertion for spontaneous pneumothorax, in 20 year old." Clearly, there are very few Medi-

care patients who fit this description. In spite of this fact, however, the relative values for all of the services reported under this code are based on this vignette. In the average elderly Medicare patient, this procedure would be quite complex and involve considerably more effort during the post-procedure period than would be required for a younger patient. The CPT code applies to tube the acostomies that are done for a wide range of indications, many of them serious, and could involve associated problems, such as infection and hemothorax.

Inguinal hernia repair (CPT code 49505) is the reference procedure for general surgery. The vignette that was used for this code in the Harvard project was, "Uncomplicated indirect inguinal hernia repair, 45-year-old male." By contrast, however, the procedure that is associated with this code is stated in the CPT-4 manual as, "Repair inguinal hernia, age 5 or over." Therefore, resource input data for an "uncomplicated" procedure that is performed on an otherwise healthy younger patient are proposed as the basis for determining the Medicare payment for the services that are associated with CPT code 49505. We believe the intra-service time that was reported by the Harvard project for the vignette (41.3 minutes in Phase I and 49.5 minutes in Phase II) is at the low end of the range of time that is required for services reported using CPT code 49505. A panel of general surgeons that was convened by the College at the request of the Physician Payment Review Commission (PPRC) concluded that a more reasonable average time would be 65 to 70 minutes or more. Procedure time data from two institutions support this conclusion. Data from the University of Cincinnati for inguinal hernia repair cases (excluding those procedures performed for recurrent hernias and cases where more than one procedure was performed) for all of 1990 showed that the geometric mean intra-procedure time was 100 minutes. Data from the Maricopa Medical Center in Phoenix for uncomplicated inguinal hernia repairs that were performed in December 1990 and January 1991 showed a geometric mean intra-operative time of 82 minutes. (These data were abstracted by hand from operative records at the hospital.)

Many of the other surgical vignettes that were used in the Harvard project are problematic in that they also resulted in the collection of resource input information about the care of younger, non-Medicare patients. That result would be acceptable if HCFA were proposing a physician payment system for other than Medicare patients. But, of course, HCFA is not. It should not surprise this Subcommittee to learn that the amount of care that is required by the average Medicare patient for at least some surgical procedures will be greater than the time that is required by the average non-Medicare patient. Medicare patients often have accompanying complications and comorbidities. Their lengths of stay often are longer, which obviously means that the amount of care provided by the surgeon during their inpatient stays will be greater than for patients who are discharged earlier. In addition, the amount of postoperative care often will be greater.

PPRC has acknowledged the need to assure that relative values reflect the actual work that is involved in caring for Medicare patients. The Commission discussed this issue in its 1990 and 1991 reports to Congress. In the 1991 report, the Commission made reference to a Medicare adjuster. By contrast, the proposed regulations are silent on this matter, even though HCFA received numerous comments with regard to this problem in response to the Medicare fee schedule that was published on September 4,1990. We urge the Subcommittee to insist that HCFA address this issue prior to implementing Medicare physician payment reform.

The College also is bothered by the double standard that applies to many physicians' services under the proposed fee schedule. While the payment system is purported to be resource-based, many services are discriminated against. Policymakers speak of a resource-based system, but then propose to pay for assistants at surgery in a manner that is not based on the resources that are needed to provide the service. Policymakers speak of a resource-based system, but then propose to pay lower amounts to physicians for up to their first 4 years and 23 months of practice. We urge the Subcommittee to address both of these inequities.

The College believes very strongly that the same valuation rules (that is, resource-based relative values) that are adopted for physicians' services generally also should apply to assistants at surgery. In addition, the College believes that payment should be made for the services of assistants at surgery whenever these services are medically required in order to assure that Medicare patients receive optimum care. In our view, current Medicare payment rules that arbitrarily set the payment at 16 percent of the global fee and that deny payment if an assistant at surgery is used less than 5 percent of the time nationally are inconsistent with the theoretical underpinnings of Medicare physician payment reform, as well as good medical practice.

Similarly, we find it unconscionable to provide lower payments to newly practicing surgeons. Does anyone believe that new physicians have lower practice costs or malpractice insurance costs, or that they do not have substantial education-related debt, or that they somehow do not require the same amount of time and effort to perform a hernia repair or a cholecystectomy? Once again, if resource inputs are to be the determinant of value, then payment should not vary—and certainly should not be lower—for newly practicing surgeons.

We also are concerned that multiple operations, such as those that are required by trauma patients, may not get paid fairly under the policies that are proposed by HCFA, and we are continuing to examine this issue. Proposing to pay for multiple operations using an inflexible formula under which each succeeding procedure would be paid a smaller and smaller fraction of the surgical global fee once again violates the premise under which Medicare physician payment reform is based. Why not at least pay the full value of the intra-operative portion of each succeeding procedure, instead of some lower amount?

Care also needs to be taken to assure that the relative values for transplantation services are appropriate, especially since almost no resource input information was collected for these services, either as part of the Harvard project or any other government-sponsored effort. Preliminary analysis suggests that the proposed fee schedule would reduce payments for kidney transplantation about 30 percent below what they were two years ago (according to Medicare BMAD data), despite growing public interest in improving access to transplantation services.

Simply stated, to the extent that the process for setting relative values does not reflect fully the resource inputs that are associated with the care of Medicare patients, the premise upon which the entire system is theoretically based is violated. If Congress and the Administration believe that relative values for Medicare payment purposes should be based on resource inputs, then the American College of Surgeons must insist that surgeons be given "credit" for all of the resource inputs that are associated with surgical care.

PROPOSED POLICY FOR DEFINITION OF GLOBAL SURGICAL SERVICES

The College is deeply concerned about several other elements of the proposed regulations. We object to the double standard that relates to preoperative services. The proposed regulations would include in the global surgical fee the preoperative visits that may be required during the 30-day period prior to the operation. The regulations state that separate payment would be made for those visits that are provided by a surgeon to "seriously ill patients who need to be stabilized before surgery . . . *when documentation justifying the need for the surgeon's service is submitted*" (emphasis added). Special documentation requirements are not proposed when the same services are provided by someone other than the surgeon. In our view, this requirement will create an expensive, administratively burdensome system that has no purpose.

Moreover, the resource-based relative values developed under the Harvard project did not include preoperative visits within 30 days of operation. Yet, ophthalmologists must treat glaucoma before they can perform eye operations; transplant surgeons must manage patients awaiting kidney transplant; and otolaryngologists must treat infection before proceeding to operation. The relative values that are proposed by HCFA do not include any resource inputs for these services, and separate payment may be denied under the definition of global surgical services, which continues to broaden in scope.

PPRC has concluded that only the preoperative in-hospital visits on the day of or the day before operation should be included in the definition of global surgical services. We believe that PPRC's approach is more practical and less discriminatory than the option that is recommended by HCFA. We ask this Subcommittee to urge HCFA to modify definition of global surgical services accordingly.

However, we agree with HCFA's decision to provide separate payment for the initial evaluation or consultation leading to the decision to operate. And we also agree with the decision to allow separate payment for medically necessary return trips to the operating room to treat postoperative complications.

With regard to postoperative services, the College is not satisfied that, when the values for surgical services were determined, full credit was given for all of the postoperative visit services that now are included in the definition of global surgical services. Here again, the information that was used often pertained to the typical patient, not to the typical Medicare patient.

CONVERSION FACTOR

The American College of Surgeons also wishes to add its strong opposition to the behavioral offset that is proposed by HCFA. Among other things, HCFA has not given sufficient information to judge the reasonableness of the conversion factor before any offsets. In our view, this contrasts markedly with the amount of information that was released by HCFA in 1983 with regard to the budget neutrality calculations under the hospital prospective payment system. Many changes in payment policies are proposed that would reduce Medicare payments for physicians' services below what they would be, absent the fee schedule, and yet there is little evidence in the proposed regulations that all of these changes were taken into account in the budget neutrality calculations.

For example, the regulations propose to terminate or restrict payment for the following services, which currently are recognized for Medicare payment:

- prolonged physician attendance (CPT codes 99150 and 99151), "after hours" services (CPT codes 99050 and 99052), unusual travel (CPT code 99082), and extra supplies and materials (CPT codes 99070 and 99071);
- preoperative visits that are provided by a surgeon within 30 days of an operation;
- visit services that are provided following a minor surgical procedure or "scopy;" and
- subcutaneous, intramuscular, intravenous, and intra-arterial injections.

However, the proposed regulations include no information to indicate that HCFA took these payment reductions into account when the conversion factor was calculated.

As the original supporters of the MVPS concept, we believe that the MVPSs provide a new method of addressing concerns about volume and intensity. Moreover, HCFA has several other tools now in place, such as physician profiling by carriers, to specifically guard against medically unnecessary care.

The College believes, in fact, that the use of the surgical and nonsurgical MVPSs on a more timely basis is the best way to address the rates of increase in spending for physicians' services under Medicare, rather than applying so-called "behavior" assumptions that are based on incomplete data. We have discussed with HCFA the idea of using Medicare's current data systems to report estimates of volume and expenditure changes every 120 days, or even on a quarterly basis, and to share these estimates with the physician community. This approach would provide a mechanism for the physician community to help address the trends in the volume of services, as well as to take corrective action in a timely way where necessary. We also think this approach would allow for more timely but gradual adjustments to conversion factors than now provided for by law, if adjustments are justified.

When HCFA was faced with the budget neutrality requirement for the hospital prospective payment system, the agency did not make any payment offset, even though policymakers feared that the number of hospital discharges would increase under the new per-discharge payment system. Instead, HCFA took other steps, including implementing a system of monitoring admission patterns. More importantly, the feared increase in discharges never materialized. In short, we believe that the information that is available is too scanty to justify any behavioral offset in the conversion factor, especially given the long-term impact of such an offset. In addition, we strongly object to HCFA's statement that surgeons would perform additional or questionably necessary operations in order to replace lost income. If HCFA truly believes unnecessary treatments will occur, we do not understand how the agency can offer this physician payment reform plan to its beneficiaries.

We also wish to remind the Subcommittee that many surgical services already have experienced substantial payment reductions under past budget reconciliation acts. HCFA's fee schedule impact analysis overlooks all of these past reductions, and then projects additional reductions of as much as 35 percent. For example, coronary artery bypass procedures were reduced by 9 percent in 1990 and by an equal dollar amount in 1991. Yet, the proposed regulations project an additional reduction of 31 percent in payments for thoracic surgery by 1996.

A preliminary analysis shows that some of the Medicare fee schedule amounts that were published on June 5, 1991, are lower than Medicaid payments that were made in 1989 for the same services in many locales. For example, according to data included in PPRC's 1991 report to Congress, the median Medicaid payment in 1989 for a total hysterectomy (CPT code 58150) was $614. Under HCFA's proposed Medicare fee schedule, the national average fee schedule amount is approximately $592. Looking specifically at the state of California, the 1989 Medicaid payment for CPT

code 58150 was approximately $810. By comparison, the proposed Medicare fee schedule amount for California for the same code is only $668, or about 18 percent less than the amount Medicaid paid in 1989. It also should be pointed out that, in two-thirds of the state Medicaid programs, the 1989 Medicaid payments for pediatric hernia repair (CPT code 49500) were higher than the proposed Medicare fee schedule amounts for the same procedure.

We believe these comparisons strongly suggest that Medicare physician payment reform is producing unreasonable payment reductions for many surgical services. These reductions are far in excess of those originally contemplated by the Congress and are in addition to those already mandated under previous legislation. In other words, what is being proposed are relative values that bear no relation to the absolute value of the services that are important to the health and well-being of Medicare beneficiaries.

CONCLUSION

In conclusion, the American College of Surgeons finds that much remains to be done before the new Medicare fee schedule will be ready for use. We hope that our initial views about the recently published regulations are helpful to the Subcommittee; and we look forward to working with the Congress, HCFA, and PPRC in completing a formidable agenda for fee schedule corrections, adjustments, and refinements.

RESPONSE OF RICHARD J. FIELD, JR. TO A QUESTION SUBMITTED BY SENATOR BENTSEN

Question. Doctors, all of your specialties will experience substantial payment reductions under the new system. The witness for the American Medical Association, Dr. Seward, has indicated that AMA prefers to make any budget-neutrality adjustment for the transition exclusively on the historical portion of the blended payments. This seems as if it would speed up the transition for your members, thereby accelerating the payment reductions they experience. What is your view on this matter? Do you support the AMA on this matter?

Answer. As you recall, the College was a strong supporter of the five-year transition period to the Medicare fee schedule. The implementation of physician payment reform represents one of the most significant changes to the Medicare program since its inception in 1965. It has been our view that serious disruptions could result if such massive changes were imposed too abruptly.

While we have not studied the AMA's proposal for any budget neutrality adjustments, we would object to any options that did not affect equally all physicians and all services or which did not preserve a scheduled phase-in to the new payment system.

PREPARED STATEMENT OF ROBERT GRAHAM

Good morning, Mr. Chairman and Members of the Committee. I am Robert Graham, M.D., Executive Vice President of the American Academy of Family Physicians. Our 70,000 members provide vital primary care services to Medicare patients across the nation, and serve especially in rural communities where access to health care is never taken for granted. We appreciate the opportunity to comment on the recently published notice of proposed rulemaking (NPRM) implementing the Medicare fee schedule.

We also very much appreciate your leadership in enacting Medicare physician payment reform. Without your efforts in particular, Mr. Chairman, payment reform might not be the law today. We know well that you are deeply committed to the public policy underlying Medicare physician payment reform. We continue to share your commitment in this regard.

Addressing the critical shortage of primary care physicians in America today was a key goal of physician payment reform. While most developed nations train a majority of their physicians in family medicine, only 13% of American doctors are family physicians. In fact, the percentage of primary care doctors in this country has declined steadily over the past 50 years.

Unless we reverse this trend, expanding access to health care and controlling health costs will be extremely difficult. Your own recommendations in the Pepper Commission, Mr. Chairman, as well as those in various bills before this Committee, depend implicitly on expanding the supply of primary care physicians. Expansion of "managed care" to control costs and improve quality of care requires more trained care managers—like family physicians—to do the job. Greater access to basic health

care, prenatal care, well-child care requires more primary care doctors who provide those services.

The efficacy of cost containment policies hinges on the appropriate medical specialty mix. A recent study of urban/rural health care utilization found that the ratio of primary care physicians to other specialties, more than any other factor accounts for the lower Medicare spending in rural areas.[1]

When Medicare physician payment reform was enacted two years ago, it promised to address underlying inequities and economic incentives that promote inappropriate utilization and contribute to the shortage of rural and primary care physicians. The Academy believed that this reform would elevate not only payment for, but also the status of primary care in medicine and in national health policy.

Unfortunately, the recently published NPRM threatens this outcome. We urge Congress to mandate faithful implementation of Medicare physician payment reform as originally intended. Our testimony today highlights the main areas of concern with the Secretary's notice of proposed rulemaking (NPRM.) The Academy's detailed comments on the NPRM will be available to the Committee in the near future.

INTERPRETATION OF LEGISLATIVE INTENT

The Academy believes Congress made clear its intent for implementation of Medicare physician payment reform. Even so, the Health Care Financing Administration (HCFA) has offered a different interpretation of the statute which results in a 16 percent reduction in the RBRVS conversion factor.

The difference in interpretation arises from section 1848(d)(1)(B) of OBRA 1989, which directs the Secretary to calculate an initial, budget neutral RBRVS conversion factor. The law states:

> "the conversion factor specified in this subparagraph is a conversion factor (determined by the Secretary) which, *if this section were to apply during 1991* using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services *in 1991.*" [emphasis added]

HCFA's interpretation of this language involves two assumptions with which the Academy strongly disagrees. First, HCFA assumes the law requires budget neutrality in 1992, even though the statute says 1991.

Second, HCFA assumes that budget neutrality must be calculated by applying only the 1992 transition payment rules to 1991 payments. This interpretation is problematic because in the first year of the transition, one-third of physician payments are based on the RBRVS conversion factor; the rest are based on the old payment system. Further, the movement of payments to the RBRVS in 1992 is asymmetric. When HCFA applies this partially implemented payment system and tries to achieve budget neutrality through adjustments to the conversion factor, the result is multi-billion dollar cuts in Medicare physician payments.

A more logical reading of the law would avoid this problem. The plain language of the law says the Secretary should calculate a 1991 conversion factor as "if this section were to apply" in that year. "This section" means section 1848 of the Medicare law, establishing the RBRVS fee schedule in its entirety. It does not mean subsection (a)(2)(A), a brief portion of the law outlining unique transition rules for 1992. The plain language of the law also says "using such conversion factor." Only the fully implemented fee schedule bases all payments on the conversion factor. If Congress had meant for the Secretary to assume partial implementation of the RBRVS, the law would read, "using such conversion factor and the historical payment basis."

If HCFA would apply a fully implemented RBRVS in 1991 and divide aggregate payments by the total number of RVUs, the result would be a conversion factor that yields a budget neutral reallocation of existing Medicare physician payments under the new RBRVS, as Congress intended.

The Academy acknowledges that our interpretation of the statute raises 1992 Medicare spending for physician services 2 percent above what would have occurred that year in the absence of payment reform. This is due to the asymmetric movement of payments during the first year of the fee schedule transition. However, the asymmetry is temporary and phases out automatically by 1996, when annual physi-

[1] Dor, A. and Holahan, J. Urban-Rural Differences in Medicare Physician Expenditures. Inquiry 27: 307-318 (Winter 1990).

cian outlays under RBRVS would equal those under the old payment system, as Congress intended. Further, a slight amendment to the law could eliminate the 2 percent spending increase altogether. By contrast, HCFA's reading of the law produces budget neutrality only in 1992, and ever growing budget cuts thereafter.

The Academy's reading of OBRA 1989 is more logical and consistent with Congressional intent than the interpretation outlined in the NPRM. We hope HCFA will agree and amend the proposed rule. If not, we urge the Congress to pursue the legislative remedies we outline below.

BUDGET NEUTRAL CONVERSION FACTOR

As we have stated, HCFA's interpretation of the law's budget neutrality requirements result in a major reduction in RBRVS payments to physicians. These reductions are triple what they would otherwise be due to the so-called leveraging effect of the transition. According to the NPRM, all adjustments to physician payments necessary to produce budget neutrality are applied to the fee schedule's conversion factor in 1992. Since only one third of physician payments reach the fee schedule in that year, all adjustments must be tripled.

HCFA acknowledges these budget neutrality adjustments will, in fact, reduce Medicare's payments to physicians by $3 billion in 1996 and $7 billion over the course of the five-year transition.[2] Instead of a budget neutral redistribution of Medicare dollars from overpriced procedures to underpriced services, primary care payments will remain low, payments for other services will be reduced far more than anticipated, and much of the savings will be reserved for deficit reduction. AAFP finds it unconscionable that budget neutral payment reform could be parlayed into an enormous Medicare budget reduction.

This budget cut is not only unfair and contrary to Congressional intent, it threatens the very purpose of payment reform. According to the NPRM, family physicians can expect to realize only half of the anticipated 30 percent increase in Medicare fees. Payment for our most frequently provided service, office visits, will increase only a few dollars. Given the very low base from which so many primary care and rural physicians begin this process, every penny of promised payment reform is crucial. The nominal payment increases outlined in the NPRM make it highly unlikely that hoped-for incentives for physicians to choose primary care as a specialty and/or to locate their practice in a rural community will be effective.

Furthermore, it appears that family physicians will bear the brunt of the 16 percent reduction in the conversion factor during the transition. Ironically, although the transition to the fee schedule was intended to maximize gains for underpaid services in the first year, it will have the effect of minimizing such gains. Most family physician fees move to the RBRVS in 1992. Therefore it is predominantly family physicians who will feel the full weight of the 16 percent reduction in the conversion factor immediately and fully throughout the transition. By contrast, most other physician fees will be paid on the historical payment basis in 1992, and only blended with the fee schedule from 1993 to 1996.

AAFP urges Congress to pass legislation remedying this serious situation. We believe any budget neutrality adjustments in 1992 should be applied to all physician payments, not just to those based on the RBRVS conversion factor. This change would improve payments in two ways. First, it would eliminate the "leveraging" which effectively triples the size of any budget neutrality adjustments. Second, it would reduce the disproportionate impact of budget neutrality adjustments on primary care services that move immediately to the fee schedule.

BEHAVIORAL OFFSET

Most of the 16 percentage point reduction in the conversion factor is due to the so-called behavioral offset. In order to recoup spending for anticipated behavioral responses to declining fees HCFA proposes to prospectively reduce 1992 payments by 3.5 percent. This will be leveraged to a 10.5 percent reduction. AAFP vigorously opposes the application of a behavioral offset to physician payments for several reasons.

First, Congress has already enacted a program to moderate growth in spending for physician services, the Medicare Volume Performance Standards. HCFA says MVPS is inadequate for responding to inappropriate volume growth because default

[2] In fact, the magnitude of the budget cut is much larger. Two thirds of the reduction in the conversion factor is due to a behavioral offset, yet HCFA does not count this considerable payment reduction as producing budget savings. The behavioral offset is discussed in more detail below.

formulas in the law limit the penalty that HCFA can apply to physicians *in the absence of legislation.* We believe Congress wisely limited HCFA's discretion to implement significant fee cuts on its own. The Administration's proposed behavioral offset illustrates how such unbridled discretion would likely be used.

However, Congress placed no limits on legislative responses to inappropriate volume growth. Further, Congress called for a gradual transition to payment reform so that there would be ample opportunity to observe and correct any problems that might arise. The behavioral offset proposed by HCFA is entirely inappropriate and should be prohibited.

Second, HCFA's application of the behavioral offset is illogical and unfair, on its face. The reduction is intended to offset spending caused by anticipated behavior from physicians whose fees are declining in 1992. Yet, the offsetting cut is applied to physician fees that are *increasing* in that year—those of rural and primary care physicians. This misapplication of the offset serves only to minimize sorely needed payment increases for these physicians.

Finally, HCFA's proposed behavioral offset simply is not supported by existing research on physician payments. The assumptions about volume responses are guesses, at best, and appear to assume the worst about doctors and the Medicare program. Further, HCFA's assumptions appear to disregard the transition's leveraging effect, which converts this one-year offset into a permanent and severe downward rebasing of physician payments.

For these reasons, the Academy urges the Congress to prohibit application of a behavioral offset to the conversion factor.

GEOGRAPHIC ADJUSTMENTS

We have testified previously to this Committee on geographic adjustments for Medicare physician payments. We must reiterate our very strong objection to the proposed geographic adjustment factors. The GAF will result in Medicare fees that vary by as much as 30 percent between lowest paid rural areas and the highest paid urban areas. Such discrepancies in payment will certainly perpetuate the shortage of physicians in rural areas.

Our primary objection to the GAF is that it is flawed conceptually. A full accounting of physician practice costs would attempt to reflect the opportunity costs of practice location choices. Physicians obviously base such decisions on far many more factors than the cost of practice. Experience in this country and in the rest of the developed world clearly indicates that in order to induce physicians to locate in underserved areas, they must be paid more, not less than if they locate in areas already served by an abundance of physicians.

While the AAFP opposes the imposition of any GAF, we would urge, at a minimum, that immediate steps be taken to make the proposed GAF more accurate and equitable. First, we recommend that a study be undertaken to validate the accuracy of the GAF before it is implemented. A validation study was already mandated in OBRA 1990, though study results are not mandated before July 1992. The index proposed in the NPRM relies on proxy measures of medical practice costs. Surveys of actual practice costs, however, show that rural practice costs are equal to, or even exceed, those in urban areas.

Second, we believe that HCFA's proposed GAF will systematically and inequitably under-reimburse family physicians for practice expenses. Of all specialties, family physicians have the highest practice costs as a proportion of gross practice revenue. This is due in part to the fact that we provide a much wider range of health care services for our patients and because we locate disproportionately in rural areas where economies of scale are much more difficult to achieve. According to the statute, the practice expense relative values reflect a weighted average of the practice-expense-to-gross practice-income ratio of all specialties providing a given service. Because of the class of services that we provide, virtually every service provided by family doctors is also provided by other specialties, all of which have lower practice expenses. The averaging used to calculate the practice expense relative values, therefore, always results in a practice expense relative value that is reduced relative to family physicians' actual practice expense proportion. HCFA's practice expense GPCI tends to further reduce the practice expense relative value for family physicians, simply because they are more likely to be located in rural areas. We think this inequitable.

Section 1848(e)(1)(B) authorizes the Secretary to establish class-specific geographic cost of practice indices when the application of the general practice expense index would be substantially inequitable. We urge the Committee to change this permissive language to a requirement that separate adjustments be applied to reverse this systematic under-payment of rural physicians.

Third, the Academy urges Congress to adopt recommendations by the PPRC concerning consolidation of geographic payment areas. PPRC recommends the 240 current carrier areas be replaced with statewide fee schedule payment areas except in states with high intrastate price variation. Under this policy, the number of statewide fee schedule areas would increase from 14 to 34, and the total number of payment areas would decrease from 236 to 94. AAFP recognizes the administrative difficulties of implementing payment areas changes simultaneously with pricing and coding changes. We hope carrier areas can be consolidated as early as 1993.

PAYMENT FOR DIRECT AND INDIRECT PRACTICE COSTS

The Academy urges Congress to adopt another PPRC proposal relating to direct and indirect practice costs. PPRC would divide practice costs into direct and indirect components and pay the direct portion only when the physician actually absorbs the direct cost of providing the service. Direct costs are the nonphysician employee time, supplies, and equipment that are actually consumed in providing a service. Indirect costs are the overhead expenses such as maintaining an office and administrative staff that accrue to all services regardless of where they are delivered. For example, while the direct cost of providing an inpatient surgical procedure is borne largely by the hospital, the NPRM would include a full portion for practice costs in the surgical fee. The NPRM does propose to limit payment for practice expense for a list of specific services which Medicare currently covers in ambulatory surgery centers (ASCs).

AAFP urges the Congress to replace the current method of estimating practice expense relative values with a resource-based method that distinguishes between direct and indirect costs incurred by physicians when a service is provided in different settings. Such a resource-based method should incorporate alternative equipment-use volume assumptions that do not compromise access to care in rural areas.

BUDGETARY CONSIDERATIONS

The Academy understands that budget scoring rules adopted under the 1990 budget summit agreement significantly complicate Congressional consideration of some of the legislative remedies we have proposed. We are sympathetic to the need for deficit reduction, as well as the need to control health care costs in general. In the past, we have worked closely with this Committee and others in Congress on both of these economic concerns. For example, AAFP supported enactment of the MVPS program to address the rising cost of medical services. We pledge our future, continued efforts to control the cost and volume of services in ways that are fair and appropriate.

At the same time, we must state strongly our conviction that the budget cuts inadvertently produced by the transition to RBRVS must not be permitted to occur.

Further, OMB scoring rules should not be applied in such a way that the bill for righting this unanticipated wrong is handed to physicians, taxpayers or Medicare beneficiaries. We ask simply that the promised budget neutral transition to fee reform be delivered.

CONCLUSION

Mr. Chairman, when we started on the road to Medicare physician payment reform, we had great hopes. A national system of resource-based payment for physician services held the potential to neutralize perverse financial incentives contributing to a host of serious problems:

- the overprovision of expensive medical procedures coupled with an under-reliance on cost effective primary care;
- the maldistribution of physicians between urban areas and underserved rural areas; and
- the propensity of medical graduates to select careers in procedure-oriented specialties over primary care medicine.

We never believed that the Medicare RBRVS, alone, would solve these problems, But it was a tremendous first step, and one, we hoped, that signalled Congress' willingness to pursue solutions to these problems throughout our health care system.

The promise of Medicare physician payment reform is still the goal of family physicians. We cannot overstate the need for that promise to be kept. Legislative action is needed, both to make the law work as intended, and to prevent the Administration's preemptive strike on the Medicare budget.

The behavioral response to payment reform Congress should fear most is perpetuation of the status quo. If payment methods continue to encourage physicians to

make specialty choice and practice location decisions that discourage access to primary care, our nation's health care problems will only grow worse.

RESPONSE OF DR. ROBERT GRAHAM TO A QUESTION SUBMITTED BY SENATOR BENTSEN

Question. Dr. Graham, in your written testimony you indicate that, unless HCFA changes its position, legislation may be necessary to address some of the problems in the proposed rule. We have been told by HCFA that further legislative changes on the eve of implementation may delay the date on which the new system goes into effect. If that is true, are you prepared to accept that outcome?

Answer. Mr. Chairman, as I noted in response to a question by Senator Rockefeller, the Academy strongly urges the Committee to do everything possible to bring about a resolution of this conversion factor problem so that the fee schedule can be implemented on time in 1992. Allowing administrative bureaucratic concerns to push that back would not serve any of our interests at all.

Technically, restoring the 16 percent reduction in the conversion factor is very simple and straightforward. The Congress could instruct HCFA on the proper interpretation of the budget neutrality requirement, legislate a temporary 2 percent reduction in fees to restore budget neutrality during the transition, and prohibit application of a behavioral offset. There is no reason why that change should cause a delay in implementation of the fee schedule.

We understand that the politics of convincing the Administration to back down are more complex. Even so, we hope the Congress will not permit the Administration to effectively hold this important reform hostage to a tight time frame. Delaying Medicare physician payment reform would only exacerbate serious problems faced by doctors and patients in rural Texas and elsewhere. It is vitally important that the Medicare fee schedule, with a fair conversion factor, be implemented on time in 1992.

The Academy would note that, beyond the conversion factor issue, we have other serious concerns with the proposed fee schedule—geographic payment policies, relative work values for visit services, and others. We have not sought legislative relief for these problems yet, precisely because we do not seek to delay implementation of payment reform. We have voiced our strong concerns in our formal comments to the NPRM, however. In addition we will continue to work with the Congress throughout the fee schedule transition to improve Medicare payment for rural and primary care services, as payment reform promised to do.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Mr. Chairman, thank you for calling this hearing on a matter which is very important to all of us.

Mr. Chairman, I have consistently supported physician payment reform. The Iowa physician community did also. For us a lot is riding on it.

We supported physician payment reform because we thought it was a good idea on the merits. We also thought it was a very good idea for the State of Iowa because it was going to help us to recruit, and keep, primary care physicians of the kind we need in our rural communities across the State but have a hard time finding.

At the present time, 170 communities in Iowa are seeking more than 200 doctors. I am also hearing from Medicare beneficiaries in the eastern part of Iowa that they are having trouble finding physicians who will add them to their case loads. This seems to reflect increasing frustration with the Medicare program on the part of physicians.

Part of our problem lies in our low Medicare reimbursement levels. Of the 240 Medicare payment areas around the country, the eight in Iowa rank 196th and lower in reimbursement.

Iowa is also a State with a great many Medicare beneficiaries. So any physician who practices in Iowa is likely to be very dependent on the Medicare program.

We believed, with everyone else, that Medicare physician payment reform was going to re-allocate money toward primary care practitioners and was going to more equitably allocate Medicare reimbursement around the country as well.

This we thought would help us considerably in finding and keeping physicians for our smaller communities.

Unfortunately, it doesn't look like the recently published rule is going to help us at all.

It is true that Iowa does relatively well compared to other states according to the averages released by HCFA.

However, in year five of the reform Iowa will be losing four percent in charges per service compared to current law and two percent in outlays.

It appears that the gains which will be made by Iowa physicians compared to current law will be so modest that they will really not change our overall situation very much.

From this Senator's perspective this is just not acceptable. I sincerely hope we can work with the health care financing administration to make this payment reform a success.

If physician payment reform is widely seen by physicians as being prevented from fulfilling the purposes for which we created it, the problems we are currently experiencing with Medicare could be seriously compounded.

PREPARED STATEMENT OF JAMES M. MOOREFIELD

The American College of Radiology is pleased to present the following testimony on the Bush Administration's proposed Medicare fee schedule for 1992.

The ACR believes that the proposed fee schedule is a violation of the intent and spirit of physician payment reform. We believe it ignores the fact that radiology procedures, among others, have been subjected to reductions over the last four years. These reductions were made under legislation aimed at reform of Medicare payments to physicians. For radiologists, these prior reductions amount to 18 percent.

If the proposed fee schedule were to be implemented, radiology procedures in 1996 would be reduced by 50 percent from the 1988 base year used in physician payment reform studies. No study, public or private, has ever categorized radiology procedures as overvalued by 50 percent.

In the work of the Physician Payment Review Commission, radiology was projected to be overvalued by 21 percent. This projection was the basis of discussion on the extent of overvalue in radiology in the Finance Committee report accompanying the budget reconciliation bill passed by this subcommittee in 1990. In that report, the subcommittee discussed the remaining overvaluedness in radiology. At that point, only last fall, the Health Care Financing Administration believed radiology to be overvalued by 15 percent. The ACR believed the number to be 10 percent. The subcommittee elected to use 13 percent as the benchmark for overvalue in radiology.

The 13 percent benchmark was to be used in the radiology fee schedule to begin to adjust radiology conversion factors for any remaining overvalue. Nine percent of that adjustment took place in 1991. The remaining 4 percent, along with adjustments for geographic practice cost differences, was to be phased in through a transition for radiology outlined by the subcommittee.

Even though there is specific language for a transition in payments in the law, the administration has adopted a method for converting the radiology values with the RBRVS values in a manner that causes addjtional reductions to the physician work component of radiology relative values. The proposed fee schedule produces radiology relative values for physician work which are drastically below 1991 levels. We believe this is contrary to the intent of the law and we certainly believe it is contrary to the spirit of physician payment reform.

We ask the subcommittee to closely examine the Medicare amendments contained in OBRA of 1990 relative to radiology. We believe that the administration has misinterpreted these provisions. We also believe that a legislative change may be necessary to correct this interpretation. The misinterpretation of the radiology provisions, coupled with the ill-conceived transitional and behavioral offsets compound to a total additional reduction in radiology professional work values of 38 percent.

The behavioral offset concept should also be scrutinized by the subcommittee. To our knowledge, HCFA has never published data or analysis for public review and comment which justifies their contention of a 50 percent volume response to payment reductions. In fact, Medicare actuarial data show that volume growth has been slightly slower from 1984 to the present, than for the period before 1984. Obviously, from 1984 to 1991, Medicare fees have been significantly constrained. This data contradicts the volume response contention.

We have found further evidence of contradiction in the behavioral response concept. By examining 1989 HCFA BMAD data, we have found evidence that the reduction in payments to radiologists under the fee schedule did not generate a volume increase response. In fact, during that first year of the fee schedule, the rate of increase in volume actually dropped compared to the rate for previous years. While HCFA has used its "best guess'l in determining a behavioral response under the fee schedule, there is actual evidence, specifically found in implementing cuts under a

fee schedule, that the behavioral response assumptions are incorrect for radiology. Since radiology is a referral based specialty, we are unsure of the broader implications of our findings to the Medicare Fee Schedule. However, the fact that there is concrete evidence that radiology is different and that the data shows no behavioral response, focuses the need for further study.

In light of the conflicting findings regarding behavioral response, we believe that before a behavioral offset adjustment is made to conversion factors, there should be a formal and thorough study of behavioral response that offers data and analysis to support it. This study should be subjected to scrutiny by the Congress and the public before a behavioral offset is used. We urge the Congress to request such a study from HCFA.

In 1987, the American College of Radiology asked the Congress for the opportunity to work with you and the Health Care Financing Administration to devise a fee schedule for radiology services that was fair to Medicare patients, the government and radiologists. The Congress agreed and we have spent the last three years working with HCFA and American radiologists to make a fee schedule work. It has required a great deal of effort and sacrifice.

We agreed to work with you because we sincerely believed we could develop a payment schedule that was fair and equitable. Until June 5, 1991, we believed we were doing that. The Bush administration's proposed fee schedule is an outrageous violation of our mutual goals. We ask for your support and assistance in putting physician payment reform back on the right track.

Attachment.

RESPONSES OF DR. JAMES M. MOOREFIELD TO QUESTIONS SUBMITTED BY SENATOR BENTSEN

Question 1. Do you favor making a budget neutral adjustment for transition exclusively on the historical portion of the blended payments under the Medicare fee schedule as proposed by the AMA?

Answer. The ACR would not favor a transition adjustment the reduces the historical payment base. We believe this would place an extraordinary burden on radiologists by increasing the amount of payment transition in 1992. OBRA of 1990 required that no payment reduction in radiology may exceed 9 percent of the fee schedule amount in 1992. This provision was added by your committee and included the provision for 13 percent remaining overvaluedness in radiology under physician payment reform. We believe that limit is reasonable and that it should not be increased because of the problem of asymmetry in the transition to the fee schedule for physicians.

The transition asymmetry occurs because the contributions to physician payment reform of radiologists and other physicians over the last several years have been credited to federal budget deficit reduction instead of physician payment reform. Crediting these prior reductions to deficit reduction instead of physician payment reform has already had the affect of reducing the conversion factor for physician services. This action has increased the reduction that radiologists will experience under physician payment reform over and above the reductions for "overvaluedness." It is therefore inappropriate to exacerbate this reduction by asking radiologists to take further reductions in 1992.

We believe that physician payment reform can be implemented in a budget neutral way over the entire transition period making the need for first year reductions, some of which would never be returned, unnecessary.

Question 2. What does ACR research on behavioral response of radiologists to budget cuts in prior years show? Are you sharing this information with HCFA?

Answer. Whatever the behavioral response of physicians in general, there is clear and strong evidence that the response of radiologists to Medicare fee reductions has, if anything, been a reduction in the rate in volume of services, not an increase as HCFA assumes. Therefore, radiology and the conversion factor applied to it should be exempted from any behavioral offset. We have shared this extensive information with HCFA.

With respect to radiology, our point is that whatever conclusions one reaches about physicians generally, it is clear that radiologists did not increase their volume of services when they were subjected to payment reductions and a fee schedule under Medicare. Rather, if anything, their volume decreased.

Our analysis examines the rate of growth of radiological services provided by radiologists and others (principally multi-specialty clinics) who came under the Medicare radiology fee schedule. It examines how this growth rate differed from its previous trend once the payment cuts that introduced the fee schedule went into effect.

The analysis uses a control group to assure that the change in trend that it measures is accurately attributable to the payment reduction.

To obtain sound results, we use physicians not affected by the fee schedule cuts in 1989 as a control group. A control group is essential because year-to-year growth rates in the BMAD data are affected by a variety of factors other than payment level changes. Most obviously, the completeness of BMAD reporting has varied. It presumably has improved as the data system has matured, but has also shown fluctuating variations as claims processing speed has varied, both deliberately as a matter of national policy and in response to circumstances at individual carriers.

In addition to using a control group, we eliminated from the analysis states with major problems in their radiology data. For example, Rhode Island was eliminated because it provided no data for 1989; Maryland was eliminated because inpatient and outpatient radiological services (roughly half of all radiological services) were largely missing from its data before 1989.

To investigate the effects of cuts fully, we examined growth rates not only of the number of services, but also of allowed charges and relative value units (RVUs) as measured by the radiology relative value scale. Because of problems in the 1989 BMAD data on radiation therapy, we have had to omit this part of radiology from the analysis of RVUs.

We measure how the rate of growth of radiology services (or allowed charges or RVUs) provided by radiologists (and all others who came under the fee schedule) compared with the growth rate in the control group. We focus on whether this relationship differed from its previous state once the fee schedule reduced payments to radiologists. The Proposed Rule's behavioral assumption implies that the growth of radiologists' radiological services (relative to the growth of radiological services provided by the non-radiologist control group) sped up when the fee schedule went into effect. On the other hand, the Medicare actuaries' data suggest we should expect to find the growth of radiologists' services slowed relative to the control group. This is the reverse of what one would expect based on the assumptions in the Proposed Rule.

To check the robustness of results, we used two alternative base periods, 1986-88 or 1987-88, as the period over which we measured the prefeeschedule trend. Similarly, we used two different approaches to ultrasound because of a peculiarity of CPT coding for ultrasound: There—are 90,000 series codes for cardiac and vascular ultrasound that are similar or identical to the 70,000-series codes; indeed, some of the 70,000 series cardiac codes were eliminated in 1989 with instructions that the 90,000 series codes should be used instead. Thus, some ultrasound services that, in the base period, appeared in the 70,000 series were required to shift to the 90,000 series. Other billing may have shifted voluntarily as reimbursement in the 70,000 series was cut while there were no special changes to reimbursement in the 90,000 series. Consequently, to obtain a consistent data series requires either omitting all cardiac and vascular ultrasound or including the relevant codes in both the 70,000 and 90,000 series. We analyzed data both ways. To analyze RVUs when 90,000 series ultrasound services are included required assigning relative values to these services. For 90,000 codes for which there were identical codes in the 70,000 series, we used the relative values of the 70,000 series services. For other 90,000 series codes, we assigned relative values based on allowed charges relative to the 90,000 series services for which relative values were assigned as described in the preceding sentence.

Results are presented in several three-page sets. The first page of each set presents the finding graphically. The next two, tabular pages then present the finding numerically and in greater detail. The first tabular page presents data for radiologists and all others who came under the fee schedule; the second presents data for the control group consisting of those who did not have their payments reduced.

The first three-page set deals with counts of procedures. It shows that before fee cuts, the growth of procedures performed by radiologists was a fraction of a percent faster than the growth in the control group. In contrast, after the cuts, procedures done by radiologists grew about 4½ percent more slowly. The downward swing of some 5 percent in relative growth rates—from slightly positive to about 4½ percent negative—is the measure of the effect of the 3 percent reduction in radiology payment levels made in 1989. In contrast, as shown on the graph, the Proposed Rule's behavioral assumption calls for a 1½ percent upward swing, in order to offset half the 3 percent cut in payments. The tabular pages show the data that underlie the graph and also break down the total number of services (which appears in the graph) by type of radiology.

The next three-page set shows the same data except that the base period is 1987-88 rather than 1986-88. The choice of base period has little effect. Again, the effect

of the 3 percent payment reduction shows up as a downward swing—this time of approximately 4 percent—in the relative growth rate of the number of services.

The next three-page set deals with allowed charges. The effect of the three percent payment reduction is a 10 percent reduction in the relative rate of growth of allowed charges. In contrast, a no-change scenario would call for a three percent reduction in the relative rate of growth of allowed charges (because the payment level was lowered by 3 percent). The Proposed Rule behavioral assumption would be that only a 1½ percent reduction would result because increased volume and intensity would offset half the reduction in payment levels.

The next three-page set again deals with allowed charges, but this time we illustrate the effect of using the narrower formulation for ultrasound. (The first formulation is preferable, as it includes the full range of ultrasound services.) Again, the data show a downward swing of approximately 10 percent in the relative growth rate. Thus, the alternative formulations for ultrasound have little effect.

The remaining analyses deal with relative value units (RVUs). The first graph (and tables) on RVUs show the effect of payment reductions using the broad definition of ultrasound. The rate of growth of RVUs for radiologists' services fell by 3 percent, relative to the control group, when payments were reduced. Using the narrow measure of ultrasound, (see the next graph, and accompanying tables) shows the decline in the growth rate at 4 percent.

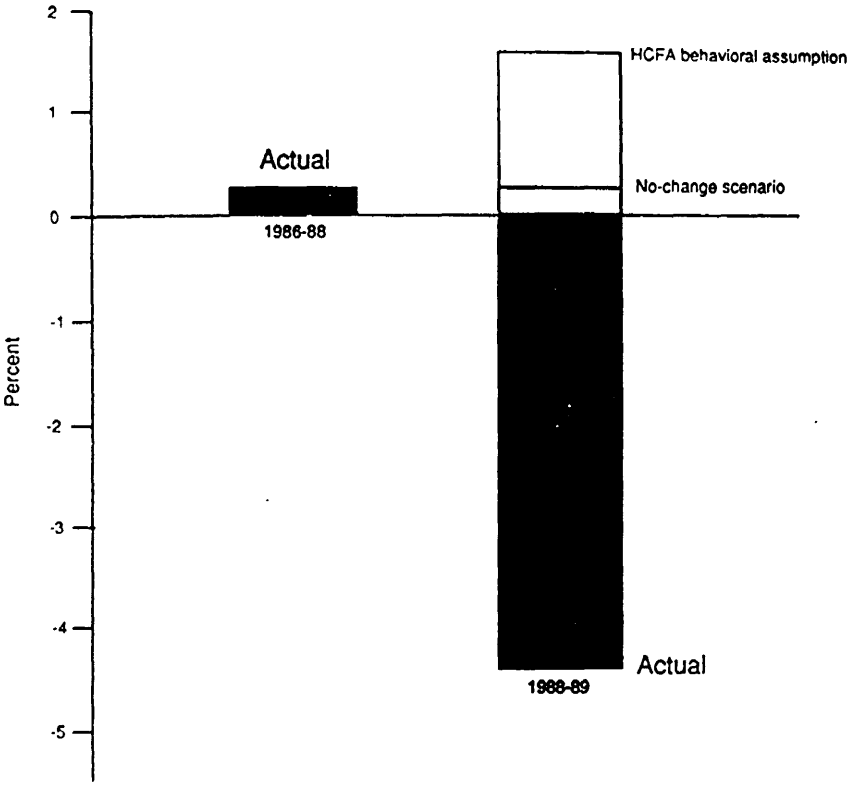
In summary, the data clearly show that, contrary to the general Proposed Rule behavioral assumption, no increase in services resulted from the fee reductions accompanying the introduction of the radiology fee schedule. Instead, the evidence is strong that the effect of the payment reduction was a reduction in the rate of increase of services, and of RVUs. Also, the relative rate of growth of allowed charges fell by more than the 3 percent reduction that would have been expected simply from a 3 percent reduction in payment.

Even-those who believe physicians usually respond to payment reductions by increasing services should not be surprised that this does not happen with radiologists. Unlike most physicians, radiologists only get patients referred from other physicians—they have very little initial contact. Also, the referring physician usually specifies the study to be performed. Thus, radiologists have much less opportunity than most physicians to vary the content of a patient encounter. With the number of encounters and their content largely determined by the referring physician, radiologists have relatively little opportunity to influence the volume or intensity of services they provide.

In short, both the empirical evidence and theory indicate that radiologists do not increase volume/intensity when their fees are reduced. Hence, no behavioral offset should be applied to the radiological services of radiologists and others who have been under the radiology fee schedule. If HCFA insists on using a general behavioral offset, exempting them from it would require an additional conversion factor. This would not add any new complexity to the Medicare fee schedule. Multiple conversion factors are already to be expected because of the separate VPS for surgery.

Growth Rate of Radiologic Procedures

(Rate for radiologists & all others under the fee schedule compared to rate for those not under fee schedule [non-radiologist physicians]; uses broad measure of ultrasound)



EFFECT OF RVS ON
GROWTH RATE OF RADIOLOGIC PROCEDURES
ALL UNDER FEE SCHEDULE
OMITS 9 STATES
Source: HCFA/BMAD Data

Type of Radiology	# of Procedures 1986	# of Procedures 1988	Compounded Annual Growth rate 1986-1988 (Percent)	# of Procedures 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1986-88 to 1988-89 (Percentage Points)
Angiography	698,295	789,212	6.3	842,359	6.7	0.4
CT/MR	2,793,401	3,834,833	17.2	4,374,791	14.1	-3.1
General Radiology	32,388,372	36,020,108	5.5	38,077,082	5.7	0.3
Nuclear Medicine	1,594,842	2,056,378	13.6	2,210,793	7.5	-6.0
Ultrasound 70000 U.S. excl. vascular & cardiac	1,449,553	1,761,818	10.2	1,914,037	8.6	-1.6
Ultrasound 70000 U.S. Vascular	29,822	62,792	45.1	113,641	81.0	35.9
Ultrasound 70000 U.S. Cardiac	131,624	202,636	24.1	70,954	-65.0	-89.1
Ultrasound 90000 Vascular	255,508	403,660	25.7	476,666	18.1	-7.6
Ultrasound 90000 Cardiac	92,598	144,763	25.0	254,851	76.0	51.0
Subtotal, Expanded Ultrasound	1,959,105	2,575,669	14.7	2,830,149	9.9	-4.8
Not Classified *	316,205	12,973	NA	66,319	NA	NA
Subtotal, Diagnostic Radiology	39,750,220	45,289,173	6.7	48,401,493	6.9	0.1
Radiation Oncology	1,840,711	2,234,996	10.2	2,598,135	16.2	6.1
Total, All Radiology	41,590,931	47,524,169	6.9	50,999,628	7.3	0.4

Revised 7/23/91.

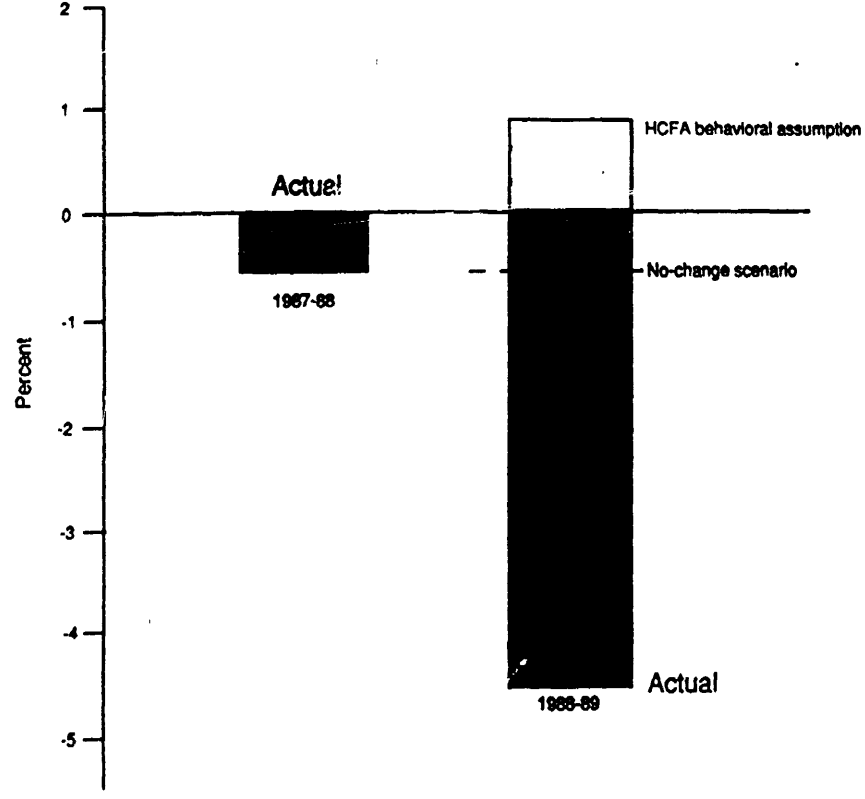
EFFECT OF RVS ON
GROWTH RATE OF RADIOLOGIC PROCEDURES
NON RADIOLOGIST PHYSICIANS
OMITS 9 STATES
Source: HCFA/BMAD Data

Type of Radiology	# of Procedures 1986	# of Procedures 1988	Compounded Annual Growth rate 1986-1988 (Percent)	# of Procedures 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1986-88 to 1988-89 (Percentage Points)
Angiography	84,792	118,353	18.1	143,475	21.2	3.1
CT/MR	86,251	88,992	1.6	94,905	6.6	5.1
General Radiology	7,624,385	8,017,004	2.5	8,764,997	9.3	6.8
Nuclear Medicine	160,211	268,824	29.5	307,947	14.6	-15.0
Ultrasound 70000 U.S. excl. vascular & cardiac	885,427	1,121,467	12.5	1,199,653	7.0	-5.6
Ultrasound 70000 U.S. Vascular	32,559	50,512	24.6	82,231	62.8	38.2
Ultrasound 70000 U.S. Cardiac	522,118	613,021	8.4	294,014	-52.0	-60.4
Ultrasound 90000 Vascular	649,765	899,090	17.6	1,110,596	23.5	5.9
Ultrasound 90000 Cardiac	708,873	1,156,373	27.7	1,810,852	56.6	28.9
Subtotal, Expanded Ultrasound	2,798,742	3,840,463	17.1	4,497,346	17.1	0.0
Not Classified *	96,677	5,529	NA	2,488	NA	NA
Subtotal, Diagnostic Radiology	10,851,058	12,339,165	6.6	13,811,158	11.9	5.3
Radiation Oncology	95,180	115,844	10.3	119,778	3.4	-6.9
Total, All Radiology	10,946,238	12,455,009	6.7	13,930,936	11.9	5.2

Revised 7/23/91.

Growth Rate of Radiologic Procedures

(Rate for radiologists & all others under the fee schedule compared to rate for those not under fee schedule [non-radiologist physicians]; uses broad measure of ultrasound)



EFFECT OF RVS ON
GROWTH RATE OF RADIOLOGIC PROCEDURES
ALL UNDER THE FEE SCHEDULE
OMITS 5 STATES
Source: HCFA/BMAD Data

Type of Radiology	# of Procedures 1987	# of Procedures 1988	Annual Growth rate 1987-1988 (Percent)	# of Procedures 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1987-88 to 1988-89 (% Points)
Angiography	876,266	922,431	5.3	986,953	7.0	1.7
CT/MR	3,982,531	4,560,214	14.5	5,192,123	13.9	-0.6
General Radiology	40,238,166	42,251,969	5.0	44,690,791	5.8	0.8
Nuclear Medicine	2,129,196	2,434,536	14.3	2,628,839	8.0	-6.4
ULTRASOUND 70000 U.S. excl. vascular & cardiac	1,780,047	2,069,894	16.3	2,265,238	9.4	-6.8
70000 U.S. Vascular	43,070	94,977	120.5	154,273	62.4	-58.1
70000 U.S. Cardiac	165,906	217,038	30.8	71,130	-67.2	-98.0
90000 Vascular	385,589	545,639	41.5	626,406	14.8	-26.7
90000 Cardiac	142,008	197,982	39.4	330,311	66.8	27.4
Subtotal, Expanded Ultrasound	2,516,620	3,125,530	24.2	3,447,358	10.3	-13.9
Not Classified *	31,205	16,657	N.A	91,619	N.A	N.A
Subtotal, Diagnostic Radiology	49,773,984	53,311,337	7.1	57,037,683	7.0	-0.1
Radiation Oncology	2,518,517	2,769,748	4.9	3,103,022	12.0	7.2
Total, All Radiology	52,292,501	56,081,085	3.6	60,140,705	7.2	3.7

Revised 7/31/91.

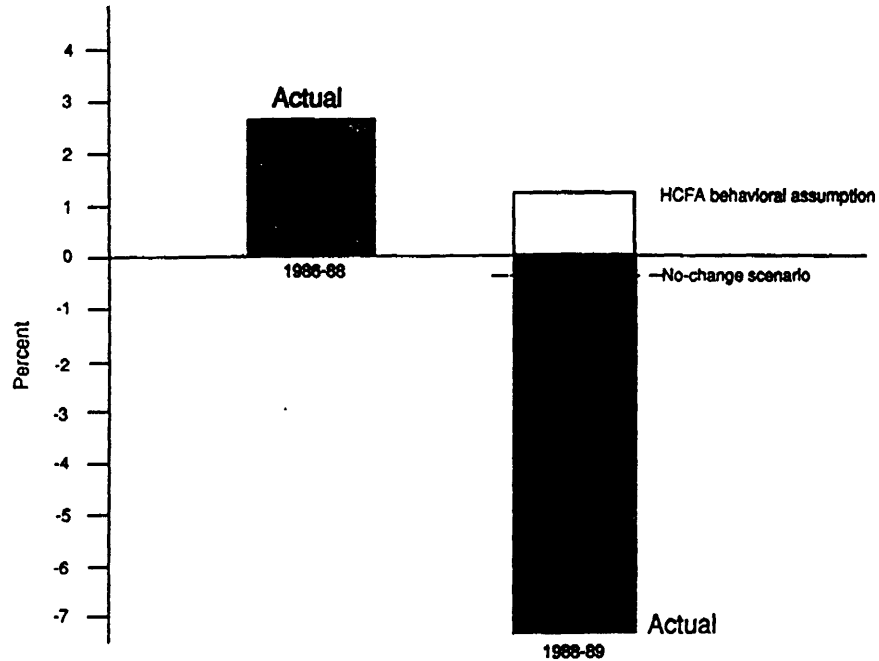
EFFECT OF RVS ON
GROWTH RATE OF RADIOLOGIC PROCEDURES
NONRADIOLOGIST PHYSICIANS ONLY
OMITS 5 STATES
Source: HCPA/BMAD Data

Type of Radiology	# of Procedures 1987	# of Procedures 1988	Annual Growth rate 1987-1988 (Percent)	# of Procedures 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1987-88 to 1988-89 (% Points)
Angiography	107,392	140,074	30.4	180,032	28.5	-1.9
CT/MR	102,287	112,427	9.9	118,017	5.0	-4.9
General Radiology	9,423,081	9,607,551	2.0	10,495,465	9.2	7.3
Nuclear Medicine	279,015	355,032	27.2	401,927	13.2	-14.0
ULTRASOUND						
70000 U.S. excl. vascular & cardiac	1,103,465	1,351,314	22.5	1,456,500	7.8	-14.7
70000 U.S. Vascular	44,498	72,194	62.2	116,345	61.2	-1.1
70000 U.S. Cardiac	646,536	645,334	-0.2	294,775	-54.3	-54.1
90000 Vascular	961,621	1,115,822	16.0	1,379,394	23.6	7.6
90000 Cardiac	1,083,423	1,537,796	41.9	2,283,010	48.5	6.5
Subtotal, Expanded Ultrasound	3,839,543	4,722,460	23.0	5,530,024	17.1	-5.9
Not Classified *	11,058	6,009	N.A	3,938	N.A	N.A
Subtotal, Diagnostic Radiology	13,762,376	14,943,553	8.6	16,729,403	12.0	3.4
Radiation Oncology	150,262	161,731	3.7	163,819	1.3	-2.5
Total, All Radiology	13,912,638	15,105,284	4.2	16,893,222	11.8	7.6

Revised 7/31/91.

Growth Rate of Allowed Charges

(Rate for radiologists & all others under the fee schedule compared to rate for those not under fee schedule [non-radiologist physicians]; uses broad measure of ultrasound)



EFFECT OF RVS ON
GROWTH RATE OF ALLOWED DOLLARS
ALL UNDER THE FEE SCHEDULE
OMITS 9 STATES
Source: HCFA/BMAD Data

Type of Radiology	Allowed Charges 1986	Allowed Charges 1988	Compounded Annual Growth Rate1986-1988 (Percent)	Allowed Charges 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1986-88 to 1988-89 (% Points)
Angiography	102,814,889	132,081,183	13.3	144,554,594	9.4	-3.9
CT/MR	339,963,878	561,150,552	28.5	577,144,496	2.9	-25.6
General Radiology	665,503,022	799,824,374	9.6	871,067,136	8.9	-0.7
Nuclear Medicine	99,360,183	158,950,130	26.5	160,982,002	1.3	-25.2
Ultrasound: 70000 U.S. excl. vascular & cardiac	83,798,719	113,946,525	16.6	123,876,971	8.7	-7.9
Ultrasound: 70000 U.S. Vascular	1,925,400	4,382,552	50.9	7,148,073	63.1	12.2
Ultrasound: 70000 U.S. Cardiac	11,155,284	21,615,677	39.2	5,755,636	-73.4	-112.6
Ultrasound: 90000 Vascular	23,703,970	38,517,655	27.5	48,158,676	25.0	-2.4
Ultrasound: 90000 Cardiac	8,689,373	14,661,612	29.9	27,493,499	87.5	57.6
Subtotal, Expanded Ultrasound	129,272,746	193,124,021	22.2	212,432,855	10.0	-12.2
Not Classified *	28,970,368	1,155,177	NA	21,857,466	NA	NA
Subtotal, Diagnostic Radiology	1,365,885,086	1,846,285,437	16.3	1,988,038,549	7.7	-8.6
Radiation Oncology	216,908,181	296,280,148	16.9	368,442,484	24.4	7.5
Total, All Radiology	1,582,793,267	2,142,565,585	16.3	2,356,481,033	10.0	-6.4

Revised 7/23/91.

EFFECT OF RVS ON GROWTH RATE OF ALLOWED DOLLARS NONRADIOLOGIST PHYSICIANS ONLY OMITS 9 STATES

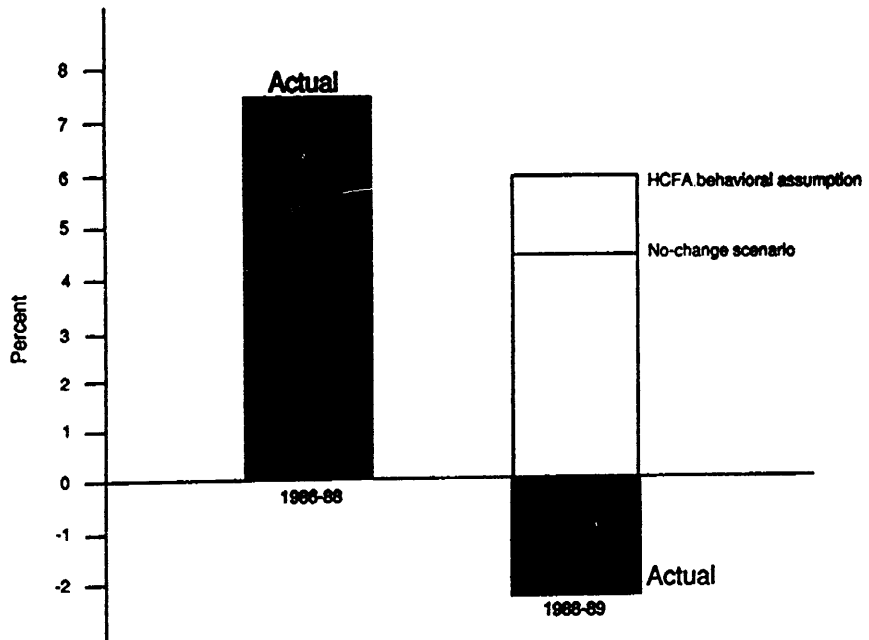
Source: HCFA/BMAD Data

Type of Radiology	Allowed Charges 1986	Allowed Charges 1988	Compounded Annual Growth Rate1986-1988 (Percent)	Allowed Charges 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1986-88 to 1988-89 (% Points)
Angiography	13,899,239	24,024,799	31.5	30,948,617	28.8	-2.7
CT/MR	13,476,560	18,325,130	16.6	20,815,155	13.6	-3.0
General Radiology	251,987,034	290,841,440	7.4	328,999,617	13.1	5.7
Nuclear Medicine	10,440,605	30,686,297	71.4	42,714,480	39.2	-32.2
Ultrasound 70000 U.S. excl. vascular & cardiac	110,190,182	120,383,846	4.5	121,531,157	1.0	-3.6
Ultrasound 70000 U.S. Vascular	2,493,565	3,894,020	25.0	7,134,691	83.2	58.3
Ultrasound 70000 U.S. Cardiac	53,773,625	75,239,077	18.3	34,492,864	-54.2	-72.4
Ultrasound 90000 Vascular	62,706,227	88,969,420	19.1	115,431,548	29.7	10.6
Ultrasound 90000 Cardiac	72,931,789	127,791,525	32.4	215,293,034	68.5	36.1
Subtotal, Expanded Ultrasound	302,095,394	416,277,888	17.4	493,883,294	18.6	1.3
Not Classified *	12,045,796	875,746	NA	881,612	NA	NA
Subtotal, Diagnostic Radiology	603,944,628	781,031,300	13.7	918,242,775	17.6	3.8
Radiation Oncology	9,635,723	11,219,936	7.9	10,826,849	-3.5	-11.4
Total, All Radiology	613,580,351	792,251,236	13.6	929,069,624	17.3	3.6

Revised 7/23/91.

Growth Rate of Allowed Charges

(Rate for radiologists & all others under the fee schedule compared to rate for those not under fee schedule [non-radiologist physicians]; uses narrow measure of ultrasound)



EFFECT OF RVS ON
GROWTH RATE OF ALLOWED DOLLARS
ALL UNDER THE FEE SCHEDULE
OMITS 9 STATES
Source: HCFA/BMAD Data

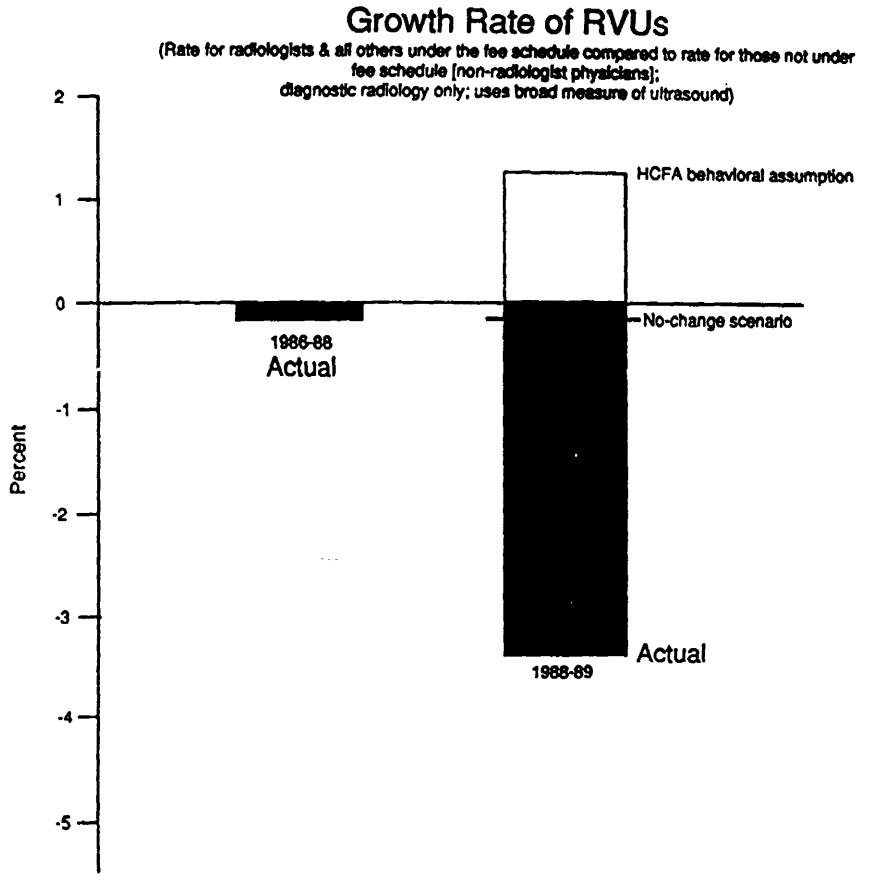
Type of Radiology	Allowed Charges 1986	Allowed Charges 1988	Compounded Annual Growth rate 1986-1988 (Percent)	Allowed Charges 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1986-88 to 1988-89 (% Points)
Angiography	102,814,889	132,081,183	13.3	144,554,594	9.4	-3.9
CT/MR	339,963,878	561,150,552	28.5	577,144,496	2.9	-25.6
General Radiology	665,503,022	799,824,374	9.6	871,067,136	8.9	-0.7
Nuclear Medicine	99,360,183	158,950,130	26.5	160,982,002	1.3	-25.2
Ultrasound exc. vascular & cardiac	83,798,719	113,946,525	16.6	123,876,971	8.7	-7.9
Not Classified *	28,970,368	1,155,177	NA	21,857,466	NA	NA
Subtotal, Diagnostic Radiology	1,320,411,059	1,767,107,941	15.7	1,899,482,665	7.5	-8.2
Radiation Oncology	216,908,181	296,280,148	16.9	368,442,484	24.4	7.5
Total, All Radiology	1,537,319,240	2,063,388,089	15.9	2,267,925,149	9.9	-5.9

Revised 7/23/91.

EFFECT OF RVS ON
GROWTH RATE OF ALLOWED DOLLARS
NONRADIOLOGIST PHYSICIANS ONLY
OMITS 9 STATES
Source: HCFA/BMAD Data

Type of Radiology	Allowed Charges 1986	Allowed Charges 1988	Compounded Annual Growth rate 1986-1988 (Percent)	Allowed Charges 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1986-88 to 1988-89 (% Points)
Angiography	13,899,239	24,024,799	31.5	30,948,617	28.8	-2.7
CT/MR	13,476,560	18,325,130	16.6	20,815,155	13.6	-3.0
General Radiology	251,987,034	290,841,440	7.4	328,999,617	13.1	5.7
Nuclear Medicine	10,440,605	30,686,297	71.4	42,714,480	39.2	-32.2
Ultrasound exc. vascular & cardiac	110,190,188	120,383,846	4.5	121,531,157	1.0	-3.6
Not Classified *	12,045,796	875,746	NA	881,612	NA	NA
Subtotal, Diagnostic Radiology	412,039,422	485,137,258	8.5	545,890,638	12.5	4.0
Radiation Oncology	9,635,723	11,219,936	7.9	10,826,849	-3.5	-11.4
Total, All Radiology	421,675,145	496,357,194	8.5	556,717,487	12.2	3.7

Revised 7/23/91.


Growth Rate of RVUs
(Rate for radiologists & all others under the fee schedule compared to rate for those not under fee schedule [non-radiologist physicians];
diagnostic radiology only; uses broad measure of ultrasound)
Percent
2
1
0
-1
-2
-3
-4
-5
HCFA behavioral assumption
No-change scenario
1986-88
Actual
1988-89
Actual

EFFECT OF RVS ON
GROWTH RATE OF RVUs
ALL UNDER THE FEE SCHEDULE
OMITS 9 STATES
Source: HCFA/BMAD Data

Type of Radiology	# of RVUs 1986	# of RVUs 1988	Compounded Annual Growth Rate1986-1988 (Percent)	# of RVUs 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1986-88 to 1988-89 (% Points)
Angiography	10,520,639	11,389,635	4.0	12,315,594	8.1	4.1
CT/MR	25,139,734	38,496,020	23.7	44,951,901	16.8	-7.0
General Radiology	59,050,174	65,255,098	5.1	67,734,310	3.8	-1.3
Nuclear Medicine	6,930,842	10,439,424	22.7	11,768,202	12.7	-10.0
ULTRASOUND 70000 U.S. excl. vascular & cardiac	7,084,423	8,762,868	11.2	9,466,760	8.0	-3.2
70000 U.S. Vascular	145,100	296,615	43.0	522,163	76.0	33.1
70000 U.S. Cardiac	638,833	1,140,473	33.6	374,307	-67.2	-100.8
90000 Vascular	1,049,796	1,670,368	26.1	1,950,183	16.8	-9.4
90000 Cardiac	472,496	782,331	28.7	1,330,409	70.1	41.4
Subtotal, Expanded Ultrasound	9,390,648	12,652,655	16.1	13,643,822	7.8	-8.2
Total Diagnostic Radiology	**111,032,037**	**138,232,832**	**11.6**	**150,413,829**	**8.8**	**-2.8**

Revised 7/30/91.

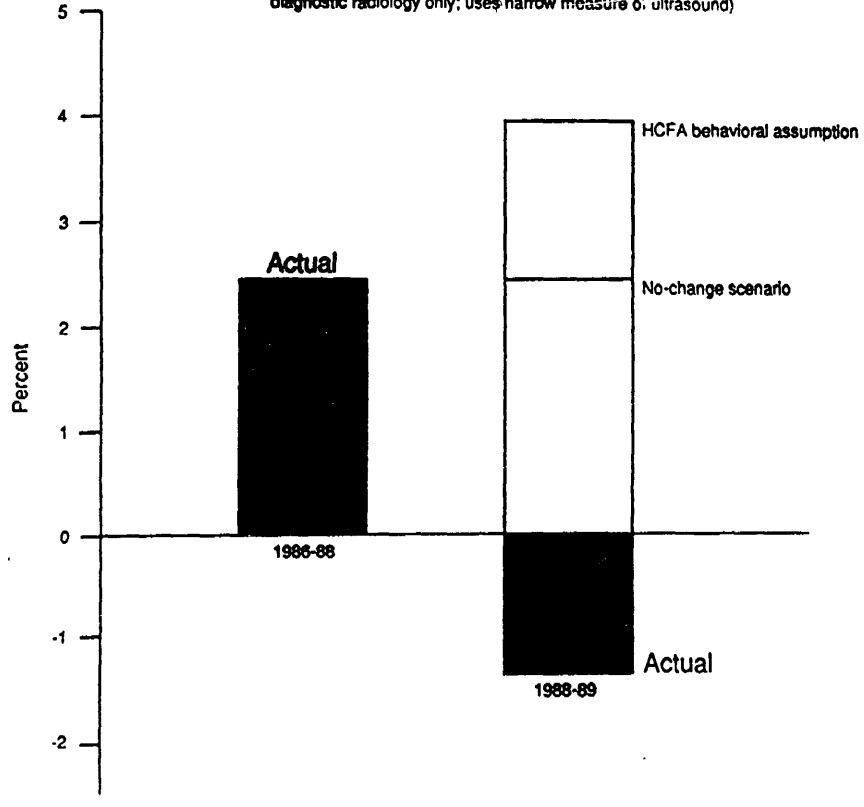
EFFECT OF RVS ON
GROWTH RATE OF RVUs
NONRADIOLOGIST PHYSICIANS ONLY
OMITS 9 STATES
Source: HCFA/BMAD Data

Type of Radiology	# of RVUs 1986	# of RVUs 1988	Compounded Annual Growth Rate1986-1988 (Percent)	# of RVUs 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1986-88 to 1988-89 (% Points)
Angiography	1,578,249	2,192,476	17.9	2,563,634	16.9	-0.9
CT/MR	1,226,606	1,553,410	12.5	1,762,406	13.5	0.9
General Radiology	21,853,974	23,250,962	3.1	25,394,637	9.2	6.1
Nuclear Medicine	808,720	2,291,407	68.3	2,883,896	25.9	-42.5
ULTRASOUND 70000 U.S. excl. vascular & cardiac	5,896,824	7,813,822	15.1	8,289,093	6.1	-9.0
70000 U.S. Vascular	214,244	299,924	18.3	501,628	67.3	48.9
70000 U.S. Cardiac	2,954,236	3,713,581	12.1	1,765,796	-52.5	-64.6
90000 Vascular	3,105,491	4,279,752	17.4	5,342,869	24.8	7.4
90000 Cardiac	3,864,179	6,522,197	29.9	9,759,802	49.6	19.7
Subtotal, Expended Ultrasound	16,034,974	22,629,276	18.8	25,659,188	13.4	-5.4
Total Diagnostic Radiology	**41,502,523**	51,917,531	**11.8**	**58,263,761**	**12.2**	**0.4**

Revised 7/30/91.

Growth Rate of RVUs

(Rate for radiologists & all others under the fee schedule compared to rate for those not under fee schedule (non-radiologist physicians);
diagnostic radiology only; uses narrow measure of ultrasound)



EFFECT OF RVS ON
GROWTH RATE OF RVUs
ALL UNDER THE FEE SCHEDULE
OMITS 9 STATES
Source: HCFA/BMAD Data

Type of Radiology	RVUs 1986	# of RVUs 1988	Compounded Annual Growth rate 1986-1988 (Percent)	# of RVUs 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1986-88 to 1988-89 (Percentage Points)
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CT/MR	25,139,734	38,496,020	23.7	44,951,901	16.8	-7.0
General Radiology	59,050,174	65,255,098	5.1	67,734,310	3.8	-1.3
Nuclear Medicine	6,930,842	10,439,424	22.7	11,768,202	12.7	-10.0
Ultrasound exc. vascular & cardiac	7,084,423	8,762,868	11.2	9,466,760	8.0	-3.2
Total Diagnostic Radiology	**108,725,812**	**134,343,045**	**11.2**	**146,236,767**	**8.9**	**-2.3**

Revised 7/23/91

EFFECT OF RVS ON
GROWTH RATE OF RVUs
NON RADIOLOGIST PHYSICIANS ONLY
OMITS 9 STATES
Source: HCFA/BMAD Data

Type of Radiology	RVUs 1986	# of RVUs 1988	Compounded Annual Growth rate 1986-1988 (Percent)	# of RVUs 1989	Annual Growth rate 1988-1989 (Percent)	Change from 1986-88 to 1988-89 (Percentage Points)
Angiography	1,578,249	2,192,476	17.9	2,563,634	16.9	-0.9
CT/MR	1,226,606	1,553,410	12.5	1,762,406	13.5	0.9
General Radiology	21,853,974	23,250,962	3.1	25,394,637	9.2	6.1
Nuclear Medicine	808,720	2,291,407	68.3	2,883,896	25.9	-42.5
Ultrasound exc. vascular & cardiac	5,896,824	7,813,822	15.1	8,289,093	6.1	-9.0
Total Diagnostic Radiology	31,364,373	37,102,077	8.8	40,893,666	10.2	1.5

Revised 7/23/91

PREPARED STATEMENT OF P. JOHN SEWARD, M.D.

The American Medical Association (AMA) acknowledges the Committee's long standing interest and involvement in Medicare physician payment reform. We appreciate the extraordinary letter dated June 28, 1991 to the Department of Health and Human Services (HHS) signed by several members of the Committee. We share your concerns and appreciate your assistance in resolving these issues.

Over the past few weeks there has been much discussion of the options under the law available to the Health Care Financing Administration (HCFA) Administrator in resolving the conversion factor problem. All agree that there are ambiguities in the law that need interpretation. To assist HHS, HCFA and others, the AMA requested a letter of opinion from the respected law firm of Sidley and Austin concerning these issues. This letter of opinion indicates that the 16% reduction is not inevitable and in fact contravenes the statute. A copy of this letter of opinion is attached as Appendix I for your reference.

The physicians of America are upset at the proposed payment levels in the June 5, 1991 Notice of Proposed Rule Making (NPRM) on Medicare physician payment reform. The NPRM reflects a devastating and immediate 16% reduction in the schedule's initial conversion factor. *Overall payments*, not *just payments per service*, will be reduced by this 16% payment reduction. The medical profession appreciates the Committee's prompt action to hold this hearing to identify problems in the NPRM so that you can assist by making corrections that will keep physician payment reform on track.

Two years ago the medical profession put special interests aside and worked with Members of Congress to enact a historic revision of the Medicare payment system for physicians' services. The common goal was to implement a more rational and predictable method of physician payment. Legislative history makes it clear that Medicare physician payment reform was not to be used as a budget cutting device. In fact, Congress went to great lengths to emphasize that the transition to the new payment system should be implemented on a budget neutral basis. However, budget neutral implementation will not occur if the NPRM is allowed to become final as proposed.

The medical profession supported payment reform based on assurances from Congress and the Physician Payment Review Commission (PPRC) that it would be implemented in a fair and reasonable manner, and would not be used as a device to slash the budget. Contrary to Congress' intent and its commitment to physicians, and as HCFA's own analysis demonstrates, the proposed conversion factor transform payment reform into a budget cutting tool. Physicians' confidence in and cooperation with payment reform and the Medicare program are in serious jeopardy. However, these cuts are not automatic or inevitable. The AMA hopes that we can work with Congress and the Administration to eliminate these cuts.

According to the physician payment reform provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA-89), payment amounts in each locality will be determined by an RBRVS, a geographic adjustment factor, and a monetary conversion factor, which converts the relative value units (RVUs) into dollars. Congress intended for payment reform to neither increase nor decrease overall Medicare payments to physicians. However, HCFA's own interpretation of the OBRA-89 legislation that is reflected in the NPRM produces a severe 16% reduction in the proposed conversion factor for the new payment schedule from an otherwise "budget neutral" level.

This drastic reduction is in turn reflected in the NPRM's simulations of the impact of payment reform on specialties and states. The simulations show projected payment increases for physicians in rural states and in primary care specialties to be substantially lower than previous forecasts. The simulations also show steeper payment cuts for urban areas and for surgical specialties.

In contrast, the Congressional intent of physician payment reform was to increase Medicare payments to physicians providing primary care and rural services for physicians such as those in family practice and internal medicine and to moderate losses. If these proposals are finalized in their present form, physicians can only conclude that the federal government has broken faith with the medical profession and its patients.

PROPOSED CONVERSION FACTOR REDUCTION

The proposed 16% reduction in the conversion factor results from a misinterpretation by HCFA of the mandate for budget neutrality contained in OBRA-89, as well as from inappropriate and demeaning assumptions about anticipated physician behavior in response to payment reform. OBRA-89 requires the agency to establish a conversion factor such that aggregate Medicare expenditures for physician services

in 1992 will be the same as they would have been under a continuation of the current payment system. HCFA has interpreted this provision as requiring two reductions in the conversion factor: One to offset volume increases that it projects will occur as a behavioral response to payment reductions; and one to offset spending projected to result from the payment system's transition formula for 1992.

Volume Offset Assumption

The proposed volume offset is based on the view that payment changes alter the volume of services. This offset is based on HCFA's undocumented belief that expenditures will increase by $0.50 for every $1 payment reduction as physicians offset payment cuts. This assumption is not justified and the AMA strongly opposes the use of any "behavioral" offset to reduce 1992 payments.

In the section of the NPRM that discusses global surgical packages, HCFA's statements about physician volume responses completely contradict its earlier statements in the conversion factor section. Explaining its appropriate decision to exclude all return trips to the operating room from the global package, HCFA states:

> We do not believe that paying for a surgeon's services during return trips to the operating room would result in abuse. *We do not believe physicians would subject their patients to risk merely to secure additional payment.* Nor do we believe that hospitals or peer review groups would permit this practice to continue if it did occur. (p. 25831, emphasis added.)

Because most of the services for which payments will be reduced under payment reform are surgical services, the agency is essentially advocating a contradictory view that physicians will subject their patients to unnecessary risk for an initial operation merely to secure additional payment, but they will not subject their patients to the risk of reoperation merely for financial gain.

Furthermore, a recent symposium on this issue, jointly sponsored by the AMA and Project Hope, demonstrated that there is no firm analytic basis for HCFA's predictions about volume responses to payment changes, and that there is considerable uncertainty regarding the existence, magnitude, and direction of any potential changes in utilization as a response to changes in payment.

A PPRC analysis of data from the 1990 Supplementary Medical Insurance Trustees Report demonstrates that volume growth was lower in the 5 years including and following the 1984 and 1986 Medicare fee freeze than it was in the five years prior to the freeze. At minimum, these data provide absolutely no support for widespread physician behavioral responses to Medicare fee restrictions.

In the NPRM, HCFA attempts to justify its volume offset assumptions by citing the many simultaneous changes occurring under payment reform, such as payment increases and decreases, new visit codes, global surgical packages, and balance billing limits. HCFA goes on to argue that these changes will in turn lead to utilization changes, and that their net effect will be an increase in Medicare spending. On the contrary, the many simultaneous changes only add to the uncertainty surrounding volume and expenditure projections.

The mechanism established by Congress, the Medicare Volume Performance Standard (MVPS), was to respond to potential inappropriate increases in volume. HCFA attempts in the NPRM to refute this argument by stating that the MVPS is an inadequate tool for correcting such increases. The reasons given are that there are limits on the amount by which the payment update may be reduced if the MVPS is exceeded, there is a full two-year period between the volume increase and the reduction in the payment update, and there is an inability to reverse increases in the expenditure baseline. However, the limit applies only if Congress does not act on the payment update. Congress still has the authority to supersede the limit if it deems volume increases are excessive.

Moreover, HCFA's volume offset assumption is demeaning to physicians and patients. Regardless of its statements about responses to coding changes and limiting charges, the basis for this proposed conversion factor reduction is HCFA's belief that physicians will purposely increase volume to offset payment reductions. In responding to the Congressional Budget Office (CBO) position that payment increases will also produce volume decreases, HCFA states that: "We have much less experience with observing behavioral responses to increases in fees" (p. 25823). In truth, the agency has no clear evidence of a behavioral response to payment reductions.

Transition Formula Correction

Because HCFA estimates the transition formula will lead to an increase in Medicare spending in 1992 as a result of payment increases occurring faster than payment decreases, a payment reduction to correct for the effects of the transition for-

mula is proposed. HCFA does acknowledge that OBRA-89 does not reconcile the transition rules with the budget neutrality requirement.

We believe that the statute is, in fact, clear on this point. The statute requires that the budget neutral conversion factor is to be calculated "without regard" to the transition paragraphs and their potential budget consequences. This language is plain on its face and consistent with Congress' intent to accelerate increases in primary care and rural services and to prevent precipitous cuts in other services.

Tripling Effect

The third factor contributing to the severe proposed reduction in the conversion factor is HCFA's interpretation of the OBRA-89 budget neutrality provision as requiring that the behavioral offset reduction and the transition correction be addressed solely through the payment schedule conversion factor even though Medicare payments for most services in 1992 will be a blend of the new payment schedule and adjusted current payments. HCFA has estimated that because of the resulting tripling effects, a 16% reduction in the conversion factor is required to produce the 5% reduction in Medicare payments (a 3% volume offset plus a 2% transition formula correction) that it estimates is necessary to maintain budget neutrality in 1992. In addition, although there is no requirement for budget neutrality in the years subsequent to 1992, the 16% reduction will have a substantial down-the-road impact. By 1996, when the payment schedule is fully implemented, the cut will constitute enormous reductions in Medicare physician payments.

While there are numerous sections of the NPRM where HCFA attempts to assess Congressional intent and concludes that the statutory language must be in error or is sufficiently ambiguous to allow for various interpretations, no such analysis of Congress wishes is reflected in this section. In fact, this massive cut is contrary to Congressional goals. In reforming Medicare's physician payment system, Congress clearly intended to increase patient access to primary care services and improve the availability to physicians' services in rural areas. In sharp contrast to this intent, HCFA's regulatory impact analysis demonstrates that its proposed 16% conversion factor reduction, if finalized, would nullify projected payment increases for primary care physicians and rural areas.

In addition, the proposed reduction would deepen payment cuts for surgical and other specialties. Proposed cuts of 20% for general surgeons, 35% for ophthalmologists, and 31% for thoracic surgeons, particularly following several years of "overvalued" procedure reductions, will bring some Medicare payments near to or below Medicaid levels, with serious consequences for elderly and disabled patients' access to care. For example, data on five physician services, from a limited PPRC survey of national Medicaid payments indicate that Medicare rates will be near or below the Medicaid rate for all five services in Arkansas, Minnesota, and Texas.[1] Furthermore, increases in rural areas will be substantially reduced with 40 states suffering losses in Medicare payments in 1992 and 49 states suffering losses in the next five years. Out of the 240 Medicare payment localities in the nation, only 14 will see a payment increase by 1996.

AMA PROPOSED SOLUTION

The AMA, working with all of organized medicine, is embarking on a major effort to reverse these cuts. We have initiated an unprecedented grassroots campaign to encourage physicians to provide their comments to HCFA. It is our desire to address this issue through the regulatory process. We believe these matters can be and will be best handled by modifications to the proposed rules.

We expect that many physicians will call for repeal of physician payment reform. These sentiments are certainly understandable. We want to assure you, however, that the AMA remains committed to physician payment reform. We simply want to make it work. Thus, we will focus our attention on correction of the policy decisions based on HCFA's statutory misinterpretations so that payment reform can go forward as intended.

Our administrative or legislative approach includes the following elements:

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[1] The services involved were hysterectomies, upper GI endoscopy, cataract removal with lens implant, inguinal hernia repair and a chest x-ray (2 views—professional component.) Although to date we have not reviewed all states, California, Connecticut, Florida, Georgia, Illinois, Kansas, Massachusetts, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Dakota, West Virginia and Wisconsin all had one or more of the services reimbursed at or below the Medicaid rate.

First, for the so-called transition asymmetry, we will seek further clarification that OBRA-89 neither requires nor allows HCFA to cut payments because the 1992 transition might not be budget neutral. The statute (42 U.S.C. §1395 w-4(a)(2)(A-B)) states that services subject to transition limits will be paid "at an amount equal to the adjusted historical payment basis plus (or minus) 15 percent of the fee schedule amount *otherwise established (without regard to this paragraph).*" (Emphasis added.)

In the event that any transition-related adjustment is allowed, we will seek a correction for the current ambiguity so that any such adjustment is applied to the historical payment basis only, and not to the conversion factor. *Success on this point eliminates about one third of the 16% cut.*

Second, we will seek a Congressional directive that HCFA use no "behavioral offset." As stated earlier, there is *no clear analytic basis* for any such response. The fact that both the CBO and PPRC interpret the available evidence as indicating an offset of *only 1%* illustrates the range of legitimate opinion on this issue.

If any offset is to be allowed, however, we will seek a legislative instruction that HCFA utilize CBO assumptions that volume also will be reduced where payments increase. We also will ask that the statute be revised by requiring that any such offset be equally applied to the historical payment basis and the conversion factor. *Eliminating or reducing this offset, and not placing all of the adjustment on the conversion factor, removes all, or at least most of the balance of the 16% cut.*

Concerns have been raised that such a solution would be difficult to implement because of the Congressional "pay-as-you-go" budget rules, which would require that alternate budget savings be found to replace the savings projected to result from making all of the budget neutrality adjustments through the conversion factor. As is stated in the legal memorandum in Appendix I, the AMA does not believe that the "pay-as-you-go" budgetary scoring process applies to administrative proposals such as the NPRM. Accordingly, they do not preclude the Secretary from adopting regulations or policies that would result in budgetary projections that are different from the projections resulting from the Secretary's current proposal. Reiterating a point made in a June 10 hearing before the PPRC by James S. Todd, MD, AMA Executive Vice President: "We would prefer administrative and legislative approaches that will not trigger budget concerns. Nevertheless, we do not believe that physicians should be penalized under these 'pay-as-you-go' rules as a result of drafting ambiguity. We will not allow a faulty automatic pilot to drive payment reform onto the shoals of disaster."

CONCLUSION

Congress, as much as anyone, has a major stake in seeing a smooth transition to physician payment reform. For example, Congress based its call for balance billing limits on a belief that physicians should accept "fair" payments. These limits must now be reconsidered. *"Fair" relative values linked to an absurd conversion factor do not produce fair payment levels.* Access may become a real concern.

In conclusion, we would like to acknowledge that the NPRM involves much more than the conversion factor. We have many areas of concern. A copy of our final comments to the NPRM will be forwarded to the Committee this August. We are certainly gratified that HCFA worked so closely and effectively with the CPT editorial panel on visit code reform and has expressed clear interest in our proposal for an AMA/specialty society RVS update process.

Thank you for calling this hearing and inviting the AMA to testify. Your interest and letter reflect our strong view that we have all invested too much time and effort on payment reform to see it destroyed.

RESPONSES OF DR. SEWARD TO QUESTIONS FROM SENATOR BENTSEN

Question. Doctors, your members are understandably upset about the unanticipated and unintended reduction to the conversion factor on account of the so-called transition problem. I and other members of the Committee are looking for ways to correct it without having to cut Medicare payments further or raise taxes.

In your testimony, however, you both urge the Committee (absent a change from HCFA) to amend the law to mandate that the budget neutrality calculation not include the projected net cost of the transition provision.

Am I mistaken or does this mean that you want Congress to permit Medicare physician spending to increase 2 percent above budget neutral levels?

I thought physicians simply wanted a transition that is truly budget-neutral?

Answer. Although the NPRM proposes a conversion factor reduction to "correct" for the effects of the transition formula asymmetry, there is no authority for this reduction. As HCFA states in the preamble (p. 25820), OBRA-89 "does not specify

precisely how the application of the transition rules . . . is to be reconciled with the budget neutrality requirement." In fact, in our view, the statutory language is quite clear. The statute states that services subject to transition limits are to be paid "at an amount equal to the adjusted historical payment basis plus [or minus] 15% of the fee schedule amount *otherwise established (without regard to this paragraph)*" (Section 1848(a)(2)(A-B) of the Social Security Act, emphasis added). This language is plain on its face and consistent with Congressional intent. The legal opinion attached to our written statement more fully discusses this issue. In enacting physician payment reform for Medicare, it is our understanding that Congress intended to: (1) accelerate increases in payment for primary care services; (2) accelerate increases in payment for care provided in rural settings; and (3) prevent precipitous cuts in other services. We believe that the new system should be consistent with the Congressional intent.

Question. Dr. Seward, in your written testimony, you indicate that if it is impossible to eliminate the transition problem completely, the American Medical Association supports making any budget neutrality adjustment solely to the historical portion of the blended payment formula.

While I understand that this approach would leave the conversion factor untouched, I am somewhat surprised to hear the AMA adopt this approach, since it would seem to accelerate significantly the transition for surgeons, anesthesiologists, and radiologists, many of whom are also AMA members. Could you explain how you arrived at this position?

Answer. The Association believes that there is no authority to make adjustments for any "behavioral" or transition effects. However, at the very least if HCFA insists on maintaining its positions on the transition and the volume offsets, we believe that where adjustments are made in response to the transition or to projected volume responses that they should be applied only to the final payment levels. Our previous statement had indicated that any adjustment in response to the transition should be applied to the adjusted historical payment basis (AHPB) out of a desire to avoid a *permanent* conversion factor reduction. Upon further consideration, we have concluded that applying any adjustment to the final payment level is a preferred solution, as it would prevent the effect of compounding any "correction" beyond the 1992 period when budget neutrality would be applicable without accelerating the transition for services and specialties facing costs, and without the multiplier effect of loading the reduction onto the AHPB.

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July 11, 1991

James S. Todd, M.D.
American Medical Association
515 North State Street
Chicago, Illinois 60610

Re: Computation of Initial Conversion Factor for
Medicare Fee Schedule: Proposed HHS Rule

Dear Dr. Todd:

You requested our opinion concerning certain aspects of the regulations proposed by the Secretary of Health and Human Services (the "Secretary" or "HHS") on June 5, 1991. See 56 Fed. Reg. 25792. As you know, the proposed regulations implement sweeping payment reforms under Part B of Medicare. These reforms have their origin in the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, 103 Stat. 2106 ("OBRA '89"). OBRA '89 requires the Secretary to develop a fee schedule for physician services based on a resource-based relative value scale ("RBRVS"). 42 U.S.C. § 1395w-4(b). The fee schedule will be phased in between 1992 and 1995, with the new system fully effective in 1996. 42 U.S.C. § 1395w-4(a).

The Secretary's June 5 proposal implements the OBRA '89 reforms by, among other things, calculating a "conversion factor" that will determine the total amount of Medicare expenditures for physician services once the transition to the fee schedule begins in 1992. Under the Secretary's approach, two "offsets" are applied that substantially reduce the initial conversion factor: (1) a volume offset to account for increases anticipated by HHS in the volume and intensity of services provided by physicians in response to payment reform, and (2) a transition offset to account for the projected effects of an "asymmetry" in the statutory formula for phasing in the fee schedule. The Secretary maintains that each of these offsets is necessary in order to comply with a statutory mandate of "budget neutrality."

You asked for our opinion as to whether the Secretary's proposed method for calculating the initial conversion factor is consistent with the terms of OBRA '89. You also asked us to consider whether the Secretary has discretion to adopt

alternative approaches. Finally, you asked whether the "Pay-As-You-Go" provisions of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, 104 Stat. 1388 ("OBRA '90"), impose any constraint on the Secretary's ability not to include the offset proposals in the final rulemaking.

Our conclusions, in brief, are as follows:

SUMMARY OF CONCLUSIONS

I. In enacting OBRA '89, Congress did not intend the Secretary to reduce the initial conversion factor to offset projected increases in volume and intensity of services.

A. The proposed volume offset is contrary to congressional intent. Both the language and the history of OBRA '89 indicate that Congress intended the Secretary to make any adjustments for behavioral changes retrospectively through the MVPS mechanism, rather than through a prospective offset to the initial conversion factor. This approach was consistent with the congressional purpose of phasing in payment reform slowly to avoid jarring dislocations in availability of and access to services. Moreover, it reflected Congress' concern that any prospective volume offset would be based on highly speculative projections rather than actual volume performance.

B. The volume offset that the Secretary proposes is too high and should not be loaded on to the conversion factor. Even if the Secretary were permitted to apply some volume offset, nothing in OBRA '89 compels the Secretary to apply a volume offset in the amount of 3%. Further, the Secretary is incorrect in assuming that any offset must be applied to the initial conversion factor. When coupled with the transition offset, the Secretary's approach results in a 16% reduction not only in the initial conversion factor, but in all subsequent conversion factors. As a result, Medicare payments will be reduced dramatically -- indeed, for some services and in some states, they may fall below Medicaid levels. The Congress that enacted OBRA '89 did not intend this result.

II. OBRA '89 prohibits the Secretary from reducing the initial conversion factor to offset any potential impact of the transition formula.

A. The proposed transition offset is inconsistent with OBRA '89. The statutory language of OBRA '89 clearly indicates that the fee schedule amount must be established "without regard to" the effects of the transition formula. Because the conversion factor is a necessary component of the fee schedule amount, it too must be determined without regard for any "asymmetry" resulting from application of the transition formula. Only after the conversion factor has been established is the transition formula to be applied to determine a 1992 transition payment amount. This approach is consistent with the congressional purpose of phasing in payment reform on a graduated basis. It is also consistent with the so-called "budget neutrality" provision.

B. In any event, the Secretary has discretion not to apply a transition offset. The Secretary's conclusion that "asymmetry" will result from the transition formula is based on questionable assumptions that are by no means compelled by the statute. If the Secretary used more supportable assumptions regarding the effects of the transition, there would be little or no asymmetry and therefore no need for a transition offset. If some transition adjustment is made, however, it should not be applied to the initial conversion factor.

III. The OBRA '90 "Pay-As-You-Go" provisions do not require the Secretary to apply a volume offset or a transition offset. These provisions do not apply to administrative determinations. Moreover, they do not bind the Secretary to the assumptions made by the Congressional Budget Office and the Office of Management and Budget in the course of preparing their required budget estimates. Accordingly, the "Pay-As-You-Go" provisions do not prevent the Secretary from deciding not to include the offset proposals in the final rulemaking.

The reasons for these conclusions are set forth below. To place the issues in perspective, this letter begins by describing (a) the relevant statutory provisions of OBRA '89, and (b) the Secretary's proposal.

BACKGROUND

A. Relevant Statutory Provisions

Section 6102 of OBRA '89, 42 U.S.C. § 1395w-4, sets forth the basic requirements for physician payment reform. Under section 6102, physician payment under a fully implemented fee schedule is based on three components:

- a relative value assigned to each medical service based on the resources (in work, practice costs, and professional liability costs) required to perform the service;
- geographic adjustment factors based on the costs of operating a medical practice and obtaining professional liability insurance in the particular geographic region where a physician practices; and
- a conversion factor that transforms the geographically-adjusted relative value for a service into a payment amount under the fee schedule.

42 U.S.C. § 1395w-4(b)(1). Multiplying these components together produces the fee schedule amount for any particular medical service. Id. Payment is based on the lesser of the fee schedule amount and the physician's actual charge for the service. 42 U.S.C. § 1395w-4(a)(1).

The Initial Conversion Factor. Subsection (d)(1)(B) of section 6102, 42 U.S.C. § 1395w-4(d)(1)(B), requires the Secretary to compute an initial conversion factor for 1992. In doing so, the Secretary must establish a figure that:

> if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.

Id.[1] As a convenient shorthand, subsection (d)(1)(B) is sometimes said to establish a requirement of "budget neutrality." See, e.g., H. Conf. Rep. No. 386, 101st Cong., 1st Sess. 759 (1989), reprinted in 1989 U.S. Code Cong. & Admin. News 3362

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[1] The resulting figure is then "updated" to 1992. 42 U.S.C. § 1395w-4(d)(1)(A).

("Conference Report") ("the initial conversion factor is a conversion factor . . . which if the provision had applied during 1991 would result in budget neutrality for that year").

Payments During Transition Period. During the transition period from 1992 through 1995, payment is made according to a mixture of the current customary, prevailing, and reasonable charge system ("CPR") and the new fee schedule. The formula for blending the old and new payment amounts is set forth in subsection (a)(2), 42 U.S.C. § 1395w-4(a)(2).

Under this provision, calculation of the 1992 payment amount for each service begins with the "fee schedule amount otherwise established (without regard to this paragraph [i.e., subsection (a)(2)])." Id. Thus, to apply the transition formula, fee schedule amounts must already have been computed in accordance with subsections (b)(1) and (d)(1)(B). The fee schedule amounts are then compared to the "adjusted historical payment basis" ("AHPB") for each service within each locality. The AHPB is essentially the weighted average prevailing charge for the service in 1991, updated to 1992. 42 U.S.C. § 1395w-4(a)(2)(D)(i). If the service has an AHPB between 85% and 115% of the fee schedule amount, it is reimbursed at the fee schedule amount.

All other payments are made at a blended rate. If the AHPB for a service is less than 85% of the fee schedule amount, the 1992 transition payment will be equal to "the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established." 42 U.S.C. § 1395w-4(a)(2)(A)(i). Similarly, if the AHPB exceeds 115 percent of the fee schedule amount, the 1992 transition payment will be equal to "the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established." 42 U.S.C. § 1395w-4(a)(2)(A)(ii). Payments in 1993 through 1995 continue in transition using blended rates until the fee schedule is fully implemented.

Updates to Conversion Factor. Section 6102 also provides a mechanism for making annual updates to the conversion factor. These updates are linked to the Medicare Volume Performance Standard ("MVPS") established either by Congress or by a statutory default formula. 42 U.S.C. § 1395w-4(f)(1)(A). The MVPS is a spending goal -- based largely on anticipated volume of services -- that provides a point of comparison between projected and actual expenditures.

The process operates as follows: In the spring of each year, HHS makes recommendations to Congress regarding the MVPS

for the following year. 42 U.S.C. § 1395w-4(f)(1)(A). Shortly after HHS submits its recommendations, the Physician Payment Review Commission ("PPRC") provides its recommendations to Congress concerning the appropriate MVPS. 42 U.S.C. § 1395w-4(f)(1)(B). After receiving these recommendations, Congress either establishes the MVPS or allows the statutory default formula to go into effect. 42 U.S.C. § 1395w-4(f)(2). The default formula ties the MVPS to a number of factors, including:

- the average annual rate of growth in volume and intensity over the preceding five year period,
- the increase in physician fees for the relevant year,
- the effect of changes in the law, and
- the "performance standard factor" established by Congress for the year.[2]

42 U.S.C. § 1395w-4(f)(2)(A).

The MVPS for a particular year plays an important role in establishing subsequent updates to the conversion factor. In the spring of each year -- along with its recommendations to Congress concerning the MVPS -- HHS also submits recommendations regarding the update to the conversion factor for the following year. 42 U.S.C. § 1395w-4(d)(2). In making its recommendations, HHS is required to consider, among other things:

- changes in volume or intensity of services,
- the amount by which any increase or decrease in actual expenditures during the preceding year was greater or less than the goals established under the MVPS,
- the percentage change in the Medicare Economic Index,
- access to services, and

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[2] The performance standard factor is .5 percentage points for 1990, 1 percentage point in 1991, 1.5 percentage points in 1992, and 2 percentage points for 1993 and thereafter. 42 U.S.C. § 1395w-4(f)(2)(B).

- other factors that may contribute to changes in volume or intensity of services or access to services.

42 U.S.C. § 1395w-4(d)(2)(A). The Secretary may also consider "unexpected changes by physicians in response to the implementation of the fee schedule." 42 U.S.C. § 1395w-4(d)(2)(B)(i). As with the MVPS, the PPRC reviews the HHS recommendations and submits its own recommendations to Congress regarding the update to the conversion factor. 42 U.S.C. § 1395w-4(d)(2)(F). And, as with the MVPS, Congress is expected to enact legislation to establish the update to the next year's conversion factor.[3]

If Congress does not act, however, the statute again provides a default formula. The default formula for the conversion factor update begins with the Medicare Economic Index ("MEI"), a measure of general inflation in the cost of operating a medical practice. The default formula adjusts the MEI by the difference between the MVPS and the actual change in expenditures. 42 U.S.C. § 1395w-4(d)(3)(B)(i). For example, if the MVPS is 9% and expenditures increase by 10%, the update will be the MEI minus 1 percentage point.

In addition, the statutory default formula places a floor on negative adjustments to the conversion factor update. 42 U.S.C. § 1395w-4(d)(3)(B)(ii). In 1992 and 1993, the limit is 2 percentage points below the MEI. The limit is 2.5 percentage points for 1994 and 1995, and 3 percentage points for 1996 and thereafter. These limits do not apply if the update is established by Congress rather than by the default formula. PPRC, 1990 Annual Report to Congress 29.

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[3] See PPRC, 1990 Annual Report 28 (OBRA '89 "calls for the Congress to make annual decisions on the performance standard . . . and on the conversion factor update"); PPRC, 1991 Annual Report 128 (noting that, in enacting 1990 budget legislation, Congress did not allow MVPS default formula to take effect and concluding that "Congress plans to exercise its judgment concerning the appropriate rate of growth of outlays and the concomitant fee update."); see also H. Conf. Rep. No. 386 at 760, 1989 U.S. Code Cong. & Admin. News 3363 ("The MVPS is to be established by the Congress").

B. The Secretary's Proposal

The Secretary's June 5 Notice of Proposed Rulemaking ("NPRM") interprets subsection (d)(1)(B) as requiring that each of two offsets be applied to the initial conversion factor in order to achieve "budget neutrality." First, the Secretary proposes a "volume offset" to reflect increases anticipated by the Secretary in the volume and intensity of services provided by physicians in 1992. See 56 Fed. Reg. at 25822-23. In this regard, the Secretary assumes that physicians will attempt to recoup losses resulting from payment reductions by "bill[ing] for a higher level of services, particularly visits, or furnish[ing] more concurrent care, consultations, assistants at surgery, and diagnostic tests" than they had prior to the reforms. Id. at 25822. Likewise, the Secretary assumes that "beneficiaries could seek additional services because of lower out-of-pocket costs." Id. The Secretary concludes that average payments in 1992 must be lowered by 3% in order to offset the anticipated volume increases and maintain budget neutrality. Id. at 25823.

Second, the Secretary proposes a transition offset to account for the projected effects of an "asymmetry" in the statutory transition formula.[4] Specifically, the Secretary concludes that, under the transition formula, payments for those services that will incur an increase will rise faster than the decline in payments for those services that will incur a decrease.[5] The Secretary asserts that, without an adjustment to account for this asymmetry, budget neutrality will not be maintained. 56 Fed. Reg. at 25820. In the Secretary's judgment, a 2% reduction in average payments is necessary to offset the 2% net cost resulting from application of the transition formula. Id. at 25848.

Taken together, the two offsets proposed by the Secretary would result in a 5% reduction in total payments. In addition, however, the Secretary contends that OBRA '89 requires

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[4] These projected effects follow from the Secretary's assumption that all physicians will charge the full fee schedule amount beginning in 1992. See 56 Fed. Reg. at 25823.

[5] As the PPRC explained in its 1991 Annual Report to Congress: "[Under the transition formula], a service with an AHPB of $50 and a fee schedule payment of $100 will be paid at $65 ($50 plus 15 percent of $100), a 30 percent increase. A service with an AHPB of $200 and a fee schedule payment of $100 will be paid at $185 ($200 less 15 percent of $100), a 7.5 percent decrease." Id. at 117 n.2.

that any volume or transition offsets be achieved through adjustment of the conversion factor, rather than reduction of payment amounts. See 56 Fed. Reg. at 25847-48 ("The only statutorily authorized method for re-establishing budget neutrality is to reduce the [conversion factor]."); id. at 25823. Because Medicare payments for most services in 1992 will be a blend of the fee schedule and the AHPB, the Secretary estimates that it is necessary to reduce the conversion factor by about 3% for each 1% in desired budget savings. Id. This "leveraging effect" means that the conversion factor must be reduced by 16% in order to achieve the 5% reduction in Medicare payments that the Secretary concludes is necessary. Id. at 25848.

Under the terms of OBRA '89, the initial conversion factor forms the basis for computation of all subsequent updates to the conversion factor. See id. at 25821-22; PPRC, 1991 Annual Report to Congress 128. As a result, the 16% reduction proposed by the Secretary will continue every year thereafter. Id. at 129-30. This "carryover effect" means that, when the fee schedule is fully implemented in 1996, payments will be 16% lower than they would have been without the two offsets to the initial conversion factor.

DISCUSSION

I. In enacting OBRA '89, Congress did not intend the Secretary to reduce the initial conversion factor to offset projected increases in volume and intensity of services.

Subsection (d)(1)(B) -- the so-called "budget neutrality" provision -- calls for the Secretary to estimate expenditure levels in 1991 under the current payment system. The Secretary must then develop an initial conversion factor that is predicted to result in the same projected level of expenditures under the payment reform as under the current system. In making this prediction, the Secretary must necessarily establish volume figures for each medical service. In the proposed rulemaking, the Secretary establishes these figures based on the assumption that volumes will increase for services that will incur a fee cut. See 56 Fed. Reg. at 25822-23.

In our opinion, this assumption is inconsistent with the intent of Congress in enacting OBRA '89. As explained in Part I-A below, Congress -- in considering the various legislative proposals that led to OBRA '89 -- affirmatively rejected the notion that prospective volume adjustments should be made to the initial conversion factor. It did so in part based on HHS' own assessment of the "uncertainties" regarding any behavioral response to the implementation of the RBRVS. Instead,

Congress intended the Secretary to set the initial conversion factor based on actual volume data extrapolated into 1991. Any volume responses were to be accounted for retrospectively through the MVPS mechanism -- based on actual "volume performance" -- not through a prospective, and necessarily speculative, offset to the initial conversion factor.

Even assuming arguendo that the Secretary may apply some volume offset, the Secretary's proposed 3% offset is excessive and should not be loaded on to the conversion factor. As explained in Part II-B below, the only proposal that Congress ever considered was for an offset of less than 1%. Even that proposal was rejected. Yet the Secretary's proposed volume offset will result in a greater than 10% reduction to the initial conversion factor -- and to subsequent conversion factors -- due to the leveraging and carryover effects. See 56 Fed. Reg. at 25848. Congress plainly did not intend the initial conversion factor to become a means of imposing drastic payment reductions.

A. The proposed volume offset is contrary to congressional intent.

1. The statutory language indicates that the Secretary was not to apply a volume offset in calculating the initial conversion factor.

The Secretary interprets subsection (d)(1)(B) as mandating a volume offset. 56 Fed. Reg. at 25822-23. That subsection, however, makes no reference whatsoever to volume effects. Subsection (d)(1)(B) simply states that an initial conversion factor is to be developed for 1991 that "would result in the same aggregate amount of payments under [Part B of Medicare] for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991." 42 U.S.C. § 1395w-4(d)(1)(B). Even accepting the Secretary's premise that this provision mandates some form of "budget neutrality," the statutory language does not define what is meant by that concept.[6] It certainly does not identify any specific behavioral assumptions that the Secretary is required to use in computing the initial conversion factor.

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[6] Likewise, the Conference Report simply states that "the initial conversion factor is a conversion factor . . . which if the provision had applied during 1991 would result in budget neutrality for that year," without expressly defining what volume figures the Secretary is to use to calculate an initial conversion factor. H. Conf. Rep. No. 386 at 759, 1989 U.S. Code Cong. & Admin. News 3362.

Nevertheless, the Secretary interprets subsection (d)(1)(B) as implicitly instructing the Secretary to make prospective adjustments in the initial conversion factor to account for volume responses and the transition "asymmetry." See 56 Fed. Reg. at 25817. As the Secretary acknowledges, this interpretation is difficult to reconcile with other OBRA '89 provisions regarding payment reform. See id. at 25820 (describing tension between Secretary's interpretation of budget neutrality and transition formula); id. at 25822 (discussing MVPS limits on conversion factor update). Accordingly, the question arises whether an alternative interpretation of subsection (d)(1)(B) is available that would be more harmonious with the language and purposes of the statute as a whole. See, e.g., Bethesda Hospital Ass'n v. Bowen, 485 U.S. 399, 403-05 (1988) (interpretation of statutory provision requires analysis of its language as well as structure and design of statute as a whole).

In our judgment, looking at the entire OBRA '89 statute and its legislative history, the proper interpretation is that a volume offset is not to be applied to the initial conversion factor. Instead, if any volume adjustments are necessary, they are to be made through the MVPS mechanism for adjusting the conversion factor update. 42 U.S.C. § 1395w-4(d)(2), (3); see pp. 6-7, supra. Adjustments are to be made retrospectively based on actual "volume performance" -- not prospectively based on speculation.

Under this approach, the determination of an initial conversion factor involves a relatively straightforward calculation based on three figures: (1) the estimated payment amounts for each service for 1991, (2) the estimated 1991 number of relative value units for each service, and (3) the estimated 1991 volume of each service. The third figure -- volume -- is estimated based on the most current actual volume data available, without any behavioral adjustment. To the extent that the volume figures determined in this fashion end up being either too high or too low, the differences are accounted for through the MVPS mechanism.[7]

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[7] An initial conversion factor calculated in this way would, by definition, be "budget neutral": Aggregate projected expenditures would neither increase nor decrease due to the implementation of the RBRVS. The only difference between this approach and the Secretary's approach is that, in determining projected expenditures, volumes would be assumed to remain constant rather than to increase based on the Secretary's highly speculative behavioral assumptions. See p. 8, supra.

This construction finds support in the statutory designation of 1991 as the base year for computing the initial conversion factor. See 42 U.S.C. § 1395w-4(d)(1)(B). Rather than being a fee schedule year, 1991 is the last year in which the CPR system is in place. Even assuming that a volume response to payment reform might occur for years after 1991, it cannot reasonably be projected that such a response will occur prior to the implementation of payment reform. Accordingly, the selection of 1991 as the base year suggests that Congress did not anticipate that any volume adjustment would be made in the initial conversion factor.

Moreover, this interpretation gives full significance to the MVPS provisions of OBRA '89 -- including the statutory floor on negative adjustments to the conversion factor update -- rather than treating these provisions as a defect in the legislation. Cf. 56 Fed. Reg. at 25823. The MVPS provisions specifically address the subject of volume and intensity effects. For example, they require HHS -- in making its annual recommendations regarding the update to the conversion factor -- to consider any "changes in volume or intensity of services" and any "other factors that may contribute to changes in volume or intensity of services." 42 U.S.C. § 1395w-4(d)(2)(A)(iv), (vi); see also 42 U.S.C. § 1395w-4(d)(2)(B)(i) (advising HHS that it may also consider "unexpected changes by physicians in response to the implementation of the fee schedule"). Likewise, the MVPS default formula links the MVPS to the rate of increase in volume and intensity over the preceding five years. 42 U.S.C. § 1395w-4(f)(2)(A). In contrast to these provisions, subsection (d)(1)(B) is silent on the subject of volume and intensity adjustments. Taken together, the MVPS provisions and subsection (d)(1)(B) indicate that Congress viewed the MVPS as the appropriate vehicle for making any necessary adjustments to account for volume responses.

The Secretary maintains that the "MVPS is not a timely nor an adequate substitute" for a volume offset to the conversion factor because it places a floor on negative adjustments to the conversion factor update. 56 Fed. Reg. at 25822. There are two principal flaws in the Secretary's reasoning, however. First, the statutory floor on negative adjustments only applies if the update is established through the default mechanism. See p. 7,

supra. If Congress establishes the update through legislation, the statutory floor has no application.[8]

Second, the Secretary's argument treats the statutory limitation on negative adjustments to the update as an obstacle to be bypassed, rather than as an intrinsic part of the legislative design. A better view, more consistent with the statute as a whole, is that the adjustment limitation furthers the congressional goal of phasing in payment reform on a graduated basis, to avoid potential disruptions in availability of and access to medical services. See, e.g., PPRC, 1990 Annual Report to Congress 29 (design of MVPS mechanism "suggests an intention to slow the expenditure growth rate gradually"). The Secretary's interpretation of subsection (d)(1)(B) would undercut this congressional goal.

2. The legislative history makes clear that the Secretary's proposed volume offset is inconsistent with congressional intent.

The legislative history of OBRA '89 confirms that Congress intended any volume adjustment to be made through the MVPS rather than the initial conversion factor. An early version of the legislation, passed by the House Energy and Commerce Committee, explicitly required the Secretary to apply a volume offset in establishing the initial conversion factor. H.R. 3299, 101st Cong., 1st Sess. § 4001. Notably, the Energy and Commerce bill contained no proposal regarding the MVPS or any comparable retrospective adjustment mechanism. H. Conf. Rep. No. 386 at 750, 1989 U.S. Code Cong. & Admin. News 3353. Moreover, the Energy and Commerce bill anticipated a volume offset "on the order of a fraction of one percent," H.R. Report No. 247, 101st Cong., 1st Sess. 327, 345 (1989), reprinted in 1989 U.S. Code & Cong. Admin. News 1906, 2071 -- far less than the adjustment that the Secretary now proposes.

At the same time that the Energy and Commerce bill was being developed, the House Ways and Means Committee was developing its own payment reform legislation. H.R. 3299, 101st Cong., 1st Sess. § 10123. Unlike the Energy and Commerce bill, the Ways and Means bill did not call for a volume offset to the

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[8] The Secretary's concern about the "inadequacy" of the MVPS provisions can only be premised on a fundamental skepticism regarding Congress' ability or willingness to enact an annual conversion factor update. The PPRC, by contrast, views the MVPS provisions as reflecting a strong expectation that Congress will act. See p. 7 n. 3, supra.

initial conversion factor. See H. Conf. Rep. No. 386 at 747, 1989 U.S. Code Cong. & Admin. News 3350. Instead, the Ways and Means bill introduced the concept of a volume performance standard linked to the annual updates in the conversion factor. Id. at 750, 1989 U.S. Code Cong. & Admin. News 3353. Because these performance standards retrospectively adjusted the update to account for any increases in actual volume, they obviated any necessity for a prospective adjustment based on volume projections.[9]

Ultimately, Congress rejected the Energy and Commerce bill and adopted the Ways and Means Committee's approach. In doing so, Congress was acutely aware of the uncertainties inherent in making any prospective volume adjustment. Indeed, HHS made sure that Congress was aware of those uncertainties. In a September 1989 report to Congress -- submitted at the same time that the various budget proposals were being considered -- HHS reviewed the available literature on volume responses to fee reform and concluded that "the effects of an RBRVS on [volume and intensity] of physician services are not predictable." HHS, Reports to Congress: Medicare Physician Payment, Volume and Intensity of Physician Services 5-3 (1989). HHS noted that the fee schedule was not comparable to previous Medicare fee reforms in that some services would experience an increase while others would experience a decrease.[10] It emphasized that "the contemplated changes are very different from those for which we have historical evidence." Id.; see also PPRC, 1991 Annual Report to Congress 124 (volume response following "a long series of fee freezes, low fee updates, and reductions in fees . . . . might be quite different from the volume response observed historically").

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[9] As initially proposed in the Ways and Means Committee, the performance standards were known as "expenditure targets." Although the Conference Committee subsequently amended various features of the expenditure target proposal to create the MVPS, these amendments do not undercut the point made in text -- i.e., that Congress eschewed a mandatory volume offset to the initial conversion factor in favor of a retrospective mechanism for adjusting the update based on "volume performance."

[10] HHS also made this point in its September 4, 1990 NPRM regarding a model fee schedule. See 55 Fed. Reg. 36192 (questioning whether the volume offset used in connection with previous Medicare fee reductions is appropriate for calculation of initial conversion factor, because of simultaneous fee hikes and fee cuts under RBRVS).

Because of the "uncertainty as to behavioral response," HHS concluded that "the most prudent approach . . . might be to adopt a growth target that would enable Medicare to take care of any behavioral response as it took place" -- i.e., a mechanism such as the MVPS. HHS, Reports to Congress: Medicare Physician Payment, Volume and Intensity of Physician Services 5-3 (1989). Similarly, during the same period, the Energy and Commerce Committee -- which supported a small volume offset -- recognized that there was "a good deal of speculation about what will happen, but very little reliable information" regarding volume responses to payment reform. H.R. Report No. 247 at 345, 1989 U.S. Code & Cong. Admin. News at 2071. These reports to Congress confirm that Congress decided that a prospective volume adjustment through the initial conversion factor was too conjectural and that the MVPS provided the appropriate mechanism for taking any volume responses into account.

In sum, the Secretary's proposal to apply a volume offset to the initial conversion factor is inconsistent with OBRA '89. Both the language of the statute and the historical evidence indicate that Congress made a deliberate judgment that any volume adjustments should be applied retrospectively based on actual volume performance, rather than prospectively based on projections. This approach was consistent with the overriding congressional purpose of phasing in payment reform slowly to avoid jarring dislocations in availability of and access to services. Moreover, it reflected Congress' concern that any prospective volume offset would necessarily be highly speculative.

B. The volume offset that the Secretary proposes is too high and should not be loaded on to the conversion factor.

1. A 3% volume offset is plainly excessive and contrary to congressional intent.

Even if the OBRA '89 statute does not prohibit the Secretary from applying some adjustment for anticipated volume increases, the 3% figure that the Secretary proposes is arbitrary and contrary to the intent of OBRA '89. The Secretary arrives at the 3% figure by assuming (a) that volume increases will be associated with fee cuts, and (b) that no corresponding volume decreases will be associated with fee hikes. 56 Fed. Reg. at 25823. Each of these assumptions is highly questionable, however.

First, the assumption that volume increases will occur in connection with fee cuts is not supported by firm evidence --

as the Secretary himself represented to Congress at the time of OBRA '89's enactment. See pp. 14-15, supra. The economic literature on this question is inconclusive. See HHS, Reports to Congress: Medicare Physician Payment, Volume and Intensity of Physician Services 5-3 (1989) (reviewing literature and concluding that volume response is "not predictable"); PPRC, 1990 Annual Report to Congress 25 ("the research literature offers little guidance concerning how physicians will react to changes in relative values"). Moreover, the Secretary's experience under previous Medicare payment cuts is inapplicable. As the Secretary acknowledges, the OBRA '89 reforms are both qualitatively and quantitatively different from previous changes in reimbursement policy. 56 Fed. Reg. at 25821, 25823.

Second, once the Secretary assumes that volume increases will occur in connection with fee cuts, it is arbitrary for the Secretary to conclude that no countervailing volume decreases will occur. The Secretary finds that there is a "lack of data" concerning volume decreases. 56 Fed. Reg. at 25823. More accurately, however, there is a lack of data concerning volume responses under payment changes that involve simultaneous fee hikes and fee cuts. See HHS, Reports to Congress: Medicare Physician Payment, Volume and Intensity of Physician Services 5-3 (1989); PPRC, 1991 Annual Report to Congress 124 ("even if an accurate estimate were available for the response of volume to fee cuts, this would tell little about the symmetry of responses to increases and decreases in fees"). If the Secretary concludes that there is inadequate data to support an assumption that volume will decrease for some services under the payment reforms, he must also conclude that there is inadequate data to assume that volume will increase under the fee schedule to the same extent as under previous, purely cost-cutting fee reforms.

Significantly, both the Congressional Budget Office ("CBO") and the PPRC -- using the same data bases as the Secretary -- concluded that volume decreases would partially counterbalance volume increases. The CBO analysis led to a volume offset of a fraction of 1%. This analysis was directly incorporated into the Energy and Commerce bill.[11] See p. 13,

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[11] The Energy and Commerce bill provided that the Secretary had to compute the offset "in the precise manner specified in Appendix B" to the Committee Report that accompanied the bill. H.R. 3299, 101st Cong., 1st Sess. § 4001(a)(5); see H.R. Report No. 247, 101st Cong., 1st Sess. 327, 523 (1989), reprinted in 1989 U.S. Code & Cong. Admin. News 1906, 2248. Appendix B set forth "explicit instructions on how to take such behavioral

(continued...)

supra. That bill was the only specific legislative proposal regarding prospective volume offsets that Congress considered in the course of enacting OBRA '89. Id.

Similarly, the PPRC analysis led to a recommended 1% volume offset. The PPRC observed that "the size of the fee changes in 1992, the presence of large increases in fees, and the potential for changes in assignment behavior all add uncertainty to the actual 1992 offset." PPRC, 1991 Annual Report to Congress 128. It concluded that, in these circumstances, "it seems sensible to use a lower figure" than the 3% offset that would result from the Secretary's assumptions. Id. The PPRC estimated that use of the CBO's assumptions would result in a 1.2% offset for 1992. Id. at 126.

In short, none of the key participants in the creation of the RBRVS and the statute that enacted it contemplated a 3% volume offset to the initial conversion factor. Indeed, alternative assumptions are available that are more consistent with the sparse economic data.

2. The Secretary is incorrect in assuming that the entire weight of any adjustment must be loaded on to the conversion factor.

According to the Secretary, "budget neutrality" means that any volume offset "can only be applied to the [conversion factor]." See 56 Fed. Reg. at 25823. This conclusion finds no support in the statutory language of OBRA '89. Subsection (d)(1)(B) simply provides that the initial conversion factor must be designed to result in "the same aggregate amount of payments" under the fee schedule as under CPR. 42 U.S.C. § 1395w-4(d)(1)(B). This language neither instructs the Secretary to load any adjustments on to the initial conversion factor, nor precludes the Secretary from adjusting other elements of the reimbursement formula. Other approaches, such as applying any adjustment to the overall payment amounts for 1992, would be less directly violative of the statute -- although, as explained in Part I-A, supra, it is our judgment that any volume offset is at odds with the statutory language and purposes.

The Secretary's approach is particularly inappropriate for at least two reasons. First, due to the "leveraging" effect of applying the volume offset to the initial conversion factor,

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11 (...continued)
responses into account" based on the CBO analysis. Id., 1989 U.S. Code & Cong. Admin. News at 2071.

see p. 9, supra, the Secretary's approach results in a volume offset that is equivalent to the offset that would have resulted if budget neutrality were established for each year of the transition. See 56 Fed. Reg. at 25823. Yet the statute only mandates budget neutrality for 1992. Second, the Secretary's approach results in a "carryover effect" that depresses the conversion factors for each year after 1992. See p. 9, supra.

Taken together, the leveraging and carryover effects result in a significantly distorted conversion factor. They reduce fee schedule amounts by 16% not only for 1992, but for each year thereafter. Indeed, Medicare payment levels may fall below those of Medicaid for some physician services. See Statement of the American Medical Association to the House Ways and Means Committee, Health Subcommittee 7 (June 25, 1991). The evidence is abundant that, in enacting OBRA '89, Congress intended to introduce a new system of payment -- but not to introduce drastic cuts in aggregate payment levels, particularly for 1992. See, e.g., H.R. Report No. 247 at 345, 1989 U.S. Code & Cong. Admin. News at 2071 ("It is important to the successful implementation of this reform that it not become a vehicle for budget reductions or be viewed as a means of achieving some desired level of spending for Medicare.").

In sum, the Secretary's assumption that any adjustments must be applied to the initial conversion factor is incorrect. The Secretary's approach results in a significantly distorted conversion factor. Accordingly, the Secretary's approach is inconsistent with the language and purposes of OBRA '89.

II. OBRA '89 prohibits the Secretary from reducing the initial conversion factor to offset any potential impact of the transition formula.

The Secretary's 2% transition offset is contrary to the language and purposes of OBRA '89. Under subsection (a)(2), the fee schedule amount -- including the initial conversion factor -- is to be determined "without regard to" the transition formula. See Part II-A, infra. In any event, the statute does not require the Secretary to make the underlying assumptions that lead to his conclusion that a transition asymmetry exists. Neither does the statute compel the Secretary to apply the offset to the initial conversion factor. See Part II-B, infra.

A. The proposed transition offset is inconsistent with OBRA '89.

The Secretary's proposal to impose a transition offset suffers from the same flaw as the decision to impose a volume offset: It gives broader effect to subsection (d)(1)(B) than its terms justify, while neglecting other provisions of OBRA '89. In particular, the Secretary's analysis overlooks a significant portion of the statutory language setting forth the transition formula. This language clearly indicates that any "asymmetry" resulting from application of the transition formula is intentional and should not be "corrected" through a transition offset.[12]

The transition formula for 1992 is set forth in subsection (a)(2) of section 6102. See p. 5, supra. The first part of that subsection limits the amount by which 1992 payment amounts can increase due to the implementation of the fee schedule. It provides that, if the AHPB for a service is less than 85% of the fee schedule amount, the 1992 transition payment will be equal to the AHPB plus "15 percent of the fee schedule amount otherwise established (without regard to this paragraph [i.e., subsection (a)(2)])." 42 U.S.C. § 1395w-4(a)(2)(A)(i) (emphasis added). Likewise, the second part of subsection (a)(2) limits the amount by which 1992 payment amounts can decrease. It states that, if the AHPB is more than 115% of the fee schedule amount, the 1992 transition payment will be equal to the AHPB minus "15 percent of the fee schedule amount otherwise established (without regard to this paragraph)." 42 U.S.C. § 1395w-4(a)(2)(A)(ii) (emphasis added).

The statutory phrase "fee schedule amount otherwise established (without regard to this paragraph)" clearly indicates that the fee schedule amount must be determined prior to the application of the transition formula. Because the conversion factor is a necessary component of the fee schedule amount, the conversion factor likewise must be determined prior to -- and "without regard to" -- any asymmetry resulting from application of the transition formula. Only after the conversion factor has been established is the transition formula to be applied to determine a 1992 transition payment amount.

In contrast to this approach, the Secretary apparently determines a tentative fee schedule amount based on a tentative

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[12] As explained in the section that follows, the Secretary's conclusion that a 2% asymmetry exists is itself based on questionable premises. See p. 21, infra.

conversion factor. The Secretary then computes the 1992 payment amounts, estimates a 2% adjustment to reflect the supposed asymmetry of the transition, and then reduces the conversion factor by 6% due to the "leveraging effect." See pp. 8-9, supra. This approach cannot be squared with the statutory language. When subsection (a)(2) refers to the "fee schedule amount otherwise established" it can only mean the final fee schedule amount -- i.e., the amount determined in accordance with subsection (b)(1). See 42 U.S.C. § 1395w-4(b)(1) (defining fee schedule amount; applicable under subsection (a)(2) by cross-reference in subsection (a)(1)). Application of the transition formula prior to the computation of the fee schedule amount cannot be accomplished without engaging in circularity.[13]

Nowhere in the seventy-page NPRM does the Secretary discuss the statutory phrase "fee schedule amount otherwise established (without regard to this paragraph)." Instead, the Secretary treats the transition asymmetry as a congressional mistake that must be forcibly "corrected" by reducing the initial conversion factor below the value it would have in the absence of any transition. 56 Fed. Reg. at 25847-48. This approach changes the transition from a means of phasing in the fee schedule to a means of imposing a permanent 6% reduction in the fee schedule. It is inconsistent with the congressional purposes of phasing in payment reform and avoiding drastic cuts in aggregate Part B spending. See H.R. Report No. 247 at 343, 1989 U.S. Code & Cong. Admin. News 2069 (transition formula designed to provide adjustments "substantial enough to result in significant progress toward the RBRVS fee schedule, without being so large as to cause a serious disruption").

Subsection (d)(1)(B) does not alter this conclusion. That provision relates solely to the computation of the initial conversion factor. By contrast, the transition formula applies after an initial conversion factor has been computed. Moreover, nothing in OBRA '89 precludes adjustments to elements of the reimbursement formula other than the initial conversion factor. It certainly does not preclude adjustments that are expressly

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[13] One of the peculiar results of the Secretary's approach is that the initial conversion factor is adjusted to account for the 1992 transition formula, even though the initial conversion factor is based on the estimated aggregate amount of expenditures for 1991. See 56 Fed. Reg. at 25817. It is implausible to postulate that Congress intended this anomaly. Thus, as above, see p. 12, supra, the selection of 1991 as the base year for calculation of the initial conversion factor counsels against the Secretary's interpretation of the statute.

mandated by other provisions of the statute such as subsection (a)(2).

B. In any event, the Secretary has discretion not to apply a transition offset.

Even if subsection (a)(2) did not prohibit the Secretary from making an adjustment to account for effects of the transition, the Secretary would be mistaken in concluding that such an adjustment is required. See 56 Fed. Reg. at 25847. Nothing in OBRA '89 compels the Secretary to make the underlying assumptions that lead to his conclusion that a 2% "asymmetry" exists. Moreover, nothing in the statute requires that any transition adjustment be applied to the initial conversion factor.

To begin, the Secretary's estimate of a 2% expenditure effect of the asymmetry is highly questionable. The 2% estimate rests in part on the assumption that all physicians will charge at or above their 1992 payment amounts. 56 Fed. Reg. at 25823. The Secretary provides no empirical support for this assumption, however. To our knowledge, no such support exists.

On the contrary, data from the Medicare files indicates that, under the current CPR system, nearly 25% of all Medicare allowed charges are paid at a figure below the Medicare prevailing charge. See 1989 Part B Medicare Annual Data ("BMAD") Provider File. This suggests that not all physicians will, in the Secretary's phrase, "conform their charge structures" to the highest level permitted by Medicare. 56 Fed. Reg. at 25823. The Secretary appears to believe that, because the fee schedule will introduce greater uniformity in Medicare reimbursement amounts, physicians will be more likely than under the current system to raise their fees to the highest level allowed. Again, however, the Secretary provides no data to support his assertion. Given the lack of support for the assumptions that lead the Secretary to find a 2% expenditure effect, the Secretary plainly has discretion to make alternative assumptions that would lead to little or no expenditure effect.[16]

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[16] The estimate of a 2% asymmetry rests upon additional assumptions that are questionable as well. For example, the Secretary assumes that there will be no changes in the mix of services that physicians will provide in 1992. Yet one of the underlying premises of the payment reforms is that the RBRVS will induce a shift in services.

Moreover, the Secretary is wrong in asserting that any transition offset must be loaded on to the conversion factor. As explained above with respect to the volume offset, other approaches would eliminate or reduce the leveraging and carryover effects resulting from the Secretary's approach. Accordingly, they would be more consistent with the statutory language and purposes than the Secretary's proposal.

III. The OBRA '90 "Pay-As-You-Go" provisions do not require the Secretary to apply a volume offset or a transition offset.

Finally, concerns have been raised that the Secretary must apply the volume and transition offsets in order to comply with the "Pay-As-You-Go" provisions set forth in sections 252 and 253 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, 104 Stat. 1388 ("OBRA '90"). Under the "Pay-As-You-Go" provisions, whenever new legislation is enacted that would increase the budget deficit, an offsetting sequestration is automatically triggered. See OBRA '90, § 13101(a) (amending § 252(a) of Balanced Budget and Emergency Deficit Control Act of 1985, 2 U.S.C. § 901 et seq.). However, these provisions have no application to administrative determinations or to preliminary administrative proposals such as the NPRM. Accordingly, they do not preclude the Secretary from adopting regulations or policies that would result in budgetary projections that are different from the projections resulting from the Secretary's current proposal.

Furthermore, nothing in the "Pay-As-You-Go" provisions binds the Secretary to the assumptions made by the CBO and the Office of Management and Budget ("OMB") in the course of preparing their required budget estimates. On the contrary, these provisions require the CBO and the OMB to update their estimates to reflect any technical corrections that may be necessary. See id. (amending § 252(g) of Balanced Budget and Emergency Deficit Control Act). Thus, even if CBO and OMB were to estimate a savings from the transition asymmetry, such an estimate would impose no constraint on the Secretary's discretion to conclude that a transition offset is not appropriate. Likewise, if CBO and OMB were to estimate a savings from the Secretary's proposed volume offset, this would not limit the Secretary's discretion to take a different approach in the final rulemaking.

CONCLUSION

In conclusion, it is our opinion that both the volume offset and the transition offset proposed by the Secretary are inconsistent with the provisions of OBRA '89. Each of these proposals results from an overly broad reading of subsection (d)(1)(B). That reading is not supported by the language of the statute or its legislative history. Subsection (d)(1)(B) must be construed in conjunction with other provisions of the statute, particularly the MVPS provisions and the "without regard to" language of subsection (a)(2).

Under a proper reading of the statute, no volume or transition adjustments can be made. If any such adjustments were made, however, they should be much smaller than the offsets proposed by the Secretary and should not be loaded on to the initial conversion factor. For the reasons set forth in this letter, it is our opinion that the Secretary's approach -- which results in a drastic reduction to the initial conversion factor and subsequent conversion factors -- is contrary to the intent of Congress.

Very truly yours,

SIDLEY & AUSTIN

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PREPARED STATEMENT OF BETTY P. STEPHENSON

I am Betty P. Stephenson, M.D., President of the American Society of Anesthesiologists and a private practitioner from Houston, Texas. The American Society of Anesthesiologists, representing more than 27,000 physicians nationwide, appreciates the opportunity to appear before the Subcommittee today. We have many serious concerns about the recently-proposed Medicare Fee Schedule, which we believe has been developed in a punitive fashion and without regard to the legislative history of the Resource Based Relative Value Scale.

Over the past five or more years, both the Congress and the medical community have invested considerable effort and anguish as the RBRVS moved from an abstract concept to concrete legislation. Many physician organizations, including our Society, participated in this process—in our case even with the knowledge that reimbursement to our specialty would be reduced under the RBRVS. However, other inequities would be addressed, including geographic inequities for anesthesiologists, and the idea of a relative value system for all physicians held considerable more appeal.

The participation of the medical groups, however, was largely achieved by a sense of partnership with the Congress. Compromises were made on a variety of issues, but we believe passage of the Omnibus Budget Reconciliation Act of 1989 achieved a good package and one which should have been straightforward for the Health Care Financing Administration to implement.

What we see now, however, is a proposed regulation which turns that partnership and compromise into confrontation as HCFA has produced what consumer advocates would call a "bait and switch" product. Specialty societies—with strong assurances to our memberships that this was the right thing to do—entered an agreement with the Congress and bought into an advertised product that now threatens to devastate many specialties and pose quality and access problems for our patients.

ASA joins with the American Medical Association and other specialty societies in calling for (1) prohibition on the use of a behavioral offset; (2) a correction to the asymmetrical transition problem; and, (3) elimination of the tripling effect of applying all adjustments to the conversion factor.

We have very specific concerns with HCFA's approach to anesthesia services, particularly the elimination of anesthesia time as a separate component of our relative value guide. We will address the proposal to eliminate anesthesia time, the problems with the conversion factor, and some of the methodological problems.

ANESTHESIA TIME

ASA strongly opposes HCFA's proposal to eliminate separate recognition of anesthesia time under the Medicare Fee Schedule (MFS). Such an initiative is unwarranted, goes against Congressional intent, is opposed by the PPRC, and would have devastating results on the delivery of anesthesia care.

Anesthesia Payment and Development of the URVG

In order to put in context HCFA's proposal to eliminate anesthesia time, it is worthwhile to review the development of the Uniform Relative Guide (URVG) as mandated by Congress.

Anesthesiologists have been reimbursed on a relative value system—indeed, since well before the advent of the Medicare Program. Insurers approached the ASA in the mid 1950's and suggested that some consistency be brought to the many billing methods used by anesthesiologists. This led to the development of the resource-based Relative Value Guide (RVG), which has been maintained and published by the ASA since 1962. The RVG assigns base units which measure the skill, risk and complexity of the anesthetic procedure. Base units include the value of all usual anesthesia services the time actually spent in anesthesia care. Base units also include usual preoperative and postoperative visits, the administration of fluids and/or blood incident to the anesthesia care and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry.) The base units are combined with time units which measure the time actually spent with the patient by the anesthesiologist in providing direct anesthesia care. Anesthesia time is defined by HCFA and by the ASA RVG as follows:

> Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision.

Note should be taken that this definition excludes time spent by the anesthesiologist with the patient both before and after the peri-operative period, for purpose of pre-operative evaluation and usual required postoperative visits/notes. This care is considered to be included in the base units.

Even though all RVGs developed or used by Medicare carriers utilized the base unit and time unit system, substantial variations among those RVGs developed over the years—creating anomalies from a national perspective.

For this reason, ASA strongly supported section 4048 of the *Omnibus Budget Reconciliation Act of 1987,* which mandated adoption of a Uniform RVG (URVG) for use by all Medicare carriers in reimbursement of anesthesia services. Pursuant to notice and comment in the *Federal Register.* HCFA adopted the 1988 edition of 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 clams. 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. Adoption of the proper codes simplifies the system, accurately describes the anesthesiologists' service, and is in line with the general move toward code collapse.

Omnibus Budget Reconciliation Act of 1989

Prior to the Omnibus Budget Reconciliation Act of 1989, anesthesia time was counted and reimbursed in terms of units, one unit per each 15 minutes of anesthesia time when a procedure was personally performed and one unit per each 30 minutes of anesthesia time when the anesthesiologist was medically-directing nurse anesthetists. The actual time spent was always rounded up to the next whole unit, e.g., 2 hours and 3 minutes was reimbursed as if 2 hours and 15 minutes (or 30 minutes for medical direction services) of work were expended.

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 and to eliminate even the potential for gaming; 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 did bring tighter verification to anesthesia time and reduced possibilities of time manipulation.

Based on the Inspector General's study, which did not find fraud and abuse with regard to anesthesia time, the Congress legislated that actual anesthesia time, or fractional units, be incorporated into the Uniform RVG, effective January, 1990.

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 4018(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.
>
> The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish [radiology services and] anesthesia services in applying subparagraphs (A) and (B).

ASA believes the intent of Congress is crystal clear: The URVG, including base units plus actual time, should be retained under the Medicare Fee Schedule. There is no statutory language directing the Secretary to ignore or repeal the actual anesthesia time provision.

HCFA has contravened the intent of OBRA '87 and OBRA '89 by proposing the elimination of anesthesia time.

ASA believes HCFA's concern is not based on preserving the specialty of anesthesiology, or on dollars, or on fairness to physician and patient. We believe it is HCFA's administrative displeasure at the prospect of one specialty having a different conversion factor under the MFS. Indeed, as stated in the June 5 *Federal Register,* "First, program administration would be simplified." What could be simpler than continuing the existing claims processing procedure for anesthesia services?

Methodology and Rationale

It bears repeating that surgeons, not anesthesiologists, control time. Indeed, as noted by Dr. Hsiao:

> Anesthesia procedures are unique in that they are always rendered in combination with another service. Usually, the two services—the anesthesia and an invasive procedure—are performed by two physicians, one an anesthesiologist, the other a surgeon. Typically, therefore, the length of time the anesthesiologists' services are required for any given procedure depends upon the patient's condition and upon the time needed by the surgeon. Consequently, one of the key elements of anesthesiologists' work input is not under the direct control of the anesthesiologist. (*A National Study of Resource-Based Relative Value Scales for Physician Services*, Volume I, p. 586)

Hsiao further recognized that the base unit values which his study found persuasive are incomplete without the addition of time: "Relative to the other components of the ASA relative value scale, time is intended to dominate." (p. 588) While Hsiao did not rule out average time, the report stated: "Given the evidence that surgeons, not anesthesiologists, determine the total time required for a particular surgical procedure, it can be argued that the relative value units for each anesthesia service performed should reflect the predetermined basic value plus the actual time involved." (p. 589)

HCFA continues to insist that fairness can be achieved through averaging. In practice, however, the variations in time, case mix, and caseload point to the impossibility of fairness through averaging of time units. The elimination of time will adversely affect those whose caseloads include disproportionate numbers of longer or medically complicated cases, and particularly those anesthesiologists practicing in tertiary care and teaching hospitals. Such a system would cause a financial incentive to work only in the outpatient setting with healthy patients.

In the proposed Medicare Fee Schedule, HCFA rejects ASA's arguments that average times are grossly inequitable and would lead to systematic over-and-under payments and that those anesthesiologists who work on more complex procedures or with slower surgeons would be adversely affected on all cases. Yet, HCFA states in the proposed rule that the elimination of time is budget neutral. We agree that it is budget neutral—because averaging will redistribute dollars among anesthesiologists depending on their practice setting and surgical scheduling. HCFA cannot reject the inequity, which is supported by the budget neutrality.

We can only use the word "mysterious" to describe the calculations which were made between Phases I and II of the Hsiao Report and between the Hsiao numbers and the HCFA MFS. It has been a process disguised by double talk and marked with a lack of disclosure. We have not been able to determine how the calculations of pre- and post-anesthesia work were done. However, we do know that the mechanism used by Hsiao to estimate pre- and post-effort was based on individuals' responses for only three procedures—three abdominal surgical procedures which would obviously not reflect the spectrum of anesthetic procedures.

For all other specialties, the mean responses of groups were run in a regression analysis. Three procedures, however, are not enough for a regression analysis, so Hsiao used the observations of a few individual physicians. The practice expense for anesthesiologists was treated in a manner different from all other specialties, and we believe that overhead was reduced twice between Hsiao II and the MFS. Finally, anesthesia work values were reduced 36 percent due to the highly questionable crosslinks. As an example, one such link equates anesthesia for repair of an abdominal aortic aneurysm with the obstetrician's time spent with a patient in protracted labor.

Over and above our objections to the elimination of time, HCFA's methodology for averaging is seriously flawed. In essence, HCFA collected anesthesia times from claim forms and then developed "average" times for procedures. These averages were added to the base units contained in the URVG. For the 19 procedures studied by Hsiao, the resulting total was divided into the total units from Hsiao II to yield a ratio. The resulting average ratio derived from the 19 procedures was then multiplied by the base and average time units for all 248 anesthesia codes. Fortunately, the problems with this approach are more easily explained than the process.

1. As discussed, Dr. Hsiao accepted the concept of anesthesia time, but did not include anesthesia time in the RBRVS because he had not resolved integration issues. Also, the estimates of pre- and post-work, based on three similar procedures are not reliable or representative.

2. HCFA is now adding specific time increments to the evaluation and management codes. Time *is* a valid measure and should be retained for anesthesia.

3. HCFA has applied average times to the anesthesia CPT-4 codes, which we have explained are highly collapsed and cover 4,200 surgical codes. The codes cover widely varying surgical procedures with widely varying times. Consider just a few examples:

Anesthesia Code	Number of Surgical Codes
00140 eye procedures	202
00160 sinus surgery	78
00540 chest surgery	49
00562 cardiac bypass	90
00840 abdominal surgery	116

HCFA did not even collect times for more than 50 percent of the anesthesia codes. Instead, average times were "imputed" by applying the times collected for codes with the same base unit values to all procedures with that base unit value.

- For example, HCFA has no time information for code 00216, intracranial vascular procedures, a difficult anesthetic procedure which has a base unit value of 15. According to the meager HCFA data, there is more than an hour difference in the minimum and maximum times reported for all procedures with 15 base units. So, code 00216 gets an arbitrary assignment of the average time of the reported times.
- Code 01832, anesthesia for total wrist replacement, has a base unit value of 6. The times collected by HCFA for procedures with 6 base units range from 48 minutes to nearly three hours. Because code 01832, anesthesia for total wrist replacement, did not have time data collected, HCFA imputed an average time for wrist replacement, arbitrarily setting it at one hour and 47 minutes.

GAO Report

HCFA relies on a report recently submitted by the General Accounting Office as part of its justification for the elimination of time. ASA rejects this simplistic and judgmental report (termed "not statistically significant" by the Inspector General) and we have attached our comments submitted to the GAO. In essence, the GAO concludes that if an anesthesiologist has some extra time between cases, he or she will go find the next patient and start the anesthetic in order to "gain" some time units. This unsubstantiated allegation conjures up visions of hospital corridors lined with anesthetized patients—maybe even days before the scheduled surgery.

In all seriousness, this is patently absurd and totally ignores the complexity of operating room scheduling. If there is a real incentive, it is not for the anesthesiologist to linger over any one case, but to start a new case with new base units.

Physician Payment Review Commission

The Physician Payment Review Commission (PPRC) has consistently supported the move to actual anesthesia time. In its 1990 Report to Congress, PPRC found that the URVG, including time, is resource based and is appropriate for use in the Medicare Fee Schedule. In its most recent 1991 Report to Congress, the PPRC recommends that "Medicare should continue to pay for anesthesia services on the basis of base units and actual time." (page 208) The PPRC goes on to state:

> The use of actual time has been justified because the anesthesia time for a surgical service varies widely due to differences in surgical time and is largely outside the control of the anesthesiologist or CRNA. Actual anesthesia time extends from when the anesthesiologist or CRNA prepares the patient for induction (administration) of anesthesia to when the patient is placed under postoperative supervision of others. . . . The best option appears to be the continuation of the current policy of paying for anesthesia services on the basis of actual time. (page 210)

ASA agrees with the PPRC that the definition of anesthesia time can be tightened, and we offered suggestions (e.g., wording clarifying that continuous presence is intended) to HCFA. These suggestions were either ignored or rejected. We also have supported PPRC's recommendation that time be independently verifiable and believe that such verification would be relatively simple to achieve.

THE CONVERSION FACTOR

ASA was shocked at the unexpected level of reductions proposed by HCFA. Our specialty had been preparing for an 18 to 20 percent cut; HCFA now estimates an unbelievable 35 percent reduction. HCFA has transformed the RBRVS—designed to realign payments among specialties—into a harsh, indeed unlawful, budget cutting tool. ASA objects in the strongest terms to this undermining of the RBRVS and HCFA's attempt to achieve $3 billion in savings from the MFS.

ASA also opposes the use of the behavioral offset, which in essence encourages the behavior it protests. Anesthesiologists do not control volume. Further, we do not accept HCFA's premise that our surgical colleagues will be seeking out and performing unnecessary surgeries in response to MFS changes. The Medicare Volume Performance Standard was created by the Congress as a monetary control on volume and it should be allowed to work.

Considering the significant reductions which have been absorbed by anesthesiologists over the last several budget cycles, including FY 91's 7 percent reduction, we know that the cumulative cut is far deeper than the 35 percent now forecast. Anesthesiologists are already reimbursed on a relative value system, so comparison of the previous and proposed conversion factors is achieved easily. In 1990, the national average Medicare allowed conversion factor for anesthesiologists was $20.20. If we were to express the proposed reductions in terms of anesthesiologists' existing reimbursement system, we see the Medicare conversion factor drop to the $11 range—this is nearly a 50 percent cut. These losses are simply unjustified and unacceptable.

In fact, the conversion factor for anesthesiologists would be so reduced as a result of the proposed MFS that medically directed certified registered nurse anesthetists' (CRNA) pay rates—set by OBRA '90—would be 95 to 100% of the physician rate. The rates set by OBRA '90 for non-medically directed CRNAs would *exceed* those for physicians by 40 percent. These CRNA rates were not set arbitrarily by the Congress, but were predicated on the expected reductions for anesthesiologists. As stated by HCFA in the June 5 *Federal Register:* "It is our understanding that the CRNA conversion factors were established by the Congress based on an estimate of anesthesiologist conversion factors under the fee schedule using data from Phase I of the Harvard study."

REIMBURSEMENT TO TEACHING ANESTHESIOLOGISTS

HCFA has chosen the proposed MFS as a vehicle to change reimbursement for teaching anesthesiologists. HCFA cites the current rules as an unfair incentive for anesthesiologists to use residents rather than CRNAs. We object to the proposal and further we do not believe the MFS is the appropriate regulation to address this non-fee schedule issue, and we object to the arbitrary singling out of this specialty for treatment different than other teaching physicians. When a comprehensive review of the rules for attending physicians is undertaken (and we have every reason to believe that this is pending), then we will be happy to woK with HCFA on this issue. Medical education represents, obviously, the future availability of health care in this country. It is more than unfortunate that no one is willing to pay for it.

CONCLUSION

As a specialty which has embraced and defended the fairness of the relative value guide method in the Congress, the courts and innumerable state agencies, we are quite frankly awed by the way in which HCFA has converted this highly useful reimbursement tool into a budgetary bludgeon. We believe it is incumbent on the Congress to guarantee that implementation of the Medicare Fee Schedule is fair and not marked with inequities and gross inaccuracies that will build in perversities from the beginning. If reform is to work and have the support of both patients and physicians, it is imperative that Congress step in and get the train back on track.

Attachment.

RESPONSES OF DR. BETTY P. STEPHENSON TO QUESTIONS SUBMITTED BY SENATOR BENTSEN

Question. Doctors, all of your specialties will experience substantial payment reductions under the new system. The witness for the American Medical Association, Dr. Seward, has indicated that AMA prefers to make any budget-neutrality adjustment for the transition exclusively on the historical portion of the blended payments. This seems as if it would speed up the transition for your members, thereby

accelerating the payment reductions they experience. What is your view on this matter? Do you support the AMA on this matter?

Answer. ASA did not support the AMA's initial position to apply any transition adjustment to the historical portion of the blended payment. For those specialties, such as anesthesiology, slated for the largest payment reductions, this approach would mean even deeper, quicker cuts. It would also further compound the inequity that HCFA has created by refusing to consider FY 91's seven percent cut for anesthesiology as part of the transition.

ASA prefers that any reduction required to assure budget neutrality be applied across the board *after* the conversion factor is calculated.

It is our understanding the AMA has modified its position on this issue since the Committee hearing.

Question. Dr. Stephenson, HCFA bases its proposal to eliminate billing for actual anesthesia time on GAO findings that there are unexplained variations in the amount of time billed for cases involving the same type of procedure. As a result, HCFA wants to move toward the use of average times.

While the agency does not suggest that there is any fraud involved, it implies that Medicare may be paying for erroneous billings or unnecessary services. Do you have any suggestions for better ways to verify the accuracy of the actual times that are billed?

Answer. ASA believes there are several ways to assure better verification of anesthesia times. First of all, the existing definition could be improved by the addition of words clarifying that continuous presence is required, ASA provided such a definition to HCFA and the PPRC; PPRC discusses this wording in its 1991 Report to Congress:

> "For example, the definition of anesthesia time could contain the following: anesthesia time includes only the continuous actual presence of the anesthesiologist, medically-directed CRNA or nonmedically directed CRNA." (page 214)

The operating room circulating nurse can also verify on his or her record the beginning of anesthesia time; this is already done in many facilities and we have provided the Committee staff and HCFA with a sample form. In our comments on the proposed fee schedule, we suggested that the circulating nurses' recording of anesthesia start time could be put in the interpretive guidelines of the Conditions of Participation. ASA would be more than willing to work with the Association of Operating Room Nurses to bring uniformity to such reporting.

In the near future there will be increased use of automated record-keeping, which will provide another back-up verification.

We will continue to reinforce to our members the need for absolute accuracy in time recording. We strongly reject the implications by HCFA and GAO that anesthesia time claims are common vehicles for fraud and unnecessary services Of course, there are a very few individuals who may seek to undermine the system; ASA's position is that such individuals should be subject to the most vigorous sanctions through the OIG.

PREPARED STATEMENT OF GAIL R. WILENSKY

Mr. Chairman and members of the subcommittee. I am pleased to be here today to discuss progress in implementing Medicare physician payment reform.

The Omnibus Budget Reconciliation Act of 1989 enacted major legislation to reform the Medicare payment system for physicians. The reform package includes three key elements. First, the law sets a goal for the rate of Medicare physician expenditure growth, called the Medicare volume performance standard (MVPS). Second, a resource-based fee schedule replaces Medicare's customary, prevailing, and reasonable charge system. Finally, payment reform provides financial protection for Medicare beneficiaries by establishing uniform limits on balance billing by nonparticipating physicians.

The 1992 fee schedule update will mark the first year that physician payment increases will be adjusted to reflect actual expenditures relative to the MVPS. The new balance billing limits began on January 1, 1991 and will be fully in place by 1993.

The fee schedule will begin to phase-in on January 1, 1992 and becomes fully effective in 1996. A proposed fee schedule regulation was published in the June 5th Federal Register. We strongly encourage all interested parties to submit comments on the proposed rule as soon as possible before the August 5th deadline. We have

plenty of work ahead of us to develop the final regulation for October, send notices to inform physicians of program changes and fee schedule rates in November, and implement the fee schedule in January 1992.

I would like to emphasize that, even with the MVPS, the fee schedule cannot and does not control the volume of services being delivered. We predict annual increases in Medicare physician expenditures of more than 10 percent over the next five years. Total increases over the five year period will be almost 63 percent. Physician expenditures are estimated to grow from $27 billion in 1991 to nearly $45 billion in 1996. The largest factor underlying this growth is the continuing increase in the volume and intensity of services. Other factors include inflation, the growth in Medicare enrollment, and the aging of the population.

VOLUME PERFORMANCE STANDARD AND UPDATE RECOMMENDATIONS

As required by law, the Administration recommends both the MVPS and the payment update annually to Congress. The PPRC must also make recommendations on the MVPS and update. If Congress does not act on either of these recommendations or its own, both MVPS and the update are established by an automatic default formula that is set forth in the law.

FY 1992 MVPS Recommendation

The MVPS establishes an appropriate rate of expenditure growth, against which the actual rate of increase in physician expenditures is measured. The MVPS is not an expenditure target —it does not establish a cap on Medicare physician expenditures. Instead, the success or failure of meeting the MVPS is reflected in the fee schedule update two years later.

Our recommendation for the FY 1992 MVPS is 6.2 percent for all physician services—4.1 percent for surgical services and 7.1 percent for nonsurgical services. We recommend that these be adjusted to account for changes in law or regulation that affect the rate of increase in physician expenditures.

In making the MVPS recommendation, the Secretary must consider inflation, increased Medicare enrollment, the aging of beneficiaries, technology, access to services, and the appropriate utilization of services. Let me briefly summarize how each factor was used in the development of the Administration's FY 1992 MVPS recommendation.

We estimate that the total effect of inflation for fiscal year 1992 is 2.1 percent for all physician services. The increasing number of beneficiaries adds 1.3 percentage points, while the aging of the Medicare population adds 0.1 percentage points to expected expenditure growth.

Although, we cannot precisely measure changes in technology, access, and utilization, we are recommending an allowance of 3.7 percentage points to account these factors for both surgical and nonsurgical services. This is one-half of the 7.4 percent estimated annual growth in Medicare expenditures between 1986 and 1990 in excess of what is attributable to inflation, enrollment, and aging.

We have found no method that adequately measures the impact of aggregate technological change on physician expenditures. Moreover, a recent study concluded that allowing yearly increases in physician expenditures to account for technological change, regardless of cost-effectiveness, does not promote the efficient use of new technology and old technology.

We also do not have evidence of a national problem of access to care for Medicare beneficiaries. Physician participation is at an all-time high with almost 48 percent of all physicians having signed participation agreements. Over 85 percent of all physician bills are now paid under assignment. Problems of access to services in some areas of the country is best dealt with at a more localized level.

In addition, an overall level of inappropriate utilization is difficult to estimate reliably. Research has identified levels of inappropriate care anywhere from 10 to 30 percent. However, most of this research has been procedure-specific, and does not generalize well to all Medicare services. Outcomes research, the development of practice guidelines, and geographic variation analysis will ultimately lead to improvements in the practice of medicine.

Our FY 1992 MVPS recommendation also considers the impact of OBRA 1990 and the physician fee schedule. Changes due to OBRA 1990 are projected to result in aggregate decreases in the MVPS of 1.0 percentage points for nonsurgical services and 1.7 percentage points for surgical services. Implementation of the fee schedule effectively changes the relative price for surgical and nonsurgical services. To account for these changes, we recommend increasing the nonsurgical MVPS by an estimated 0.8 percentage points and decreasing the surgical MVPS by an estimated 1.2 percentage points.

A summary of all these factors is included in the appendix. The MVPS recommendations are derived by multiplying the effect of these factors.

CY 1992 Update Recommendation

The Secretary is also required to recommend an annual physician payment update. The CY 1992 update will be applied to the initial conversion factor in order to determine next year's physician payment levels. In establishing the fee schedule update, the Secretary is required by statute to consider the percent change in the Medicare Economic Index (MEI), the difference between the actual rate of growth in FY 1990 physician expenditures and the FY 1990 MVPS, changes in volume and intensity of services, access to services, and other factors that may affect volume and intensity.

We are recommending a CY 1992 fee schedule update of 2.2 percent for all physician services, which is the same as the default update. This was calculated by adjusting the MEI by the difference between the MVPS and the actual increase in physician expenditures.

Our estimate of the actual growth in all physicians' services between FY 1989 and FY 1990 is 10.6 percent. This estimated growth in physician services is 1.5 percentage points more than the established FY 1990 MVPS of 9.1 percent. Subtraction of this 1.5 percentage point difference from the adjusted MEI of 3.7 yields an update of 2.2 percent.

We are recommending that the update be applied to both surgical and nonsurgical services. The Secretary was directed to evaluate the separate performance of surgical and nonsurgical services during FY 1990. This was not possible for FY 1990 because of the limitations of our current data systems. It would be inappropriate to recommend separate CY 1992 updates for surgical and nonsurgical services since there was a single MVPS.

PROPOSED PHYSICIAN FEE SCHEDULE

Reforming the physician payment system is an enormous undertaking and is the most significant change to Part B of Medicare since the program's inception in 1965. Implementing the physician fee schedule is, in many respects, much more complicated than the hospital prospective payment system (PPS).

PPS put in place a bundled payment for hospital services, while the fee schedule largely maintains a fee-for-service system for physician services. Instead of 475 diagnosis-related groups and 6,000 hospitals, we are implementing a new payment system of 7,000 codes for 500,000 physicians. We handle more than 450 million Part B bills annually compared to 11 million hospital bills.

I believe the proposed physician fee schedule accomplishes its intended goal of setting the right relative prices for physician services. The proposed fee schedule corrects historical payment imbalances, especially in terms of the distribution of Medicare fees across types of services and geographic areas.

The statute specifies the framework of the fee schedule and gives the Secretary limited flexibility. The formula for computing payment amounts, the transition rules, and the application of the geographic adjustment factor are all spelled out in the law.

A number of key policies and technical issues, however, were left to the Secretary to resolve, including defining the global surgical package, developing new visit codes, and specifying geographic adjustments.

Probably the most complicated aspect of the proposed fee schedule is its impact on physician fees and future Medicare outlays, particularly the effects of the transition rules and behavioral adjustment. Both issues are discussed later in my statement.

Fee schedule payment levels for physician services are computed using three factors: a relative value for the service; the geographic adjustment factor for the fee schedule area; and a dollar conversion factor.

Development of Relative Values

As required by statute, we have established relative values for physician work, physician practice expenses, and malpractice insurance. Work relative values are based on the relative resources, such as time and intensity of effort, required to provide each service. Practice expense and malpractice relative values are based on historical practice costs and an allowed charge amount for each service.

Physician Work Relative Values: The physician work relative values that form the basis of the fee schedule were developed by a research team at the Harvard University School of Public Health. On September 4, 1990, we published the Model Fee Schedule, which was based on Phase I of the Harvard research team's study. Phase I produced work relative values for approximately 1400 physician services in 18 phy-

sician specialties. These relative values represented almost 70 percent of Medicare Part B charges for physician services.

After publication of the Model Fee Schedule, we received Phase II of the Harvard study, which contained relative values for 15 additional specialties. Phase II also restudied eight Phase I specialties and made a number of refinements in the study methodology. These refinements explain some of the differences between the Model Fee Schedule and the proposed fee schedule. As required by law, the existing relative values for radiology and anesthesia services were integrated into the national fee schedule by rescaling the relative values for these services.

In Phase III, the Harvard research team is developing relative work values for the remaining physician services and refining some already established relative values. Some results of Phase III are included in the proposed regulation.

Practice Expense & Malpractice Relative Values: The statute prescribes that practice expense and malpractice relative values be computed by multiplying the weighted average historical practice cost shares for all specialties performing a service and a base allowed charge for the service. By law, the base allowed charge is the estimated 1991 national average Medicare allowed charge for each service. The historical cost shares were derived mainly from a 1989 American Medical Association (AMA) survey of office-based physicians' practice expense and malpractice costs.

Once the separate work, practice expense and malpractice relative values were established for each physician service in the proposed fee schedule, they were converted to a common scale and combined to produce a single relative value for each service.

Application of the Geographic Adjustment Factor

The fee schedule formula requires that the relative value for each physician service be adjusted to account for geographic cost differences, including differences in practice expense and malpractice costs. This was done using geographic adjustment factors that are based on geographic practice cost indices, or GPCIs, developed by the Urban Institute and the Center for Health Economics Research.

In summary, the GPCIs reflect the relative cost of practice expenses for wages and office rent compared to the national average; the relative cost of malpractice insurance compared to the national average; and the relative cost of physicians' work compared to the national average. The geographic adjustment factor for each procedure is equal to the weighted average of these GPCIs for each of the three relative value components. The statute specifies that only one-fourth of the geographic variation in physician work resource costs be taken into account.

Conversion Factor

The geographically-adjusted relative values for each physician service are then transformed into dollar payment amounts using a nationally uniform conversion factor.

The statute requires that the 1992 conversion factor be budget neutral. In other words, the first year of physician payments under the fee schedule must equal the estimated 1991 payment under the existing customary, prevailing, and reasonable (CPR) system, plus the 1992 update amount. Budget neutrality means that we spend no more and no less than if the old CPR system had continued. I will discuss how a budget neutral conversion factor was calculated in greater detail later.

Other Policy Issues

Although the framework for the physician fee schedule was specified in statute, several policy areas and technical issues were left for our development. We have addressed these policy areas in detail in the proposed regulation and have requested specific public comment in a number of areas. Let me briefly highlight several of the major policy issues.

Definition of Global Surgery Package: Currently, surgeons generally bill a single, global fee for all services usually associated with a surgery, including pre-operative visits, the operation, intra-operative services, and follow-up care. The definition of global services for surgery, however, varies significantly among carriers, especially in terms of what constitutes pre-operative and postoperative care.

We are proposing a uniform, national global surgery policy that applies to all areas of the country and to all settings in order to eliminate this variation. The proposed global surgery package would not include the initial evaluation or consultation to determine the need for surgery, which would be paid separately.

All other preoperative visits from the time the decision to have the surgery is made would be included. We are proposing a pre-operative period of up to 30 days. Services needed to stabilize a seriously ill patient before surgery would be paid sepa-

rately. The operation itself and related intra-operative services would also be included in the global surgery package.

We have consulted with a number of surgeons and physician groups to establish an appropriate payment policy for complications following surgery. A separate payment for complications would not be made for medical or surgical services required of the surgeon that do not require additional trips to the operating room. Return trips to the operating room, however, would be paid separately.

The global surgical fee would also include all post-operative visits by the primary surgeon within 90 days of the surgery. This does not include visits for problems unrelated to the surgery.

Development of New Visit Codes: In its research, the Harvard team found that the current visit codes, as defined in the AMA's CPT codes, are open to varying interpretation by physicians. In particular, the narrative descriptions of the codes do not clearly delineate differences among levels of service.

In the proposed regulation, we are advancing the adoption of new visit codes. For the past several years, the AMA and the Physician Payment Review Commission (PPRC) have been developing these new visit codes to improve coding consistency among physicians. Phase II results of the Harvard study supplemented that work.

The new CPT visit codes constitute a large change in how physicians code for services. In conjunction with the AMA, we pilot tested the new visit codes to determine their reliability. Preliminary results suggest that there is an improved consistency in coding by different physicians.

Implementation of a new visit coding system requires an assessment of the distribution of visits under the new codes. Therefore, a "crosswalk" between the old and new codes was necessary. The crosswalk we used is consistent with how physicians coded services in the pilot study and is also based on the comparisons of content descriptors of the new and old codes.

A 1990 OBRA provision restricts Medicare from reimbursing physicians separately for electrocardiogram (EKG) interpretations that are performed as part of a physician visit after January 1, 1992. We increased the physician work relative values for most office and hospital visit codes to compensate physicians for routine EKG interpretations. This adds approximately 1 to 3 percent to office and hospital visit fees.

Geographic Locality Changes: The law defines fee schedule geographic areas as the existing Medicare payment localities. While we believe we can change existing payment localities, it is not administratively feasible to make extensive locality changes at this time due to the enormous amount of change that will occur with implementation of the physician fee schedule. Therefore, we are proposing to retain current geographic locality designations, with two exceptions.

We are proposing single statewide fee schedule areas in 1992 for Nebraska and Oklahoma because they have demonstrated extensive support from both urban and rural physicians for such a change. We will consider changing geographic areas in other states where such support from both urban and rural physicians is also demonstrated. Administratively, we are able to aggregate substate localities to a statewide locality, but we cannot move from one substate locality system to another.

We are reviewing options for reconfiguring the locality structure in the future. The PPRC and the Urban Institute have studied alternatives to the current locality structure.

In addition, providers furnishing services in all rural and urban health manpower shortage areas will receive a 10 percent Medicare bonus payment. The bonus payment was increased by statute from 5 to 10 percent, beginning January 1, 1991, to encourage providers to remain in these shortage areas. These bonus payments are an add-on to the fee schedule payment amounts.

Treatment of Anesthesia Time: The statute also requires that we integrate the existing anesthesia relative values into the physician fee schedule. We currently use relative values developed by the American Society of Anesthesiologists. Under the current relative value guide for anesthesia services, payment is calculated using a base unit for specific procedures and an actual time unit, multiplied by a reasonable charge conversion factor.

The inclusion of actual time in computing payments is unique to anesthesia services. In a proposed rule in 1989 and in the Model Fee Schedule in 1990, we announced our intention to eliminate the separate time unit for anesthesia payments. We are now proposing, with the implementation of the fee schedule, to replace actual time with the average time for anesthesia services concurrent with the fee schedule implementation in 1992.

The fee schedule involves an averaging concept. In other words, we will make average payments for a procedure regardless of the time or difficulty of performing

the service in a particular case. For example, we will pay one surgical fee for a procedure whether the case is unusually simple or unusually complicated.

Eliminating actual time would make the anesthesia payment methodology consistent with the methodology for all other physician services. If actual time were not eliminated, a different conversion factor for anesthesia services might be necessary, thereby separating anesthesiologists from the overall fee schedule.

Finally, we believe it is appropriate to eliminate actual time because the reporting of anesthesia time is not consistent.

For example, post-operative anesthesia time ends "when the patient may be safely placed under post-operative supervision and the physician or anesthetist is no longer in personal attendance." This definition is not explicit enough to be used consistently among physicians. In this connection, we note that a recent General Accounting Office study demonstrated that anesthesia time varies greatly for the same service. The GAO recommended that we eliminate the direct link between time and payment for anesthesia services.

Payment for Drugs: Medicare pays about $200 million annually for drugs furnished in physicians' offices that are not self-administrable. These include drugs furnished by injection or by infusion, such as chemotherapy and vitamin B-12 injections. Carriers currently use a variety of methods to pay for these drugs. We are proposing to establish a uniform drug payment policy for carriers.

A recent Office of the Inspector General study found that wholesale guides substantially overstate the true cost of drugs, and that pharmacies receive discounts averaging 16 percent of published wholesale prices. We believe that physicians also have the opportunity to achieve these discounts. Therefore, concurrent with the fee schedule implementation, we are proposing to pay physicians 85 percent of the average national wholesale price of the drug.

Drugs are not included under the fee schedule and therefore, they are outside the budget neutral requirement of the 1992 fee schedule. The estimated budgetary savings of our drug proposal is $10 million in 1992, and increases to $40 million by 1996.

Calculating a Budget Neutral Conversion Factor

The conversion factor computation was complicated by the need to simultaneously fulfill two statutory requirements—the transition rules and budget neutrality. We have set forth our best interpretation of the law, which is consistent with both requirements, without violating either. We have calculated a conversion factor of $26.873, a figure which applies before the 1992 fee update.

Accounting for Transition Rules: The transition rules require that the fee schedule be phased-in from 1992 through 1995. Physician services with a historical payment amount between 85 and 115 percent of the fee schedule will be paid at the fee schedule.

If the historical amount is below 85 percent of the fee schedule, the 1992 payment equals the historical amount plus 15 percent of the fee schedule. For physician services with historical amounts more than 115 percent of the fee schedule, the payment for 1992 is the historical amount minus 15 percent of the fee schedule. Payments in 1993 through 1995 continue to transition to the fee schedule using blended rates until the fee schedule is fully implemented for all services in 1996.

This type of transition to the fee schedule is asymmetric because services with low fees increase faster than services with high fees decrease. As a result, the transition rules have a net cost of 2 percent in 1992. To restore budget neutrality, fees must be adjusted in a way that simultaneously is consistent with the statutory transition rules.

We do not believe that we can reduce all fees by 2 percent because that would be inconsistent with the transition rules. The way to restore budget neutrality and meet the transition rules is to adjust the conversion factor. Because the fee schedule conversion factor only applies to some of the fees in 1992, the 2 percent figure "multiplies" into a 6 percent conversion factor reduction. Thus, the simultaneous fulfillment of both statutory requirements results in a 6 percent reduction in the conversion factor.

The 6 percent conversion factor adjustment does not achieve any savings in 1992. However, when the fee schedule is fully implemented in 1996 Medicare spending will be 6 percent lower than would have occurred under the CPR payment system. This 6 percent represents the $3 billion "savings" figure that has been reported.

It was not our intention for the transition to reduce Medicare spending in this way, but we believe that the proposed rule is based on the correct interpretation of the law. Indeed, we looked for other interpretations of the statute and found none that did not violate either the statutory transition or the requirement for 1992

budget neutrality. We welcome suggestions of alternative approaches that allow us to fulfill both statutory requirements.

Accounting for Volume and Intensity Changes: Implementation of the fee schedule involves massive changes in how Medicare pays for physician services. For several reasons, we believe that changes in the volume and intensity of services will occur.

Reduced payments for some services and changes to standardized definitions of services for global surgical fees and medical visits could also affect physician billing practices. Specifically, physicians may respond by billing under new definitions for services that they do not currently bill; billing for a higher level of service than they would have under the current system; or furnishing more services, particularly visits, concurrent care, consultations, and tests. Likewise, lower out-of-pocket costs may cause beneficiaries to seek additional services.

Whatever their source, we expect an aggregate volume and intensity response due to implementation of the fee schedule. Therefore, to fulfill the statutory budget neutrality requirement, adjustments must be made for anticipated behavioral changes.

Research supports this phenomenon. The PPRC, in its 1991 report to Congress, concluded that the results of several time-series studies suggest that the volume of services is affected by fee changes. In addition, Dr. William Hsiao, who developed the resource-based relative value scale, after an exhaustive review of empirical studies, reported in a recent paper that "physicians can affect the service mix and utilization rates to offset fee reductions."

In addition, our experience with the physician fee freeze in the mid-1980's showed that physicians do increase volume and intensity of services when fees are constrained. Measuring the response is complicated by other factors, particularly the implementation of the hospital PPS. However, when physician volume and intensity data are adjusted for a sharp decline in hospital admissions under PPS, there clearly seems to have been a response to the fee freeze. Increases in physician volume and intensity reached a historically high level in 1986.

We believe that it would be imprudent to ignore all this evidence and assume that no behavioral response will occur. Failure to account for these behavioral changes would set the conversion factor too high and, consequently, result in Part B trust fund outlays larger than budgeted. This would increase the overall Federal budget deficit and pressure Congress to increase the Part B premium.

The MVPS is not an adequate mechanism to correct for a conversion factor initially set too high. By law, if the MVPS is exceeded, there is a limit on how much future updates can be reduced. Because there is a lag in making adjustments for excess payments using the update process, there would be a loss to the Federal treasury for two years.

Most importantly, the MVPS does not correct for an increase in the expenditure base that occurs for volume and intensity response that have not been anticipated. Future MVPSs would be applied to the inflated base. In addition, if we underestimate the aggregate volume and mix of services, not only would the base to which the MVPS is applied increase, but also the default MVPS and the Medicare physician spending baseline would increase.

Finally, I should note that the behavioral adjustment helps physicians when establishing the MVPS. The MVPS formula requires an adjustment for changes in law or regulation affecting the baseline. For example, when we determined the MVPS for 1990 and 1991, our adjustments for the OBRA savings provisions included a behavioral adjustment. This resulted in MVPSs higher than they would have been without behavioral adjustments.

We have assumed volume and intensity changes sufficient to offset 50 percent of a physician's net loss in Medicare revenues. This adjustment does not mean that we expect to see a 50 percent increase in physicians' services. We assume that individual physicians who experience a decline in Medicare revenues due to the fee schedule will recoup half of that loss by increasing volume and mix of services delivered.

For example, if a physician's Medicare revenues decrease from $100,000 to $90,000 under the fee schedule, we estimate the behavioral effect to be 50 percent of $10,000, or a $5,000 increase in Medicare services billed. We have applied a behavioral adjustment only to physicians whose Medicare revenues decrease under the fee schedule. We have assumed that no adjustment for physicians who experience a net increase in Medicare revenues.

When all is said and done, we expect a 3 percent increase in volume in 1992. Thus, to restore budget neutrality, we would need to reduce fees for all services by about 3 percent in 1992. However, for the same reason the 2 percent transition adjustment multiplies to a 6 percent conversion factor reduction, a 3 percent increase in volume translates into a 10 percent conversion factor reduction.

The statute does not require budget neutrality for the transition years 1993 through 1995 and thus we have not proposed any behavioral adjustment for those years. Had a behavioral adjustment been made for each of those years, the 1996 conversion factor would have been reduced by approximately the same 10 percent.

Combined Effect of Transition and Behavioral Adjustment

When the interaction of both the transition and behavioral offset are taken into account, fees will be reduced 16 percent by 1996 relative to estimated CPR fees in that year. I must emphasize, however, that when volume and intensity responses are taken into account, estimates of 1996 total Medicare physician outlays under the fee schedule would be reduced only 6 percent compared to outlays that would have occurred under the CPR system.

More importantly, this 6 percent reduction in overall payments is phased-in gradually over the transition to the fee schedule and effectively reduces the annual rate of increase of total Medicare physician spending from 11.7 percent to 10.3 percent per year. This means that we expect Medicare physician spending to increase from $27 billion in 1991 to almost $45 billion in 1996. Under the old CPR payment system, spending would have increased to $48 billion. The 10.3 percent average annual rate of increase in physician spending is substantially higher than the anticipated growth in the nation's economy.

BENEFICIARY FINANCIAL PROTECTIONS

Physician payment reform also includes financial protections for Medicare beneficiaries in the form of new charge limits for nonparticipating physicians who bill above Medicare payments. These new limits replace the maximum allowable actual charge (MAAC) system, which has been in place since 1986.

The new charge limits prohibit nonparticipating physicians from charging more than 125 percent of the 1991 prevailing charge effective January 1, 1991 (except for primary care services where the 1991 limit is 140 percent). The balance billing limits are reduced for all services to 120 percent of the fee schedule amount beginning January 1, 1992. By 1993, the new charge limit is 115 percent of the fee schedule amount for nonparticipating physicians.

The implementation of the physician fee schedule and balance billing limits will effect a beneficiary's out-of-pocket expenses in terms of coinsurance and balance billing liability. The effect on any individual's out-of-pocket expenses depend on the geographic area and the mix of services received.

Typically, the coinsurance for visits and consultations would increase, while coinsurance for surgical and diagnostic services would decrease. However, virtually all beneficiaries who receive services from nonparticipating physicians would benefit from the more stringent charge limits. On balance, beneficiary out-of-pocket expenses under the fee schedule are expected to decrease.

We will monitor the effects of physician payment reform on beneficiaries. We plan to monitor changes in utilization and access, as well as changes in physician participation, assignment and beneficiary out-of-pocket expenses. Our new Common Working File will provide key claims data. The Current Beneficiary Survey, which is planned as an ongoing survey of Medicare beneficiaries, will provide us with relevant information regarding access and utilization. We plan to implement the survey this Fall.

CONCLUSION

I believe that the proposed fee schedule successfully accomplishes the goal of physician payment reform. The three-part physician payment reform was designed to moderate the rate of increase in Medicare physician expenditures, create the "right" *relative* prices for physician services, and give beneficiaries financial protection.

The fee schedule corrects historical imbalances in how Medicare pays for physicians services, both geographically and among different types of services. It redistributes Medicare fees to primary care services and low-priced geographic areas, and away from surgical and diagnostic procedures and high-priced areas. Specialty and state specific impact tables are included in the appendix.

The fee schedule will help the very physicians it was designed to help—the primary care physicians who deliver cognitive services and physicians who practice in historically low-charge areas. Fees for medical visits in 1992 will increase over 8 percent, before the fee update, compared to 1991 fees under the old system. With the recommended 2.2 percent update, which is the same as the default update, Medicare fees for medical visits under the fee schedule would average 10.7 percent higher than 1991 levels.

In addition, physicians who provide services in all rural or urban health manpower shortage areas are entitled to a 10 percent bonus. These bonus payments are an add-on to the fee schedule payment amounts.

The statute requires that the fee schedule be budget neutral in 1992 and specifies the transition rules. The simultaneous fulfillment of both statutory requirements results in a 6 percent reduction relative to the CPR system in 1996. It was not our intention for the transition to reduce Medicare spending in this way, but we believe that the proposed rule is based on the correct interpretation of the law. To fulfill the statutory 1992 budget neutrality requirement, we believe that an aggregate adjustment to the conversion factor is needed to account for anticipated changes in the volume and intensity of services.

Medicare physician spending under the fee schedule is projected to increase 63 percent over the five-year transition. While attention has focused on the 6 percent reduction in Medicare expenditures by 1996 due to the transition, this reduction is relative to where outlays would have been under the old system. It is not a drop in the absolute level of outlays. It is only a slowing of the rate of growth in Medicare physician spending between 1991 and 1996 from 11.7 percent to 10.3 percent. Medicare physician spending will increase from $27 billion to almost $45 billion between 1991 and 1996. Without the effect of the transition, Medicare spending would have increased to almost $48 billion.

This continued growth rate in Medicare physician expenditures is troubling. The simple fact is that growth in physician expenditures continues to outpace growth in the national economy. What has been labeled a "cut" is really only a "Washington" cut, that is, a reduction in the rate of increase. Outside the Washington Beltway, a 10.3 percent annual increase is significant.

The overall growth in Medicare physician expenditures will continue to put substantial pressure on the Federal budget. The fee schedule still preserves all the perverse incentives inherent in fee-for-service medicine. Although the MVPS was developed to moderate the rate of growth in physician expenditures, it is a very limited tool because it creates little incentive for individual physicians to control the volume and intensity of services delivered.

We need to devote more analytical efforts to developing approaches that create more direct incentives for physicians. That is why I am so interested in bringing more beneficiaries into coordinated care plans. Coordinated care is the best way to moderate the growth in Medicare spending, while leaving the practice of medicine in the hands of physicians.

The development of the proposed fee schedule has involved a great deal of work by HCFA and a large amount of input from outside groups. We encourage groups to submit comments by the August 5th deadline. I look forward to working with you and physician groups as we move towards a final regulation in October and successful fee schedule implementation in January.

Appendix I.—COMPONENTS OF FY 1992 MVPS RECOMMENDATION

Factor	All Services	Surgery	Nonsurgery
Inflation	2.1	2.0	2.1
Enrollment	1.3	1.3	1.3
Aging	0.1	0.1	0.1
Factors Other Than Inflation Enrollment and Aging	3.7	3.7	3.7
OBRA 1990	-1.1	-1.7	-1.0
Fee Schedule	0.0	-1.2	0.8
Total [1]	5.2	4.1	7.1

[1] The components were multiplied to achieve the recommended FY 1992 MVPS.

NOTE: Recommendation should be adjusted to account for changes in pricing and benefits resulting from legislation enacted this year, if any, affecting FY 1992 physician outlays.

APPENDIX II.—IMPACT OF PHYSICIAN FEE SCHEDULE

The attached tables show the impact of the fee schedule by physician specialty and by state. However, the impact on any individual physician would depend not only on specialty and locality, but also on historical charging patterns and the mix of services furnished.

In general, those specialties that account for more visits and fewer procedures are expected to experience larger total increases than procedure-oriented specialties.

Payments for medical visits are expected to increase by an average of 8 percent in 1992, before the fee update. Physicians providing primary care services and located in historically low-charge areas will receive higher payments under the fee schedule.

One might expect the impact of the fee schedule on internists to resemble that of family practice or general practice specialists. Those internists who provide a mix of services similar to primary care physicians will experience larger increases. Whereas, an internist who provides more procedures will fare less well. Primary care physicians whose historical charges were unusually high or who perform more procedures than is typical could experience a small increase or even a decrease in Medicare payment.

Tables 1 and 2 show impacts by specialty. Tables 3 and 4 show impacts by state. In all four tables, the columns labeled "Payments Per Service" reflect fees while columns labeled "Payments" reflect total payments or outlays and take into account volume and intensity responses.

Tables 1 and 3 show that overall payments or outlays for all specialties and for all states is budget neutral in 1992 relative to estimated CPR outlays in that year. These tables also show that all payments per service had to be reduced 3 percent in order to achieve budget neutrality due to anticipated increases in volume and intensity.

The effect of a fully phased-in fee schedule in 1996 relative to what would have occurred under the CPR system is shown in the third and fourth columns of tables 1 and 3. Payments per service or fees are reduced 16 percent relative to where CPR payments would have been in 1996 reflecting the effect of both the transition and the behavioral offset. The fourth column shows that overall Medicare payments or outlays will be reduced by 6 percent relative to where CPR payments would have been in 1996. The 6 percent reduction is due to the effect of the transition.

Between 1991 and 1996, the absolute level of Medicare outlays for physician services are projected to increase due to such factors as annual updates, enrollment growth and historical volume and intensity trends. These increases are shown in the fifth and sixth columns of tables 1 and 3. The cumulative increase in Medicare outlays is projected to be 63 percent or 10.3 percent annually over this period. This increase occurs even after the 6 percent effect of the transition.

Tables 2 and 4 display the changes in Medicare payments per service and overall payments by specialty and by state relative to the national average. The tables show that the fee schedule achieves the redistribution intended among specialties and states.

TABLE 1--Physician Fee Schedule Impact by Specialty

Specialty	Percent Change in Allowed Charges for Fee Schedule Relative to CPR				Percent Increase in Total Budget Outlays Under Fee Schedule**	
	Year 1 (1992) change in:		Year 5 (1996) change in:		Avg. Annualized 1991-1996	Cumulative 1991-1996
	Payments Per Service	Payments*	Payments Per Service	Payments*		
All physician specialties	-3%	0%	-16%	-6%	10%	63%
Family Practice	13	14	15	17	15	103
General Practice	14	15	14	16	15	101
Cardiology	-5	2	-17	-8	10	60
Dermatology	-2	1	-15	-7	10	62
Internal medicine	0	0	-3	-1	11	72
Gastroenterology	-7	-2	-25	-11	9	54
Nephrology	-4	1	-15	-7	10	62
Neurology	-4	1	-9	-4	11	68
Psychiatry	-9	-3	-5	-2	11	69
Pulmonary	-4	1	-8	-4	11	67
Urology	-4	1	-15	-7	10	62
Radiology	-6	2	-32	-14	8	49
Anesthesiology	-8	3	-35	-16	8	46
Pathology	-6	2	-30	-14	8	50
General Surgery	-5	-2	-20	-9	10	58
Neurosurgery	-6	-2	-25	-11	9	54
Ophthalmology	-8	-3	-35	-16	8	47
Orthopedic Surgery	-6	2	-19	-9	10	59
Otolaryngology	-2	3	-4	-2	11	70
Plastic Surgery	-6	-2	-17	-8	10	60
Thoracic Surgery	-7	2	-31	-14	8	50
Clinics	-1	0	-11	-5	11	65
Optometry	13	14	12	14	15	97
Chiropractic	-8	-3	-14	-6	10	63
Podiatry	5	6	16	18	15	105

* Includes changes in payments per service as well as anticipated volume/intensity responses. See text.

** Incorporates changes in payment per service and anticipated volume/intensity responses to payment changes for that specialty. In addition, for each specialty, we have assumed the same volume/intensity baseline, growth in patient population, and payment updates.

TABLE 2- Gains and Losses by Specialty Relative to the National Average

Percentage Gains and Losses Relative to the National Average

Specialty	Year 1 (1992) change in: Payments Per Service	Year 1 (1992) change in: Payments*	Year 5 (1996) change in: Payments Per Service	Year 5 (1996) change in: Payments*
All physician specialties	0%	0%	0%	0%
Family Practice	16	14	37	24
General Practice	18	15	36	23
Cardiology	-3	-2	-1	-2
Dermatology	0	-1	1	-1
Internal medicine	2	0	16	5
Gastroenterology	-4	-2	-10	-6
Nephrology	-1	-1	1	-1
Neurology	-1	-1	8	2
Psychiatry	-7	-3	13	4
Pulmonary	-1	-1	9	2
Urology	-2	-1	1	-1
Radiology	-3	-2	-19	-9
Anesthesiology	-5	-3	-22	-11
Pathology	-4	-2	-17	-8
General Surgery	-2	-2	-5	-3
Neurosurgery	-4	-2	-10	-6
Ophthalmology	-6	-3	-22	-10
Orthopedic Surgery	-4	-2	-3	-3
Otolaryngology	5	3	14	4
Plastic Surgery	-3	-2	-1	-2
Thoracic Surgery	-5	-2	-18	-9
Clinics	2	0	7	1
Optometry	16	14	33	21
Chiropractic	-6	-3	3	-1
Podiatry	8	6	39	25

* Includes changes in payments per service as well as anticipated volume/intensity responses. See text.

TABLE 3 Physician Fee Schedule Impact by State

State	Percent Change in Allowed Charges for Fee Schedule Relative to CPR				Percent Increase in Total Budget Outlays Under Fee Schedule**	
	Year 1 (1992) change in:		Year 5 (1996) change in:		Avg. Annualized	Cumulative
	Payments Per Service	Payments*	Payments Per Service	Payments*	1991-1996	1991-1996
All States	-3%	-1%	-16%	-6%	10%	63%
Alabama	-3	-1	-16	-7	10	62
Alaska	-7	2	-23	-9	9	57
Arizona	-7	-2	-21	-9	10	58
Arkansas	-1	1	-16	-7	10	62
California	-6	-2	-21	-9	10	58
Colorado	2	4	-3	-1	11	72
Connecticut	5	2	-16	-7	10	62
Delaware	1	1	-14	-6	10	64
District of Columbia	4	2	-13	-6	10	62
Florida	7	2	-25	-10	9	55
Georgia	2	0	-16	-7	10	62
Hawaii	9	3	-22	-9	10	58
Idaho	2	4	-6	-3	11	69
Illinois	-2	0	-14	-6	10	63
Indiana	1	1	-12	-5	11	66
Iowa	1	3	-4	-2	11	71
Kansas	0	2	-13	-6	10	64
Kentucky	0	2	-11	-5	11	66
Louisiana	-3	1	-17	-7	10	61
Maine	0	2	-11	-5	11	66
Maryland	5	2	-19	-8	10	60
Massachusetts	-3	-1	-13	-6	10	64
Michigan	0	2	-6	-3	11	69
Minnesota	4	6	-6	-2	11	69
Mississippi	2	4	-2	0	12	74
Missouri	0	2	-10	-4	11	66
Montana	-1	1	-13	-5	10	64
Nebraska	-3	-1	-10	-4	11	66
Nevada	-7	-3	-25	-10	9	55
New Hampshire	2	4	-5	-2	11	70
New Jersey	-1	1	-13	-6	10	64
New Mexico	-3	-1	-19	-8	10	60
New York	-2	0	-13	-5	10	64
North Carolina	0	2	-14	-6	10	64
North Dakota	-2	0	-15	-6	10	63
Ohio	-2	0	-16	-7	10	62
Oklahoma	-6	-2	-14	-6	10	63
Oregon	-2	0	-13	-5	10	64

TABLE 3 Physician Fee Schedule Impact by State

State	Percent Change in Allowed Charges for Fee Schedule Relative to CPR				Percent Increase in Total Budget Outlays Under Fee Schedule**	
	Year 1 (1992) change in:		Year 5 (1996) change in:		Avg. Annualized	Cumulative
	Payments Per Service	Payments*	Payments Per Service	Payments*	1991-1996	1991-1996
Pennsylvania	-2	0	-14	-6	10	64
Rhode Island	0	2	-10	-4	11	68
South Carolina	1	3	-8	-3	11	68
South Dakota	1	3	-10	-4	11	66
Tennessee	1	3	-13	-5	10	64
Texas	-3	-1	-21	-9	10	58
Utah	1	3	-6	-3	11	69
Vermont	1	3	-10	-4	11	68
Virginia	0	2	-9	-4	11	67
Washington	2	0	-12	-5	11	65
West Virginia	2	0	-17	-7	10	61
Wisconsin	-1	1	-12	-5	11	65
Wyoming	2	4	-4	-2	11	71

* Includes changes in payments per service as well as anticipated volume/intensity responses. See text.

** Incorporates changes in payment per service and anticipated volume/intensity responses to payment changes for that state. In addition, for each state, we have assumed the same volume/intensity baseline, growth in patient population, and payment updates.

TABLE 4--Gains and Losses by State Relative to the National Average

Percentage Gains and Losses Relative to the National Average

State	Year 1 (1992) change in: Payments Per Service	Year 1 (1992) change in: Payments*	Year 5 (1996) change in: Payments Per Service	Year 5 (1996) change in: Payments*
All States	0%	0%	0%	0%
Alabama	0	-1	1	0
Alaska	-4	-2	-7	-3
Arizona	-4	-2	-5	-3
Arkansas	2	1	1	0
California	-4	-2	-6	-3
Colorado	5	4	16	6
Connecticut	-2	-2	0	0
Delaware	2	1	3	1
District of Columbia	-2	-2	1	0
Florida	-5	-2	-10	-4
Georgia	1	0	0	0
Hawaii	-6	-3	-7	-3
Idaho	4	4	12	4
Illinois	1	0	2	0
Indiana	2	1	5	1
Iowa	4	3	15	5
Kansas	3	2	4	1
Kentucky	3	2	6	2
Louisiana	0	-1	-1	-1
Maine	3	2	7	2
Maryland	-2	-2	-3	-2
Massachusetts	0	-1	4	1
Michigan	3	2	12	4
Minnesota	6	6	13	4
Mississippi	5	4	17	7
Missouri	3	2	8	2
Montana	2	1	4	1
Nebraska	0	-1	8	2
Nevada	-5	-3	-10	-4
New Hampshire	5	4	13	5
New Jersey	1	1	4	1
New Mexico	0	-1	-3	-2
New York	1	0	4	1
North Carolina	2	2	3	1
North Dakota	1	0	2	0
Ohio	0	0	1	0
Oklahoma	-3	-2	3	1
Oregon	0	0	4	1
Pennsylvania	0	0	3	1
Rhode Island	3	2	8	3
South Carolina	4	3	10	3
South Dakota	4	3	7	2
Tennessee	4	3	5	1
Texas	0	-1	-5	-3
Utah	4	3	12	4
Vermont	4	3	7	2
Virginia	3	2	9	3
Washington	1	0	5	2
West Virginia	0	0	-1	-1
Wisconsin	1	1	6	2
Wyoming	5	4	15	5

* Includes changes in payments per service as well as anticipated volume/intensity responses. See text.

RESPONSES OF GAIL R. WILENSKY TO QUESTIONS FROM SENATOR BENTSEN

Question No. 1. Dr. Wilensky, we are being asked by physicians to legislate on a number of issues affecting the new payment system. In previous testimony, you have already expressed concern about the tight deadline HCFA is under if the law is to go into effect on January 1 of next year. Would you care to comment on the effect that legislative changes might have on the schedule for implementation?

Answer. Implementation of the fee schedule is an extremely complex undertaking and the time frame for implementation is extremely short. The regulation must be finalized, information must be provided to the Medicare carriers, the carriers must apply the transition rules and determine payment rates for individual physicians, and information must be communicated to physicians. Legislative changes could significantly complicate and almost certainly delay implementation of the fee schedule.

Question No. 2. Dr. Wilensky, aren't you afraid that the behavioral offset adjustment you are proposing will prove to be a self-fulfilling prophesy? That is, if physicians feel that they're being penalized in advance for increasing the volume of services, won't they be more likely to do just that?

Answer. The research literature and our own experience with the Medicare program confirms that the volume and intensity of physician services delivered increased when fees are reduced. Budget neutrality is required in 1992 relative to payments under the old payment system. Our actuaries advise that, in order to achieve budget neutrality, a behavioral offset is necessary.

Question No. 3. Dr. Wilensky, in the past HCFA has expressed considerable confidence that the so-called "behavioral offset" accurately predicts the behavior of physicians. But aren't there significant limitations to the studies on which this adjustment is based? For example, the CBO study is based upon an analysis of only *two* specialties in *one* State—Colorado—during the mid- 1970s, when Medicare consolidated the payment areas in that State into a single locality. And they were specialties—internal medicine and general practice—that generally have been expected to see payment increases under the new system. In fact, didn't this same study find that the volume of services furnished by Colorado surgeons actually *decreased* during the same period?

My question to you is whether it will be possible for us—at some time in the future—to determine whether you were right or wrong in your predictions about physician behavior. And is there any mechanism for holding HCFA accountable to physicians if its assumptions prove to be unduly pessimistic? Do you plan to give the money back if you are wrong in withholding $7.7 billion over five years?

Answer. We will be looking at the performance of physicians in response to the MVPS, fee schedule and balance billing limits. We will be analyzing the utilization of and access to services.

The behavioral offset has been used by HCFA actuaries to estimate savings of proposals well before the CBO study. We believe that the literature supports the long-standing 50 percent behavioral offset assumption used by HCFA actuaries. In its *1991 Annual Report to Congress*, PPRC concluded that several time-series studies suggest that the volume of services is affected by fee changes. A literature review is provided. In addition, the PPRC staff studied the impact of OBRA 1987 Medicare fee reductions cuts on the volume of services delivered by five specialties and calculated a behavioral offset coefficient of 0.56 (56 percent). In the appendix of its April 1990 *Physician Payment Reform Under Medicare* report, the CBO calculated a behavioral offset coefficient of 0.55.

Dr. William Hsiao, developer of the resource-based relative value scale, after an exhaustive review of empirical studies, reported in the recent paper, *Payment Regulations—What Impacts Did They Have?*, that "physicians can affect the service mix and utilization rates to offset fee reductions."

Our experience with the physician fee freeze in the mid-1980's showed that physicians do increase volume and intensity of services when fees are constrained. Measuring the response is complicated by other factors, particularly the implementation of the hospital prospective payment system (PPS). Increases in total physician volume and intensity reached a historically high level of 10 percent in 1986. In fact, when physician volume and intensity data are adjusted for the sharp decline in hospital admissions under PPS, there would have been a very similar increase in physician volume and intensity in 1985.

As the default MVPS is currently structured, if we *do* apply a behavioral offset, but the anticipated increases in volume and intensity do *not* occur, the full reduction in the *level* of the conversion factor *is* eventually restored. Therefore, while physician payments in the interim are reduced relative to under the old payment system, payments are fully restored in future years. On the other hand, if we do *not*

apply an offset and increases in volume and intensity *do* occur, the excess payments are *never* recouped in full and the conversion factor is never fully corrected.

Question No. 4. Dr. Wilensky, on June 10—five days after the proposed rule came out—the Finance Committee asked HCFA for an impact analysis of the rule on rural areas. Can you tell me what the status of that request is and when the members of this Committee can expect to receive a response? What is your best judgment about the rule's impact on rural areas?

Answer. We are in the process of completing an evaluation of the effects of the proposed fee schedule on rural areas. We will provide the Committee with this analysis when completed.

Question No. 5. Dr. Wilensky, in the June 5 rule, you have proposed to eliminate the use of *actual time* in determining payments for anesthesia services. I am concerned—and I know Senator Dole is concerned—that basing payments on average time will systematically underpay physicians at teaching hospitals and rural hospitals1 where surgical procedures typically take longer. We are also concerned that you don't have adequate data on which to base the average times. Would you care to comment?

Answer. For some time, the Department of Health and Human Services has favored a policy to replace payment for actual anesthesia time with the average time. In our 1989 regulation implementing the anesthesia relative value guide, we clearly indicated our desire to eliminate time in two years. Our position is based on several points.

First, the fee schedule involves an averaging concept in which the average resources for a procedure are paid, regardless of the circumstances of a particular case. We don't pay surgeons depending on whether the patient took more or less time than the average. While anesthesiologists have suggested that averaging would disadvantage them because certain physicians or physicians in certain types of hospitals are slower than the average, no data has been presented on this point. similarly, data on systematic variation in times in different types of hospitals have not been presented to us. Elimination of actual time would put anesthesia services on a level playing field, in terms of payment policy, with all other physician services.

Second, elimination of time reduces the potential abuses in reporting. GAO recently issued a report indicating some concerns about the variations in the reporting of pre and post-surgical time. GAO recommended that the link be severed between actual anesthesia time and Medicare payments. Anesthesiologists clearly have some discretion regarding the determination of when pre- and post time begins and ends. For example, under current policy, post-operative time ends "when the patient may be safely placed under post-operative supervision and the physician or anesthetist is not longer in personal attendance."

Third, not eliminating time complicates program administration and effectively takes anesthesia services out of the overall fee schedule. One of the goals of payment reform is to simplify the system. If actual time were retained, we would probably have to have a separate conversion factor for anesthesia services. This will complicate the program.

Fourth, approximately 250 anesthesia Current Procedural Terminology (CPT) codes are now used for identification of anesthesia base units for a service. It has been argued that the current 250 anesthesia codes are insufficient to average anesthesia time units. The proposed rule indicates a willingness to consider adding CPT codes for anesthesia services with widely varying operative times if data are presented to us. However, it is an inconsistent argument that the current codes are sufficient for base units, but not for time units.

Question No. 6. Dr. Wilensky, the Committee has been hearing more and more about the inadequacies of the data used to construct the geographic adjustment factor that will be used to determine payments under the new payment system. As you know, the geographic adjuster is particularly harmful in states like Texas, where economic conditions have changed since the early 1980's, when much of the data was collected.

Can you tell me what you are doing to improve the data on which the adjustment is based?

And would you care to cogent on a recommendation by the Physician Payment Review Commission (PPRC) that we fund a separate survey on the costs of office space?

Answer. Most outside reviewers, including the PPRC and the American Medical Association (AMA) have concluded that the data used to construct the geographic adjustment factors are generally adequate to account for geographic cost differences physicians face in various parts of the country. To enable future updating and refinement, HCFA has already funded the collection of more recent malpractice pre-

mium data and will acquire the 1990 census data and other data needed for updating the GPCIs in its 1992 procurement plans.

The PPRC found that the Department of Housing and Urban Development (HUD) housing rent data are a reasonable measure for office rents. The PPRC did encourage the Congress to mandate additional responsibility to an agency with ongoing nationwide data collection capabilities such as HUD, the General Service Administration, or the Census Bureau to survey for commercial rent. HCFA would welcome such a source of commercial rent data that might replace the housing rental data.

RESPONSES OF GAIL WILENSKY TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No. 1. When HCFA issued its notice of proposed rulemaking (NPRM) in June it included a provision outlining HCFA's intent to reimburse clinical psychologists the same as physicians for *diagnostic* services. But there was not a reference to a proposed reimbursement policy for clinical psychologists for *therapeutic* services. I would appreciate it if you would provide me with information relating to HCFA'S plans to reimburse clinical psychologists for *therapeutic* services.

Answer. The NPRM proposed paying for diagnostic services furnished by clinical psychologists under the physician fee schedule like all other fee schedule services beginning on January 1, 1992. The NPRM also indicated that HCFA is working on a separate regulation to codify payment policy for therapeutic services furnished by clinical psychologists. This regulation is currently under development within HCFA.

Question No. 2. Congress included a provision in OBRA 89 requiring HCFA to recommend a separate update for emergency department services. The 1992 recommendations for the MVPS did *not* include a separate update for ER physicians, nor did it provide separate data on ER services utilization. Could you please clarify HCFA's rationale for not providing a separate update of the utilization data and please give me an idea of how HCFA intends to proceed with the implementation of this provision?

As a follow-up do you see any justification for this provision or a need to track this group of physicians separately from others?

Answer. Section 1848(d) (2) of the Social Security Act requires the secretary to transmit a report to Congress each year recommending an appropriate update in the physician fee schedule for the following year. The secretary may recommend a uniform update or different updates for different categories or groups of services. In this report, the secretary is also required to include a recommended update for nonsurgical services, visit services, consultations, and emergency services.

In the report to Congress on the 1992 update, we recommended that the same update of 2.2 percent be applied to all groups of physicians' services for the following reasons:

- It would be inappropriate to compare an increase in expenditures for individual groups of physicians with a MVPS that applied to all physicians' services.
- Our present data systems did not allow us to establish and monitor separate MVPSs for separate groups of services. This will improve in future years.

Emergency physicians have argued that they exert less control over the volume of patients treated than other physicians and therefore should be treated differently under the MVPS. However, we believe that almost all physicians, including emergency department physicians, have some discretion in the services they provide or order and how they bill for those services.

Question No. 3. HCFA recently stated that the volume of emergency services has increased. Can you identify the source of this increase; that is, is it due to the number and intensity of services performed, the increase in the number of beneficiaries, or what exactly?

Answer. We do not believe that HCFA has made any statements one way or another about the volume of emergency services furnished by physicians.

Question No. 4. What methods are you using to track emergency room use as a way of monitoring changes in the way beneficiaries obtain health care services as a result of RBRVS?

Answer. We recently transmitted a report to Congress concerning our plans for monitoring access and utilization of services under the fee schedule. The report details the diverse data acquisition and information management systems under development that will improve our capability to assess the beneficiary access to services. For example, by the end of the year, we will have restructured our claims data systems to create a single large National Claims History database that will contain information about all Medicare services. We plan to use the same methods to monitor use of emergency room services.

RESPONSES OF GAIL R. WILENSKY TO QUESTIONS FROM SENATOR CHAFEE

Question No. 1. How is the Medicare weighted risk group premium constructed and what is the impact on the Rhode Island GPCI for malpractice? (see *Federal Register* 6/5/91, p. 25816)

Answer. A value was constructed for each state by creating a two-year weighted average premium across low, medium, and high insurance risk classes. A two-year period was used to even out changes in rates from one year to the next. The three risk classes were represented by general and family practitioners who do not perform surgery, general surgeons, and orthopedic surgeons. The weights are the national share of Medicare expenditures accounted for by each risk class. In this case, the underlying Rhode Island premium data are weighted by 0.55, 0.33, and 0.12 for the low, moderate, and high risk insurance groups respectively.

Question No. 2. The comparative data upon which the malpractice GPCIs are based was for $100,000/$300,000 claims-made coverage for policy years 1985 and 1986. This has been adjusted "to incorporate the costs of $1 million/$3 million coverage." How was this adjustment made, and what impact did it have on Rhode Island's GPCI for malpractice?

Answer. The adjustment for incorporating the costs of $1 million/$3 million policies is a relative computational adjustment. It was inextricably linked to the Patient Compensation Fund (PCF) adjustments for the mandatory malpractice surcharges required in Kansas, Pennsylvania, and Wisconsin.

First, the remapped Malpractice Geographic Practice Cost Index (MGPCI) values in each of the PCF states were multiplied by their unique PCF factor (2.86, 2.02, and 2.29 for Kansas, Pennsylvania and Wisconsin respectively). These were then divided by 1.9—the St. Paul Insurance Company excess coverage multiplier which converts a $100,000/$300,000 premium to a $1 million/$3 million premium. All other remapped MGPCI values were left unchanged. Finally, the remapped PFC adjusted MGPCI values were renormalized so that the population weighted index has a national average of 1.000.

The Rhode Island MGPCI of 0.734 used in the June 1991 proposed rule differs from the 0.736 September 1990 Model Fee Schedule value primarily because of the renormalization.

Question No. 3. In the years 1985 and 1986, virtually no claims-made medical liability insurance was available in Rhode Island. How was this corrected for in calculating the Rhode Island GPCI for malpractic.

Answer. There was no adjustment made for any State according to the types of medical liability insurance actually in force. We intend to examine this issue for possible future refinements of the malpractice GPCI.

Question No. 4. It would seem like a relatively simple matter to assemble more current and valid comparative data on expenses for professional liability insurance, given the presence of the St. Paul and a few other large entities doing business in a number of states. Why is this not being done? Why is it any easier to assemble data for 1985/86 than for 1989/90?

Answer. HCFA awarded a cooperative agreement in 1990 to collect more current malpractice premium data. Data collection efforts should be concluded by the end of this year. Our goal is to gather the premium data for the largest malpractice carriers in every state. After gathering the data, it must be Standardized to enable calculation of updated or refined indexes. As time permits, we can also examine relationships between actual premiums and costs of policies with fixed limits of coverage ($1 million/$3 million), self insurance, stability of premiums, market share influences (adverse selection), and premiums from other companies such as associations, mutuals and reciprocals.

When GPCI development work began under the OBRA 1986 mandate, HCFA provided researchers access to the malpractice premium 1985/1986 data used in the annual Medicare Economic Index update process. Because of the time involved in conducting competitive federal procurement, obtaining required forms clearances, and actual collection of data we could not have data from all areas in time to comply with OBRA 1989 payment reform requirements had we waited for 1989/1990 data.

OH/WV MEDICAL ONCOLOGY SOCIETY,
Independence, OH, July 22, 1991.

GAIL R. WILENSKY, PH.D, *Administrator,*
Health Care Financing Adminstration,
Department of Health and Human Services,
Attention: BPD-712-P
P.O. Box 26686
Baltimore, MD

RE: File Code BPD-712-P

Dear Dr. Wilensky: The Ohio/West Virginia Medical Oncology Society submits the following comments in response to the proposed rule pertaining to the Fee Schedule for Physician Services under the Medicare Program set out in the Federal Register Vol. 56 No. 108 on June 5, 1991. The Society consists of specialists in cancer medicine in the States of Ohio and West Virginia. Its mission is to work with regulators at the Federal and State levels and with private insurers on behalf of medical oncologists and their cancer patients in order to promote fair and reasonable policies for coverage and payment for medical services provided to them.

Medicare beneficiaries account for approximately one-half of the cancers diagnosed in the United States each year. Our Society believes that a number of the elements in the proposed rule may have serious unintended effects on the access to and quality of cancer care for many senior citizens. Our conversations with oncologists in other states indicate that the views expressed in these comments are widely shared.

These comments will focus on four issues in the proposed rules that have particular relevance to the practice of medical oncology and cancer chemotherapy. These are:

1. The Proposal to Lower the RBRVS Conversion Factor
2. Payment for Supplies, Services, and Drugs Furnished Incident to a Physician's Service
3. Chemotherapy Administration
4. CPT Definitions for Visit Codes.

Following is a summary of the principal points made in our comments:

- The proposal to lower the RBRVS Conversion Factor by 16% is unjustified, unsupported by credible data, and violates Congress' intent that the changeover to the RBRVS system be budget neutral.
- Office medical supplies used to administer cancer chemotherapy should be paid for under a separate fee schedule allowance.
- The proposal to pay for drugs at the rate of AWP minus 15% should be abandoned. Instead, the present payment methodology should be retained pending completion of a study of all costs related to drug acquisition, storage, handling, and breakage. Any new fee schedule should be based on data of costs related to each of these functions.
- The current policy of paying the same amount for services associated with administration of cancer chemotherapy whether furnished personally by a physician or by someone incident to a physician's service should be continued.
- Separate payments for chemotherapy administration should be made for all types of chemotherapy, not only for infusion.
- Chemotherapy administration should be recognized as having a professional component unrelated to the site of treatment. The fee schedule amounts for those services that were not included in the proposed rules published on June 5, 1991, should be made available informally, with documentation, as soon as possible.
- The definitions for the visit codes should eliminate references to specific time intervals.

Our detailed comments follow:

1. The proposal to lower the RBRVS Conversion Factor.

THE PROPOSAL TO REDUCE THE RBRVS CONVERSION FACTOR BY 16% IS UNJUSTIFIED, UNSUPPORTED BY CREDIBLE DATA, AND VIOLATES CONGRESS' INTENT THAT THE CHANGEOVER TO THE RBRVS SYSTEM BE BUDGET NEUTRAL.

Various components of the proposed 16% reduction in the RBRVS Conversion Factor are the subject of comments from other organizations. I wish to focus on the "behavioral offset" portion of the proposed reduction. The behavioral offset is fabri-

cated without supporting data apart from a few general and uncontrolled studies suggesting that physicians are able to increase the number of services to offset decreases in payment for services rendered.

Strict controls exist over the provision of services by physicians. These come from both within and outside the hospital setting. Within the hospital there are numerous utilization review and quality assurance mechanisms that exercise close oversight over physician practice patterns. Outside the hospital, HCFA's own PRO system exercises considerable and, physicians would argue, effective oversight over inappropriate practice patterns. Further, the development of practice guidelines in nearly all medical specialties will provide another mechanism for overseeing the appropriateness of physician services.

In light of these various levels of oversight and accountability which are operative every single day of the year, assertions that physicians will somehow modify their practice behavior to increase the number of services they provide by 5%, 10%, or 15% are unfounded and fly in the face of realities of current medical practice. Additionally, the implementation of Volume Performance Standards and the associated adjustments in physician payment that may result therefrom will provide an internal mechanism for controlling costs from increased numbers of services.

By HCFA's own admission, the 16% reduction in the RBRVS Conversion Factor will generate a surplus of 3 billion dollars. Congress never intended that the conversion to the RBRVS system for payments be a cost saving measure. Rather, Congress intended for it to be budget neutral. It clearly is not budget neutral.

The inclusion of a 16% reduction in the initial conversion factor may make Medicare payments for some physicians lower than the Medicaid fee schedule. This could have a negative effect on the access of Medicare beneficiaries to medical care.

Consequently, the proposed 16% reduction in the RBRVS Conversion Factor should be abandoned.

2. Payment for Supplies, Services, and Drugs Furnished Incident to a Physician's Service.

A. OFFICE MEDICAL SUPPLIES USED TO ADMINISTER CANCER CHEMOTHERAPY SHOULD BE PAID FOR UNDER A SEPARATE FEE SCHEDULE ALLOWANCE.

In its proposed rule of June 5, 1991, on page 25800 of the Federal Register, HCFA specifically invites comments on payment for office medical supplies apart from those enumerated in the proposed rules. Administration of cancer chemotherapy in the office is not a service that is commonly undertaken by most medical practitioners. Rather, it is a unique and specific service offered by practitioners who specialize in the field of medical oncology. Administration of cancer chemotherapy in the office setting, as in the hospital setting, involves the use of capital equipment, disposable supplies, and services, that are not required nor found in the average physician's medical office. The major *capital equipment* item is a biological hood to enable mixing of the chemotherapy drugs without contaminating the ambient air. *Disposable supplies* include bags of intravenous fluids, tubing for administering the intravenous fluids and drugs, specialized needles for accessing infusion ports (reservoirs seated in the chest wall that permit intravenous administration in patient's who lack peripheral veins), diluents for preparing chemotherapy solutions, and anticoagulants for flushing venous access sites. *Services* required for administering chemotherapy include disposal arrangements for discarding biologic wastes and chemotherapy agents to conform with OSHA and EPA requirements.

The costs for these items are not inconsiderable. Presently, the Medicare Part B carrier in Ohio pays for bags of IV solutions using the HCPCS J codes. The carrier also pays for the supplies including syringes, needles, IV tubing, etc. using other J codes. Depending upon the specific chemotherapy agents to be administered, the cost of solutions and supplies can range from $12 to $40.

The proposed method for paying for chemotherapy drugs, physician's professional services, or chemotherapy administration fail to recognize the costs for these items despite the fact that they are required to be used to administer cancer chemotherapy in the office. It bears repeating that these items are not items that would be used in the course of the physician office visit. Rather, they are used specifically for the administration of cancer chemotherapy. Thus, it is inappropriate to include the cost of these supplies in the physician's office visit. Instead, costs for office medical supplies used to administer cancer chemotherapy should be paid for under a separate fee schedule allowance.

B. THE PROPOSAL TO PAY FOR DRUGS AT THE RATE OF AWP—15% SHOULD BE ABANDONED AND REPLACED BY A FEE SCHEDULE BASED ON

DATA PERTAINING TO THE REAL COSTS FOR DRUG ACQUISITION, STORAGE, HANDLING, WASTAGE, AND BREAKAGE.

The proposed rule identifies a level of payment for drugs at Average Wholesale Price (AWP) minus 15%. Unlike other portions of the proposed rule, this specific proposal is not in response to the Congressional mandate outlined in OBRA 89. Rather, it appears to derive from proposals of the Office of Management and Budget and from data reportedly provided by the Office of Inspector General of HHS.

This proposal is wholly unjustified, unreasonable, and fails to satisfy substantive legal standards set out in the law regarding payment for drugs. HCFA is authorized to limit payment for drugs only if payments are grossly excessive or inherently unreasonable. Absent any data indicating these standards are satisfied, HCFA has no legal authority to lower payments for drugs.

The assertions that are set out in the in proposed rule that "physicians are in an excellent position to demand discounts such as those that the OIG Study finds are typically given to pharmacies" are wholly fatuous and without any basis in fact. In contrast to HCFA's assertion that "the physician has great leverage with the entity from which he or she purchases drugs to acquire a significant discount for the drug. . . . " HCFA needs to know that an individual physician or small groups of physicians do not begin to have the bargaining clout with pharmaceutical companies or wholesalers th" hospital pharmacies or consortia of hospital purchasing groups have. To assert otherwise flies in the face of common sense and any knowledge of business practices in this country.

It is important that HCFA understand several factors pertaining to the costs associated with chemotherapy administration in the office. Drug costs represent significant out-of-pocket expenditures for the oncologist. In addition to the acquisition costs of the drugs themselves, other expenses directly related to the drugs include the costs associated with ordering, inventorying, storing, handling and mixing, and disposing of drugs or drug packages. Additionally, there are costs associated with wastage of drug because of the inability to use all of a multi-dose vial, with breakage which occurs even with the most careful handlers, and with bad debt expense resulting from the failure of patients lacking financial resources to pay their 20% co-insurance.

In Ohio, the Medicare Part B carrier currently pays for drugs on the basis of the AWP price as listed in the most recent update of the Red Book. Whether and the extent to which the AWP price exceeds the actual cost paid by the practicing physician depends on a number of factors and may vary from month to month with different drugs. It is of interest to note that the price paid by the Medicare Part B carrier in Ohio does not allow for payment for sales tax which of course must be paid by the practicing physicians and amounts to 6%-7% depending on the area in the state in which the physician practices.

There are no published data on the actual costs incurred by physicians in purchasing cancer chemotherapy drugs. We are aware of a study recently completed in Tennessee and of other studies that are presently ongoing. However, it is relevant that HCFA's proposal was generated without a shred of data to substantiate it.

Preliminary data from several practices in Ohio indicate that HCFA's proposal will result in serious underpayment to physicians for the drugs which they need to acquire to administer cancer chemotherapy in their offices. Since the other aspects of the proposed rule provide no mechanism for recovery of the other costs associated with administration of cancer chemotherapy in the office, absent the development of relatively generous RVUs for the cancer chemotherapy codes, administration of cancer chemotherapy in the office will be a losing proposition financially for medical oncologists.

It is simply unrealistic for HCFA or any insurer to ask physicians to provide materials and supplies to Medicare beneficiaries at a financial loss. If indeed this proposal is finalized as it presently exists, physicians may be required to ask their patients to purchase the drugs at local pharmacies and bring them with them to the office for administration. This would be a significant hardship to many senior citizens from both a financial and personal standpoint. Indeed, the whole idea of asking patients to shop around for drugs and carry these potentially toxic drugs around with them to the physician's office is repugnant.

In summary, this proposal is unwarranted, ill-advised, unsubstantiated by any data, and capable of producing substantial hardship to senior citizens.

We propose that the present payment methodology should be retained until data are available from a study of all costs related to drug acquisition, inventorying, storage, handling, wastage, and breakage. Any fee schedule should be based on data of the costs related to each of these functions.

C. THE CURRENT POLICY OF PAYING THE SAME AMOUNT FOR SERVICES ASSOCIATED WITH ADMINISTRATION OF CANCER CHEMOTHERAPY WHETHER FURNISHED PERSONALLY BY A PHYSICIAN OR BY SOMEONE INCIDENT TO A PHYSICIAN'S SERVICE SHOULD BE CONTINUED.

In its proposed rule, HCFA requests public comment on whether the policy of paying the same amount for the service whether furnished personally by a physician for by someone incident to a physician's service should continue.

The short answer to this question is that such payment should continue. In the practice of medical oncology, the administration of chemotherapy in the office is commonly undertaken by nurses with specialized training in cancer nursing. They are highly trained and highly skilled nursing professionals who have RN degrees. Many have additional specialized training and command salaries near the top end of the pay scale for nurses. Such salaries must be paid by physicians in order to compete with the hospitals and other facilities where such treatments are provided. But for the fact that cancer chemotherapy is administered in the office, it would not be necessary for physicians to incur the expenses associated with hiring these skilled professionals. Oncology nurses provide a number of services in support of the management of cancer patients whereas these services could be provided by the physician personally, they take time and to do so would prevent the physician from providing medical services to other patients which he or she alone is uniquely qualified to provide.

Therefore, the services provided by nursing professionals in the physician's office are essential for the provision of modern cancer management including cancer chemotherapy. Although they are provided incident to a physician's service they should be paid under the fee schedule as if the physician had furnished the service.

3. Chemotherapy Administration

A SEPARATE PAYMENTS FOR CHEMOTHERAPY ADMINISTRATION SHOULD BE MADE FOR ALL TYPES OF CHEMOTHERAPY, NOT ONLY FOR INFUSION.

The proposed rule states that subcutaneous, intramuscular, intravenous, or intra-arterial injection of drugs including cancer chemotherapy would not be eligible for additional payment apart from that provided for the office visit. Administration of cancer chemotherapy by any route requires a similar degree of planning, technique, risk, and potential for complications. The present CPT-4 codes recognize different routes for administration for cancer chemotherapy. There is no logical basis for HCFA to assert that the administration of cancer chemotherapy by techniques other than infusion or administration into specialized body cavities requires any less degree of skill or requires a lesser use of resources. No data are offered by HCFA to justify omission of payment for administration of cancer chemotherapy by injection or these other routes. The administration of cancer chemotherapy by any route involves the same costs associated with procuring, handling, storing, inventorying, and disposing of drugs plus the losses from wastage, breakage, and bad debts.

Therefore, there is no logical basis to distingush payment for cancer chemotherapy when administered by these other techniques or routes from those administered by infusion techniques or into specialized body cavities. Specifically, the current CPT codes 96408 and 96420 represent distinct services that are readily separable from the office visits. To elimmate payment for these services would make it exceedingly difficult to provide them since there is no way that payment for office visits would begin to cover the costs of these services. Consequently, there could be substantial harm to patients with respect to access to these services.

B. CHEMOTHERAPY ADMINISTRATION SHOULD BE RECOGNIZED AS HAVING A PROFESSIONAL COMPONENT UNRELATED TO THE SITE OF TREATMENT.

Payment for chemotherapy administration remains to be resolved and the chemotherapy administration codes are not listed in the fee schedule accompanying the proposed rule. Thus, the proposed rules provide no means for physicians to be paid for professional services associated with administration of cancer chemotherapy in the office or non-office setting. Commonly, the latter is the hospital outpatient department.

It is widely acknowledged that the administration of cancer chemotherapy is more than a simple technical procedure. Rather, it requires the supervision of the physician which includes determination as to whether a planned dose can be properly administered as scheduled, management of complications arising during the course of administration of treatment, responding to questions raised by patients at the time of administration, and responding to questions or problems that arise after the

administration of chemotherapy, particularly with respect to side effects and complications. Not to acknowledge the legitimate nature of these professional services accompanying the administration of cancer chemotherapy is to negate an important aspect of what cancer management is all about.

It is presumed that a fee schedule will be developed after there has been an opportunity for HCFA to review the data from the vignettes presently being surveyed by Hsiao. Although the RVUs for the new chemotherapy management codes have yet to be determined, it is important that they fairly reflect the resources utilized in cancer management. We urge that the fee schedule amounts for these services that were not included in the proposed rule published on June 5, 1991, be made available informally, with documentation, as soon as possible, and that there be sufficient opportunity to comment on them.

4. CPT Definitions for Visit Codes.

THE DEFINITIONS FOR THE VISIT CODES PROVIDED IN THE PROPOSED RULES SHOULD ELIMINATE REFERENCES TO SPECIFIC TIME INTERVALS.

Addendum E of the proposed rule provides descriptors for office and outpatient medical services, inpatient hospital visits, and consultations. These have reportedly been approved by the CPT Editorial Panel of the AMA for pilot testing. The various descriptors provide estimates of average time physicians should spend face-to-face with patients and family to satisfy the code definitions.

These time estimates are wholly inappropriate. They fail to take into account the fact that the amount of time that may be involved face-to-face with a particular patient or family can vary substantially from case-to-case and is not necessarily related to the overall complexity of the service or to the amount of the other work that must be done by the physician in providing the service.

As an example, the present CPT code 90060, intermediate office visit, is utilized by medical oncologists to denote the service rendered to patients who are receiving cancer chemotherapy. This service involves taking a history from the patient of events since the previous exam, examining the patient, reviewing results of laboratory, x-ray, and other pathology studies, and making a determination regarding further therapy. The actual time spent face-to-face with a patient may range from 10-20 minutes. Additional time taken to carry out other aspects of the work including going to laboratories, reviewing the x-rays, reviewing laboratory reports, contacting other physicians about the care of the patient, and preparing a written record may take an additional 10, 15, or more minutes Thus, the overall time involved in managing the patient in this situation may be of the order of 25, 30 or more minutes.

The corresponding code in the proposed rules, OB019 denotes that physicians on the average spend 15 minutes face-to-face with the patient or family to provide this level of service This conversion is wholly inappropriate. The issue might perhaps be illustrated more clearly by the analogy with attorney work. Attorneys bill clients for services that are done outside the immediate presence of the client. No one would suggest that the attorney only bill the client for time spent in face-to-face contact. Attorneys would find this totally unacceptable and clients would never expect this.

Similarly, it is inappropriate and rather demeaning to ask physicians to restrict payment to the time they spend face-to-face with patients and discount altogether the considerable amount of time, effort, energy, and resources spent in undertaking the activities that are involved in the management of patients and that occur outside the immediate presence of the patient. Indeed, to suggest such a concept flies in the face of the underlying philosophy that informs the development of a resource-based relative value scale. That is, that payment will be made for evaluation and management where it is recognized that evaluation and management involves a variety of activities, skills, and functions in addition to and apart from that of hands on contact with the patient.

Further, and perhaps most importantly, defining different levels of service in part by denoting specific time intervals penalizes the efficient physician and rewards the inefficient practitioner. It is difficult to believe Congress or any responsible agency would support such a system.

Accordingly, we strongly urge that HCFA eliminate these stated time amounts from the definitions for the visit codes.

The Ohio/West Virginia Medical Oncology Society appreciates the opportunity to comment on the proposed rules and participate in the development and implementation of physician payment reform. We urge HCFA to consider our comments and the impact the proposed changes will have on the access of Medicare beneficiaries to cancer care. Appropriate revision of the proposed rules to accommodate the changes

we have recommended will promote physician payment reform and benefit senior citizens.

We appreciate your reviewing these comments and would be pleased to be available to discuss them further with you.

Sincerely yours,

DALE H. COWAN, M.D., *President, Ohio/West Virginia Medical Oncology Society.*

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF NEUROLOGY

The American Academy of Neurology (AAN/the Academy) is pleased to provide a statement to the Finance Subcommittee on Medicare and Long-Term Care on HCFA's Notice of Proposed Rulemaking to implement the new Medicare physician fee schedule.

AAN appreciates Chairman Rockefeller's and the Subcommittee's commitment to ameliorate the problems inherent in the Notice of Proposed Rulemaking (NPRM) on the RBRVS while moving forward with a Medicare Fee Schedule which is both fair and equitable. While AAN will provide comments to HCFA on several areas of concern, we will focus our comments here on the most problematic to all of organized medicine – the reductions to the conversion factor.

DOLLAR CONVERSION FACTOR REDUCTIONS

If the proposed rule were implemented as written, drastic, unnecessary and unanticipated reductions in physician fees of over $12 billion would be realized by 1996, due to conversion factor reductions of 16 to 22 percent, despite Congress' clear intent that transition to the new MFS be budget neutral and that Medicare physician payment reform not be used as a budget cutting device. It is because of these reductions to the dollar conversion factor, more than any other reason, that physician payments will be so much lower than originally intended by Congress. For some of these reductions, we realize that HCFA is constrained to the letter of OBRA '89, and therefore call upon the Congress to correct for them through legislative action. But, Congress need also mandate HCFA in other areas to reverse all of the unnecessary reductions to the dollar conversion factor proposed by HCFA which threaten the budget neutrality upon which physician payment reform was based.

The following briefly describes the conversion factor (CF) reductions proposed by HCFA:

BEHAVIORAL OFFSET ADJUSTMENT: By assuming that physicians will offset 50% of every dollar in lost revenue due to fee reductions, HCFA proposes to lower the conversion factor by 10.5 percent. HCFA does not attribute any dollar savings to the offset since they claim that the offset is required to prevent any increase in overall outlays under the fee schedule. However, HCFA staff have estimated that without this offset, $4.5 to $5 billion would remain within the Medicare physician expenditure pie by 1996.

The Academy maintains that no behavioral offset assumption be employed by HCFA because the Volume Performance Standards will take care of any unanticipated increase in volume as they provided a mechanism for HCFA to recommend lesser updates if expenditures exceed the target. Regarding HCFA's arguments against having the VPS take care of all unanticipated volume increases, Congress could simply recommend greater reductions in updates if merited, or change the default formula. Furthermore, scientific data supporting the concept of a behavioral offset are not well developed nor uniformly accepted by HCFA, the Congressional Budget Office (CBO), and the Physician Payment Review Commission (PPRC). Given this, Congress should legislate that HCFA be prohibited from using a behavioral offset assumption in its calculation of the conversion factor. Anything less will fall short of the goals of physician payment reform should physicians be penalized unnecessarily.

TRANSITION RULES ADJUSTMENT: Because of an unintended consequence of the transition rules for phasing in the new fee schedule (the fact that more services will receive full increases to the RBRVS rates in 1992 than will receive reductions to the full final RBRVS rates), HCFA believes that overall outlays in 1992 would be two percent in excess of budget neutrality. To "correct" for this, HCFA proposes a 6.2 percent reduction in the CF. In the proposed rule, HCFA acknowledged that this will result in outlays of physician services being $3 billion less than if the transition adjustment was not made; but HCFA staff now say that by 1996 a total of $7 billion would be saved in order to make the MFS budget neutral in 1992.

The reductions in the conversion factor appear larger than would be required to adjust for budget neutrality. For example, a 6.2 percent reduction to the CF to adjust for a predicted initial increase of outlays of 2 percent due to the transition rules seems inflated. This results in a threefold reduction in the CF to offset expected increases in outlays, an effect known as the "tripling" effect.

CROSSWALK TO THE NEW VISIT CODES: It is likely that the transition/behavior adjustments actually understate how much that HCFA has reduced the conversion factor. The staff of the Physician Payment Review Commission believe, based on a preliminary estimate, that HCFA's assumptions on the frequency that new visit codes will be billed (called the "crosswalk" by HCFA) may have reduced the CF by another 3-5 percent from what would have been the case if different assumptions were used. Instead of an almost 17 percent reduction in the CF, the reductions made by HCFA may be as great as 22 percent when the "crosswalk" assumptions are also taken into consideration.

SUMMARY OF HCFA'S CONVERSION FACTOR REDUCTIONS:

-10.5%	behavioral offset -- no "savings" estimated by HCFA, but physicians fees would be reduced $4.5 to $5 billion by 1996
+ -6.2%	transition adjustment -- $7 billion in savings by 1996
-16.7%	total conversion factor reduction due to these two factors alone -- $12 billion in reductions by 1996
+ -5.0%	preliminary PPRC estimate of possible additional cut due to visit code crosswalk -- no savings estimated by HCFA, but would translate into additional reductions in fees by 1996
-21.7%	possible total HCFA conversion factor reduction as opposed to true "budget neutral" CF -- would translate into over $12 billion (plus savings due to an inaccurate projection in the "crosswalk" due to the new visit coding system) in reductions during the transition to the new MFS, despite Congress' intent that Medicare physician payment reform be budget neutral and not be used as a budget cutting devise.

Physician payment reform will be undermined if Congress does not act to reverse these cuts. Physician trust and faith in Congress and the Administration is at stake. The Academy urges Congress to enact legislation which would return physician payment reform to the budget neutral basis on which is was intended. Congress should specifically:

(1) prohibit HCFA from employing a behavioral offset;

(2) correct the transition asymmetry problem and eliminate the "tripling effect" of applying all adjustments to the conversion factor and;

(3) correct for HCFA's "crosswalk" to the new visit codes if budget impacts show that it will further unnecessarily reduce the conversion factor.

The Academy is sensitive to the pay-as-you-go budget rules passed last year, and would prefer alternatives that would not trigger it. However, we cannot stand by and watch physician payment reform be brutalized by HCFA and by technical drafting errors. The Academy would be pleased to assist in the drafting legislative language which achieves the ends outlined above.

STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

The American Academy of Ophthalmology represents 16,000 or 90 percent of the ophthalmologists in the U.S.; the members are medical specialists who will bear a significant portion of the reductions under the new Medicare Fee Schedule.

The Academy does not support the intent of the Harvard methodology, with its inherent bias against surgery and high technology procedures. ophthalmology has made great strides in treating previously untreatable blinding conditions using new surgical techniques and technological advances. We are concerned that the new Medicare Fee Schedule will thwart advancement because of the extremely low reimbursement rates. We hope you will consider the impact of this fee schedule beyond the Medicare budget.

Our comments focus on these areas:

the impact of the conversion factor;

new policies relating to the surgical global fee;

internal HCFA policy development that should be made part of the public process;

and the recommendation for an "outlier" policy similar to the hospital DRG system that could provide a safety valve to compensate for the methodological shortcomings of the Harvard RVS study.

UNEXPECTED REDUCTIONS DUE TO THE CONVERSION FACTOR

We share our colleagues frustration with the Administration's use of the new fee schedule to gain deep cuts in physician payment. HCFA's manipulation of the conversion factor contradicts Congressional directives for budget neutrality.

While we were expecting reductions—based on the bias of the system against surgical procedures—we were surprised at the magnitude of the cuts. We could not have predicted these levels, even with the publication of the September 1990 Model Fee Schedule.

Earlier this year, incorporating the September Model Fee Schedule assumptions, we projected values based on the Harvard re-study of ophthalmology. Then we reduced those projections by 15% to account for a "worse-case" conversion factor. Even 50, the June 5 numbers are about 20% less than our projections. This is directly attributable to the gamesmanship by the Administration in developing the conversion factor.

Furthermore, the fee schedule will reimburse some ophthalmologists at rates below Medicaid's payments. Using Medicaid data provided by the PPRC for 49 states, 65% of the surveyed states will have better payments for cataract surgery under Medicaid than Medicare. In California, Medicaid pays $1005.21, under the Medicare fee schedule, some physicians will receive only $842.00. (see attached)

We urge the Committee to instruct HCFA to recompute the conversion factor as recommended by the AMA.

SURGICAL GLOBAL FEE POLICY

We also oppose HCFA's proposed definition of the surgical global fee. In its effort to nationalize a global fee policy, HCFA has gone far beyond current local practices.

In 1989, we participated in a PPRC consensus panel that developed a surgical global fee policy. In general, we support the PPRC's definition, which was incorporated into Phase II of the Harvard RVS study.

The key differences between PPRC and HCFA policies are:

(1) For pre-operative care, HCFA would include all visits by all physicians for 30-days before surgery, where PPRC and Harvard only include the day before surgery in the global fee. PPRC's policy allows for separate billing of necessary pre-operative testing and evaluation, by the surgeon or other providers, prior to surgery, which HCFA would not allow. Medicare patients often have high blood pressure, diabetes, heart conditions or other conditions that need to be assessed before surgery. Under HCFA's policy, the internist would not be paid unless the patient was very seriously ill.

(2) HCFA would include in the global fee all services performed during the post-operative period up to 90 days from the date of surgery. PPRC would include post-operative visits, but would allow other procedures to be billed separately. Harvard followed this approach in its Phase II survey. The RVS vignettes were designed to represent the average, uncomplicated case. HCFA's proposal to include all complications contradicts the intent of the RVS pricing, and unfairly reduces reimbursement for complex, severe or complicated cases.

We are concerned that HCFA's proposed drastic change will result in further significant reductions in payments related to surgery, to the surgeon and to other providers, which could have an impact on the quality of care.

We are also concerned that despite HCFA's apparent zeal to bundle services, it continues to allow optometrists to bill for seeing patients during the post-operative period.

We urge Congress to instruct HCFA to adopt the PPRC parameters for the global surgical fee, and to prohibit billing by non-M.D.s before the end of the global fee period.

MINOR SURGERY GLOBAL POLICY

Minor surgeries would be subjected to a 30 day global fee period, and no payment for office visits would be allowed, under HCFA's proposed rules. This again contradicts the survey parameters used by Harvard, and would significantly underpay minor surgeries.

Harvard did not survey or develop estimates for pre- and post-service work for minor surgeries because the researchers assumed that office visits would be billed in addition to the minor surgical procedure. HCFA should take this into account and either add in the value of or pay separately for appropriate office visits.

THE HCFA "LIST" POLICY

HCFA will be developing internal lists to assist carriers in implementing the various new nationalizing policies. These lists will take on as much importance as the rules themselves, and should be open to public scrutiny, with a comment period and accountability.

For example, the Academy was recently involved in an exercise initiated by HCFA to develop a list of services to be counted as part of the surgical global "package." A computer print-out was circulated to the AMA CPT advisory panelists for review, with an extremely short turn-around time, and with no input expected from the specialty societies. The list is now apparently in the hands of the internal HCFA medical consultants, who apparently have not accepted the comments we made, and are not likely to explain why our comments were rejected.

During the next few months, HCFA will be developing the following policy lists:

- bundle of services in the surgical global fee
- minor surgery procedures
- outpatient surgeries subject to an overhead reduction when performed in a hospital setting
- outpatient surgeries that could be performed in an office setting
- special higher-cost supplies for certain procedures performed in the office, with national fees developed for those supplies
- diagnostic tests with technical components and the value of those components

All of these lists will be developed by HCFA as carrier guidelines. More sunshine should focus on this process—the lists and other implementation policies should be included in the Federal Register for public comment, and HCFA should be required to address the comments. There is precedent for this under Medicare Part B in the periodic publication of the ambulatory surgery centers list of covered procedures.

We urge Congress to direct HCFA to extend these important policy making functions to full public involvement.

HARVARD METHODOLOGY QUESTIONS

There were many methodological problems with Phase I of the Harvard RVS study, completed in 1988. Dr. Hsiao acknowledged these shortcomings, and ophthalmology was re-studied under Phase II. Dr. Hsiao corrected some shortcomings, but his work was a disappointment, not only because the strong anti-surgery bias remained, but because many of the methodological changes appear to have been given only cursory attention.

Further, we have not yet received the final Harvard ophthalmology restudy. An important element relating to retinal services is just being completed. Some early scrutiny reveals:

- *Data "trimming" went too far.* In the Harvard study, initial survey results go through statistical transformations, and many values are deleted in order to establish an average result. Our economists have questioned whether Harvard deleted too many values.

A case in point is the estimate of the magnitude of a retinal detachment repair. The initial average response said it was *21 times more difficult than the base procedure.* After the various transformations, trimming and rescaling, Harvard left it as only *6 times more difficult than the base.*

• *Cross-linkages:* While the crosslinks used in Phase II appear to be adequate, our technical consulting group, under Harvard's direction, took pains to select vignettes with CPT codes which might also be used by other specialties, such as plastic surgery, otolaryngology, or general surgery. Harvard neglected to include any of these vignettes in the other specialties' studies.

• Subspecialty surveys were a new feature of the Phase II ophthalmology study, allowing more procedures and ophthalmologists to be included. However, only the general survey was used in the cross-linking and rescaling. It is possible that by excluding the values of the subspecialists, Harvard missed important, more severe or intensive patient vignettes. The result could be an undervaluing of our scale, and a lack of recognition of these special cases.

• *"Consensus" Process:* Harvard is conducting a Phase III study, aimed at filling in values for non-surveyed procedures. Our technical panelists takes exception to the term used by HCFA and Harvard that Phase III involves "consensus." They said that they were provided mail surveys for individual response. However, when they met in person, the session was not conducted in a manner to establish consensus on issues, and the panelists said they felt their recommended changes would not be incorporated.

The over-trimming of non-average responses, the apparent lack of meaningful utilization of subspecialty data, and the questionable treatment of recommendations by the consensus panel could mean that there are significant undervaluations of specialized procedures. However, the proposed Medicare RVS Fee Schedule has no policy for dealing with "outlier" cases. The hospital prospective payment DRG system has an outlier system for cases which significantly exceed the average care.

We strongly recommend that Congress instruct HCFA to develop a similar safety-valve "outlier" system for physician payment under the Medicare Fee Schedule.

COMPARISON OF MEDICAID RATES TO PROJECTED MEDICARE FEE SCHEDULE PAYMENTS FOR EXTRACAPSULAR CATARACT REMOVAL WITH IOL (CPT CODE 66984)

State	Medicaid fee [1]	Fee schedule range [2]		Difference range (Percent) [3]	
		Low	High	Low	High
ALABAMA	$1,121 64	$744 00	$777 00	−34%	−31%
ALASKA	2,915 00	995 00	995 00	−66	−66
ARKANSAS	874 00	728 00	728 00	−17	−17
CALIFORNIA	1,005 21	842 00	1,009 00	−16	0
COLORADO	757 12	817 00	817 00	8	8
CONNECTICUT	733 50	860 00	925 00	8	17
DELAWARE	766 00	840 00	840 00	10	10
DISTRICT OF COLUMBIA	990 00	934 00	934 00	−6	−6
FLORIDA	1,613 00	759 00	872 00	−53	−46
GEORGIA	1,637 10	731 00	830 00	−55	−49
HAWAII	1,240 20	882 00	882 00	−29	−29
IDAHO	812 00	776 00	787 00	−4	−3
ILLINOIS	835 70	775 00	924 00	−7	11
INDIANA	1,872 10	760 00	801 00	−59	−57
IOWA	1,463 20	751 00	805 00	−49	−45
KANSAS	750 00	767 00	811 00	2	8
KENTUCKY	404 45	752 00	776 00	86	92
LOUISIANA	823 15	758 00	837 00	−8	2
MAINE	663 50	758 00	802 00	14	21
MARYLAND	728 00	836 00	859 00	15	18
MASSACHUSETTS	1,157.00	864.00	896 00	−25	−23
MICHIGAN	1,032 36	826 00	916 00	−20	−11
MINNESTOA	1,450 00	769.00	842.00	−47	−42
MISSISSIPPI	591.15	728 00	763 00	23	29
MISSOURI	500 00	744.00	820 00	49	64
MONTANA	1,014 20	777.00	777.00	−23	−23
NEBRASKA	1,377.00	726 00	772.00	−47	−44

COMPARISON OF MEDICAID RATES TO PROJECTED MEDICARE FEE SCHEDULE PAYMENTS FOR EXTRACAPSULAR CATARACT REMOVAL WITH IOL (CPT CODE 66984)—Continued

State	Medicaid fee [1]	Fee schedule range [2]		Difference range (Percent) [3]	
		Low	High	Low	High
NEVADA	1,672.70	845.00	911.00	−49	−46
NEW HAMPSHIRE	750.00	816.00	816.00	9	9
NEW JERSEY	439.00	856.00	915.00	95	108
NEW MEXICO	1,876.84	782.00	782.00	−58	−58
NEW YORK	440.00	794.00	1,003.00	80	128
NORTH CAROLINA	1,147.94	745.00	770.00	−35	−33
NORTH DAKOTA	1,250.00	760.00	760.00	−39	−39
OHIO	745.42	773.00	825.00	4	11
OKLAHOMA	1,350.00	743.00	790.00	−45	−41
OREGON	1,137.92	817.00	846.00	−28	−26
PENNSLVANIA	927.00	792.00	858.00	−15	−7
RHODE ISLAND	600.00	827.00	827.00	38	38
SOUTH CAROLINA	722.00	744.00	744.00	3	3
SOUTH DAKOTA	1,040.00	736.00	736.00	−29	−29
TENNESSEE	1,089.90	754.00	754.00	−31	−31
TEXAS	1,570.44	732.00	825.00	−53	−47
UTAH	1,172.35	799.00	799.00	−32	−32
VERMONT	660.00	773.00	773.00	17	17
VIRGINIA	590.65	752.00	818.00	27	38
WASHINGTON	858.66	821.00	865.00	−4	1
WEST VIRGINIA	800.00	749.00	801.00	−6	0
WISCONSIN	1,153.07	757.00	833.00	−34	−28

[1] Medicaid fees from 1991 Physician Payment Review Commission report No. 91-4, Physician Payment Under Medicaid," pg. 77
[2] Fee schedule payment range calculated from the Health Care Financing Administration's Proposed Medicare Physician Fee Schedule published in the June 5, 1991 "Federal Register"
[3] The "difference range" is the percent by which the fee schedule payment differs from the Medicaid payment for the low and high payment in the state

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STATEMENT OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

The American Association of Nurse Anesthetists (AANA) appreciates the opportunity to comment on the proposed rule for a Medicare fee schedule for payment for physicians' services (hereinafter fee schedule) contained in the June 5, 1991 Federal Register notice. As the professional society that represents over 24,000 certified registered nurse anesthetists (CRNAs), AANA has great concerns about several of the provisions contained in the fee schedule.

As indicated in the notice, CRNAs are one of the seven nonphysician practitioner groups whose services are included in the fee schedule. We believe that the fee schedule, as proposed, would have a major impact on access to CRNA services, as well as payment for those services.

We would like to begin with a general comment on the proposed rule. We are strongly opposed to the use of a behavioral offset. We believe that Congress adopted the Medicare Volume Performance Standards as the way to deal with any potential increase in volume in physician services that may result from decreases in payments to some physician groups under the new fee schedule. If Congress had intended that HCFA use a behavioral offset, they would have legislated such a mechanism. The fact that the Omnibus Budget Reconciliation Act of 1989 (OBRA89) was silent on the issue meant that Congress did not advocate the use of a behavioral offset. The use of a behavioral offset for anesthesiologists is especially inappropriate in that neither anesthesiologists nor CRNAs control volume, with the except ion of pain management. CRNAs and anesthesiologists do not determine the need for surgery, nor the length of the surgical procedure.

Our specific comments on the proposed rule will reference pages as they appear in the Federal Register notice.

Page 25797, column 1, through page 25798, column 1: "CRNAs"

The AANA will address four issues referenced in this section: budget neutrality of the CRNA fee schedule, the elimination of time as a separate payment element, the use of the same relative value scale for CRNAs and anesthesiologists, and the need for a CRNA's payment not to exceed an anesthesiologist's payment.

BUDGET NEUTRALITY OF CRNA FEE SCHEDULE

We do not agree that HCFA developed an appropriate methodology for paying CRNA services when it implemented the Medicare CRNA fee schedule in the January, 1989 proposed CRNA fee schedule rule. We believe that the complexity of the HCFA budget neutrality computation at that time resulted in an unfair and inequitable CRNA fee schedule. We are still hopeful that this inequity will be remedied when the final CRNA fee schedule rule is issued.

ELIMINATION OF TIME AS A SEPARATE PAYMENT ELEMENT

The association has consistently opposed the outright elimination of the use of time units in the calculation of anesthesia payments for the following reasons:

—Anesthesia providers do not determine the length of the surgical procedure, therefore the anesthesia provider is not in direct control of how long it takes to do a case. Consequently, anesthesia providers could find themselves rewarded or penalized financially, not based on their productivity, but rather on arbitrary case assignments.

—If time units are eliminated, like modifier units before them, there will be no way to adjust for patient acuity and/or procedural complexity.

—We do not agree that payment fairness will be achieved through averaging. The elimination of time units will result in a redistribution of payment that will disproportionately affect CRNAs. The institutions that have the longest surgical procedures, and consequently the longest anesthesia times, are teaching hospitals, rural hospitals, and hospitals that treat a large number of Medicare patients. These institutions use CRNAs most often.

—Determining an average time for a procedure is difficult when the amount of time for a specific surgery can vary, for example, between 40 minutes and five hours.

The AANA believes that clear congressional intent to use time units was indicated in the Omnibus Budget Reconciliation Act of 1987 (OBRA87), which mandated the adoption of a Uniform Relative Value Guide (URVG) for use by all carriers when reimbursing for anesthesia services. HCFA subsequently adopted the 1988 edition of the American Society of Anesthesiology RVG and the CPT-4 anesthesia codes. The 248 anesthesia codes were able to replace the 4,200 surgical codes previously used, because the addition of anesthesia time units allows a differentiation between the several thousand surgical procedures. In OBRA89, Congress modified the use of time units to require that actual minutes be counted in fractional time units. The key point is that Congress did not statutorily eliminate time units in either OBRA87 or OBRA89, when they were directly addressing the time issue.

The proposed rule notes that the April, 1991, General Accounting Office (GAO) report "Medicare: Variations in Payments to Anesthesiologists Linked to Anesthesia Time" recommends the elimination of the direct link between anesthesia time and payment.

The AANA shared the GAO's concern about the variation in the mean preoperative anesthesia time billed for by anesthesiologists in the hospitals studied. However, we do not believe that the limited sample size and variables studied provided reliable and valid data to support the inference that the variation in preoperative anesthesia time is based primarily on inefficiency or financial incentives to perform work slower. In fact, most institutions have full surgical schedules and, as a result, there is no incentive to start providing the anesthesia services for a procedure earlier than necessary because that would decrease the number of cases that could be done in a day. In addition, because surgeons are paid by the case and not by the length of time necessary to perform the surgery, most surgeons want to get their cases done in a timely manner so they can move on to the next case or get to their offices to see patients.

We also question the reliability and validity of any study that didn't address factors that contribute to the length of anesthesia time that are outside the control of the anesthesia provider, such as:

—Based on patient acuity, there may be a need for invasive monitoring. The insertion of invasive monitoring devices adds to preoperative time. (It is noteworthy to recall that when modifier units were eliminated, time units were then to reflect these concerns).

—Hospital case-mixes related to patient physical status, e.g. rural hospitals that have a greater percentage of Medicare patients who have higher rates of chronic diseases. As a result, they may be in a higher risk group overall for anesthesia, and thus cause an increase in preoperative anesthesia time.
—Hospital resources available to assist the anesthesia provider with the preoperative anesthesia preparation. Institutional policy favoring the presence or absence of a preoperative holding area for some work prior to moving to the operating room may have a difference.
—The surgical preparation of the patient depends on the surgical equipment. The intraoperative preparation time, for example, in putting a hip fracture patient on the fracture table, may take longer than the actual surgical procedure itself.
—Delays when the surgeon or procedural physician must leave to deliver a baby, is called to provide emergency room care, or chooses to consult with another physician.
—Patient complications during induction.
—The type of anesthesia is sometimes chosen by the surgeon or procedural physician and one type of anesthesia may take longer to implement than another, i.e. regional versus general. Also, when epidural or spinal anesthesia is given, additional time may be required for preloading the patient with fluid, a variation which may have accounted for some of the differences in the group of patients having prostrate surgery. In some cases, both regional and general anesthesia is provided for patient safety, pain management, or other reasons.
—Assistance available during induction (if other health care providers start the IV or insert a Swan Ganz, arterial line, or a central venous catheter).
—Teaching hospitals may have longer preoperative time related to the training of anesthesia providers and surgical residents. The level of students, and the instructor to student ratio, would also be a factor in the length of preoperative time.
—In some surgical procedures, anesthesia may represent the greatest risk to the patient and thus warrant a greater amount of time than the surgery.

In our comments on the GAO draft report on anesthesia time, we stated that we believe that the crux of the problem with billing for preoperative time is that the current definition of anesthesia time is ambiguous. We believe that what is needed is a clear statement that actual physical presence is required for purposes of billing for preoperative anesthesia time. Therefore, we propose the following definition of anesthesia time:

> Anesthesia time begins with the actual physical presence of the anesthesia provider with the patient for the purpose of immediately preparing the patient for anesthesia care in the operating room or an equivalent area. The anesthesia time ends when the patient has been transferred to the continuous care of a licensed individual and the physical presence of the anesthesia provider is no longer required.
>
> The anesthesia time should reflect only the cumulative time the anesthesia provider is physically present in providing anesthesia care to the patient.

The Physician Payment Review Commission (PPRC) in its *Annual Report to Congress, 1991* also disagreed with the GAO recommendation to eliminate time units. The PPRC supported the continued use of actual time units, along with better verification procedures. The specific PPRC recommendation stated: "Medicare should continue to pay for anesthesia services on the basis of base units and actual time. It should develop a more rigorous definition of anesthesia time and implement procedures to validate the time of anesthesia services. The hospital or surgical center should be responsible for verifying anesthesia times."

The alternative payment methodology that HCFA proposes is the use of average time unit values. The AANA does not support this option for the following reasons:

—It would create administrative problems in institutions where the speed of the surgeon varies from practitioner to practitioner. Anesthesia providers would have a financial incentive to opt to work with the faster surgeons.
—This option may systemically reduce payments to CRNAs who work in teaching hospitals and smaller rural hospitals where surgeries may take longer.
—At minimum, an averaging approach would need to include some type of outliers to accommodate the factors that are outside the anesthesia provider's control.

The elimination of anesthesia time would be a significant departure from current practice, that is unwarranted merely to have anesthesia payment methodology conform to that used for other physicians' services. Administrative convenience is an insufficient rationale for such a major policy change. We believe that a clarification

of the definition of anesthesia time will obviate the need to develop an alternative payment methodology for anesthesia time. We acknowledge that it may be necessary for anesthesia services to have a separate conversion factor (CF) if we retain the use of time in determining payment. We do not oppose having a separate anesthesia CF. Alternately, the AANA would be willing to work with HCFA to develop another appropriate methodology, such as an adaption to the work component, that would allow the standard CF to still be used.

USE OF SAME RELATIVE VALUE SCALE FOR CRNAS AND ANESTHESIOLOGISTS

CRNAs providing services to Medicare beneficiaries have been paid under the URVG for over two years now, and have found it to work very well. Therefore, the AANA agrees that HCFA should use the same relative value scale for anesthesia services furnished' by anesthesiologists and CRNAs. HCFA's rationale for doing so is that it would be simpler for CRNAs, physicians, hospitals, and carriers. AANA concurs with this rationale but, but more importantly, we believe that different relative values or conversion factors should not be used for a health care providers' service based on whether the health care provider furnishing the service is a nonphysician or a physician.

CRNA PAYMENT NOT TO EXCEED ANESTHESIOLOGIST PAYMENT

The proposed rule accurately reflects the legislative history of the new CRNA CFs mandated by the Omnibus Budget Reconciliation Act of 1990 (OBRA90). Although the specific OBRA90 statutory language required that the CF used for non-medically directed CRNAs should not exceed the CF used for anesthesiologists, congressional intent was clearly that the CF for non-medically directed CRNAs and the CF for medically directed CRNAs should not exceed the CF for an anesthesiologist who personally performs an anesthesia service in the same locality.

Having stipulated that, however, the AANA does not believe that there needs to be an adjustment factor applied to the payment amount for non-medically directed CRNA services to assure that payments are not in excess of the payment for a personally performed anesthesiologist procedure The simplest and most logical way to prevent excess payment to non-medically directed CRNAs is to require them to use the proposed AA modifier to the CF for a personally performed anesthesiologist procedure in that locality, with an additional modifier of "N" to signify non-medically directed CRNA The addition of the "N" would result in the non-medically directed CRNA rate being paid at the same rate as the anesthesiologist, but it would clarify that a non-medically directed CRNA had performed the anesthesia service.

We would then suggest that a medically directed CRNA in that locality use the proposed "AA" modifier with an additional modifier of "M" to signify a medically directed CRNA. The addition of the "M" modifier would result in the non-medically directed CRNA's payment level being multiplied by 70 percent, which is the rate for medically directed CRNAs that was agreed to in OBRA90.

Page 25808, column 2, through 25811, column 2: Anesthesia Services

The AANA will address four issues referenced in this section: method for integrating anesthesia services into the fee schedule, payment for specialized services, monitored anesthesia care, and teaching anesthesiologists.

METHOD FOR INTEGRATING ANESTHESIA SERVICES INTO THE FEE SCHEDULE

We have serious concerns with the use of the cross linking method HCFA is proposing because it does not take into account the previous payment reduction that anesthesiologists have already received. OBRA90 mandated that the weighted national average CF for anesthesiologists be reduced by seven percent, effective January 1, 1991. This reduction has not been factored into the baseline used to determine the remainder of the reductions to be made in anesthesiology services.

PAYMENT FOR SPECIALIZED SERVICES

The AANA agrees with the decision to allow separate payment for specialized procedures when these procedures are furnished in conjunction with an anesthesia procedure or as an unrelated procedure. In that virtually all carriers permit separate payment for these services when furnished by nonanesthesiologists, equity demands that anesthesiologists also be reimbursed for these services. In that same vein, equity also requires that CRNAs be reimbursed for these services as part of their integration into the physician fee schedule.

The Omnibus Budget Reconciliation Act of 1986 clearly established coverage and direct payment under Medicare Part B for anesthesia services *and related care* fur-

nished by a CRNA. Unfortunately, in the January 1989 proposed rule implementing the Medicare CRNA fee schedule, HCFA incorrectly concluded that there was no need to recognize separate payments for related services performed by CRNAs. AANA strongly disagrees with HCFA's treatment of CRNAs with regards to related services because it is inconsistent with its policy for other health care providers.

AANA believes there should be a separate payment for "related services" for all providers for the following reasons:

—Many "related services" such as intubations and arterial lines are provided for patients that are not surgical patients. In fact, some CRNAs provide nothing but the aforementioned services, and therefore, their entire salary is based upon revenues generated from providing these services.

—Frequently the reason for invasive monitoring is not only for intraoperative management, but is also done at the request of physicians for purposes of postoperative management.

—We believe that if a pre-anesthetic initial evaluation/consultation is done by a CRNA and the surgery is not performed, the evaluation/consultation should be paid for separately, i.e. as a related service.

The AANA applauds HCFA's decision to not bundle payment for specialized procedures into the anesthesia payment, but rather to allow separate payment for the services. If anesthesiologists and other physician providers are paid separately for "related services," then CRNAs who provide the same services should not be discriminated against in the provision of payment. Hopefully, HCFA has been consistent in its policies and has incorporated similar payment for specialized procedures in the final CRNA fee schedule that has been approved by Administrator Wilensky and awaits approval by HHS Secretary Louis Sullivan and the Office of Management and Budget.

MONITORED ANESTHESIA CARE

The AANA opposes the development of a uniform modifier to be used with the anesthesia code to identify monitored anesthesia care (MAC). We believe that there is no longer any reason to distinguish between anesthesia provided by nerve block, intravenous, or inhalation technique for purposes of Medicare payment. The proposed rule erroneously implies that any anesthetic that is not a general anesthetic is monitored anesthesia care.

The procedural physician, often in consultation with the CRNA or anesthesiologist, determines whether a patient would benefit from anesthesia. Once that decision has been made, it is the patient's needs that determine whether a general anesthetic, regional anesthetic, local anesthetic, or conscious sedation should be administered. Several years ago, HCFA decided to eliminate payment for "local standby," which had allowed an anesthesia provider to be reimbursed for being on call in case there was a need to administer an anesthetic during a procedure. HCFA was concerned that the anesthesia providers were being paid for "local standby," when they may never have entered the room while the case was in progress. When payment for "local standby" was eliminated, it was replaced with the concept of MAC. The notice references the Office of Inspector General's report entitled "Medicare Coverage and Reimbursement for Monitored Anesthesia Care." The AANA does not concur with the report's implication that the current policy of paying the same amount for MAC and general anesthesia is inappropriate. We believe that the current MAC payment policy is appropriate for these reasons:

—The preparation of the patient and equipment is identical.

—The technical skill of the anesthesia provider is the same.

—MAC cases frequently involve patients who are too sick for general anesthesia, so the patient acuity is higher.

—Anesthesia providers do not determine who monitors the patient, the surgeon does.

—While 20 percent of surgical cases are done under local anesthesia, it is only the more seriously ill patients that get monitored. If MAC is not medically necessary, then carriers should exercise their right to not pay for it.

—The fact that there are not regular and frequent complications associated with MAC cases is a result of the patient education, patient selection, monitoring, and skill of the anesthesia provider, not because there wasn't a need to monitor.

—The use of MAC emphasizes prevention first, consequently there is often no need for vasopressors, IVs, hospitalization, or high cost anesthesia equipment and supplies utilized during general anesthesia.

—MAC makes the use of local and regional anesthesia possible in outpatient surgical settings, rather than necessitating the use of general anesthesia in an inpatient setting.
—Patients receiving potent tranquilizers, sedatives, and narcotics require close monitoring by qualified anesthesia providers to ensure quality care, to prevent serious complications from occurring, and to allow the procedural physician to focus on the procedure itself.

If HCFA is concerned about anesthesia providers billing for MAC when they are not actually with the patient, we submit that the tightened definition of anesthesia time that the AANA has proposed should obviate the need to develop a MAC modifier. The anesthesia time should reflect only the cumulative time the anesthesia provider is physically present in providing anesthesia care to the patient.

The AANA is very concerned that HCFA may be intending to use data obtained from requiring a MAC modifier to justify a decrease in payment for MAC. We firmly believe that the decision regarding whether to provide general anesthesia, regional anesthesia like an epidural block for a woman in labor, local anesthesia, or conscious sedation should be made based on individual patient needs and not for financial reasons. It is not good public policy to create a situation where the patient has to be put to sleep in order for an anesthesia provider to receive payment for their service.

TEACHING ANESTHESIOLOGISTS

The AANA applauds HCFA's decision to remove the financial incentive for a teaching anesthesiologist to choose an anesthesiology intern or resident over a CRNA. We agree that there should be a consistent medical direction payment policy for concurrent procedures, regardless of whether they involve interns, residents, CRNAs, or student nurse anesthetists. Medicare carriers currently allow full base units and 15-minute time units for physician concurrent medical direction of up to two anesthesiology residents. However, the lack of an official HCFA policy on payment for teaching anesthesiologist or CRNA direction of nurse anesthesia students has led carriers to uniformly deny payment for the concurrent direction by a teaching anesthesiologist or CRNA of up to two nurse anesthesia students. While we are pleased that HCFA has proposed to remedy the current inequity between anesthesiology residents and CRNAs, we are concerned that the HCFA proposal does not deal with the fact that anesthesiology residents and nurse anesthesia students are also being treated differently.

However, we are hopeful that the disparity between anesthesiology residents and nurse anesthesia students will be changed by HCFA in the final CRNA fee schedule rule. In a June 15, 1990 memo from Charles R. Booth, Director, Office of Payment Policy, BPD, HCFA, to the Associate Regional Administrator for Medicare, Atlanta, Mr. Booth stated in relevant part that, "We are considering, in the final CRNA regulations, the adoption of a policy that would recognize medical direction whenever an anesthesiologist medically directs concurrent procedures involving student nurse anesthetists. It is our position that if State law does not prohibit the student nurse anesthetists from administering anesthesia, then the carrier can recognize medical direction payment prospectively. If it is not clear that North Carolina State law does not impose a prohibition, the carrier or your office might wish to obtain a legal opinion from the State's Attorney General Office." If the approach that HCFA ultimately adopts is to reduce payments for concurrent medical direction regardless of who is directed, we strongly recommend that it be applied across-the-board to anesthesiologists and CRNAs who also work with nurse anesthesia students.

The AANA appreciates the opportunity to have our comments on the fee schedule considered.

STATEMENT OF THE AMERICAN COLLEGE OF CARDIOLOGY

The American College of Cardiology is an 18,500 member non-profit professional medical society and teaching institution whose purpose is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and formulation of health care policy.

Thank you for the opportunity to provide this distinguished Committee with the College's initial assessment of the Health Care Financing Administration's (HCFA) notice for proposed rulemaking implementing the Medicare fee schedule (MFS) beginning in 1992. The College is troubled by several aspects of the proposed rule, but

is most concerned with: (1) recognition of the value of the professional interpretation of electrocardiograms (ECG); (2) the assignment of relative values units (RVUs) to visit codes; (3) the development of RVUs for the technical component of diagnostic services, and (4) the absence of RVUs for several important classes of cardiovascular specialty services including echocardiography and coronary artery bypass graft surgery (CABG).

ELECTROCARDIOGRAMS (ECGS)

As this Committee knows, the College strongly objects to the implementation of the Omnibus Budget Reconciliation Act of 1990 (OBRA90) provision that eliminates payment for the interpretation of electrocardiograms. *There is no factual basis for this provision.* The medical community was given no opportunity to provide input prior to the passage of this law. As we have testified in the past and as the PPRC and 15 other health organizations have declared, *the law should be repealed.*

To make matters worse, HCFA's proposal for implementation of the law includes an attempt to recognize some value for ECG interpretation through the incorporation of a "mark-up" (additional RVUs) for the ECG into payment for visits. Unfortunately, this results in underpayment of physicians who perform ECGs and overpayment of those who do not, undermining an important goal of physician payment reform: to pay for physician services based on true resource costs, regardless of specialty.

As PPRC stated in its March 1991 Report to Congress (page 255):

> Although bundling EKG interpretations with visits could encourage more appropriate utilization and result in budget savings, it would create inequities among specialties and physicians because of differences in the average number of EKGs performed per visit. For example, Medicare claims files show that cardiovascular physicians bill Medicare for more than four times as many EKGs per office visit as the average physician. Variations among individual physicians are even greater.

If HCFA's plan is implemented, the incremental increase for office visits would be .024 RVUs or 65 cents on the MFS common scale. It is evident that this approach is both inappropriate and inequitable, particularly in light of the fact that HCFA has already assigned a stand-alone value of .18 work RVUs to ECG interpretation.

The College stands ready to support congressional attempts to modify the ECG provision, and to adopt PPRC's recommendation to reinstate payment for ECG interpretation. A more appropriate mechanism with which to protect Medicare beneficiaries from overuse, underuse or misuse of any medical service is the adoption of well developed and tested practice guidelines. Toward this end, the ACC and the American Heart Association will complete guidelines for electrocardiography this October.

We are also concerned that payment for the technical component of ECGs may be inappropriately included in the proposed regulation. The technical payment would be denied "if the 'diagnostic' service is considered to be covered by the visit." Under current law, this could be interpreted to include ECGs. Congress intended, however, that "payment would continue to be made for the technical component of ECGs performed on an outpatient basis," according to the OBRA 90 report.

VISIT CODES

An explicit goal of physician payment reform is to redistribute Medicare physician payments from procedural to evaluation and management services. Reductions in procedural services were expected to be offset by an increase in payments for visits. Instead, our preliminary estimates show that cardiovascular specialists will experience a *4 percent reduction* in 1992 for evaluation and management service payments, in addition to substantial reductions for procedures in the first year of the MFS implementation (based on 1989 national average allowed charges aged to 1991, BMAD-1 data and OBRA 89 and 90 updates for visit codes).

While we recognize that the proposed reimbursement for visits is in part related to the conversion factor, it is also true that the calculation of the conversion factor is based in large part on the assumptions made by HCFA as to how physicians will use the new coding system for visits. Although HCFA supported an AMA pilot test to determine how physicians would use the new visit coding system, recent deliberations at a PPRC hearing revealed that HCFA did not utilize the results of this study to project the total number of visit RVUs expected in 1992. We lack confidence that the proposed visit RVUs and aggregate RVUs represent reality and urge that some attempt be made to utilize the pilot test results to support this important element of the new payment method.

TECHNICAL COMPONENT OF DIAGNOSTIC TESTS

As noted above in relation to ECG services, the College is troubled by several aspects of HCFA's proposal for calculating the technical component of diagnostic tests. For example, for some services it is difficult to determine the true costs of the technical component when that service is routinely billed as a complete procedure in the office or as a professional component only in the hospital. Using the difference between the global and professional fees may be an adequate interim measure; however, the ACC strongly urges HCFA to collect data to more accurately assess the costs of technical components of diagnostic services.

MISSING SERVICES

Subjecting physicians to payment based on relative values for services for which no opportunity to comment was provided is inappropriate. The College is alarmed by the RVUs missing from the proposed rule that would apply to several key services provided by cardiovascular specialists. The total absence of certain classes of codes such as coronary artery bypass graft surgery, echocardiography, and electrophysiology is unacceptable. Even if values established before 1992 are considered temporary, it is likely that changes would not take place for at least a year, resulting in considerable disruption to the delivery of necessary cardiovascular services to Medicare beneficiaries. Only one echocardiography code, a technical component of doppler echo, was included on HCFA's list and this service has not yet been surveyed.

CONVERSION FACTOR

The ACC joins the rest of medicine in opposing the implementation of HCFA's proposed conversion factor. Physician payment reform was intended to be budget neutral, and in reality, Medicare payments to physicians will decrease by 16 percent over the next four years, without accounting for previous reductions taken from 1988-1990. Two factors inappropriately reduce the conversion factor: (1) the unanticipated effect of the transition from historical fees to the Medicare fee schedule [illegible]; (2) the assumption by HCFA that physicians will increase the volume of services by 50 percent.

The College urges Congress to pass legislation to correct the transition problem. We do not believe it was the intent of Congress to cut physician fees by an additional 16 percent. Also, a device intended to control the volume of physician services, the Medicare Volume Performance Standard (MVPS), already exists.

OTHER ISSUES

Site of service differential—HCFA plans to publish a national list of procedures subject to a site of service limitation (those performed more than 50 percent of the time in the physician's office). HCFA is also considering including services which are performed less than 50 percent of the time in the office, but which exceed a certain volume threshold. According to a statement by the HHS Inspector General's office, this would apply to many consultations. Although the limit would apply only to the practice expense component of the fee schedule amount, the practice expense for consultations consists primarily of billing and overhead costs, which are legitimate expenses in both office and hospital settings. This results in another major and unwarranted reduction in an essential cognitive service for the diagnosis and treatment of Medicare patients with heart disease.

Global Surgery Definition—The College is concerned about the application of a greater than 90-day post-operative period for certain services, such as coronary artery bypass graft (CABG) surgery. While a patient may require longer than 90 days to fully recover, typically the care of the patient is transferred back to the primary physician well in advance of the 90 day limit.

Under a global fee system for payment for surgical services, HCFA proposes that each physician be directly paid based on the RVUs of the component of the service provided to the beneficiary. More information is needed to determine how this approach would work and what impact it could have on relations among patients and physicians.

Also, to determine the RVUs for the separate components of care when more than one physician is involved, HCFA has suggested working with a preoperative, intraoperative and postoperative segment breakdown, and plans to apply one standard percentage breakdown to an entire surgical family. For example, virtually all cardiovascular surgical services are included in the same family, using the pacemaker breakdown as the standard. The mix of pre-, intra-, and postoperative inputs varies

significantly among cardiovascular services and we can not support the use of a simplistic generic formula based on a single service, to be applied across all cardiovascular surgical services. If HCFA maintains this approach, the College strongly believes the families should contain fewer and more homogeneous services so that payment more accurately reflects the resources of the particular service provided.

SUMMARY

In summary, Mr. Chairman, the College believes the support of the physician community is essential to the successful implementation of the Medicare fee schedule. There are simply too many problems with the regulation implementing the MFS to meet the goals of physician payment reform, or for the cardiovascular community to feel confident that this effort will result in more good than harm. We stand ready to work with you and the Administration to try to resolve these major concerns, but we are beginning to conclude that January 1, 1992 may be an overly ambitious goal for the onset of the fee schedule transition.

STATEMENT OF THE AMERICAN COLLEGE OF NUCLEAR PHYSICIANS

We appreciate this opportunity to present our initial assessment of the proposed Medicare Fee Schedule (MFS) to the Senate Finance Subcommittee on Medicare and Long Term Care. The American College of Nuclear Physicians (ACNP) and the Society of Nuclear Medicine (SNM) represent approximately 14,000 physicians, physicists, radiopharmacologists, and technologists who specialize in the use of radioisotopes in medicine. Nuclear medicine procedures are an integral part of the management of diseases, such as cancer and heart disease, that afflict our older patients.

PROFESSIONAL COMPONENT

It is our impression that the proposed MFS, which will result in an unwarranted 52% reduction in fees for imaging specialists, is unmindful of the impact on medical practice in this country. The proposed fees for our most common procedures in the Medicare population (78306—bone scan imaging, 78481—cardiac function, 78461—thallium heart stress test, and 78585—lung imaging for clots) are all *lower than paid under Medicaid*. The proposed fee for thyroid imaging, a procedure used to diagnose the President's and Mrs. Bush's hyperthyroidism, is less than twenty dollars.

By professional fee reduction alone, the proposed MFS may preclude the provision of nuclear medicine procedures in all but urban areas and in multispecialty imaging practices. So severe are the proposed reductions in reimbursement that they would contradict and nullify the basic premise of Medicare by limiting Medicare beneficiaries' access to nuclear medicine. Certainly, this was not the intent of Congress or the Administration.

TECHNICAL COMPONENTS

Nuclear medicine is a specialty with many fixed costs and regulatory obligations. In 1991, five major regulatory rules which will directly impact nuclear medicine overhead have been published in the Federal Register. These include Nuclear Regulatory Commission (NRC) User Fees, Radiation Safety Standards (10 CFR Part 20), Environmental Protection Agency National Emission Standards for Hazardous Air Pollutants, NRC Quality Management Regulation, and Package Insert Deviation record keeping. Compliance by medical facilities will increase the cost of nuclear medicine services by an estimated average of $30 per procedure. In fact, the cost of the uptake and treatment service given the First Family will increase by, $144 which is almost double its current price. Technical component fees, as currently drafted in the NPRM, will not cover the costs of doing nuclear medicine. The MFS was intended to reform physician payment, not overhead and regulatory costs. Therefore, *we recommend that solid cost data be used to determine and regularly update relative values for the technical component.*

CONVERSION

The conversion of the radiology fee schedule (RFS) into the MFS assumes that Hsiao data is complete. However, nuclear medicine crosslinks have not yet been finalized and Phase III of the Hsiao study is pending. We believe it is reasonable that *nuclear medicine be given the opportunity to reanalyze and submit comments on the Medicare fee schedule upon publication of complete Hsiao RBRVS data.*

RADIOPHARMACEUTICAL COVERAGE

Nuclear medicine procedures utilize radioactive material—in the form of radiopharmaceuticals—to treat and diagnose diseases. All of our services are very dependent upon the appropriate reimbursement of these products. We were pleased to see that the MFS would pay for physician administered drugs and some supplies separately on a cost basis and applaud HCFA for identifying the need to establish a separate method for radiopharmaceutical reimbursement.

These radiopharmaceuticals should be reimbursed according to a national price list rather than on a local basis. As stated in the NPRM, physician administered drugs will be covered according to national "Red Book" prices. The nuclear medicine community is already working with HCFA to *establish a national price resource for radiopharmaceuticals* that would follow the "Red Book" model. We hope that Congress will support the development and maintenance of this document.

BEHAVIORAL OFFSET

The ACNP and SNM strongly support the stance of the American Medical Association on the unfairness of the proposed reduction in the conversion factor by the Asymmetrical Transition and Behavioral Offsets. Obviously, as a medical specialty to whom patients are referred, our practice reflects the utility of what other physicians consider it to be. Therefore, we do not control fluctuations in volume. Moreover, as part of the Radiology Fee Schedule (RFS), many nuclear medicine providers have experienced fee reductions since 1988. Preliminary data shows that there was *no behavioral increase in volume due to reduced reimbursement for nuclear medicine.* The "offsets" on the conversion factor for all procedures should be eliminated.

TRANSITION

We completely concur with the American College of Radiology in its dismay at the Administration proposing such extreme fee reductions on imaging after the agreement with Congress that has already resulted in a voluntary 20% reduction in fees over the past several years. The MFS ignores this and proposes to further reduce nuclear medicine professional fees resulting in a total reduction of 52 percent since 1988! Two independent studies agree that cuts to nuclear medicine were inappropriate. In fact, in 1989 and 1990, nuclear medicine was protected from reductions applied to the Radiology Fee Schedule (RFS) through an act of Congress. Based on available data and expert opinions, *this additional 45 percent decrease is an oversight that must be rectified.*

TECHNICAL CORRECTIONS ACT HISTORICAL VALUES

Pending the passage of H.R. 1555 and S. 750, the Technical Corrections Act of 1991 (TCA), nuclear medicine is the subject of a specialty differential. In 1989 and 1990, Congress passed a special rule which acknowledged nuclear medicine's concern over the RFS. Full-time nuclear medicine physicians were separated from the RFS and treated like all other physicians pending the development of a Harvard RBRVS. As a result of this rule, there is a difference in historical values between the full-time nuclear medicine physicians and other practitioners who provide these services on an occasional basis. *We ask that Congress pass H.R. 1555 and S. 750 this year in order to provide HCFA with the appropriate basis for the transition of nuclear medicine into the MFS.*

CONCLUSION

In summary, the nuclear medicine community joins the medical community at large in its hope that Congress will help rectify the apparently budget driven proposed MFS. We support the ideals behind the resource based relative value system, including the expectation of equitable compensation of all physicians. What has been proposed will not accomplish that, and we fear an adverse impact on the provision of medical care. We will work with Congress and the Administration in implementation of this major change in medical practice, but are concerned that time will not permit reasonable and rational answers to the problems in the proposed MFS.

STATEMENT OF THE AMERICAN COLLEGE OF RHEUMATOLOGY

The American College of Rheumatology (ACR/the College) is pleased to provide a statement to the Subcommittee on Medicare and Long-Term Care, Committee on Finance on HCFA's Notice of Proposed Rulemaking to implement the new Medicare physician fee schedule. The ACR is the world's largest organization of rheumatologists, both physicians and scientists, dedicated to the prevention, treatment and eventual cure of arthritis and the more than 100 types of rheumatic diseases.

The College appreciates Chairman Rockefeller's and the Subcommittee's commitment to identify and resolve the problems inherent in the Notice of Proposed Rulemaking (NPRM) on the RBRVS while moving forward with a fair and equitable Medicare Fee Schedule. The College will provide comments to HCFA on several areas of concern, but will focus our comments here on the two most problematic – 1-HCFA's estimations of practice costs and 2-the reductions to the conversion factor.

PRACTICE EXPENSES

The College is opposed to basing the computation of practice expense relative value units (RVUs) on the current charged-based system. Although, HCFA is following the statute in this area, the current formula is highly inequitable to rheumatologists and other office-based physicians, and is not consistent with an overall resource-based approach to physician payment reform. The College strongly recommends that Congress amend OBRA '89 to base practice expense relative values on estimates of resources used, rather than on historical charges. This recommendation has the support of the Physician Payment Review Commission.

There are several reasons why using the charged based system for estimating practice expenses is inequitable to rheumatologists and other physicians. Under this system, the amount rheumatologists are paid for a given service is influenced by the historical charge levels and the averaging of practice expense shares of all the other physicians who most often perform the service, rather than by the actual resource costs involved in providing the service. Because historical charge levels cannot be explained by the actual input costs of providing a service, it is unlikely that those charge levels will lead to accurate payment for practice costs. In addition, while rheumatologists are few in number, it is clear that the averaging plan will result in total relative value units which are too high for all other physicians who provide the services most often and too low for rheumatologists. This will increase reimbursement for all physicians and decrease reimbursement levels for rheumatologists. Lastly, since rheumatology is not recognized by HCFA as a distinct specialty, we are not listed separately in the data presented by HCFA in the proposed rule for the purposes of calculating the percentage of mean total revenue that goes to overhead and medical liability. Rather, we are lumped in with internal medicine. This lack of specialty recognition by HCFA has caused numerous problems for rheumatologists in other areas as well. Without specialty recognition, it is impossible to identify the true impact of the averaging plan.

In keeping with the intent of a resource-based relative value scale, the Harvard study constructed a practice cost index value for each specialty to ensure practice cost reimbursement levels were fair and equitable. The OBRA '89 methodology for practice costs challenges the construct and philosophy of the Harvard study and physician payment reform because it is (1) not resource-based, and (2) does not allow for the differences in practice costs of all specialties. This is particularly troublesome for rheumatology because averaging practice costs across all physicians would put rheumatology at a significant disadvantage when compared to family physicians and internists who provide the greatest portion of evaluation and management services with lower overhead costs. According to the Harvard study, "Relative Cost Differences Among Physicians' Specialty Practices" (*JAMA*, October 28, 1988), practice costs for rheumatologists were higher than any of the other medical specialties studied with the exception of orthopedics. The study also stated that "the range of relative differences in practice costs among most specialties as a percentage of gross revenue is approximately 15 percent."

It is clear that HCFA's averaging plan is unfair to rheumatology, both because it is not resource based, and because it does not consider the higher overhead costs incurred by rheumatologists. Rheumatologists should be appropriately compensated for the extra resource costs involved in providing services to beneficiaries. The College urges the Congress to replace the OBRA '89 methodology for estimating practice costs with one that is resource-based, and mandate that

HCFA employ separate calculations for overhead for rheumatology since we have higher overhead costs than most other medical specialties. Congress should encourage HCFA to return to the original Harvard data on practice costs. With this, we will move more fully toward addressing the issues which prompted a change in physician payment in the first place.

REDUCTIONS IN THE DOLLAR CONVERSION FACTOR

The proposed rule mandates a drastic, unnecessary and unanticipated reduction in physician fees of over $12 billion by 1996, due to conversion factor reductions of 16 to 22 percent. This contradicts Congress' clear intent that transition to the new MFS be budget neutral and that Medicare physician payment reform not be used as a budget cutting device. Rheumatology, a specialty that provides primary care for many patients and is unique in its case mix and overhead costs, will face an inappropriate reduction in physician reimbursement as a consequence of the unanticipated conversion factor reductions. It is because of these reductions to the dollar conversion factor, that physician payments to rheumatologists and others will be so much lower than originally intended by Congress. For some of these reductions, we realize that HCFA is constrained by OBRA '89, and therefore we call upon the Congress to correct them through legislative action. Congress should also mandate HCFA to reverse the remaining unnecessary reductions to the dollar conversion factor which threaten the budget neutrality upon which physician payment reform was based.

The following briefly describes the conversion factor (CF) reductions proposed by HCFA:

Behavioral offset adjustment: By assuming that physicians will offset 50% of every dollar in lost revenue due to fee reductions, HCFA proposes to lower the conversion factor by 10.5 percent. HCFA does not attribute any dollar savings to the offset since they claim that the offset is required to prevent any increase in overall outlays under the fee schedule. However, HCFA staff have estimated that without this offset, $4 5 to $5 billion would remain within the Medicare physician expenditure pie by 1996.

The College maintains that no behavioral offset be assumed by HCFA because we believe that the Volume Performance Standards will compensate for any volume increase In the unlikely case that the VPSs do not take care of all unanticipated volume increases, Congress could recommend greater reductions in updates, or change the default formula Furthermore, scientific data supporting the concept of a behavioral offset are not well developed nor uniformly accepted by the Congressional Budget Office (CBO) and the Physician Payment Review Commission (PPRC). HCFA, CBO, and the PPRC all admit uncertainty as to physician responses to the new payment system, and the lack of substantial data on the subject (even the most relevant data employed by HCFA on this issue (Christensen)) is severely limited -- it is outdated (1976), only general practitioners and internists were studied, the data was gathered from a single state, etc. Until such data are validated, we strongly urge Congressional legislation prohibiting HCFA from employing a behavioral offset assumption its calculation of the conversion factor. Anything less will fall short of the goals of physician payment reform should physicians be penalized unnecessarily.

Transition rules adjustment: Because of an unintended consequence of the transition rules for phasing in the new fee schedule (the fact that more services will receive full increases to the RBRVS rates in 1992 than will receive reductions to the full final RBRVS rates), HCFA believes that overall outlays in 1992 would be two percent in excess of budget neutrality. To "correct" for this, HCFA proposes a 6.2 percent reduction in the CF. In the proposed rule, HCFA acknowledged that this will result in outlays of physician services being $3 billion less than if the transition adjustment was not made. However, HCFA staff now explain that by 1996 a total of $7 billion would be saved in order to make the MFS budget neutral in 1992.

The reductions in the conversion factor appear larger than would be required to adjust for budget neutrality. For example, a 6 2 percent reduction to the CF to adjust for a predicted initial increase of outlays of 2 percent due to the transition rules seems inflated. This results in a threefold reduction in the CF to offset expected increases in outlays, an effect known as the "tripling" effect.

Crosswalk to the new visit codes: It is likely that the transition/behavior adjustments actually understate how much that HCFA has reduced the conversion factor. The staff of the Physician Payment Review Commission believe, based on a preliminary estimate, that HCFA's assumptions on the frequency that new visit codes will be billed (called the "crosswalk" by HCFA) may have reduced the CF by another 3-5 percent from what would have been the case if different assumptions were used. Instead of an almost 17 percent reduction in the CF, the reductions made by HCFA may be as great as 22 percent when the "crosswalk" assumptions are also taken into consideration.

SUMMARY OF HCFA'S CONVERSION FACTOR REDUCTIONS:

-10.5%	behavioral offset -- no "savings" estimated by HCFA, but physicians fees would be reduced $4.5 to $5 billion by 1996
+ -6.2%	transition adjustment -- $7 billion in savings by 1996
-16.7%	total conversion factor reduction due to these two factors alone -- $12 billion in reductions by 1996
+ -5.0%	preliminary PPRC estimate of possible additional cut due to visit code crosswalk -- no savings estimated by HCFA, but would translate into additional reductions in fees by 1996
-21.7%	possible total HCFA conversion factor reduction as opposed to true "budget neutral" CF -- would translate into over $12 billion (plus additional cuts due to an inaccurate projection in the "crosswalk" due to the new visit coding system) in reductions during the transition to the new MFS. These data are in direct contradiction to Congress' intent that Medicare physician payment reform be budget neutral and not be used as a budget cutting devise.

Physician payment reform will be undermined if Congress does not act to reverse these cuts. Physician trust and faith in Congress and the Administration is at stake. The College urges Congress to enact legislation that will return physician payment reform to a budget neutral basis which was the initial intent. Congress should specifically:

(1) prohibit HCFA from employing a behavioral offset;

(2) correct the transition asymmetry problem and eliminate the "tripling effect" of applying all adjustments to the conversion factor and;

(3) correct for HCFA's "crosswalk" to the new visit codes if budget impacts show that it will further reduce the conversion factor.

The College understands and supports the pay-as-you-go budget rules passed last year. However, we cannot stand by and watch physician payment reform be destroyed. Technical drafting errors should not be used to call these rules into force. The College would be pleased to assist in the drafting legislative language which achieves the ends outlined above.

STATEMENT OF THE AMERICAN NURSES ASSOCIATION

The American Nurses Association (ANA), and its 53 constituent state and territorial nurses associations, is pleased to have this opportunity to present its views on the Medicare fee schedule for physician services and its impact on registered nurses and nurses in advanced practice.

The American Nurses Association represents the nation's two million registered nurses including nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists.

NURSES IN ADVANCED PRACTICE

Our comments will focus on nurse practitioners and clinical nurse specialists who are independent providers of Medicare services to beneficiaries. The Medicare Fee Schedule will have a direct impact on the ability of these nurses to provide services to beneficiaries in rural areas and in nursing facilities. We would like to review the services provided by these two groups of advanced practice nurses as well as their education, training and the locations where they practice.

Nurse practitioners are registered nurses prepared through a formal, organized education program for an advanced practice role that meets the guidelines established by the nursing profession. The majority of their training and education is in the area of primary care. They receive the advanced education and clinical training either in a certificate program or a master's program. Certificate programs are at least one year in length and are followed by a period of supervised clinical practice. Almost 50 percent of nurse practitioners are educated at the master's level. All nurse practitioners must meet requirements for certification in their area of specialty. By 1992, the ANA will require all nurse practitioners to be educated at the master's level in order to meet the requirements for certification. There are currently approximately 25,000 nurse practitioners nationwide.

Nurse practitioners provide primary health care that includes traditional medical services, as well as nursing care. The primary health care services encompass the identification, management and/or referral of health problems, the promotion of health maintaining behavior and the prevention of illness. It is their health care delivery approach that takes into account the needs and strengths of the whole person.

Nurse practitioners are able to deliver independently the majority of primary care services. Several studies have shown that 60 percent to 80 percent of primary care services traditionally provided by physicians can be provided by nurse practitioners. (Hausner, 1983 and Record, 1980).

Nurse practitioners are found in almost every health care setting: clinics, hospitals, schools, businesses, nursing homes, HMOs, college campuses, prisons, day care centers and in private practice. They also provide health care services in settings where physicians are not available such as rural and inner city areas, and to Medicare beneficiaries, such as the disabled, poor, minorities and residents of nursing homes, who otherwise might have no access to care.

A clinical nurse specialist is a registered nurse (PN) who, through study and supervised practice at the graduate level (Masters or Doctorate), has become an expert in a defined area of knowledge and practice in a selected area of clinical nursing. The clinical nurse specialist must have earned a graduate degree that represents study and advanced clinical practice related to the specialty.

The role of the clinical nurse specialist is multi-faceted, including clinical practice, education, consultation, research and administration. Clinical practice includes direct care to selected clients and families in practice areas such as oncology, rehabilitation, psychiatric and mental health, pediatrics, specialized acute, medical, surgical and gerontology.

Clinical nurse specialists are similar to nurse practitioners in that they deliver primary health care in the community, in settings such as outpatient clinics, HMOs, home health agencies and in private practice, as well as delivering care to the elderly and disabled in long-term care facilities.

Clinical nurse specialists must be certified or meet requirements for certification by the profession. This credentialing provides a safeguard to the consumer who has evidence that the RN is a specialist at the advanced level of clinical practice. There are currently approximately 16,000 clinical nurse specialists nationwide.

Both nurse practitioners and clinical nurse specialists are trained not only to provide substitute services for physicians, but also to provide the additional support, patient education and preventive services that physicians generally do not provide.

Conversion Factor Calculations. The American Nurses Association is surprised and extremely concerned about the effects that the conversion calculations described in the notice of proposed rule making (NPRM) would have on payment levels under the new Medicare fee schedule. In our judgment, the Health Care Financing Administration (HCFA) has gone much too far in using the concepts of "transition asymmetry" and "behavioral offset" to achieve major Medicare budgetary goals, instead of legitimate practitioner payment reforms. As a result, much of the long-expected reform in the values for cognitive and procedural services will simply not be realized under the severe assumptions used in calculating the conversion factor. These calculations, of course, will affect payments for all services affected by the new plan, including the services of nonphysician providers.

Services "Incident" to a Physician's Service. The ANA supports the intention of HCFA to continue the payment of services under the "incident to" rules. This rule allows payment for the services delivered by registered nurses that are commonly furnished as part of, and billed for as, a physician's service. Such rules allow for the efficient provision of patient care services by physicians and nurses working together in a collaborative manner, and reflect the fact that a "physician's service" often includes the services of other health professionals.

ANA recognizes, however, that under payment reform, further steps may be needed to refine the "incident to" rules to more accurately identity the extent and type of services provided by some nonphysician providers, including the services of nurses in advanced practice, such as nurse practitioners and clinical nurse specialists. Thus, ANA also supports HCFA's plans to use coding modifiers to gather this type of information under the payment reform plan.

Payments for the Services of Nonphysician Providers (NPPs). Beginning on January 1, 1992, payments for the covered services of certain nonphysician providers (NPPs) will, in general, be limited to the lowest of the actual charge, the reasonable charge, or a specified percentage of the new physician fee schedule for such services. For example, the services of a nurse practitioner furnished in a skilled nursing facility will be limited to 85 percent of the new fee schedule amount effective January 1, 1992, and by other percentages of the fee schedule amounts applicable to covered services furnished in rural areas.

The NPRM takes note of the fact, however, that recommendations for changing the current NPP payment rules were recently submitted by the Physician Payment Review Commission (PPRC) in its 1991 Report to Congress. In its Report, the PPRC states the view that payments for NPPs should be based on resource costs, using the same resource-based methodology that was used to develop payments or physicians' services under the new Medicare fee schedule. In general, the ANA supports this recommendation with some important modifications, and hopes that at the earliest opportunity Congress will examine ways to make payments for NPP services more consistent with the overall goals of payment reform for all practitioner services.

PHYSICIAN PAYMENT REVIEW RECOMMENDATIONS ON PAYMENT TO NPPS

ANA is supportive of many of the recommendations made by the Physician Payment Review Commission (PPRC), however some fall short of ANA's goal to have services provided by nonphysician providers recognized and valued the same as when provided by a physician. While the recommendations are a major step toward controlling the cost of health care, the proposal is flawed in that it would not pay nonphysician providers equally for services they perform that are the same as those provided by a physician. In addition, equitable payment levels for nonphysician providers would provide benefits for consumers who would have increased access to health care services, another goal of ANA.

The Medicare fee schedule for physician services is based on the principle that Medicare is paying for a service, not a credential. Thus, when physicians perform the same service, they will be reimbursed at the same level, regardless of their level of training. Unfortunately the Commission fails to apply this same principle to the services provided by nonphysician providers when they substitute for a physician.

ANA's specific response to the PPRC's recommendations on payment levels for NPPs are as follows:

• *The ANA agrees with the PPRC recommendation that the payments for NPPs be based on resource costs.* ANA has concerns with the logic and science utilized by the Commission when they assert the premise that payments for NPP services should be different than those of physicians. "Current percentage differentials, however should be replaced with differentials that reflect differences in physicians' and nonphysicians' resource costs: work, practice expense, and malpractice expense."

• *Work Component.* The PPRC recommends a different valuation standard for services performed by NPPs than it recommends when those services are provided by physicians. They recommend that the work component reflect differences in education and training costs between each NPP category and physicians. The Commission rejected the use of an education and training factor in setting values for services provided by the different physician specialties. In addition, the Commission arbitrarily reduces the work values for NPPs even further through a methodology that fails to fairly compare NPPs with physicians for whom the NPPs are alternative providers of Medicare services. *The ANA strongly objects to this recommendation as inconsistent with the underlying principles of the resource based relative value scale, and that the Commission's proposals are inequitable and discriminatory.*

• *Practice Expense. The ANA supports the Commission's recommendation that the "practice expenses for a type of service should be roughly the same whether it is provided by an NPP or a physician" and that the practice expense component should not be differentiated in setting NPP payments.*

• *Malpractice Expense. The ANA supports the Commission's recommendation that the differences between the NPPs' and physicians expenses for malpractice insurance be reflected in the fee schedule.* The ANA believes this is consistent with the resource based relative value scale (RBRVS) principle.

• *The ANA agrees with the Commission recommendation that NPPs receive the same bonus payments that physicians receive in health professional shortage areas (HPSAs).*

The ANA believes that the Commission's recommendations provide a framework for inclusion of NPP services in the new Medicare fee schedule using a common resource-based approach to payment for those services. The ANA recommends that the work component of the fee schedule for NPPs should differ only if the service is different and should not differ based on training and education costs. Since there is no evidence to suggest that similar services delivered by NPPs and physicians are different in value, then the value of the work component should be the same. In fact, the Rural Health Advisory Council has recommended that actual payments to NPPs be the same as to physicians in order to increase access to health care in rural areas.

The ANA would welcome the opportunity to discuss our views on this issue in more detail with the Members of the Subcommittee. In addition, we look forward to working with the Subcommittee as the issues of health care cost containment and the provision of quality care are addressed.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

The American Society of Internal Medicine (ASIM) appreciates the opportunity to share internists' views on Medicare physician payment reform.

It will come as no surprise to this subcommittee that internists are tremendously concerned about the administration's proposed fee schedule for physician services. Actually, concern is a rather mild description of what we are hearing from our members. Anger, frustration, and a profound sense of betrayal characterize the responses from most internists. Much of ASIM's statement today will explain why internists are concerned about the administration's proposal, and what we believe can be done about it.

Before we do so, however, we believe a word of thanks is in order. Given the intensity of physicians' disillusionment with the new fee schedule, thanking Congress for the law that gave us the fee schedule is probably the last thing on most physicians' minds. ASIM does believe, however, that Congress—and this subcommittee in particular—deserves thanks for what you have accomplished so far. It is important that we not lose sight of those accomplishments despite the intense criticism—all deserved in ASIM's opinion—of the administration's recently-released notice of proposed rulemaking (NPRM).

The 1989 mandate for reform was enacted largely because of the leadership provided in the Senate by Senators Bentsen, Rockefeller and Durenberger, and by Representative Waxman in the other chamber. ASIM believed then, and continues to believe now, that the balanced package of reforms that was enacted by Congress is a great accomplishment. It offered—and still offers—the promise of correcting serious inequities in payments that adversely affect care of Medicare patients. It offered—and still offers—the promise of greater predictability in payments and reduced out-of-pocket expenses for beneficiaries. it offered—and still offers—the hope of restoring physician confidence in the Medicare program. You have our continued appre-

ciation for your leadership on this issue, and your willingness throughout the years to listen to our concerns and to respond in a fair and constructive manner.

In fact, the NPRM shows how much good the OBRA 89 reform can still accomplish, *if it is implemented fairly and appropriately.* The resource based relative value scale—or RBRVS—is accomplishing the desired objective of significantly reducing the *relative* disparity between cognitive and procedural services. Cognitive services, such as visits and consultations, are valued far more in comparison to other services under the RBRVS than has been the case in the past. The RBRVS also helps protect the most undervalued services from the full impact of budget cuts in the Medicare program. Localities that have been underpaid in the past also gain relatively more under the RBRVS and the geographic adjustments mandated by Congress.

Unfortunately, the NPRM shows that the administration does not intend to implement the OBRA 89 reforms fairly or appropriately. The result is that actual payments for the most undervalued services will increase only marginally, if at all, and payments for other services will be cut far more than Congress envisioned when it enacted the mandate for reform. The law you enacted is good. The administration's implementation is not.

Unless modified by Congress, the administration's proposed rule will undo all or much of what was accomplished by enacting the 1989 reforms. Ironically, the administration argues that it is just "following the law." It is ASIM's firm belief, however, that what the administration has proposed is not at all what Congress intended. Specifically, on several key issues relating to calculation of a budget neutral conversion factor, the administration chose a course of action that is in direct violation of the spirit, if not the letter, of the law.

ECONOMIC IMPACT OF CONVERSION FACTOR REDUCTIONS

We believe that Congress intended that the new law be budget neutral. While the administration tries to argue that the law says something else, ASIM does not see how any other interpretation of your intent is possible. Congress expected that the new fee schedule would be implemented in a manner that would neither increase or decrease expenditures from what would be the case under current payment rules. But the fee schedule conversion factor proposed by the administration is estimated to set spending levels in 1996 a much as $12 billion less than required to maintain budget neutrality, resulting in reductions in payments for physician services of at least 16% compared to what would occur under current payment rules. (A breakdown of these reductions is available from ASIM.)

The administration admits the new fee schedule will not be budget neutral in 1996, but tries to downplay the impact by reporting that the reduction will be more in the range of $3 billion—not $12 billion—since they believe physicians will offset much of the reduction in payment levels by inducing volume. As explained later, ASIM believes that the administration's volume assumptions are invalid. If physicians do not offset the reductions in overall payments for the fee schedule, the impact will be far more deleterious than the administration suggests. The administration also attempts to discount the impact of the reductions by pointing out the overall Medicare outlays for physicians' services, even on a per capita basis, will continue to increase at a rate faster than the overall inflation rate—the implication being that physicians' revenues from Medicare will increase even with the conversion factor reductions. But it is misleading to suggest that increased outlays will result in increased Medicare revenue to physicians. Medicare may purchase more *medically appropriate* services for beneficiaries, thus increasing overall outlays, but if the payments for those services are reduced under the proposed conversion factor, physicians may be providing those services at or below cost. This is especially likely to be the case for physicians in primary care. Moreover, those increased outlays will be spread out among a greater number of physicians. *In short, higher outlays do not necessarily mean higher physician revenue from Medicare. More likely, an overall reduction of 16 percent or more in payments for physician services will result in payments to most physicians not keeping pace with the costs of delivering services to beneficiaries.*

CF REDUCTIONS DUE TO TRANSITION ASYMMETRY

The administration also claims that it had no choice but to establish the conversion factor at less than budget neutrality because of the asymmetrical transition mandated by Congress.

It says that because Congress mandated that payments for undervalued services go up faster than overvalued services will be reduced, it has no choice but to reduce

the initial conversion factor by 6.2 percent to offset increased outlays that could result from this policy.

But the problem is not that the administration had no choice on this or other issues, but that whenever it had a choice, it chose the option that was designed to lower federal expenditures, regardless of the impact of such cuts on the objectives of physician payment reform. And it apparently chose not to be fully forthcoming in notifying Congress and the public of those reductions.

Knowing—as it should have—that Congress did not intend for the asymmetrical transition to set the conversion factor at less than budget neutrality, the administration could have advised Congress at the earliest moment possible of its interpretation that the asymmetrical transition would have the unintended consequence of lowering conversion factor. It could have advised Congress of its view that the law requires all budget neutrality adjustments to be applied only to the conversion factor, thus tripling the effect of each reduction. It could have asked Congress for a clarifying technical correction or other expression of the intent of Congress to prevent such reductions. In other instances where it has served the administration's interest in obtaining such clarification, it has readily done so. But it chose not to do so in this instance.

BEHAVIORAL OFFSET REDUCTIONS

The administration also chose to include a behavioral offset reduction that will lower the conversion factor by another 10.5 percent by 1996. It claims that it had no choice but to follow the recommendations of HCFA's actuaries in establishing the conversion factor.

But again, *the problem is not that it had no choice, but that it chose wrongly.* Despite the administration's efforts to present its speculations on how physicians will respond to the new fee schedule as being based on data, the truth is that it has no reliable basis for making any assumptions on what will occur with volume.

You need not take our word for that, however. Look at what one of HCFA's own experts in its Bureau of Policy Development had to say in an article published in the agency's September, 1990 *Health Care Financing Review.* The author states:

> *"Since we do not know whether the specialists most affected will be able to induce demand for their services, we cannot predict the responses of other insurers, and the contemplated changes are different from those for which we have historical evidence, projections of physician response to the RBRVS are uncertain. The uncertainty of physician response . . . provided support for the coupling of RBRVS-based fee schedule with Medicare volume performance standards in OBRA of 1989 to more directly control the impact of VI (volume/intensity) growth on Medicare outlays."*

Now, however, the administration argues that the volume performance standards should not be relied on to correct for unintended or inappropriate increases in volume. Its argument is that the VPS takes too long to recoup any overpayments, and the amount that can be recouped is limited by the default formula mandated by law. The truth, however, is that Congress—upon recommendation from the administration—can enact whatever changes in payments it believes are necessary to offset volume increases. The default update was intended to be only a last resort if Congress otherwise fails to act. The administration could have chosen to use the VPS to make adjustments based on a retroactive review of how physicians actually respond to the fee schedule, instead of prejudging such responses. It did not, unfortunately.

It is especially interesting that despite the admitted "uncertainty" of likely volume responses to the RBRVS, the administration now says that it can with confidence predict that 50% of all reductions in revenue will be offset by increased volume. It could have instead chosen to include no behavioral offset in the conversion factor calculations, and to rely instead on the volume performance standards. But here again, it chose the option that would lower the fee schedule conversion factor.

ASIM does not claim that we can predict with certainty how physicians will respond to the RBRVS. We do believe, however, that Congress intended to rely on the volume performance standards to address increases in volume, rather than prejudging how physicians might respond in setting the conversion factor. Indeed, the need for a mechanism to make adjustments in future payment levels, based on a comparison of how actual volume under the RBRVS compares with projected increases based on historical trends, was the primary argument presented for including the volume performance standards in the OBRA 89 package. At that time, the administration insisted that the VPS be included for precisely this reason, i.e., to make adjustments based on a *retrospective* review of volume responses to the new fee sched-

ule. But now, it wants it both ways: it wants to lower the conversion factor in advance in anticipation of volume responses, and it wants to maintain the VPS as a mechanism to lower future updates.

Physicians strongly object to prejudging their responses based on speculation.

They specifically object to the presumption that physicians will increase volume to keep their incomes up. The administration says that it is making no such presumption of abusive behavior, that it is simply saying volume will go up without making a judgment on whether the increase is appropriate. But what the behavioral offset says is that volume will increase specifically *in response to the reductions in revenue occurring from the RBRVS*, not that it will increase for other reasons. That is why physicians view HCFA's behavioral offset as an implicit and unwarranted judgment that physicians will increase volume just to offset their income losses—and why they find such a position so offensive.

Professional ethics still matter to the vast majority of physicians, although such ethics are sorely tested when the government tells physicians it expects them to game the system. Most physicians, however, will not subject their patients to unnecessary services simply to increase volume. Since the specialties that lose the most revenue under the RBRVS tend to be surgical ones, one would have to conclude that surgeons will submit their patients to risky and unnecessary surgical interventions for HCFA's offset assumptions to be valid. Internists do not believe that their surgical colleagues will place patients at risk in order to maintain their incomes. Moreover, external utilization and peer review, such as hospital tissue committees, and professional liability concerns, would guard against increases in unnecessary surgical procedures.

HCFA not only chose to assume a volume offset, it chose those assumptions that resulted in the greatest reduction in the fee schedule conversion factor. Both the Physician Payment Review Commission and the Congressional Budget Office have recommended an offset adjustment that would have a far lesser impact on the conversion factor than that proposed by the administration.

The NPRM never really explains why the administration believes that its assumptions are more valid.

Moreover, the administration makes two judgments that clearly inflate the behavioral offset reductions in the conversion factor from what they otherwise would have been. HCFA assumes that *all* losing specialties will offset reductions in volume to the same degree. Common sense, however, tells us that such a response is impossible. Physicians in specialties that are dependent on referrals, and have few elective procedures, are hardly in a position to increase volume. Neurosurgeons, for example, are not going to schedule more brain surgery on patients because their revenue will decline under the RBRVS. Similarly, pathologists and anesthesiologists have virtually no control over the volume of their services.

Again, the analysis prepared by HCFA's own staff supports the view that volume responses will vary by specialty and individual physician. The same article quoted earlier states that:

> *"Ability to induce demand includes not only the ability to recoup losses by inducing volume, but also many other factors, such as ability to substitute other services, the amount of physician discretion as to billing for services, the degree of physician dependence on income from Medicare, ability to recapture losses from non-Medicare patients, and whether other payers also adopt payment schedules based on an RBRVS.*
>
> *An example may help clarify this point. Ophthalmologists and thoracic surgeons are likely to receive sharply lower payments under an RBRVS . . . Their ability to increase their volume off services, however, may differ. Ophthalmologists provide a substantial amount of routine primary eye care. Therefore, it might be feasible for them to identify new candidates for cataract surgery and lens implantation, which is the procedure from which they receive the most income, and to offer the procedure to patients. In contrast, thoracic surgeons provide little primary care and are heavily dependent on referrals from nonsurgeons, especially cardiologists. Thus, it might be far more difficult to induce demand for their services."*

ASIM does not believe that ophthalmologists are likely to do unnecessary eye surgery on their patients. But this article does illustrate the point, however, that to the extent that any volume responses occur, they are likely to vary by the specialty of the physician and other factors. HCFA, however, simplistically assumes the same response by all specialists.

The significance of this is that if it was instead accepted that some specialties are not able to increase volume, or to a very small degree, the overall behavioral offset applied to the fee schedule would be far lower than what HCFA has proposed. Such

a finding would not require creation of separate conversion factors by specialty, but only that the overall conversion factor would be reduced far less than proposed by HCFA under its across-the-board behavioral assumptions.

ASIM firmly believes that given the uncertainty of any projections on volume responses to the RBRVS; the damage that such assumptions do to the intended benefits of the fee schedule and to the credibility of Medicare with physicians; and the availability of volume performance standards, practice guidelines, and utilization review as alternative controls over volume, it is appropriate that *no* volume response or behavioral offset be assumed in establishing the fee schedule conversion factor.

VISIT CROSSWALK CF REDUCTION

There is at least one other area that the administration may have exercised choices that lower the conversion factor even beyond the 16% reduction occurring because of the behavioral offset and asymmetrical transition. In estimating how physicians are likely to bill under proposed new visit codes, HCFA created a "crosswalk" from the old codes to the new ones. The assumptions used in creating this crosswalk, according to the Physician Payment Review Commission, may have lowered the conversion factor another 3-5 percent. In other words, HCFA appears to be assuming that physicians will bill for more visits at higher levels (and payments) than under the current coding system. In a sense, this represents a second behavioral offset adjustment for visit coding on top of the overall offset for all services. Once again, when given a choice in assumptions, the administration appears to have embraced those that it can use to justify lowering the conversion factor. The overall may be to reduce the conversion factor as much as 22 percent below what is truly required to maintain budget neutrality.

PROHIBITING CONVERSION FACTOR REDUCTIONS

So despite the administration's insistence that it had no choice in how it calculated the conversion factor, the truth is that it exercised plenty of choice. Each of those choices—on the transition rules, behavioral offset, and visit crosswalk—resulted in a reduction in the fee schedule conversion factor.

The answer for Congress, then, is obvious: take away the administration's choices so that implementation of the fee schedule meets your original intent. This can be accomplished by:

1. *Prohibiting HCFA from making a behavioral offset assumption in calculation the conversion factor.* This would result in volume performance standards and practice guidelines being the primary mechanisms for addressing changes in volume, as originally intended by Congress.

2 *Prohibiting HCFA from reducing the conversion factor to correct for the transition asymmetry, and eliminate the tripling effect of transition adjustments.*

In addition, ASIM believes that the agency's visit crosswalk assumptions should be reviewed by the PPRC and other interested parties. The conversion factor should be revised upward to reflect more appropriate assumptions on billing for visits.

"SCORING" UNDER "PAYGO" RULES

Congress should also prohibit the administration from "scoring" as savings under the new budget rules the reductions caused by the transition asymmetry and tripling effect, or scoring any congressionally-mandated change in the behavioral offset assumptions as a cost item. The OBRA 89 package clearly was not scored by HCFA, OMB, or the CBO as a budget-savings item when it was originally enacted, since it was never intended to be anything but budget neutral. In fact, because the budget rules in 1989 required that any provisions in reconciliation must reduce outlays, physician payment reform was temporarily dropped from reconciliation in 1989 because the package was estimated to cost $100 million because of a requirement that physicians file all claims for patients. Clearly, if it was known or intended that the OBRA 89 reform would *save* billions of dollars, it would have been scored in 1989 as a savings item, and its inclusion in reconciliation legislation never would have been in doubt.

WHY CORRECTIVE LEGISLATION IS IMPERATIVE

Whether the administration deliberately circumvented the original intent of Congress in order to achieve budget savings, or whether it acted in what it believed to be a prudent manner in accordance with the law, is impossible for any outsider to say. Ultimately, though, the administration's motivation is irrelevant. Whatever the reason, the fact is that the conversion factor proposed by the administration is pa-

tentiy unacceptable. *Since we know now what the outcome is when things are left to the administration's discretion. The only sure way to guarantee that the new fee schedule will satisfy Congress' intent is to limit that discretion.*

Many members of Congress may prefer to find some way to avoid having to take up corrective legislation on physician payment reform this year. ASIM understands that sentiment. Having dealt with physician payment reform only two years ago, and having enacted a balanced package that enjoyed broad support among the physician and beneficiary community, Congress understandably is reluctant to take these issues up again this year. You passed a good law. It would have been far preferable if the adminlstrtion could have implemented it in the manner intended without further congressional action.

But that did not happen. The stakes are too great for physicians and concerned members of Congress to just express their concerns to the administration, in the hope that the final rule issued at the end of October is acceptable. ASIM believes that the administration is unlikely to make sufficient changes in the conversion factor without congressional direction. And it is too great a risk to wait until the final rule is released next Fall and to then try to make changes, with only three months left until implementation.

IMPACT ON MEDICARE'S CREDIBILITY

What are the consequences if Congress does not act to require the administration to restore the conversion factor reductions? ASIM believes if the conversion factor is implemented unchanged from the administration's proposal, there will be long-term damage to the Medicare program and to the overall credibility of the federal government with the physician community.

Physicians do indeed feel betrayed. They are angry. They are disillusioned. Internists in particular feel betrayed, because they had invested so much in physician payment reform based on the RBRVS. And, as the specialty that sees more Medicare patients each week than any other (median number of Medicare visits weekly is higher for internists than any other specialty, according to AMA surveys), the Medicare fee schedule has a particularly important impact on individual internists and the overall future of internal medicine.

Some say betrayal is too strong a word. If one looks at things from the perspectives of practicing internists, it is understandable why they do indeed feel betrayed.

They feel that way because for years they had been told by many of their colleagues that nothing is gained by working with government, and that the RBRVS would not be used to improve payments for undervalued cognitive services, only to cut everyone's fees. Yet internists, through ASIM, supported constructive engagement with government, despite the comments of the cynics and naysayers. They believed that by working with government, a balanced and fair package of reforms was possible. The OBRA 89 physician payment reform legislation bore out that belief—until the NPRM was released on June 5.

Now they learn that because of the administration's conversion factor reductions, payments for physicians services on average will be cut by billions of dollars in 1996. They hear that the gains for undervalued cognitive (or evaluation and management) services will be nominal in many cases, and that those gains for every specialty except family practice will be more than offset by greater-than-warranted cuts in other services. A mid-level office visit for an established patient will increase by only four percent (excluding inflation updates) from 1991-1996, instead of increasing a minimum of 23 percent under a fair "unadjusted" conversion factor (a conversion factor without the administration's behavioral offset and transition rules adjustments). But cuts in their procedures will be far greater than are warranted by the RBRVS.

The sense of betrayal is particularly acute for individual internists and communities that were counting on the RBRVS fee schedule to make marginal practices more viable. Under the administration's conversion factor, every state in the country will lose revenue, including many that are primarily rural and which might have been expected to gain under the new fee schedule. While there may still be small gains for some rural locales within those states, they are unlikely to be sufficient to attract new physicians and to keep existing ones, particularly physicians who provide primary care services. With a fair conversion factor, by contrast, 35 states in the country will gain in total payments.

Because of the conversion factor reductions, localities that were expected to lose revenue under the new fee schedule because of the geographic limits, will lose considerably more than anticipated when Congress enacted payment reform.

IMPACT ON ACCESS

Will access be affected by the administration's conversion factor reductions? Yes, we believe, but not because physicians will turn away from their Medicare patients. Internists ad other physicians will, by and large, continue to provide their own patients with the care that they need, no matter how little Medicare chooses to pay for those services. A few may decide otherwise. But most will not.

But access is likely to suffer, nonetheless. It will suffer if physicians decide that they cannot afford to take on new Medicare patients. Their current patients will be taken care of, but they will not seek out new Medicare patients. Many internists have already told ASIM that they do not now accept new Medicare patients. Because of the conversion factor cut, that trend is likely to grow.

IMPACT ON FUTURE OF INTERNAL MEDICINE

Access will also suffer because fewer and fewer physicians will choose to go into specialties such as internal medicine. And since internal medicine provides more primary care and subspecialty care to Medicare patients than any other specialty, a failure to attract enough physicians into the specialty could be disastrous for future Medicare patients. For four years in a row, fewer physicians have chosen to go into internal medicine than available residency positions. While payment is certainly not the only factor that influences physician specialty choice, the fact that internal medicine is now projected to lose overall payments under the new fee schedule is likely to act as a further disincentive to become an internist.

HCFA has suggested that internal medicine loses total payments under the RBRVS because internists perform a significant number of procedures and tend to practice in metropolitan areas that lose under the geographic limits. That however is misleading: by HCFA's own admission, internal medicine would gain 16 percent in total payments on average by 1996 if a fair, unadjusted conversion factor was used. It is true that internists have been expected to gain less than family physicians because of the mix of services they provide, practice location, and elimination of specialty differentials. But the point is that if HCFA used a fair conversion factor, both internal medicine and family practice—the two principal sources of primary care services to Medicare patients—would have gained under the RBRVS and geographic policies mandated by Congress. Therefore, reversal of the administration's conversion factor reductions are essential if the trend toward fewer and fewer physicians going into internal medicine is to be reversed. ASIM is willing to accept reductions in payments for internists' services that are called for by the RBRVS and the geographic adjustments mandated by Congress. What we cannot accept is seeing the gains for internists' evaluation and management services being inappropriately compromised, and the cuts in their other services being inappropriately increased, because of the administration's conversion factor cuts.

OTHER LEGISLATIVE CHANGES

ASIM also strongly believes that Congress should repeal the prohibition on payments for EKG interpretation that were enacted in OBRA 90. The OBRA 90 prohibition is also contrary to the intent of physician payment reform based on the RBRVS. It denies payments for a service that is highly beneficial for patients, and that has distinct resource costs according to the Hsiao RBRVS study. For physicians whose patients frequently require EKG interpretation, the loss in revenue from the OBRA 90 prohibition will more than offset the small gains in payments for their visits, especially given the fact that the gains for visits will be far less because of the conversion factor cut than originally predicted. The prohibition is also likely to prove highly disruptive to care, especially in rural areas.

The administration has proposed in the NPRM to slightly raise visit fees to cover EKG interpretation. That proposal, however, will not come close to solving the problems created by the OBRA 90 prohibition. Since all visit fees would be slightly increased, not just those visits that require an EKG, physicians whose patients never need EKG interpretation would benefit, while those (such as internists and cardiologists) whose patients often need to have EKGs interpreted would still be penalized. That is why the PPRC rejected raising the visit fees as a solution, and agreed that restoring separate payments for EKG interpretation is the only fair solution.

ASIM also believes that Congress should re-examine the methodology for establishing practice expenses for each service that was mandated by OBRA 89. Under OBRA 89, the work associated with physician services is based on the RBRVS, but the practice expenses are based on historical charges. This has the effect of perpetuating the bias for services that historically were overpaid. To give just one example, the work associated with a coronary bypass under the RBRVS is equal to 65

intermediate office visits; but the overhead of the bypass would be paid at a rate 102 times that of the visit! It doesn't make face value sense that a single surgical procedure done in the hospital generates more physician overhead than seeing 102 patients in a physician's office. The PPRC is planning to submit recommendations to Congress to correct this inequity and to make the allocation of practice expenses truly resource based. ASIM calls on Congress to direct the administration to allocate practice expenses under the new fee schedule based on the resource costs incurred in providing each service, rather than on historical charges. If such a change cannot be made for the first year of implementation, it should be phased in gradually during the latter years of the transition. If Congress does not feel that is has enough information at this lime to mandate a change in the OBRA 89 formula, it would be helpful to direct the Secretary to report back to Congress next year with legislative options to make the practice expense component of the fee schedule resource based.

With the exceptions of prohibiting the conversion factor reductions, restoring payments for EKG interpretation, and reassessing the OBRA 89 practice cost formula, ASIM does not support other changes in the physician payment reforms enacted in 1989. We specifically oppose delay in implementation of the fee schedule, or efforts to change the RBRVS as the basis of establishing the work associated with physician services. Congress should reject calls for legislative intervention in disputes over the relative values determined by the RBRVS, or delay in implemention until those disputes are resolved to everyone's satisfaction. Alternative administrative processes are available for specialties to present data to HCFA and to Dr. Hsiao to support their view that the relative values are inaccurate. The RBRVS methodology remains fundamentally sound, and Congress should resist any efforts to reopen the debate on that methodology.

CONCLUSION

Congress deserves credit for what it accomplished when it enacted physician payment reform in 1989. It was then, and remains now, a good law. But that law is being unacceptably compromised by the decisions made by the administration on the conversion factor. The result is that the federal government is suffering a tremendous loss of credibility with the physician community

ASIM is not among those who believes that nothing is gained by working with government. ASIM's philosophy has always been that the profession must be part of the process of finding solutions, not part of the problem. For years, we have stood up to the naysayers who have said that nothing will be gained by working with government on physician payment reform, and that the RBRVS will be used just to cut fees. Nor are we interested in placing blame. The issue is not whether the administration intended to undermine the intent of reform. Nor is it whether or not Congress' legislative intent was clear enough. The issue is that we have a big problem, and we all have a responsibility to work together to fix it.

This subcommittee has helped us in the past in our decades-long effort to improve fairness in the physician payment system You have come through before, and we thank you for that. Now that we are so close to realizing that goal, we need your help once again.

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Mr. Chairman, the American Psychiatric Association (APA), a medical specialty society representing more than 37,000 psychiatric physicians nationwide, is pleased to have this opportunity to present testimony on our analysis of the impact of the new Medicare Fee Schedule (MFS) for physician payments proposed on June 5, 1991, by the Health Care Financing Administration (HCFA).

As you know, the underlying premise of physician payment reform through the Resource-Based Relative Value Scale (RBRVS)—on which the MFS is based—is that "intrusive services" (mostly surgical) are overvalued relative to "cognitive services" (such as psychiatry) under existing Medicare payment rules. Certainly, Congressional intent for the new RBRVS physician payment schedule was to redistribute Medicare payments such that payments for cognitive services would increase.

Psychiatry is the epitome of a "cognitive" medical specialty. Thus, the APA had reason to believe that reimbursement for psychiatric services under the new MFS would increase or, at worst given "budget neutrality" requirements imposed by the Congress for 1992, be unchanged compared to current reimbursement levels

Yet, the MFS developed by HCFA nets to an inexplicable 9% reduction in payments per service for psychiatry in the first year of implementation of the MFS, and to a 5% reduction over the full five year phase-in of the MFS. Worse, the 9% is an

average reduction. In many cases, the first year reductions will be much higher, on the order of 35% or more. Our grave concern about this outcome is compounded by the fact that the first-year 9% reduction for psychiatry is the largest payment reduction for any medical specialty under the MFS, including surgical specialties.

The APA believes that the HCFA MFS for psychiatry is seriously flawed. We are concerned that the impact of the MFS on psychiatry is so adverse that there will be a substantial impact on patient access to care. As does a broad spectrum of medical professional organizations, we also take strong exception to the impact of the $3 billion behavioral offset which HCFA has proposed and developed.

In particular, we note that because time is a constant for most psychiatric services, psychiatrists cannot "compensate" (as the behavioral offset assumes all medical specialties will attempt) for fee reductions by increasing either intensity or volume of service. HCFA's behavioral offset compounds the impact of what we believe to be the underlying flaws in the HCFA proposed MFS for psychiatry.

The proposed MFS as published in the Federal Register provides just 60 days for comment, the final rule will be published in October 1991, and the MFS will become effective on January 1, 1992. As our testimony will outline below, we believe that the data and methodology used to develop the MFS as published on June 5 is demonstrably flawed. HCFA Administrator Gail Wilensky, Ph.D., has acknowledged that the impact of the proposed MFS on psychiatry was not as otherwise expected. We are now working with HCFA to correct the errors that now exist in the proposed MFS for psychiatry.

However, many of the problems with the MFS for psychiatry stem from conceptual shortcomings in the RBRVS methodology itself. We have only now been able to identify these errors because the results of the MFS for psychiatry are so anomalous that they have illuminated the conceptual and methodological shortcomings in the RBRVS itself. While HCFA has expressed a willingness to at least consider alternatives, the reality is that we now have less than three weeks to develop a detailed analysis of these just-identified shortcomings, provide HCFA with a justification for altering the MFS, and propose specific conceptual and methodological alternatives. This is in contrast to the *years* it has taken to develop the RBRVS methodology and data and the MFS itself.

As noted, we believe that there are substantial statistical and methodological errors in the HCFA MFS. These include:

1. Failure to adjust the Fee Schedule for the fact that, for psychotherapy, time is a highly significant non-variable component of service.
2. Failure of Current Procedural Terminology (CPT) Codes to properly capture work components inherent in psychiatric services.
3. Lack of finality to presumed "site of service" modifiers which may materially affect payment for psychiatric services.
4. Fundamental problems in the cross specialty time links which equate fifty minutes of psychotherapy with, for example, draining of a finger abscess. .
5. Questionable "cleaning and trimming" of the BMAD average allowed charge data files by HCFA.
6. Errors in HCFA's use of the Medicare Part B (BMAD) data to develop the fee schedule conversion factor.
7. Collateral errors in the BMAD data and its use which devalue the office expenses and malpractice components of the final Fee Schedule reimbursement for psychiatric billing codes.
8. Devaluation of actual current psychiatric reimbursement by HCFA's apparent use of BMAD data showing average allowed charges as opposed to some other more appropriate statistical measure.
9. Unspecified—and, we believe, unauthorized—use of Phase III Hsiao RBRVS work in the proposed MFS. We have not seen the Phase III work and have had no opportunity to verify it or comment on it.

Our analysis to-date of major problems is as follows:

1. HCFA has Disregarded Time in Setting Work RVUs:

The most troublesome problem with the new MFS for psychiatry appears to be a general discounting of the importance of time in establishing relative values for psychiatric services.

As Dr. Wilensky herself noted in testimony before the Ways and Means Health Subcommittee on June 25, "the (new Medicare) fee schedule involves an averaging concept. In other words, we will make average payments for a procedure regardless of the time or difficulty of performing the service in a particular setting."

HCFA's proposed MFS will abandon the use of real time for anesthesia, and instead substitute an average time methodology. Dr. Wilensky has justified HCFA's decision to abandon the use of actual time for anesthesiology "because the definition of when anesthesia time begins and ends is not consistently used by physicians." Precisely the opposite is true for psychiatry, where the CPT Codes define not simply a specific psychiatric procedure, but also the time used universally by psychiatrists in providing the service.

The MFS will, in effect, squeeze payment toward the average charge for each segment of service provided by physicians, and efficient physicians will economize on the time it takes to deliver each segment. This may be true for other physicians under Medicare, but it is not true for psychiatry. We have roughly 15 procedural Codes under Medicare, as opposed to the thousands which or colleagues uses.

Psychiatric CPT Codes already package specific psychiatric work components such as diagnosis, evaluation, and therapy, into a single CPT Code and pay for it as a "package" which is essentially deemed under the CPT Codes to be a equivalent to a routine office visit. There are no concomitant "procedures" for which we bill when providing therapy. Our average, in effect, is already our "standard." So the MFS averaging system simply does not work for psychiatry.

It is a contradiction for HCFA to disregard time for psychiatry when our services are already clearly wedded to time. The psychotherapy CPT Code (90844) is *by definition* 50 minutes of therapy. We cannot deliver it in less than 50 minutes. To "economize" by providing less than 50 minutes of therapy would be to commit fraud.

In testimony before the Ways and Means Health Subcommittee, John M. Eisenberg, M.D., representing the Physician Payment Review Commission (PPRC), took issue with HCFA's disregard of actual time for anesthesiology by noting that, in 1991, the PPRC "recommended continuing the use of actual time after finding other alternatives, including that described in the NPRM, either inequitable or not operational. Development of a better operational definition of anesthesia time and more rigorous procedures to validate time would best address criticisms of current policy." We would suggest that the same approach would be helpful for psychiatric services under the MFS. HCFA should be encouraged to understand that time is a significant component of many psychiatric services It therefore follows that to discount time as a relevant factor is to discount reimbursement to psychiatry.

As further evidence of the impact of HCFA's disregard of the importance of defined time for psychiatric services, the APA submits the following examples:

- The first example can be found by comparing two Current Procedural Terminology (CPT) Codes, 90844 (individual psychotherapy for fifty minutes) and 26011 (drainage of a finger abscess) both of which have nearly the same Work Value Unit (RVUs). Clearly the time it takes a physician to treat a finger abscess is significantly less than fifty minutes, the time required to perform individual psychotherapy. Thus, it is not credible that these two physician services, if time is any factor in performing a procedure, are valued to be equal in work in the proposed Medicare Fee Schedule.
- In addition, other short duration procedures—for example, 36489 (insertion of a catheter, vein), and 27648 (injection for an ankle X-ray), have work RVUs similar to the fifty minute psychotherapy procedure. We believe that these services do not compare in time with that inherent in the 90844 psychotherapy procedure nor are they time "driven."

2. Failure of CPT Codes to Capture Psychiatric Work Components:

The psychotherapy RVUs fail to acknowledge that psychotherapy is actually a unique blend of several procedures, including on-going diagnosis, evaluation, management, and treatment; however, the current CPT coding system fails to capture the full range of tasks comprised in a psychotherapy visit. Psychiatrists, unlike other physicians, do not have a multiplicity of CPT Codes that reflect all aspects of the specific services they provide during an "office visit." To the extent that current CPT Codes do not adequately capture the work that is performed by psychiatrists, the use of CPT Codes for the new Fee Schedule will inherently and inappropriately skew final reimbursement under the Fee Schedule downward for psychiatric CPTs.

Further, the psychiatric CPT Codes do not properly account for significant factors that affect the particular work performed under specific Codes. For example, the CPT Code for 50 minutes of individual psychotherapy (90844) reflects, in effect, an *average* of all psychiatric patients and therapy alternatives, regardless of the particular characteristics of individual patients or appropriate therapeutic modalities. Clearly, many patients will—at any given moment in time—require significantly more intensive and stressful relative work than others. Nor does CPT 90844 capture

the fact that the individual patient's characteristics—and hence the applicable treatment modalities as well as physician stress and intensity in performing the service—may well change many times during the prescribed course of treatment.

HCFA cannot assert that the failure of current CPT coding to accurately reflect the work performed by psychiatrists is outside the scope of HCFA's appropriate value-setting authority. The June 5th NPRM is replete with comments about reconfiguration of office visit descriptors with time considerations as part of the HCFA MFS such as, for example, in bundling EKG interpretation values into certain visits. In another vein, HCFA has made a decision to specifically disregard actual time for anesthesiology, as discussed above.

The PPRC testimony of June 25 to the Ways and Means Health Subcommittee also substantiates the APA's concern about CPT Code problems. As Dr. Eisenberg noted, "Refinements in the scale of relative work will require not only changes in work values, but also changes in some of the codes that are used to describe physician services. CPT codes that are ambiguous or that encompass a broad range of services entailing substantially different amounts of work will need to be revised if they are to provide a sound basis for equitable payment."

PPRC recommends convening "properly structured" panels of experts to assure face validity of relative work. We concur in that recommendation. We note that this is particularly true where HCFA appears to be integrated Hsiao Phase III work into the NPRM without providing physicians with an opportunity to "validate" this work.

3. HCFA has Not Yet Provided any Explanation of Site of Service Modifiers which will Affect Psychiatric Payment under the MFS:

As we have noted, psychiatry has an extremely limited number of CPTs used for Medicare billing purposes. For example, CPT 90844 may be used for hospital inpatients, outpatients, patients treated in a Community Mental Health Center, or patients treated in the psychiatrist's office. The NPRM indicates that HCFA will include, as part of the Final Rule, modifiers which will adjust payments to reflect variations in the site of service. We cannot determine in quantitative terms how the site of service modifiers will actually affect psychiatric payment under the final MFS. Since the average payment for psychiatric services under the MFS is anomalously low, we are concerned that the site of service modifiers will be used to further reduce payments for psychiatry under the Final Rule, particularly given the overriding budget neutrality requirement for 1992. Unfortunately, we will not be able to review the impact of the modifiers until the comment period has closed and the Final Rule is actually promulgated.

4. HCFA's "Behavioral Offset" is Inequitable for Psychiatry:

APA believes the apparent disregard for time in calculating work RVUs affects psychiatry more than any other physician specialty because our services are historically and inextricably bound to time considerations.

The disregard for time is compounded by the behavioral offset HCFA has proposed to ensure budget neutrality in 1992. In essence, the behavioral offset is a hedge against under-compensation for physician response to the fee schedule in the first year of phase-in, since it assumes that physicians will respond to reduced reimbursement by increasing volume or intensity of service at a rate which requires adjustment for budget neutrality.

While we are troubled by this non-scientifically supported allegation, we are even more troubled by HCFA's failure to appreciate that not all physicians or physician services can respond in this fashion. As we have noted, most psychiatric services are highly time dependent. As a result, psychiatrists, for example by their most used CPT Code (90844), cannot respond to the fee schedule by increasing time or intensity of service in a way which would justify the behavioral offset under HCFA's behavioral offset proposal.

Put another way, time *may* be a relatively inconsequential variable for other procedures, but it is a *significant constant* for psychotherapy. We cannot, for example, perform two fifty minute psychotherapy sessions in a single hour. Accordingly, we believe that the behavioral offset for psychiatry is unfounded and should be eliminated.

5. There are Serious Questions about HCFA's "Cleaning and Trimming" of the Raw BMAD Data Files:

Paul Ginsberg, Ph.D., Executive Director of the PPRC, noted in his testimony to the House Energy and Commerce Subcommittee on Health and the Environment that PRRC has identified a number of problems with HCFA's methodology to "clean

and trim" the BMAD data tape used to project Medicare Part B outlays, and from which the MFS adjustments for malpractice and practice expenses are derived.

Our independent analysis of the BMAD data files has confirmed the PPRC findings, at least with respect to psychiatry. For example, our analysis shows that HCFA "cleaned" the data by discarding any charge data which included any HCFA Common Procedure Coding System Codes (HCPCS) modifiers or carrier CPT standard pricing modifiers. As a result, significant numbers of specific claims, including many psychiatric claims, may have been excluded from the data base from which HCFA developed outlay projections and assumptions about adjustments for malpractice and practice expenses.

Further, in its efforts to trim outliers so that the data base was of a statistically valid and manageable size, HCFA appears to have "trimmed" BMAD charge data which are more than two standard deviations from the *national* mean. While we believe that too much data has been trimmed from the files in general, we are also concerned that HCFA may have failed to use weighted data which would account for geographic variations in frequency relative to the national mean. In conjunction with the geographic adjustment, HCFA has, in effect, discounted *twice* for charge data which is above the national mean.

Our preliminary analysis, for example, shows that the use of the national mean has resulted in the *exclusion of as much as 50% of charge data for one psychiatric CPT Code alone—90844—in the New York City area.* If this skewed data was in fact used to deveMticare outlay projections, the result would be that the national average allowed charge for individual psychiatric CPTs may be substantially too low, with a concomitant understatement of the malpractice and practice expense RVUs for individual psychiatric CPT Codes.

6. There are Numerous Questions Surrounding HCFA's use of BMAD:

HCFA "aged" BMAD data in order to project Medicare Part B outlays for 1992. As you know, the 1992 Medicare Part B outlay projection is of critical importance due to the statute requiring budget neutrality of the new RBRVS Medicare Fee Schedule during its first-year implementation. APA believes that significant errors are present in the BMAD data or in HCFA's use of the data pertaining to psychiatric services. Our concerns are summarized as follows:

• BMAD data may not adequately reflect low charge histories that flow from statutory limits on Medicare payment for psychiatric services.

Medicare reimbursement for psychiatric medical services is unique. Because of the complex regulatory and legislative history of Medicare reimbursement for psychiatry (such as, for example, the $250 federal share cap on Medicare payment for outpatient psychiatric services rate, which was raised incrementally and ultimately eliminated) APA believes that low historical charge data for psychiatric services has had an impact on the BMAD allowable charge data set used by HCFA for the MFS.

• BMAD data or its use may not account for the effective fifty percent beneficiary copayment for outpatient psychiatric services.

The effective fifty percent co-payment imposed upon outpatient psychiatric services—through the antiquated 62.5% of 80% statutory limit on allowable charges—adds a greater complexity to calculating Medicare allowable charge figures and reimbursement amounts for psychiatric services. APA believes that these factors have led to errors in calculating and the use of the BMAD data files. HCFA has informally confirmed that an as-yet undetermined number of carriers in fact reported average allowed charges as 62.5% of the 80%, rather than at the 80% rate.

• BMAD data or its use may not account for low charges that flow from site of service.

APA is very concerned that HCFA has used BMAD average allowable charges that may have integrated inpatient and outpatient hospital and office charge data. Psychiatric services provided to non-elderly disabled Medicare beneficiaries are very often provided in hospital outpatient departments or community mental health centers. Charges for services provided in these locations are historically low, not because the service provided is low-cost, but because payment is subsidized from other sources. If these charges have not been disaggregated from office outpatient or hospital inpatient payments, they will have the effect of "low balling" payment calculations based on BMAD averages. HCFA has informally confirmed that some carriers failed to properly disaggregate for site of service when reporting BMAD data.

• Use of BMAD average allowed charges may be particularly inappropriate for psychiatric services under Medicare.

To the extent that specialties such as psychiatry have "clustered" their payments around the Medicare prevailing charge in a charge locality, use of a BMAD average allowed charge will substantially understate the appropriate payment for services.

APA believes that some other more appropriate statistical measure, rather than the average "allowable charge" should be used to produce the 1992 Medicare Part B outlay projections.

The average allowable charge roughly represents the fiftieth percentile of allowable charges, in any given geographic area, and thus understates actual charge experience. Using both the allowable charge data plus geographic adjustment factors acts as a "double hit" upon all physicians, including psychiatrists, who have had historical charge patterns above the fiftieth percentile, especially those located in geographic areas where the prevailing charges are above the national norm for any given physician service, thus producing substantial reductions in reimbursement.

• Flawed BMAD data may have significantly skewed psychiatric RVUs for malpractice and office expenses.

As noted, we believe that the BMAD data failed to account for the fact that Medicare pays "50 cents on the dollar" for outpatient psychiatric services, as opposed to the normal "80 cents on the dollar" for other services under Medicare Part B. HCFA has proposed under the NPRM that the relative value of malpractice and office expenses is derived from the BMAD data (i.e. 50% of the average allowable charges). If as we believe HCFA has miscalculated BMAD data for psychiatry, it must follow that HCFA has therefore also significantly understated office expenses and malpractice expense relative values for psychiatry. This in turn will have the effect of reducing reimbursement for psychiatric services under the proposed MFS. Our preliminary analysis suggests that the office expenses and malpractice RVUS for psychiatry are understated by approximately 20%.

7. Integration of the Phase III Hsiao Research:

HCFA has acknowledged informally that some preliminary Phase III work from the Hsiao Harvard team was integrated into the proposed Medicare Fee Schedule. The Phase III work will finalize the Evaluation and Management codes (i.e., the new five-level office visit coding system and the multi-level hospital visit coding system) and is of special importance to psychiatry because all of psychiatry's cross-specialty links are office visits. Not knowing what Phase III work is included in the NPRM and how the final Phase III work will affect the Fee Schedule's outcome for psychiatric services makes it exceedingly difficult to evaluate the proposed Fee Schedule. We believe that it is inappropriate for preliminary Phase III work to be included in the proposed MFS at this time, and certainly without a detailed analysis of the impact of its inclusion.

Clearly the proposed Fee Schedule is a "moving target" that will be modified by the forthcoming Phase III Harvard research, the site of service modifiers, and other variables which have yet to be specified. To say the least, APA is extremely frustrated by the "moving target" nature of the Fee Schedule. All the data are not yet in, and APA along with the every other medical specialty will not have an opportunity to analyze and comment on the entire set of Harvard research used to calculate the new RBRVS Medicare Fee Schedule before the final Rule Making.

APA fully understands and appreciates that the development of the new RBRVS Medicare Fee Schedule is a monumental and complex task but believes it arbitrary and capricious to move to a final rule without an additional comment period after the release of necessary data and analyses upon which to respond substantively for consideration. Once complete the RBRVS system will not only radically alter Medicare Part B physician payment, but also portends "adoption" by other third party payors. The broad and long-term impact of the new Medicare Fee Schedule for physician payment requires that its development be void of significant errors—such as those outlined above—as well as that it be based upon the principles of sound methodology and fairness.

APA supported physician payment reform on a budget neutral basis, not reform sacrificed on the altar of cost cutting disguised as neutrality. The imposition by HCFA of a drastic one-year behavioral offset is nothing more than a three billion dollar budget-cutting device and extremely unfair because HCFA presumes physicians will be guilty—to gross proportions—in ratcheting up utilization. The "guilty until proven innocent" approach to anticipatory increased volume of medical service beyond the so-called Medicare Volume Performance Standard (MVPS) is unwarranted and should be rejected. Moreover, whatever your response to the conversion factor and so-called "behavioral offset," we would urge your consideration of the fact that since most psychiatric services are time-constant, psychiatry cannot respond to Fee Schedule payment reductions by increasing time or intensity of service.

In sum, the impact of the proposed MFS is a devastating blow to the provision of mental health services to America's elderly. The MFS impacts not just on psychia-

try, but also on allied mental health services such as psychology and social work, whose reimbursement is a percentage of reimbursement for services provided by psychiatrists.

We find that the proposed MFS and the methodology used to develop it is so fraught with possible errors that we can reach only one conclusion: *Congress should require HCFA to withdraw the proposed MFS until HCFA has responded to concerns about its data, concepts, and methodology use in the development of the MFS and has either validated the MFS or corrected its errors.*

In addition, there must be a concomitant extension of the official comment period, to allow the medical community to respond in detail to this extraordinarily complicated NPRM. A 60 day comment period on a proposed rule of this magnitude of complexity is simply insufficient.

With respect to psychiatry in particular, we believe that we have demonstrated that key assumptions, concepts, and methodology embodied in the proposed MFS for psychiatry are open to serious challenge. HCFA has informally expressed its willingness to consider alternatives, but as we have noted, we have virtually no time to fully develop these complex alternatives prior to the close of the comment period and the 1992 implementation date. While we appreciate the statutory deadline for implementation, we believe that Congress and the Administration must also be sensitive to instances in which the MFS is too deeply flawed to be implemented as it stands without causing deep and unintended harm to physicians and beneficiaries alike. That is clearly the case with the psychiatric portion of the MFS. While we are already in the process of developing specific proposals to correct the methodological and conceptual flaws in the MFS that uniquely affect psychiatry, we must conclude that the only reasonable solution is to require that the implementation of the MFS for psychiatry be delayed.

Finally, we wish to take this opportunity to once again request that your Subcommittee—and the Congress—repeal the discriminatory provision in the Medicare statute that requires beneficiaries to pay an effective copayment of 50% for outpatient mental health services. If physician payment reform as embodied in the MFS is supposed to "rationalize" payment for services under Medicare Part B, then surely there cannot be any justification whatsoever for this anachronistic holdover from the "old" payment system. The 50% copayment requirement is discrimination by diagnosis. It is time—indeed, long past time—for the 50% copayment requirement to be repealed.

Statement of the American Society of Cataract and Refractive Surgery

Introduction and Summary

The American Society of Cataract and Refractive Surgery ("ASCRS") is pleased to have this opportunity to comment on Medicare payments for physicians' services under the resource-based relative value scale ("RBRVS"). ASCRS appreciates the concern expressed by Chairman Stark that the proposed implementation of the RBRVS-based physician payment reform methodology by the Health Care Financing Administration ("HCFA") may depart from the intent of the authorizing reform statute in significant respects. ASCRS also notes Chairman Stark's expression of interest in assembling representatives from HCFA, physician groups and Congressional staff to address these problems.

ASCRS expresses a strong interest in joining this essential dialogue, particularly because of a profound concern about flaws in the underlying basis of the proposed physicians' fee schedule. An original premise of the entire physician payment reform system was that it should reflect the expertise and consensus of the medical community, especially concerning the relative valuation of medical procedures that is at the heart of the system. For ophthalmology at least, this original premise has not been fulfilled because the valuation of ophthalmic procedures in HCFA's proposal and the Hsaio study on which it is partially based *ignored* the views of the panel of ophthalmic experts that was convened to advise on relative values for this specialty. This fact represents a failure in the process upon which the fee schedule is based and produces inaccurate and inequitable results that will be discussed in greater detail later in this statement.

At this point, ASCRS is at an early stage in its analysis of the numerous issues in HCFA's notice of proposed rulemaking ("NPRM") that affect cataract surgeons. Consequently, the bulk of our statement will be devoted to two general issues, the conversion factor calculation and the scaling of relative values. The remainder of the statement will briefly highlight some other issues of specific concern to ophthal-

mology. ASCRS respectively requests the opportunity to supplement its statement with more detailed comments on these specific issues at a later time.

GENERAL ISSUES: THE CONVERSION FACTOR CALCULATION AND RELATIVE VALUE SCALING

Conversion factor calculation

The calculation of the initial conversion factor ("CF") is in many ways the linchpin of the physician payment reform system because, more than any other aspect of that system, the CF affects the payments that *all* physicians will receive from Medicare in 1992 and all future years. ASCRS submits that the CF calculation is seriously flawed and must be carefully re-examined because it rests on several assumptions that are: (1) not supported in the statutory mandate for the physician payment reform system; (2) not supported empirically; and (3) likely to have serious, dislocating and unintended consequences, certainly for the specialty of cataract surgery and its patients. Each of these concerns about the assumptions underlying the CF calculation is explored below.

In many respects, the following discussion echoes concerns raised by the Physician Payment Review Commission ("PPRC") in its statement before this Committee. The PPRC was established by Congress to provide expert study and analysis as a basis for policy decisions involved in the physician payment reform system, and therefore the views of the Commission should be considered carefully by both HCFA and Congress in addressing the NPRM.[1]

The PPRC has identified several assumptions that are integrally involved in the calculation of the initial CF and has criticized these assumptions strongly. These assumptions are: (1) that physicians will respond to changes in Medicare payments caused by the fee schedule by increasing the volume of their services and changing billing practices to bill more frequently for higher-code items, so that a full 50% of fee reductions will be offset (the so-called "behavioral offset"); (2) specific volumes of evaluation and management services (set forth at 56 Fed. Reg. 25821) will be billed under each of HCFA's newly revised visit and consultation codes; and (3) all bills will be for the fee schedule amount or more, and no claims will be submitted for amounts less than the fee schedule levels. Each of these assumptions results in deflating the initial CF. Since the CF has a leveraging effect on payments to physicians, the consequences of these errors are extremely far-reaching.

ASCRS' first objection to these assumptions is that they are without basis in the statutory mandate for the physician payment reform system in §6102 of the Omnibus Budget Reconciliation Act of 1989 ("OBRA'89"). Nowhere in the statute is there any mandate for a behavioral offset, any particular direction about how to project the number of evaluation and management services under new visit codes, or any mandate about assumptions on the number of claims that would be billed at or above fee schedule levels. Rather, Congress only mandate concerning the conversion factor calculation was that it be "budget neutral." Congress did not direct that the CF itself be used as a means for controlling budgetary outlays; rather, that objective was to be achieved through the Volume Performance Standards ("VPS").

By making the most conservative possible assumptions concerning the CF calculation, however, HCFA's NPRM makes the CF itself a mechanism for achieving payment reduction. In many cases, particularly those of cataract surgeons, these reductions will be sudden and drastic; however, Congress did not direct this result. The overall purpose of the physician payment reform method was to establish a more rational system of physician payment under Medicare, not to slash payment radically. Indeed, Congress signified exactly the opposite intention by providing that payment for services above or below the fee schedule would be "transitioned" into the fee schedule over a four-year period, and even more significantly, that reductions in updates through the VPS system would be strictly limited. Thus, the assumptions that HCFA has used to calculate the lowest possible initial CF are without statutory basis.

ASCRS' second objection to those assumptions is that none of them is empirically justified, as the PPRC aptly stated in its testimony before this Committee. As to the behavioral offset, ASCRS is aware of no empirical study justifying the substantial 50% behavioral offset that HCFA has posited. As the PPRC has noted, the entire

[1] ASCRS wishes to note, however, that it does not agree with the PPRC on every single issue involved in the development of the fee schedule. For example, the PPRC has largely ignored the role that patient outcomes can and should play in the assignment of relative values, even though data on outcomes is now available. ASCRS believes that a true "relative value" system must incorporate the concept of value to the *patient*, a point that we will explore at greater length in later comments on the NPRM.

issue of behavioral response is one where "great uncertainty" about predictions exists, and HCFA "has made a worst-case assumption." (Statement of the Physician Payment Review Commission on HHS's Notice of Proposed Rulemaking Before the Subcommittee on Health, Committee on Ways and Means (June 25, 1991) (hereinafter, "PPRC Statement") at 4.

Indeed, there is some relevant empirical evidence that suggests that any assumption about a "behavioral offset" is completely unjustified. First, Medicare actuaries' data show that physician services' volume growth has been slightly lower from 1984 to the present—a period during which physician fees in numerous specialties, including cataract surgery, were steadily reduced through a general 1984-1986 fee freeze and then a series of cuts for "overpriced" procedures--than for the period before 1984, when fee cuts were not so frequent.

Similarly, experience with the behavioral responses of hospitals to the Prospective Payment System ("PPS"), which is similar in intent and effect to the physician payment reform system, shows that hospitals did not in fact attempt to offset the fee constraints imposed by the PPS by increasing the volume and intensity of services. Notably, when confronted with the same "budget neutral" mandate for the PPS as it confronts today, HCFA did *not* choose to assume a behavioral offset before the fact, but instead chose to cope with the prospect of such responses through admission pattern monitoring.

Third, it must be noted that all physician specialties are not able to respond to fee cuts by increasing the volume and intensity of services because they do not order their own services. Such specialties, for example, include radiology, anesthesiology, pathology and others. Since these specialties can achieve, in effect, only a 0% "behavioral offset," HCFA's general 50% behavioral offset assumption implies a greater than 50% behavioral offset assumption for other specialties—a radical assumption that, again, is without support in any empirical studies of which we are aware.

For cataract surgeons, the 50% assumption itself is also wrong because it is inconsistent with trends in the demand for Medicare-covered cataract surgeries and recent evaluations of the utilization of such procedures. Specifically, the Department of Health and Human Services Office of Inspector General ("OIG") recently concluded that only *1.7%* of cataract surgeries were unnecessary. This experience has occurred following a period of time when cuts in cataract surgery and intraocular lens ("IOL") payments occurred almost annually for several years—i.e., a period when cataract surgeons could certainly have been expected to employ a "behavioral offset" by providing more unnecessary surgeries. The 1.7% OIG figure shows that any such "behavioral offset" was minimal. Additionally, it is critical to note that the average age of cataract patients has dropped from over 65 to under 65, so that the population of *Medicare* cataract patients from whom a behavioral offset could be drawn is shrinking, not growing. Peak volume for cataract surgeries occurred in 1988 and has fallen since.

With respect to the the numbers of evaluation and management services that will be billed under newly revised visit and consultation codes, again, HCFA has made an extreme assumption in an area where important empirical data is lacking. As the PPRC has noted in its statement, "regrettably, HCFA had little data to guide it." *Id.* Indeed, HCFA itself admits in the NPRM that all of its data sources for this projection are very inadequate. *See* 56 Fed. Reg. 25821. The Commission simulated alternative assumptions that were actually based on data from logdiary surveys of physicians. The Commission's simulation resulted in 13% lower projected outlays for visits, and consequently a CF 5% higher than HCFA's prediction.

The PPRC has also pointed out that data concerning actual physician billing patterns is relatively easy to accumulate because physician billing patterns for visits have been relatively stable over time. The Commission suggests that Congress could direct HCFA to revise the CF in the future if visit patterns vary significantly from the projection. While the Commission does not state that this option suggests HCFA should make the most moderate assumption about visit code billing, ASCRS does so suggest. Once embedded in the CF calculation, an unwarranted visit code assumption will have immediate and substantial effect on physician payments and, consequently, patterns of service, that will not be able to be reversed even if the assumption is later revised on the basis of experience.

Finally, HCFA's assumption that all bills will be for the fee schedule amount or more is similarly without empirical basis. Indeed, this assumption is contrary to current experience, which shows that, in the PPRC's terms, "a significant minority of claims" are billed for amounts below current prevailing charge levels. The PPRC has labeled HCFA's assumption in this area "unrealistic," and ASCRS agrees. While the PPRC suggests that Congress could direct HCFA to revise the CF in the future on the basis of actual experience, ASCRS urges that, to avoid unintended dislocating

effects of a too-low CF, HCFA be directed to make an assumption concerning billing levels that is consistent with existing experience under the customary, prevailing and reasonable ("CPR") physician payment system.

ASCRS' third objection to HCFA's conversion factor calculation is that it results in draconian payment cuts for cataract surgeries that will adversely beneficiary access. The projected impact of the physician payment reform system as proposed in the NPRM is that payments per service for ophthalmology and for anesthesiology, upon which cataract surgery relies, will each decline by 35% by the end of the transition period in 1996—the two largest specialty cuts under the entire fee schedule. Much of this decrease will be accomplished even faster. For two specific cataract surgery codes (66821 and 66984), the payment picture is even grimmer. For code 66821, average payments will fall 44% by the end of the transition; for code 66984, the cumulative drop will be 38%. These total drops in cataract surgery payments under the physician payment reform proposal come on the heels of series of substantial physician payment and cataract surgery-specific payment cuts throughout the second half of the 1980s. Thus, during the decade 1986 through 1996, the cumulative decline in Medicare payments for cataract surgery will be a whopping 58%. Fee schedule levels for cataract surgery will be lower than Medicaid's; payments for IOLs will be below levels that prevailed over 15 years ago in 1974.

These enormous payment cuts are very likely to affect beneficiary access to care. Contrary to HCFA's assumptions, the most logical response of cataract surgeons to these drastic cuts will be to shift their practice patterns away from Medicare business rather than pursuing a "behavioral offset" by increasing nonremunerative Medicare work. For example, some cataract surgeons will shift their practices to refractive surgery, which is more heavily weighted toward non-Medicare work, or to dispensing. Others will simply choose to take early retirements rather than continue under the pressures of demanding and now unrewarding cataract practices.

These kinds of responses will be especially severe in rural areas, where cataract surgery is performed infrequently. In such localities, individual physicians perform only a handful of such surgeries per month, and will most likely choose not to bother continuing to offer this service. Thus, rural patients in need of cataract surgery will suffer a loss of access—a result contrary to the intention Congress has expressed in Medicare laws throughout the 1980s to preserve the availability of medical services to patients in rural areas. Certainly, curtailing beneficiaries' access to needed Medicare-covered services that improve their physical and mental wellbeing was not one of the objectives of the physician payment reform statute.

Relative value unit scaling

After the conversion factor, the other component of the physician payment reform system that most determines payment levels is the Relative Value Unit ("RVU") scale. As with the calculation of the CF, HCFA's NPRM reflects some errors and omissions that have been identified by the PPRC and require correction before the fee schedule system can be implemented. Among those errors that the PPRC has identified in the RVUs are the following.

First, the NPRM includes no policy for categorizing invasive services (including cataract surgery) as global or nonglobal. The difference between global and nonglobal services is extremely important because a surgical global payment covers the entire range of services provided within several months of the surgical procedure that are related to the condition requiring surgery, while a nonglobal payment only covers those services that are directly related to the performance of the surgical procedure itself. Without a policy in this area, payment inequities and billing confusion will result because services that are usually provided for patients with disparate conditions may be categorized as global surgeries rather than nonglobal procedures. Consequently, there can be substantial variations in the actual work covered by the global fee between procedures on different patients, yet the payment will be the same.

An additional reason why the NPRM's treatment of invasive services is flawed and needs further work is that, as the PPRC has noted, HCFA did not establish its global and nonglobal surgery definitions in time for the Hsaio team to incorporate those definitions into the determination of physician work RVUs for invasive services. Consequently, the PPRC points out, "all nonglobal procedures . . . are substantially undervalued in the NPRM. The relative work values for these services reflect only the work involved in performing the procedure itself, whereas the payment is intended to cover all services directly related to the procedure that are performed within 30 days." Obviously, this error creates a serious payment inequity that was not intended by Congress and must be corrected.

Another area of RVU scaling where the PPRC has identified errors in the NPRM is that the RVUs for evaluation and management services do not reflect differences in the work effort required to provide different types of visits, such as a visit or consultation for a brand new patient versus a routine visit with an established patient. Again, this omission in HCFA's RVUs will result in unintended payment inequities.

The PPRC has also noted that the RVUs proposed by HCFA may in some cases require changes to align the Hsaio study scale for work to the Medicare population and to correct inaccuracies in the underlying vignettes upon the Hsaio study was based. As the Commission points out (PPRC Statement at 7), "these problems are not uncommon, affecting as many as 10% of the services provided by some specialties."

Still another potential problem area in the RVUs that ASCRS has identified relates to the ranking of ophthalmic RVUs. Specifically, studying the ophthalmic RVUs in the model fee schedule published by HCFA September 4, 1990 versus those in June 5, 1991 NPRM, ASCRS noted that the ranking of values of the ophthalmic codes has changed substantially without explanation by HCFA. This change suggests additional potential errors in the RVU scaling or, at a minimum, an area requiring further examination before the physicians' fee schedule can be implemented.

In summary, the numerous and significant areas in which HCFA's RVU scale is flawed means that the new system cannot be implemented as currently proposed by HCFA and truly achieve the original intent of Congress to create a more rational and equitable system of Medicare payment for physicians.

SPECIFIC ISSUES

The following is a brief and partial list of those specific issues in the NPRM that ASCRS has identified as problem areas for ophthalmic procedures. We are now in the process of completing this list of issues and beginning to work on recommendations for solutions which we hope to be able to bring to the Committee's attention in the near future.

Undervaluing of ophthalmic survey RVUs

ASCRS wishes to point out that HCFA's RVUs for ophthalmic surgery may reflect significant undervaluing of retinal and vitreous surgery. Contrary to an assertion in the NPRM that Phase III of the Harvard study used "small groups of physicians to detect and correct erroneous values," (56 Fed. Reg. 25795), concerns expressed by the ophthalmic Technical Review Panel with regard to undervaluing of these surgeries were simply ignored by the Hsaio study team. This situation results in inaccuracies and inequities in the RVUs scale and fails to reflect the consensus evaluation that was one of Congress' key objectives concerning the development of the RVU scale.

Inappropriate global survey definition

HCFA's global surgery definition is an extremely broad package that includes all preoperative hospital and office visits for 30 days preceding surgery, all intraoperative work, all postoperative visits for 90 days following surgery, and most postoperative complication treatments. This definition is inappropriate for ophthalmic surgeries because it does not take into account important specific conditions in ophthalmic surgery. Ophthalmic surgery patients may suffer conditions requiring intensive preoperative and postoperative care that would not be adequately compensated under the global surgery fee.

For example, in the preoperative area, if the patient had conjunctivitis, the surgeon would have to perform diagnostic tests and numerous re-examinations of the patient before making a final decision to proceed with surgery. If the patient developed a miotic pupil due to chronic use of pilocarpine drops, discontinuation of the drops, substitution of other agents and extensive monitoring before surgery would be required. With regard to postoperative complications, a patient may develop hyphemia requiring several days of hospital care by the physician. A patient may develop endophthalmitis requiring intensive antibiotics and careful co-management by the primary surgeon and the vitreous surgeon. Similar co-management would be required in the case of dislocated nucleus in the vitreous.

As these examples suggest, HCFA's global surgery definition is not sufficiently refined to deal with the conditions existing in ophthalmic surgery.

Inequitable multiple surgery policy

In a case where a patient has multiple surgeries on the same date, HCFA proposes to establish surgery fees by paying 100% of the global surgery fee for the most

expensive surgery, 50% of the global fee for the second most expensive surgery and 20% of the global fee for the third most expensive surgery, etc. The proposal may produce some inequities and results that are contrary to the best interests of the patient. For example, a patient may sustain trauma to orbit with a blowout fracture of orbit and a corneal laceration, both of which must be repaired. The blowout fracture repair is the most expensive procedure, and would probably best be performed by an oculo-plastic surgeon. However, if the general ophthalmologist would only receive 50% of the global surgery fee for repairing the corneal laceration, he might well be tempted to perform the repair of the blowout fracture himself, even though the best care for the patient required repair by the oculo-plastic surgeon.

Incentives for provision of surgical services by nonphysicians

HCFA's proposed policy for addressing situations where portions of the global surgery package are provided by different practitioners (56 Fed. Reg. 25842) raises concerns about the prospect of preoperative and postoperative care being furnished by nonphysicians. HCFA's proposal is that the sum of the amounts paid to individual practitioners will not exceed the global surgery fee. This proposal creates incentives for surgeons to delegate some preoperative and postoperative care to nonphysician practitioners with lower fee levels, a result that may in many cases deprive the patient of adequate care—particularly where very sensitive decisions concerning surgical risks are involved or complications occur.

Inadvisable elimination of time for anesthesia services

HCFA's proposal to eliminate time as a separate payment element for physician anesthesia services will have a particular effect on ophthalmic surgery which is seriously adverse to patient interests. Elimination of time as a payment element for anesthesia will create an incentive for anesthesiologists to perform simpler, faster anesthesiology procedures that may not be nearly as effective. Additionally, in ophthalmic surgery, constant intraoperative and postoperative monitoring by the anesthesiologist are essential because patients are elderly and often have systemic illnesses such as diabetes and cardiac arrhythmias that may be affected by anesthesia. The elimination of time as a criterion for anesthesia payments will create incentives to curtail this essential monitoring by the anesthesiologist. The elimination of the time criterion will also place pressure on ophthalmic surgeons themselves to perform procedures quickly because intraoperative monitoring by the anesthesiologist is essential throughout. Consequently, HCFA's policy may produce less than the best performance from those ophthalmic surgeons who are extremely effective in their surgical results but work thoroughly and slowly.

Inequitable treatment of new physicians

The NPRM proposes to address payments for new physicians by limiting payment in the first year of practice to 80% of the fee schedule amount, payment in the second year to 85% of the fee schedule amount, payment in the third year to 90% of the fee schedule amount, and payment in the fourth year to 95% of the fee schedule amount. While we recognize that this policy predates the physician payment reform system, the substantial cuts that this system will produce demand a re-evaluation of the new physician policy to avoid discouraging physicians from entering into the practice of ophthalmology altogether. In ophthalmology, unlike many other specialties, startup of practice requires a very substantial investment in equipment. Thus, the beginning practitioner bears a much greater financial burden than his more senior colleagues that the new physician policy does not recognize. Moreover, there is no evidence in the area of ophthalmology that beginning ophthalmic surgeons are less skillful than others. Thus, the new physician policy constitutes an unwarranted and discouraging penalty.

The summaries above represent only a few of the aspects of the NPRM that may be ill-designed for ophthalmology and possibly other specialties. Again, ASCRS wishes to emphasize that this list is apparently only partial and that we are still in the process of developing recommendations for changes. However, the above list amply points out the serious need for closer examination and more careful design of numerous policies reflected in the NPRM. The need for careful consideration of these policies is heightened by the potentially devastating effects of the CF calculation.

Conclusion

For the foregoing reasons, ASCRS strongly urges Congress to assure that the physician payment reform system is not implemented by HCFA without adequate consideration and without the physician input necessary to avoid unintended and inappropriate results. ASCRS expresses its hope to play an active role in this process,

given the extensive effects of this system and the NPRM policies on ophthalmic surgery.

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC) is pleased to submit testimony to the Senate Committee on Finance, the Subcommittee on Medicare and Long Term Care on the proposed regulations implementing the Medicare physician payment reform as mandated by OBRA 1989.

The AAMC represents the nation's 126 accredited medical schools, over 350 of the nation's major teaching hospitals participating in the Medicare program, 123 medical school-based faculty practice plans, 92 academic and professional societies and approximately 60,000 full time clinical faculty. The Association's members have a strong interest in the proposed regulation and its impact on teaching physicians. AAMC data, using the model fee schedule, suggest that teaching physicians will experience large fee reductions.

Academic health centers and most teaching hospitals differ from other provider settings because they have three principal missions: the provision of comprehensive patient care; the education of health professionals including medical students, residents, and fellows; and, the provision of an environment for biomedical research. This unique social mission compels them to serve the needs of their communities differently than non-teaching provider settings. AAMC data on major teaching hospitals illustrate this point:

- 60 percent operate trauma centers whereas as only 12 percent of all other hospitals provide this service;
- 55 percent provide organ transplant services compared to 9 percent of all other hospitals;
- 98 percent provide inpatient AIDS services compared to 65 percent of all other hospitals in the United States.

Academic health centers and most teaching hospitals serve as "medically innovative hubs" within their communities by providing specialty and sub-specialty care. Frequently, community physicians access the "hub" by referring patients to the clinical faculty for the complex diagnosis and the innovative treatment of illness and disease. Academic health centers and teaching hospitals care for a disproportionate share of severely ill and complex patients. These institutions also provide access to health care services for the poor and uninsured populations. Academic and teaching physicians are critical components of the United States health care delivery system. If the proposed regulation is implemented, the practice of medicine within the academic medicine and teaching hospital communities will be jeopardized and impede the social goals of these institutions.

The AAMC strongly recommends that Congress urge HCFA to return to the original goals of Medicare physician payment reform as supported by the medical community and as legislated by the Congress in OBRA 1989. That is, to pay physicians' fees fairly based on resource costs, and to improve payment to primary care and general medicine specialties. If HCFA's proposed regulations are implemented without serious modifications, then the Congressional intent of the law will be undermined because general medicine and family practice physicians will realize much smaller increases in Medicare payments while procedural specialties, such as, cardiology, radiology, anesthesiology and surgical specialties will experience far greater reductions than were originally intended. Medicare physician payment reform was not intended to produce additional Medicare savings but rather it was intended as a new payment system that would more equitably compensate physicians. Current estimates project that if HCFA's proposed regulation is implemented it will reduce physician payments by $7 billion by 1996.

This testimony addresses the AAMC's significant concerns with HCFA's proposed Medicare physician payment regulation. AAMC organizes these concerns into 12 categories and the remainder of this testimony addresses the Association's objections to HCFA's proposed regulation.

I. THE CONVERSION FACTOR, BUDGET-NEUTRALITY AND THE BEHAVIORAL OFFSET

A. The Conversion Factor

The AAMC strongly recommends that the Congress urge HCFA to apply the 2% reduction in physician fees, if necessary to achieve budget-neutrality in 1992, to both the conversion factor and the adjusted historical payment base (AHPB). In

addition, the AAMC recommends that HCFA re-examine the 2% reduction annually and modify the adjustment in subsequent years based on actual experience.

The AAMC believes HCFA's proposed reduction to the conversion factor to achieve budget-neutrality is a misinterpretation of 42 U.S.C. 1395w-4 section 6102 subsection (d)(1)(B). HCFA's interpretation is contrary to Congressional intent and is inconsistent with the statute. The AAMC interprets the law as requiring the computation of the initial conversion factor to be based on estimated 1991 expenditures and not on the impact of the transition. HCFA has incorrectly interpreted the law by concluding that an adjustment only to the conversion factor is required and not does not allow for an adjustment to the historical payment base. The statute does not specifically mandate this requirement.

HCFA's proposed regulation contains transition rules beginning January 1, 1992. These rules require any service whose current payment basis is 85 percent to 115 percent of the new fee schedule amount to be paid the new fee schedule amount in 1992. Services whose historical payments are outside this range are moved gradually toward the full fee schedule, but cannot be reduced or increased by more than 15% of the new fee schedule amount for the service in 1992. By 1996 all services must be paid at the full fee schedule amount. Because of these transition rules, increases may be more than 15 percent of the historical payment amount while decreases are always less than 15 percent. As a result, more Medicare dollars will be spent in 1992 to increase payments for undervalued services than will be offset by reductions in payments for historically overvalued services, requiring physician fees to be reduced by 2 percent in order to achieve budget neutrality.

OBRA 1989 requires physician payment reform to be budget neutral. The issues are the base line assumptions, the methodology, and the interpretation of the statute used by HCFA to achieve neutrality. This represents an additional 3 percent reduction in fees. HCFA interprets the law so that only the portion of the payment based on the new fee schedule and not the historical charge portion of the payment can be reduced, causing transition "asymmetry" to occur. Beginning January 1, 1992, the portion of the total payment based on the fee schedule is estimated to be only one-third. If HCFA implements its present interpretation of subsection (d)(1)(B) then a long-term, 2 percent reduction in fees requires a 6 percent reduction in the conversion factor transition causing the asymmetry problem. Therefore, beginning January 1, 1996 physician fees will be permanently lower by 6 percent. HCFA should apply the 2 percent reduction in physician fees to both the conversion factor and the adjusted historical payment base (AHPB). In addition, the AAMC recommends that any reduction in physician fees be examined annually and be based on actual experience, rather than projected experience.

B. Behavioral Offset

The AAMC strongly recommends that the Congress urge HCFA to eliminate the proposed behavioral offset and rely upon the retrospective adjustment, that is the MVPS, mandated by the OBRA 1989.

The Association opposes a behavioral offset because inadequate data exist to substantiate and justify HCFA's assumption that physicians will attempt to increase volume. HCFA's proposed behavioral offset is contrary to Congressional intent and Congress should urge HCFA to utilize the Medicare Volume Performance Standard (MVPS) as it was statutorily intended. The proposed regulation assumes budget neutrality beginning in January 1992 and further reduces the conversion factor with a physician behavioral offset. This offset is intended to compensate for unsubstantiated anticipated volume/intensity changes in response to the new payment system. The proposed regulation assumes that physicians who experience reductions in Medicare fees will increase the volume of provided services sufficient to replace 50% of their revenue loss. Congress included the MVPS in the law as a mechanism to permit HCFA to make adjustments for changes in volume retrospectively, not prospectively. HCFA has circumvented statutory authority by proposing a retrospective behavioral offset or MVPS. The behavioral offset is unnecessarily penalizing all physicians and particularly teaching physicians already slated to experience large fee reductions under the fee schedule.

C. Other Issues Related to the Conversion Factor

The AAMC strongly recommends that the Congress urge HCFA to calculate properly the conversion factor by including data from new physicians, non-participating physicians, and physicians billing below the fee schedule amount. In addition, when calculating the conversion factor, HCFA should be required to include the eliminated BMAD data.

When calculating the conversion factor, HCFA excluded those physicians billing below the fee schedule amount, new physicians and non-participating physicians.

Excluding these groups of providers results in a lower conversion factor which in turn lowers total physician payment outlays beginning in 1992. The AAMC recommends that the Congress urge HCFA to recalculate the conversion factor by including these physicians.

HCFA eliminated BMAD data if the average charge for a procedure was more than two standard deviations above or less than two standard deviations below the national mean. Editing the data in this manner causes further reductions in the conversion factor because high-charge records are excluded from the calculation causing the average charge per service to be lowered. Academic and teaching physicians often care for the most critically ill and scientifically complex patients. These patients require intensive attention by physicians with innovative medical knowledge. Therefore, these patients are often billed the prevailing rate in order to compensate these physicians for their advanced knowledge, training, and abilities. The AAMC requests that HCFA make explicit in the final rules all assumptions actually used to project changes in service mix and that HCFA use historical trend data in making these projections.

II. ANESTHESIA SERVICES

A. Time units

The AAMC strongly recommends that the Congress urge HCFA to continue billing for anesthesia services on the basis of actual time units.

The AAMC strongly opposes HCFA's proposal to use average encounter time as the primary variable for anesthesia services whereby payment for anesthesia services would be based on average time units rather than actual time units. The AAMC strongly disagrees with this approach for the following reasons:

• Average time for anesthesia services is extremely difficult to define due to the fact that variations in anesthesia time (and consequently resources provided), are closely related to variations in surgical practice and patient characteristics beyond the control of the anesthesiologist. This conclusion was reported in a major study completed in 1987 by the Battelle Memorial Institute, in conjunction with the American Society of Anesthesiologists.

• Average time will adversely affect those anesthesiologists practicing in tertiary care and teaching hospitals, where typical caseloads include a disproportionate number of medically complicated cases requiring longer anesthesia time.

The AAMC believes other alternatives are not feasible in a teaching setting. A better operational definition of anesthesia time and more rigorous procedures to validate time would best address criticisms of current policy.

B. Payment to teaching anesthesiologists

The AAMC strongly recommends that the Congress urge HCFA to study the impact of reducing payments for the concurrent supervision of two residents on academic anesthesiology departments prior to adopting changes in current policy.

HCFA proposes to pay anesthesiologists a reduced rate when supervising concurrent cases performed by two residents, or one resident and one certified registered nurse anesthetist (CRNA). Supervision of residents would be paid on the same basis as supervision of two CRNA's. Presently, teaching anesthesiologists are paid the full amount for both cases when supervising two residents concurrently. The AAMC believes the proposed regulation would disadvantage teaching anesthesiologists and may encourage these physicians to migrate to private community practices where income levels are substantially higher. Currently, academic medical centers and most teaching hospitals have difficultly recruiting specialists because compensation levels are often significantly lower than in private practice. A sudden shift in existing compensation levels for anesthesiologists and the financial status of academic and teaching anesthesia departments, will have dire long term effects by exacerbating the process of recruiting and retaining qualified anesthesiologists to the teaching environment. The unintended effect of this change in policy may impair the institution's ability to deliver health care services to a broad spectrum of patients. HCFA should be strongly encouraged to engage in discussions with the Association of University Anesthesiologists, the Society of Academic Anesthesia Chairs, the Association of Anesthesiology Program Directors, and the American Society of Anesthesiology to develop and evaluate alternatives for the appropriate compensation of anesthesiology services in the teaching setting.

III. RELATIVE WORK VALUES (RVUS)

The AAMC strongly recommends that the Congress urge HCFA to correct all known distortions in the relative work values to assure physicians will be paid eq-

uitably under the fee schedule. The AAMC opposes permitting local carriers to assign "interim work values."

The AAMC agrees with the Physician Payment Review Commission (PPRC) that the relative work values must continue to be refined until the final rule is published. This is particularly true for a broad range of services, including evaluation and management, global surgical services and invasive services. The Association believes this goal can be achieved by establishing an expeditious process for refining Relative Work Units (RVUs). AAMC strongly recommends that HCFA provide physician specialty societies with the opportunity to review the reasonableness of RVUs prior to publication of the final rule to assure the RVUs are valid.

For new or unspecified procedures, typically billed under codes for "unlisted " services and for which there is no national code, the AAMC opposes HCFA's proposal to permit the local carrier to assign "interim" relative values until there is a national code and value for the service. The AAMC believes this is an inappropriate role for the local carriers and it would undermine the uniformity of payment under the fee schedule. As an alternative, the AAMC supports assigning the responsibility for developing new or revising existing work values to a national committee with representatives from physician groups, carrier and Federal organizations. Because many of these new services, procedures and technologies are developed by clinical faculty based at academic medical centers and teaching hospitals throughout the country, the AAMC may be able to provide valuable representation on this committee. The AAMC also recommends that there be an opportunity for public comment prior to permanent RVUs being assigned. To expedite implementation of the proposed RVUs for new services, the comment period should be for 30 days and should focus on comments from those specialists who would most frequently perform the service.

IV. MINOR SURGERIES AND "SCOPIES"

The AAMC strongly opposes payment for minor surgeries or scopies using the proposed global fee policy.

The Association believes that services performed by internists/sub-specialists should not be treated the same as services performed by surgeons. Furthermore, the application of a global fee policy is neither appropriate nor justified for internists and sub-specialists. The proposed regulation requires minor surgeries and scopies performed by internists and sub-specialists to be paid on a global fee basis. This payment would include office visits for a period of 30 days after the minor surgery or scopie is performed. Internal medicine consultations and medical follow-up visits establish the diagnosis, evaluate and manage the underlying medical problem and begin a therapeutic regimen. In contrast, surgical consultations are used exclusively to determine if a procedure needs to be performed, while post-operative visits are for the purpose of monitoring the patients' recovery after surgery. It is improper to apply a similar "global" payment policy to both internists and surgeons when the purpose of medical and surgical consultations and visits differ.

The AAMC strongly supports the following payment policy for minor surgeries and scopies (eg. endoscopies) performed by internists and sub-specialists:

- the initial evaluation or consultation should be paid separately;
- a visit that is provided for the sole purpose of performing a scopie or minor surgical procedure should not be billed separately in addition to the procedure fee, provided that the RVU for the procedure includes all related evaluation and management work;
- post-operative visits after the minor surgery or scopie should continue to be paid separately without additional documentation by the physician because these visits are typically for treatment of the patient's underlying condition. Additional documentation would create an unnecessary "hassle" for participating physicians. If HCFA implements the global fee, then the AAMC urges HCFA to adopt a much shorter time frame, certainly no more than 2 days, for the inclusion of post-operative visits after the minor surgery or scopie.

The proposed regulation does not address the issue of referrals from a community physician to a faculty specialist. The AAMC seeks clarification on whether the referring physician is permitted to bill for services to treat an underlying condition after the minor surgery or scopie is performed by the specialist.

V. INVASIVE SERVICES

The AAMC strongly recommends that the Congress urge HCFA to develop a clear policy for categorizing invasive services and how referrals for invasive procedures from one physician to another should be paid.

HCFA's proposed regulation does not contain a policy specifying those invasive services that should be categorized as global and those that should be non-global. The AAMC is concerned about the following:

- In both the academic medical center and the teaching hospital setting, specialty physicians receive referrals from a private, community physician or a faculty physician from another specialty to only perform an invasive procedure. If HCFA categorizes an invasive service incorrectly, the referring physician would be penalized by not being paid for other services provided to the patient for 90 days after the specialist performs the invasive procedure.
- Invasive services are routinely performed on patients with underlying clinical conditions which require separate and distinct management of that condition. Services for the management of the underlying disease should be billable as a separate service in order to maintain an equitable payment system which accurately reflects physician work.

These issues should be resolved with input from physician specialty groups and payers. A listing of services categorized as global or non-global should be published for public comment prior to implementation.

VI. PAYMENT MODIFIERS

The AAMC strongly recommends that HCFA should provide an improved definition of how and when modifiers are to be used under the fee schedule's revised coding system.

The Association is concerned with the following proposed modifiers:

A. Multiple Surgery (Modifier 51)

The AAMC recommends that the Congress urge HCFA to publish the methodology for establishing percentage reductions in payments for multiple surgeries and permit public comment.

The AAMC firmly opposes sharp reductions for multiple procedures and believes that the large proposed payment reductions are arbitrary. Clinical faculty in teaching hospitals often perform multiple surgeries particularly for trauma and burn victims as well as transplant surgery patients. The proposed regulation requires payment for multiple surgeries at 100% of the global fee for the highest value procedure, 50% of the global fee for the second most expensive procedure, 20% for the third, and 10% of each succeeding procedure.

The AAMC recommends that the Congress urge HCFA to develop an appropriate policy and modifier for trauma, transplant and burn surgery. In addition, the proposed regulation's "Unusual Services Modifier #22," is vague and provides the local carrier with too much discretion. The AAMC recommends that HCFA work with the specialty societies in developing an equitable policy for the payment of these complex surgeries using a case-specific approach.

B. Bilateral Surgery (Modifier 50)

The AAMC recommends that the Congress urge HCFA to: 1) continue to study the use of a bilateral modifier before the final rule is published; 2) consult with specialty societies to develop a list of surgeries which are frequently performed at the same time; and, 3) determine the correct RVUs and practice costs for bilateral procedures.

HCFA would continue to pay 150% of the global fee to encourage surgeons to perform the bilateral procedure in a single session. The Association believes that in many cases, the bilateral procedure requires as much physician work effort and practice costs as the first procedure performed.

C. Physicians Who Assist at Surgery (Modifiers 80, 81, 82)

The AAMC opposes reductions for assistants-at-surgery. Payments should be maintained at 20 percent of the fee until a resource-based payment is determined for assistants-at-surgery.

HCFA implements OBRA 1990 by setting the payment level for assistants-at-surgery at the lower of the actual charge or 16% of the fee schedule amount for the global surgical service. The AAMC opposes this provision of OBRA 1990.

VII. PAYMENT REDUCTIONS FOR NEW PHYSICIANS

The AAMC strongly recommends that the Congress urge HCFA to eliminate its discriminatory policy of reducing payments to new physicians.

The AAMC strongly opposes payment reductions for new physicians. New physicians perform the same services, extend the same work effort, and incur the same practice costs as any other physician in the Medicare program. Although HCFA has proposed a restatement of current law, the Association believes that this provision is contradictory to the goals of payment reform and under a fee schedule system based on relative values and resource costs. Since the new fee schedule is based on work values and a policy of uniform payment for physicians, it seems irrational that HCFA would propose to reduce payments to new physicians.

VIII. CODING REVISIONS FOR EVALUATION/MANAGEMENT SERVICES

The AAMC recommends that the Congress urge HCFA to develop a simpler coding system that will accurately reflect the value of the services provided in the academic and teaching setting.

The AAMC has a number of concerns with respect to the proposed coding system:

• The proposed coding system seems to provide appropriate payment for shorter visits but undervalues longer ones. In the academic and teaching setting, specialty consultation and intensive treatment are the norm. The level of physician time and intensity is far greater than in a community hospital setting. Physicians in academic medicine and in the teaching setting require a coding system which will accurately reflect the level of physician encounter time, intensity, and services delivered to complex, severely ill patients seen in teaching settings. They will be unfairly penalized for providing longer services. Based on the AAMC's review of the PPRC's analysis of the proposed coding system concludes that HCFA's proposed system is seriously flawed and will not provide equitable payment to physicians providing services requiring complex evaluation and management.

• The coding system in the proposed regulation is overly complex and will be tremendously difficult to implement given the hundreds of faculty physicians and residents practicing at the typical teaching hospital. Since the PPRC's proposed coding system is simpler, the AAMC urges HCFA to field test the PPRC's system to determine its reliability compared to the proposed system in the proposed regulation. A simpler coding system is in the best interests of all involved.

• The time frame for implementation of a new system is wholly inadequate to provide training to the vast numbers of physicians and support personnel who will need to understand any new coding system. While the AAMC recognizes that the statute imposes a January 1, 1992 implementation date, the Association believes successful implementation will only be achieved if adequate lead time is provided between the final rule and the beginning of the new system.

IX. OTHER CODING ISSUES

The AAMC wishes to reiterate some of its recommendations on coding as stated in its comment letter on the Model Fee Schedule:

A. The AAMC seeks clarification on how intra-specialty referrals would be coded.

Referrals to specialty physicians at academic medical centers and teaching hospitals often come from community based physicians of the same specialty. The AAMC urges HCFA to adopt the policy that intra-specialty referrals constitute a consultation and not a new patient visit. For example, a general cardiologist in the community may refer a patient to a cardiologist at the academic center who has particular expertise in a highly specialized clinical area of cardiac care or treatment. Would this be considered a transfer of care to the second cardiologist and coded as a new patient visit? Or, would this be considered as a request for consultation by the community cardiologist?

B. A modifier should be used rather than a one-level upgrade policy to differentiate payment for physicians treating patients with communication barriers, cognitive and physical impairments.

C. The AAMC supports the elimination of separate CPT codes for prolonged physician attendance (99150 and 99151), provided that they are replaced by a special modifier for "unusual services."

The Association stresses that in the academic medical center and in most teaching hospitals, unusual services, such as prolonged physician attendance at the bedside and in critical care units, are customary and should be recognized for payment differentials by HCFA.

X. GLOBAL SURGERY FEE POLICY

The AAMC supports the following provisions in the proposed regulation:

A. The initial consultation or evaluation by the surgeon should be paid separately and not be included in the global fee.

B. All intra-operative services should be included in the fee.

C. All post-operative visits for a standard 90 day post-operative period should be included in the fee unless the visit is for a problem unrelated to the diagnosis for which the surgery is performed.

We support HCFA's proposal to establish special post-operative periods for certain procedures which by definition or demonstrated complexity would not be fairly treated under the 90 day rule. The AAMC is willing to provide assistance with this task.

The AAMC urges that only pre-operative visits performed within 24 hours prior to or the day of the surgical procedure be included in the global fee.

A. The Association strongly recommends that the proposed regulation be modified with respect to pre-operative visits and the payment of re-operations due to complications after surgery at a reduced rate. The 30 day pre-operative period is too long. Because a disproportionate share of complex surgeries are performed in teaching hospitals on patients which often require a period of stabilization prior to surgery, the Association strongly disagrees with HCFA's proposal to include all pre-operative visits in the global fee. HCFA's proposal to allow payment only when additional documentation justifies the medical necessity of the surgeon's service is submitted and unfairly burden surgeons providing care to complex patients. This would increase the administrative "hassle" of participating in the Medicare program. In addition, a 30 day pre-operative period will be extraordinarily difficult to administer and result in billing errors and confusion.

B. Complications cannot be predetermined and are patient specific. Furthermore, data on the relative work of complications are not available, the Association agrees with HCFA that re-operations due to complications should be billable separately, *but at a rate which accurately reflects the physician work involved.* If these provisions are not changed, surgeons will be financially penalized when treating seriously ill Medicare patients. PPRC recommends that re-operations due to complications should not be included in the global fee RVUs. The AAMC has considered the PPRC's suggestion to establish a "complications modifier" whereby global fees are increased by a fixed percentage. The Association would support this approach only after additional study could document that this would promote more equitable payment for surgeons in the teaching setting.

XI. EKG INTERPRETATIONS

The AAMC supports a technical amendment to the OBRA 1990 to permit interpretation of EKGs under the fee schedule, based on their full relative value as determined in the Harvard study.

Beginning January 1, 1992, OBRA 1990 eliminates payments for interpretations of most EKGs performed in the office, outpatient and inpatient setting. HCFA proposes to incorporate additional relative value units (RVUs) into selected visit codes to "reflect" the additional physician work for EKG interpretations. The additional RVUs will be incorporated in proportion to the average expected use of EKG's in that service. This will tend to overcompensate physicians who never do an EKG and undercompensate physicians who always do an EKG.

XII. PAYMENT AREAS

The AAMC remains supportive of the PPRC's proposal to create statewide designations permitting up to five "intra-state" designations for states with high intrastate variation. We believe this method would be an improvement over the current payor locality method. The Association urges HCFA to consider special payment area designations for certain cities which have extreme variation in costs.

At a minimum, the Association believes that current payer localities are outdated and need revision to reflect the economic and demographic changes which have occurred since these localities were designated 25 years ago. Also, the AAMC supports further study of using alternatives to the existing payer localities to determine and assign the geographic practice cost indices (GPCI). Feedback from a number of AAMC member medical school practice plans have indicated that using existing payor localities to assign the GPCI does not adequately account for the high variation in the cost of practice in their states. For example, the payor localities for Flori-

da include: Miami, Fort Lauderdale, North/North Central Florida Cities and Rural Florida. The University of South Florida College of Medicine in Tampa falls into the Rural Florida locality and most likely is subject to a much lower practice cost index than it deserves. The Association believes that certain metropolitan areas, such as Manhattan, should be carefully studied by HCFA to ascertain if a special designation is warranted for these areas.

The AAMC appreciates the opportunity to submit testimony on this important issue. AAMC staff are prepared to answer any questions.

STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists appreciates the opportunity to discuss problems with the Administration's calculation of Medicare physician fee schedule amounts for 1992 through 1996. The College represents more than 12,000 board-certified pathologists who provide diagnostic and consultative services to Medicare patients in hospitals, nursing homes, clinics and offices, and other settings in which health care services are provided.

The College is extremely concerned that the methods used by the Secretary of Health and Human Services (HHS) in calculation of the Medicare relative value scale (RVS) conversion factor (CF) for 1992 are erroneous and produce fee schedule amounts that are ridiculously low. We ask that the Omnibus Budget Reconciliation Act (OBRA) of 1989, which created the RVS payment system, be amended to prohibit the Secretary from using these methods. This change will allow the RVS CF to increase, while maintaining the budget neutrality envisioned by the Congress.

PROBLEMS IN CONVERSION FACTOR CALCULATION

The Secretary of HHS has used several techniques in calculation of the RVS CF that reduce the CF by 16 percent for 1992 and that will have the long-term effect of even more severely reducing fee schedule amounts in 1996 when the RVS is fully phased-in. These are:

1. The Secretary assumes that physicians will respond to RVS changes by increasing the volume and intensity of services provided so that 50 percent of any expected losses would be recouped. The CF is decreased by 10.5 percent to enable the government to recapture these monies.

There is no evidence to support the Secretary's assumption. In fact, available research leads to the conclusion that no one can predict what effect this totally new relative value system will have on volume and intensity of services. Since pathologists do not control the volume of surgeries, consultations, or other events that produce the need for pathology services, there is no way for our specialty to respond to the RVS by increasing services provided. Yet the CF reduction would apply to our services.

The Medicare Volume Performance Standard (MVPS) limit on the increase in Medicare payments was designed to adjust physician payments if volume increases do occur. That mechanism is in place. The behavioral assumptions made by the Secretary preempt that mechanism and are unwarranted.

2. The Secretary has reduced the CF by an additional six percent to adjust for effects of the RVS phase-in methodology. The five-year phase-in was explicitly designed to allow increases in Medicare payments for certain services to proceed more quickly than would decreases for services scheduled to be reduced. This mechanism protects against large decreases in early phase-in years and allows time for RVS refinement and correction as necessary.

Because of this phase-in asymmetry, the Secretary has reduced the CF to maintain budget neutrality. The effect is to take money out of the Medicare payment system that would be spent under true budget neutrality and to reduce Medicare fee schedule amounts even further.

We ask that the Secretary be prohibited by statute from using these techniques to reduce the conversion factor.

SPECIAL PROBLEMS WITH LOW FEE SCHEDULE AMOUNTS

The Medicare fee schedule amounts proposed by the Secretary for many pathology services are far too low. We are providing data to HCFA to support adjustments to pathology services values that are more realistic as discussed later in our statement. In rural areas there is an additional problem, pathologists' travel. Pathologists travel to rural locations to provide needed surgical pathology services in hospitals that do not have onsite pathologists. These services are necessary to the contin-

ued ability of the hospital to provide surgical services and should be adequately compensated to ensure continued beneficiary access and hospital viability. Adequate compensation must include payment for the time the pathologist is travelling to the distant practice site and is not able to provide any other medical services and thus receive compensation for the time. The proposed fee schedule amount for surgical pathology will not provide payment adequate to cover all the physician resource costs incurred. The following example illustrates the situation:

> An Oklahoma pathologist travels 180 miles roundtrip to provide a pathology consultation during surgery with frozen section diagnosis for a scheduled surgery for a Medicare patient. At an average rate of 45 miles per hour the pathologist spends four hours in transit. One hour is spent at the hospital including time waiting for the surgical specimen to be available for evaluation and provision of the consultation. The service is appropriately described using CPT code 88331, Consultation during surgery with frozen section(s), single specimen. The proposed Medicare fee schedule amount for 88331 in Oklahoma when the fee schedule is fully phased-in is $52.05 for the five hours involved in providing the service (four hours travel time and one hour at the hospital).
>
> Transportation costs in automobile maintenance are included in the $52.05. Using the Federal mileage rate of 27.5 cents per mile, vehicle transportation costs would consume $49.50 of the $52.05, leaving $2.55 for physician compensation including compensation for other practice costs, or 51 cents per hour.

Pathologists travelling to provide services to rural patients in Montana, Texas, Kansas, South Dakota, Oregon, and Minnesota would also receive about $50.00 for this service.

Clearly, the fee schedule amount for the surgical consultation itself is not adequate to compensate the pathologist for the five hours required to provide the service. The Secretary proposes to make no additional payment for travel, although neither the Hsiao physician work studies nor the practice cost data used to develop the proposed relative values include physician travel time. Clearly pathologist travel time is necessary to provide services in certain locations. A travel allowance is necessary to continued access to pathology services in rural areas.

We will be pursuing this issue with HHS and ask for your support for a travel allowance in your communications with the Secretary.

ADDITIONAL RELATIVE VALUE SCALE CONCERNS

The College has additional concerns with other aspects of the plans for RVS implementation. These include:

A. The legislation creating the Medicare RVS fee schedule includes a provision for lower fee schedule amounts for new physicians in their first four years of practice. There is no sound basis for this provision under a resource-based payment methodology such as the RVS fee schedule. The very basis of the fee schedule is that all physicians would be reimbursed on the basis of average resources involved. New physicians should be treated like all others as there is no reason to think they expend less resources.

We ask that this OBRA 1989 provision that treats new physicians inequitably be repealed.

B. The Medicare resource-based relative values for pathology and most other services are based primarily on the work of Harvard University researchers. The Secretary has the discretion to use the data in various ways to calculate relative values and has the authority to develop other payment policies for RVS implementation. We have several concerns with how the Harvard data have been used to calculate relative values, with the manner in which agreed-to crosslinkages have been manipulated, and with the assumptions used to develop the technical component relative values for pathology services. Adjustments are necessary for proper use of the Harvard data and to ensure adequate relative values for the technical components. We will be pursuing those refinements with HHS.

We strongly encourage the Committee not to assume that the work necessary to support RVS implementation is completed and that relative values are final. Substantial refinement is needed in the proposed relative values.

SUMMARY

The College has serious concerns with plans for implementation of the Medicare RVS in 1992. The Secretary of HHS should be prohibited from presuming physician

behavioral changes and from reducing the fee schedule conversion factor to adjust for asymmetry of the phase-in period. There is no basis for the behavioral assumptions, and the phase-in asymmetry was planned to protect against access problems in early years of the RVS.

The impact of low fee schedule amounts for services to rural beneficiaries is particularly dramatic. An additional travel allowance for physician time in transit to and from these rural locations is needed.

In addition, we urge repeal of the OBRA 1989 provision establishing lower fee schedule amounts for physicians in their first four years of practice. There is no basis for this differential.

We encourage the Committee to be aware that RVS refinements are needed.

Thank you for the opportunity to present the College's concerns with plans for Medicare RVS implementation.

STATEMENT OF DR. ALMA ROSE GEORGE

PRESIDENT

NATIONAL MEDICAL ASSOCIATION

THE NATIONAL MEDICAL ASSOCIATION ("NMA") WOULD LIKE TO FORMALLY JOIN THE OUTCRY OF OTHER PHYSICIAN GROUPS WITH RESPECT TO THE JUNE 5, 1991 NOTICE OF PROPOSED RULEMAKING ("NPRM") PUBLISHED IN THE FEDERAL REGISTER FOR MEDICARE PHYSICIAN PAYMENT REFORM. WE REALIZE THAT WE ARE NOT ALONE IN THIS OPPOSITION, AND IT IS OUR HOPE THAT THIS COALITION OF OPPOSITION WILL RESULT IN A FINAL PROPOSAL FROM THE HEALTH CARE FINANCING ADMINISTRATION ("HCFA") WHICH INCORPORATES THE INTENT OF CONGRESS WHEN IT ADOPTED MEDICARE PHYSICIAN PAYMENT REFORM.

NMA IS AN ORGANIZATION FOUNDED IN 1895 WHICH TODAY REPRESENTS OVER 16,000 PHYSICIANS THROUGHOUT THE UNITED STATES, THE VIRGIN ISLANDS AND PUERTO RICO. NMA MEMBERS ARE PRIMARILY AFRICAN-AMERICANS, AND ARE THE PRIMARY PROVIDERS TO THE MEDICALLY UNDERSERVED AND LOW INCOME MINORITY POPULATIONS. AS SUCH, WE VIEW FIRST HAND DISPROPORTIONATELY HIGHER RATES OF INFANT MORTALITY, CANCER, HEART DISEASE, AIDS AND OTHER DISEASES PARTICULARLY AMONG THE INDIGENT SEGMENT OF THE MINORITY COMMUNITY.

STUDIES SHOW THAT ELDERLY AFRICAN-AMERICANS SUFFER MORE HEALTH CARE PROBLEMS THAN THEIR WHITE COUNTERPARTS. ECONOMICALLY, AFRICAN-AMERICANS GENERALLY HAVE LESS PERSONAL POST-RETIREMENT INCOME THAN THEIR WHITE COUNTERPARTS, AND ARE MORE DEPENDENT ON SOCIAL SECURITY BENEFITS FOR THE MAJORITY OF THEIR RETIREMENT INCOME. MEDICARE IS OFTEN TIMES THE ONLY SOURCE OF INSURANCE FOR MANY AFRICAN-AMERICAN ELDERLY. WE ARE, THEREFORE, CONCERNED ABOUT THE IMPLEMENTATION OF LEGISLATION WHICH AFFECTS THE BASIC STRUCTURE OF THE MEDICARE PROGRAM.

BUDGET NEUTRALITY

AS YOU KNOW, THE NPRM PROPOSES A 16 PERCENT REDUCTION IN THE CONVERSION FACTOR OF THE RESOURCE BASED RELATIVE VALUE SCALE ("RBRVS"). THIS REDUCTION WILL HAVE AN ADVERSE AFFECT ON MANY MEDICAL SPECIALTIES, PARTICULARLY SURGEONS, RADIOLOGISTS, ANESTHESIOLOGISTS AND PATHOLOGISTS, WHO WILL SEE PAYMENTS OF THEIR SERVICES REDUCED 25 TO 35 PERCENT.

WE BELIEVE THAT THIS REDUCTION IS CONTRARY TO THE CONGRESSIONAL INTENT TO MAINTAIN BUDGET NEUTRALITY IN THE IMPLEMENTATION OF THE FEE SCHEDULE PROPOSAL. IN FACT, THE REDUCTION PROPOSED WOULD SAVE THE FEDERAL GOVERNMENT OVER $3 BILLION DURING THE FIRST FIVE YEARS OF THE PLAN. HCFA HAS

THEREFORE USED THE REDUCTION AS A BUDGET-CUTTING TOOL FOR THE FEDERAL GOVERNMENT THAT WAS NOT INTENDED.

BEHAVIORAL OFFSET

ALSO INCLUDED IN THE 16 PERCENT REDUCTION IS AN ALLOWANCE FOR THE INCREASE IN THE VOLUME AND INTENSITY OF PHYSICIAN SERVICES AS A RESULT OF THE IMPLEMENTATION OF THE FEE SCHEDULE. IN ANTICIPATION OF THIS BEHAVIOR, HCFA REDUCED THE CONVERSION FACTOR.

WE FIND THAT THERE IS NO SUGGESTION IN THE LEGISLATIVE HISTORY THAT A BEHAVIORAL OFFSET WOULD BE CONSIDERED IN THE IMPLEMENTATION OF THE FEE SCHEDULE. THE MOST OFFENSIVE ASPECT OF THE BEHAVIORAL OFFSET RATIONALE, HOWEVER, ARE THE ASSUMPTIONS THAT HCFA MAKES ABOUT PREDICTED PHYSICIAN BEHAVIOR. IN THE NPRM, HCFA MAKES THE FOLLOWING ASSUMPTIONS WITH RESPECT TO THE IMPLEMENTATION OF THE FEE SCHEDULE:

- PHYSICIANS COULD BILL FOR SERVICES FOR WHICH THEY DO NOT CURRENTLY BILL;
- BENEFICIARIES COULD SEEK ADDITIONAL SERVICES BECAUSE OF LOWER OUT-OF POCKET COSTS; AND
- PHYSICIANS COULD BILL FOR A HIGHER LEVEL OF SERVICES OR FURNISH MORE CONCURRENT CARE, CONSULTATIONS, ASSISTANTS AT SURGERY AND DIAGNOSTIC TESTS.

NOT ONLY IS HCFA'S PROPOSED CONVERSION FACTOR REDUCTION UNWARRANTED, IT IS ALSO DEMEANING, SINCE IT OCCURRED AFTER HCFA SOLICITED INPUT FROM PHYSICIANS WITH RESPECT TO IMPLEMENTING THE FEE SERVICE. THE REDUCTION REPRESENTS A PENALTY ESTABLISHED BY HCFA BASED ON ASSUMPTIONS ABOUT BEHAVIOR THAT HAS NOT OCCURRED.

WE THEREFORE FIND IT OFFENSIVE AND DEMEANING THAT HCFA WOULD THEN ASSUME THAT PHYSICIANS WOULD ATTEMPT TO MANIPULATE THE SYSTEM IN ORDER TO SECURE ADDITIONAL PAYMENTS. HCFA THEN PENALIZES PHYSICIANS FOR ASSUMPTIONS ABOUT BEHAVIOR THAT HAVE NOT OCCURRED.

CONGRESS ALREADY DEVELOPED ANOTHER DEVICE, THE MEDICARE VOLUME PERFORMANCE STANDARD ("MVPS"), TO ADJUST PHYSICIAN PAYMENTS FOR INCREASES IN VOLUME OF SERVICES. IN ITS TESTIMONY BEFORE THE SUBCOMMITTEE ON MEDICARE AND LONG TERM CARE, HCFA STATED THAT THE MVPS WAS NOT AN ADEQUATE MECHANISM TO CORRECT FOR A CONVERSION FACTOR INITIALLY SET TOO HIGH. HCFA IS MAKING AN ASSUMPTION THAT THE CONVERSION FACTOR IS PRESENTLY SET TOO HIGH. HOWEVER, HCFA IGNORES THAT MANY OF THE PHYSICIAN SERVICES HAVE ALREADY BEEN SUBJECT TO REDUCTIONS WITH RESPECT TO OTHER LEGISLATION AIMED AT REFORM OF THE MEDICARE PAYMENTS TO PHYSICIANS. THUS SOME SERVICES WHICH HAVE ALREADY BEEN REDUCED MUST ENDURE ADDITIONAL REDUCTIONS AS A RESULT OF HCFA'S ACTION. HCFA HAS FAILED TO TAKE INTO ACCOUNT THESE PRIOR REDUCTIONS AND HAS OFFERED NO ACCEPTABLE BASIS FOR ITS ASSUMPTION THAT THE CONVERSION FACTOR IS SET TOO HIGH.

ACCESS TO HEALTH CARE

WE ARE EXTREMELY CONCERNED THAT THE REDUCTION PROPOSED IN THE NPRM WILL IMPEDE ACCESS TO HEALTH CARE. THE PROPOSED CUTS IN SOME PHYSICIAN SERVICES WILL RESULT IN RATES THAT ARE NEAR OR BELOW MEDICAID RATES IN SOME AREAS. WE ACKNOWLEDGE THE FACT THAT SOME PHYSICIANS REFUSE TO TREAT MEDICAID PATIENTS BECAUSE OF THE LOW PAYMENT RATES. IMPLEMENTATION OF THE PROPOSED CUTS COULD HAVE THE SAME EFFECT WITH RESPECT TO MEDICARE. THEREFORE, ACCESS TO HEALTH CARE FOR THE ELDERLY COULD BE A SERIOUS PROBLEM.

IT IS NO SECRET THAT APPROXIMATELY 37 MILLION AMERICANS EITHER HAVE NO INSURANCE OR ARE UNDERINSURED. MEDICARE IS THE ONLY FORM OF HEALTH INSURANCE FOR MANY AMERICAN ELDERLY, PARTICULARLY AFRICAN-AMERICAN ELDERLY. MEDICARE IS BASED ON THE PRINCIPLE OF PROVIDING ACCESS TO ADEQUATE HEALTH CARE TO THE ELDERLY. REIMBURSEMENT RATES WHICH DISCOURAGE PHYSICIANS FROM ACCEPTING PATIENTS RUN COUNTER TO THAT PRINCIPLE.

WE ARE THE PRIMARY PROVIDERS TO THE LOW INCOME AND MINORITY POPULATIONS, AND WE ARE PARTICULARLY CONCERNED ABOUT ANY MEASURES WHICH WOULD AGGRAVATE THE PROBLEM OF ACCESS TO HEALTH CARE. THE AFRICAN-AMERICAN ELDERLY ARE CURRENTLY THE FASTEST GROWING SEGMENT OF THE TOTAL AFRICAN-AMERICAN POPULATION. IT IS PROJECTED THAT BY THE YEAR 1999, THE NUMBER OF AFRICAN-AMERICANS OVER THE AGE OF 65 WILL INCREASE TO THREE MILLION. WE MUST ENSURE THAT ACCESS TO HEALTH CARE IS AVAILABLE TO THIS SEGMENT OF OUR SOCIETY.

STATEMENT OF THE MICHIGAN SOCIETY OF HEMATOLOGY AND ONCOLOGY

The Michigan Society of Hematology and Oncology represents 125 oncologists in the state of Michigan. The Society believes that should the proposed rules go into effect there will be significant losses for clinical oncologists. Cancer patients will also be impacted by these changes as their access to care in rural areas will diminish if the significant costs associated with outpatient chemotherapy are not reimbursed.

COMMENTS ON THE PROPOSAL TO PAY AWP-15%

Drug reimbursement effects oncology in a very dramatic way. Oncologists provide the chemotherapy drugs for an ever increasing variety of treatments which are being moved from the hospital setting to their offices. The oncologists have found themselves in the past few years in a war over the cost of chemotherapeutic drugs. Some carriers have arbitrarily denied reimbursement for off-label, though medically accepted, indications for chemotherapy drugs, or for new drug therapies which prevent significant side effects. This new proposal adds additional burden to the oncologists' operating costs.

Drug costs represent significant out-of-pocket expenditures for the oncologist. Experience in the oncology office has found that other costs incidental to drug acquisition are incurred.

(1) Handling costs are the costs associated with the procurement and mixing of these drugs. OSHA regulations require the use of a laminar flow hood when preparing some of these very toxic drugs for injection.

(2) Storage costs are incurred in any oncology office where chemotherapy is administered in order to keep the drugs available at any given time for patient treatment.

(3) Waste costs are incurred whenever a dosage requirement is less than the packaging. Also to be included in waste cost is the loss when the drug is accidently spilled, or when the expiration date is reached.

(4) Bad debt expenses are incurred when patients' cannot pay their co-pays, which can be significant for the costly oncology drugs. For example, in Michigan auto retirees have the unfortunate situation of not having their chemotherapy treatment for prostate cancer covered by their Medicare supplementary insurance because of an outdated policy on the coverage of injectable chemotherapy. The co-pay on this particular drug runs approximately $80 a month. A significant sum to a retiree, which is often absorbed by the oncologist.

(5) Sole-source drugs and orphan drugs are not available at a discount. For example, Mitoxantrone (Novantrone) is a new tool in the battle to win the odds against breast cancer. This is a sole-source drug and not discounted from AWP. Surely, HCFA does not intend for an oncologist to eat the 15% of cost which is not reimbursed under this policy.

(6) Generic drugs are another concern for oncologists. While there are generics available for some chemotherapy drugs, physicians are not always comfortable with these products. Chemotherapy is a very exacting science; variations in drug manufacturing can have dramatic effects. Oncologists do not want to be forced to use a product because of cost without concern for patient safety and efficacy.

Currently, in Michigan our carrier reimburses AWP + 4% (to cover sales tax). This represents a decrease of 20% over 1986 reimbursement. The current proposals would cause significant losses for the oncologists of Michigan. It is feared that office clinics established in the less populous areas of the state would not be able to remain open if their costs are not covered, and the patients access to care will suffer.

HCFA should to withdraw this regulation as it applies to oncologists. The proposal does not take into account the hard costs associated with drug reimbursement. The Society believes that the AWP-15% drug proposal is not a fair, budget neutral reimbursement.

COMMENTS ON PROPOSAL TO LOWER THE RBRVS CONVERSION FACTOR

HCFA makes the assumption that utilization will go up as a result of the new reimbursement system. They propose to penalize physicians in advance for this assumed over-utilization.

Oncologists treat patients with cancer. Cancer affects 1.1 million people each year, many of them elderly. Oncologists are becoming more and more successful in their ability to fight and win the battle with cancer. Consequently, more and more of the population are cancer survivors. Utilization levels probably reflect both an increas-

ing number of patients needing oncology services, and an increasing population beating their disease with long term chemotherapy. It is difficult to over-utilize oncology services. Either a patient needs chemotherapy or they do not. When office visits are provided to our patients there is a specific need that is the result of the toxicity associated with chemotherapy, the overall general health of the patient, or the result of the cancer itself.

In Michigan physicians contend with the discrepancies brought on by having the distinction of being the second lowest state in terms of Medicare reimbursement, and having one of the highest malpractice insurance rates in the country. The unfortunate consequence of lowering Medicare reimbursements for out-of-pocket costs will be to reverse the trend away from expensive hospital-based clinics to the more cost-effective physician office setting, and this cost shift will create an additional burden for Medicare Part A.

We request that HCFA revise this policy on the conversion factor, which should be budget neutral as required under the law.

ONCOLOGISTS' OPPOSITION TO HCFA PROPOSAL TO DENY PAYMENT FOR CHEMOTHERAPY INJECTIONS

The Michigan Society of Hematology and Oncology is concerned about the proposal published in June 5, 1991 56 Federal Register 25792 as section 5b (page 25801). The proposal would limit payment for the administration of a chemotherapy injection when an office visit is performed. The AMA's Common Procedural Terminology (CPT) states that an office visit is to be considered a separate service from the chemotherapy administration. HCFA's proposal directly contradicts the AMA recommendations.

There is significant technical skill involved in the administration of chemotherapy, no matter what route of administration is used. One chemotherapy drug that is injected for the treatment of prostate cancer is Zolodex, which is actually a time released hormone. The FDA labeling recommends that the injection be administered by the physician experienced in cancer chemotherapy. HCFA proposes not to reimburse the physician for this service when he has performed an office visit. The Society believes this would be a detriment to the patients and oncologists in this state.

The office visit is an vital part of the chemotherapy regimen. It is the time for the physician to perform a interval history on the patient, noting any significant side effects or other general health concerns. It is the time to provide the valuable counseling that insures patient compliance. There is a re-evaluation of the patient's whole physical and mental condition. This information must be evaluated before there is a continuation of therapy.

The office visit is a wholly separate procedure from the actual administration of chemotherapy drugs, which can be done a number of ways. Most commonly chemotherapy is administered by an intravenous infusion. Sometimes the drugs are administered by placing them in an infusion bag, or at times, and perhaps, in a single chemotherapy episode, the drugs are injected into a catheter in the intravenous tubing. HCFA proposes not to pay for the service when the drug is administered by injection into the intravenous line or intra-arterial line.

In addition there are hard supply and support costs associated with chemotherapy administration, regardless of whether chemotherapy drugs are injected or infused. The costs to be considered are needles, intravenous solution, tubing, etc. HCFA proposal does not take these significant out-of-pocket costs into consideration.

We believe that the above proposal should be withdrawn. It is obvious that HCFA needs to study the field of oncology before promulgating regulations which limit reimbursement for standard procedures whicl have consistently been reimbursed in the past. This proposal flouts the budget neutrality mandate imposed by Congress.

STATEMENT OF THE NATIONAL ASSOCIATION OF PORTABLE X-RAY PROVIDERS

INTRODUCTION AND SUMMARY

The National Association of Portable X-ray Providers ("NAPXP") appreciates this opportunity to comment on the proposed application of the Medicare physicians' fee schedule to portable x-ray suppliers.

Portable x-rays are the services of a specially trained *nonphysician* portable x-ray technologist who drives a van containing an unassembled portable x-ray machine to a nursing home or patient's house, assembles the machine, takes the x-ray, disassembles the machine, and travels to the destination of another home bound patient. The portable x-ray consists of three components—the transportation component, the

technical component (the taking of the x-ray), and the physician's interpretation component (which is performed by an outside radiologist, *not* the nonphysician portable x-ray supplier).

Portable x-rays are among those diagnostic procedures incorporated in the broad definition of "physicians' services" established by the statutory mandate for the physicians' fee schedule in the Omnibus Budget Reconciliation Act of 1989 ("OBRA 89"). That definition, however, gives the Secretary of the Department of Health and Human Services ("HHS") discretion to exclude individual items or services from that definition. The Health Care Financing Administration's proposal for implementing the physicians' fee schedule (56 Fed. Reg. 25792, June 5, 1991) (hereinafter, "NPRM") chooses to include portable x-rays within the scope of the fee schedule, but does not prescribe a precise methodology for doing so. Specifically, the proposal for coverage of portable x-ray services in the physicians' fee schedule is that:

> all three components of the services of portable x-ray suppliers be paid under the fee schedule for physicians services using the same CF as is applicable to all other services payable under that fee schedule. We are currently studying how to standardize the billing and RVUs assigned to the transportation component and specifically invite comments on this issue. If we do not standardize these payments in a final rule, the carriers will continue to establish RVUs for the transportation components based on the circumstances under which portable x-ray services are furnished in their service areas.

56 Fed. Reg. 806 (Jan. 5, 1991).

Thus, HCFA apparently proposes to calculate payments for the portable x-ray technical and professional components using the RVUs and conversion factor in the proposed physicians' fee schedule, but proposes no definite methodology for payment for the transportation component.

The NAPXP is now in the early stages of formulating its detailed comments on this proposal. At this stage, the Association's positions are two-fold: (1) that HHS should be directed to use its discretion to exclude portable x-ray suppliers from the fee schedule; and (2) alternatively, if the agency maintains its current position that these services should be included within the scope of the fee schedule, the reimbursement methodology should maintain payment levels that are "budget neutral" for this industry with respect to payment levels in 1991.

Both of these positions are addressed in the following statement. However, inasmuch as HCFA has proposed to incorporate portable x-ray services within the fee schedule, we first address the Association's second position, i.e., that if portable x-rays are so treated, transportation component payments should preserve budget neutrality. Among the reasons for this position that will be explored below is the devastating financial impact that implementation of this proposal could have on the portable x-ray industry if budget neutrality is not maintained, an impact that the NAPXP has estimated for a sample of 23 individual companies. The methodology and results of this estimate are summarized below, and a complete tabulation of the results and explanation of the methodology are appended hereto.

THE METHODOLOGY FOR CALCULATING PORTABLE X-RAY PAYMENTS UNDER THE FEE SCHEDULE SHOULD PRESERVE BUDGET NEUTRALITY

The reasons why HCFA should develop a methodology for reimbursing portable x-ray suppliers so as to preserve budget neutrality with respect to portable x-ray payments in 1991 are: (1) neither the method proposed by HCFA for achieving a "budget neutral" national conversion factor nor the Volume Performance Standard ("VPS") system is applicable to portable x-ray suppliers; and (2) failure to maintain budget neutral portable x-ray payments will likely destroy an industry which it is in Medicare's interest to sustain. Each of these arguments is discussed below.

1. *Inapplicability of CF and VPS methodologies.* The methodology used by HCFA to calculate a "budget neutral" national conversion factor ("CF") is not appropriate for portable x-rays and results in unwarranted punitive impact. HCFA's calculation incorporates a "behavioral offset" that assumes physicians whose fees for individual procedures will fall under the fee schedule will make up 50% of the loss by increases in volume. This concept is completely inapplicable to portable x-ray suppliers. Unlike physicians, portable x-ray suppliers have absolutely no control over the volume of their procedures. These procedures can only be provided pursuant to a physician's prescription. Moreover, unlike providers in some other non-physician specialties, portable x-ray suppliers are never consulted by physicians considering the advisability of performing the test in a particular case; thus, portable x-ray suppliers cannot even exert any *indirect* influence over the volume of their services.

The same point applies to the imposition of the VPS system on portable x-ray suppliers. The underlying rationale of the VPS is that the Medicare reimbursement system must incorporate incentives for physicians to restrain the growth in utilization of their services. Again, portable x-ray suppliers cannot be affected by such an incentive because they have no ability to control their volume. Indeed, the VPS may in fact create incentives for physicians to order *fewer* of those procedures, such as portable x-rays, from which they derive no financial gain, so as to make more "room" under the VPS for their own services.

Notwithstanding the inapplicability of these aspects of the physicians' fee schedule to portable x-ray suppliers, under HCFA's proposal, portable x-ray suppliers will be adversely affected by both of these facets of the fee schedule because both are incorporated in the calculation of the conversion factor. The "behavioral offset" affects the calculation of the initial conversion factor and the VPS affects the update for the conversion factor every year. Thus, portable x-ray suppliers will be unfairly and inappropriately penalized by the physicians' fee schedule. To offset this unfair and inappropriate penalty, the methodology for calculating portable x-ray payments should be developed so as to achieve an overall level of budget neutrality with respect to the level of portable x-ray payments in 1991.

2. *Devastating impact on portable x-ray industry.* The second reason why portable x-ray payments under the fee schedule should be developed in this fashion is that, if transportation component payments were to remain at current levels while technical and professional component payments were calculated pursuant to the fee schedule as HCFA proposes, the level of portable x-ray payments would fall dramatically and result in the virtual eradication of this industry.

This conclusion is supported by a survey that the NAPXP has conducted among 23 companies represented by members of its Board of Directors and Legislative Committee. For these companies, the effect of the proposed physicians' fee schedule on portable x-ray payments using the above assumptions was calculated according to a methodology described in detail in Attachment 2. The results, aggregated in Attachment 1 and illustrated for several individual companies in Attachment 3, show that most of the 23 companies surveyed are operating *today* on margins well below 10%, and some are currently operating in the red. Under the proposed physicians' fee schedule, every single company would be operating in the red, and the majority would experience profit margin declines of well over 100%. The average 1992 profit margin under the fee schedule would be −28%, and the average decline in profit margin would be −697%.

It should be emphasized that portable x-ray suppliers, unlike most other Medicare-covered industries, could not obtain any relief from such drastic *cuts* by shifting to non-Medicare work because they have almost no non-Medicare work; since they serve only elderly, homebound patients, Medicare covers about 95% of their services. Medicare literally controls the destiny of this industry.

This devastating result is completely unsupported in the Congressional mandate for the fee schedule and is entirely contrary to the Medicare program's overall interest in the cost-effective provision of medical services to the nation's elderly. Nowhere in OBRA' 89 is there any mandate for HCFA's "behavioral offset," for payment *cuts* for physicians' services as a whole or cuts for any particular industry, certainly not for the portable x-ray industry. Indeed, in the same statute, portable x-ray suppliers were exempted from a payment cut of approximately 4% that was applied to other radiology services on the grounds that they were overpriced; thus, Congress demonstrated its view that portable x-rays are *not* overpriced procedures, and consequently, there is no basis for imposing payment cuts on portable x-ray suppliers through the physicians' fee schedule.

Moreover, it would be counterproductive to permit fee schedule payment levels that would have the effect of virtually destroying this industry because it is the most cost-effective possible way for Medicare to deliver x-rays to patients in nursing homes. When a portable x-ray shows a negative result for the suspected diagnosis, the cost of more expensive medical treatment procedures is eliminated. Even when a portable x-ray is positive, where the diagnosis is pneumonia, tuberculosis, or other pulmonary disease or a simple fracture, treatment can be provided in the nursing home without removing the patient to the much more costly setting of a hospital. Where portable x-rays are unavailable, the patient must be transported in an ambulance to a hospital for the x-ray, an alternative that costs 3-4 times as much as the portable x-ray. (See Attachment 4, data on ambulance versus portable x-ray costs in several localities.) Furthermore, if the hospital x-ray is positive, the patient is most likely to be treated in the hospital, again, at a much greater cost than the Medicare program would bear if the patient were able to be treated in the nursing home.

Because of the cost-effectiveness of the portable x-ray service, it is in the interest of the Medicare program to encourage the continued existence of the portable x-ray industry so that there is enough capacity to meet the demand for portable x-rays by nursing home and homebound patients. That demand will grow exponentially in the next decade because the bulk of portable x-ray patients are the oldest and sickest of Medicare patients—those in the 75–84 and the 85-and-over age groups, both of which are forecasted to grow at a much greater rate than the general Medicare beneficiary population (those 65 and over). Specifically, figures provided by the American Health Care Association ("AHCA"), based on recent Census data, indicate that, while the population of those 65 and over is expected to grow by 38% from 25.7 million in 1980 to 34.9 million in the year 2000, Americans aged 75 to 84 will grow by 58% in that 20-year period from 7.7 million to 12.2 million, and those 85 and older will grow by 102% from 2.2 million in 1980 to 5.1 million in the year 2000.

Existing data indicates that the capacity in the portable x-ray industry is already too small to meet the needs of nursing home and homebound patients for portable x-rays. A portable x-ray technologist x-rays an estimated average of 6.7 patients in a day and about 1560 in a year. Currently, there are about 220 active portable x-ray suppliers in the United States,[1] employing an average number of six technologists each. Thus, the total annual capacity of the industry in 1990 is 2,059,200 nursing home/homebound patients x-rayed. The latest data available from the AHCA for the total United States nursing home resident population indicates that in 1985, the nursing home population totalled 1,491,400. The NAPXP estimates that the average nursing home resident needs a conservatively estimated annual figure of approximately three portable x-rays per year. Using these figures, the total estimated need for portable x-ray services is 4,474,200 x-rays, as compared to a portable x-ray industry capacity of only 2,059,200. Thus, the capacity of the industry currently fulfills only 46% of the need for the service; the rest is not being met or is being met through the much more costly alternative of the hospital.

If the proposed physicians' fee schedule were implemented without the budget neutral method urged by the NAPXP, eventually less or none of the total need for portable x-rays would be met by portable x-ray suppliers because the devastating impact described above would force portable x-ray suppliers to eliminate some and eventually all of their services, starting with the most costly rural routes and after-hours runs. Where a portable x-ray is not available, one of two things happens: either the patient is taken to a hospital in an ambulance instead, costing Medicare more; or the patient goes untreated, becoming sicker or dying. Neither of these results is in the interest of the Medicare program or its patients.

THE PORTABLE X-RAY STATUS QUO SHOULD CONTINUE AT THIS TIME

The NAPXP asserts that portable x-ray services should not be reimbursed under the fee schedule and that portable x-ray reimbursement should remain at status quo for the following reasons.

1. *Inadequate knowledge and study.* HCFA apparently recognized that portable x-rays are a different service, functionally and in terms of input costs, from radiologists' services. This recognition is the foundation of the separate portable x-ray fee schedule that exists today and is reflected in the following language in Section 5262 of the Medicare Carriers Manual:

> For payments under the fee schedules, it has been determined that the technical component services furnished by portable x-ray suppliers are generally different from the technical component services furnished by others.[2]

Beyond this statement, however, the agency has virtually no detailed knowledge of the portable x-ray industry upon which to base the incorporation of portable x-rays into the physicians' fee schedule.

The physicians' fee schedule itself is the product of enormous evaluation and study by a variety of expert groups: first, the Congressional policymakers who devised the general concept of an RBRVS-based fee schedule and subsequently reviewed reports on its development; second, the Harvard University team led by Dr.

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[1] There are more portable x-ray Medicare provider numbers than there are *active* portable x-ray suppliers because some of these Medicare provider numbers are inactive.

[2] The reason why this difference exists is that geriatric patients—the sole clientele of portable x-ray suppliers—present problems for the practitioner that other patients do not. This difference was recently recognized by the Physician Payment Review Commission ("PPRC"), which noted on p. 7 of its June 25 statement before this Committee: "Considerably more work is involved in providing certain services to elderly or disabled patients than to patients in the general population."

William Hsaio who conducted a multi-phased study of physicians' procedures and their resource inputs in order to identify and quantify those inputs; third, the PPRC that has many times reviewed and commented on the policy decisions of Congress and the work of Dr. Hsaio and his team; and finally, HCFA analysts and policymakers, who have also extensively evaluated the policy and payment implications of the RBRVS-based physicians' fee schedule.

As HCFA noted in the Preamble to the *model* fee schedule (55 Fed. Reg. 36178 (September 4, 1990)), this study and evaluation process "has been underway for a number of years" beginning with Congressional mandates in the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, has reflected "considerable effort" by all parties involved, and has produced no less than three reports to Congress. Id. Thus, the physicians' fee schedule reflects extremely detailed consideration from experts representing varied perspectives on all aspects of physicians' services, their resource inputs, the incentives and disincentives created by Medicare's reasonable charge payment methodology for such services, and the practical and policy implications of moving from the reasonable charge methodology to the RBRVS fee schedule.

No such consideration has occurred with respect to the portable x-ray industry and the issue of whether or how to integrate portable x-rays into the physicians' fee schedule. At this point, there has been no adequate analysis of the portable x-ray industry, its cost structures and its resource inputs, notwithstanding the study now being completed by the HHS Office of Inspector General ("OIG") pursuant to the Congressional mandate in Section 6134 of OBRA' 89. Although that study has made an attempt to analyze portable x-ray costs, the data received were inadequate to permit very reliable conclusions even about the limited subjects studied. This result is due in part to a relatively modest response rate.[3] Principally, however, it stems from the fact that the study instrument itself, a questionnaire concerning portable x-ray costs, was not designed in accordance with the cost accounting methods used by portable x-ray suppliers—despite extensive efforts by portable x-ray suppliers to explain these problems to the OIG

Moreover, even if the data obtained in this OIG effort could be considered a reliable picture of the costs of portable x-ray suppliers, the study still will not be able to answer the question that is critical to the issue of how to incorporate portable x-rays into the physicians' fee schedule: precisely how, in terms of costs and resource inputs, do portable x-rays differ from *radiologists'* services? Unfortunately, the mandate for the study did not direct that radiologists' costs of furnishing services be considered along with portable x-ray costs, thus making it impossible for the study to yield the comparative evaluation that would be necessary to answer this question.

In short, beyond the basic understanding that portable x-rays constitute a separate service from radiologists' services, HCFA is simply not armed with the detailed data and understanding that should be a prerequisite to establishing a method for incorporating portable x-rays into the physicians' fee schedule. Without such knowledge, it is premature, imprudent and unfair to propose such action. The inequity is compounded by the fact that HCFA's June 5 NPRM makes no specific proposal at all as to how portable x-ray transportation payments are to be determined under the fee schedule, thus potentially depriving the industry of a meaningful opportunity to comment.

While the portable x-ray industry is small and no doubt insignificant in the overall scheme of the fee schedule, that fact does not justify hasty action that would sweep portable x-rays into the physicians' fee schedule without due deliberation, treating portable x-ray reimbursement as an afterthought. Inasmuch as Medicare pays for about 95 percent of portable x-rays, such action would hardly be an afterthought to portable x-ray suppliers or the elderly patients who depend on their services.

2. *Unworkability of physicians' fee schedule methodology for portable x-rays.* A critical reason why it simply does not make sense to incorporate portable x-rays into the physicians' fee schedule at this time is that the concepts and categories upon which the RBRVS itself is based do not apply or do not work in the portable x-ray setting. Each of these key concepts and categories is discussed below.

a. *RVUs generally.* Overall, RVUs designed for radiologists' services may very well not reflect the *relative value* differences between portable x-rays. An assumption underlying any RVUs for radiologists' office or hospital x-rays is that the

[3] The OIG study team has informed NAPXP representatives that they received 46 responses to about 100 questionnaires sent to portable x-ray suppliers; however, the OIG team has also stated that the response rate for the organized industry, *NAPXP members*, was much higher—*80%*.

nature of patients is constant from one procedure to another, and therefore differences in the values of procedures can be based solely on the resource inputs of the physician. In the portable x-ray setting, precisely the opposite is true. The principal circumstance that differentiates one particular portable x-ray procedure from another is not what body part (i.e., what procedure code) is being addressed, but rather the condition of the patient being x-rayed at the particular day and time in question.

It must be emphasized that a critical aspect of the portable x-ray business is that it serves an almost exclusively geriatric clientele. Patients receiving x-rays in a radiologist office can generally be expected to be the same in that they are ambulatory, of average hearing, of sufficient intelligence to comprehend and follow the instructions of the doctor or technician, cooperative in attitude, robust (i.e., not susceptible to orthopedic injury during the procedure), and not suffering from incontinence. In contrast, geriatric patients who are x-rayed in their nursing home beds vary widely among each other because of the numerous conditions that may be found in elderly people and that have a significant impact on the duration and difficulty of the portable x-ray. For example, one patient may be senile, another lucid; one may be cooperative, another combative; one may be incontinent, another not; one may be suffering from extreme osteoporosis or other bone frailty that renders him/her susceptible to orthopedic injury, another not; one may be extremely hard of hearing or deaf, while another may be able to hear the technician extremely well; one may have palsy and move or shake during the procedure, requiring a repeat, while another may hold perfectly still; etc. Again, these differences between patients are by far the most significant contributing factors to differences between one particular portable x-ray procedure and another. Thus, the RVUs of the physicians' fee schedule, which assume a relatively constant patient, are entirely inapplicable to portable x-rays.

b. *RVU components.* Further, each of the components of the RVUs in the physicians' fee schedule that are to be applied to the technical component of portable x-rays, practice expense and malpractice expense, is extremely ill-suited to portable x-rays.

First, with regard to *malpractice*, there is no comparability between the RBRVS concept and the portable x-ray situation. Portable x-ray suppliers do not carry significant amounts of malpractice insurance. The principal reason for most portable x-ray suppliers to carry malpractice insurance is to cover the physician's interpretation in the case of global billers (portable x-ray suppliers who bill for their own services and also bill for the outside physician's interpretation). Portable x-ray suppliers more commonly carry general liability insurance. Insurance generally constitutes a more insignificant percentage of their overall costs (0-5 percent) than malpractice insurance does of physicians' costs (12 percent [4]).

Second, portable x-ray *practice expense* includes very significant cost items (including film, vans and portable x-ray machines, and their maintenance and depreciation [5]) that are not found in physicians' offices and were therefore not identified as input components of overhead for the physicians' fee schedule.[6] Further, portable x-ray overhead constitutes a far greater proportion of total revenues (75%-85%) than physicians' overhead does (40.2%, *see* 56 Fed. Reg. 25816).

Thus, none of the components of the total RVUs in the physicians' fee schedule make sense for portable x-rays, and the underlying methods by which these components were quantified for purposes of the physicians' fee schedule cannot be used for portable x-rays.

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[4] A chart in the NPRM (56 Fed. Reg. 25816) lists the proportions of *gross revenues* represented by physician work, malpractice and overhead across specialties. The *total costs* (represented by overhead and malpractice together) are 45.8 percent of gross revenues. Malpractice represents 5.6 percent of gross revenues and, therefore, 5.6% ÷ 45.8% = 12.2% of total costs.

[5] Another important cost incurred by portable x-ray suppliers that is *not* captured by the RBRVS overhead category relates to physician interpretations of portable x-rays. Because Medicare payments for the reading of x-rays such as chests and hips ($8.00-$14.00 per procedure, depending on locality) *already* do not compensate most radiologists adequately for the costs of performing the service, billing, collection, and bad debt, many radiologists demand that portable x-ray suppliers pay them a supplement to Medicare payments as a condition for providing portable x-ray interpretations. This situation will become more aggravated as radiologists' payments for interpreting portable x-rays fall dramatically under the fee schedule, particularly because portable x-ray procedures are the least remunerative radiology procedures for physicians to interpret.

[6] The NPRM identifies physician overhead components as employee wages, office rents, and equipment/supplies. *See* 56 Fed. Reg. 25816.

c. *GPCIs.* In terms of concept and methodology, the geographic practice cost indices ("GPCIs") of the physicians' fee schedule are also inapplicable to portable x-rays. Conceptually, the kinds of geographic variations that exist from one locality to another for physicians are unlike the kinds of geographic variations that can affect the portable x-ray service.

Because of the very fact that they are mobile services, portable x-rays are affected by actual physical geography and the urban/rural character of a locality in a way that physicians' services are not. For example, the cost of furnishing portable x-rays may be significantly greater in a highly rural area than in a suburban area because the significantly greater mileage that must be travelled increases the time required to complete each procedure and the costs of gas, depreciation and maintenance for portable x-ray vans. Similarly, the extremely dense traffic conditions that may exist in a highly urbanized setting may make portable x-rays more time-consuming to provide in that setting than in a suburban or less dense urban area. The quality of roads and difficulty of terrain also affect the time and difficulty involved in delivering the service and the cost of van maintenance and depreciation. Additionally, weather conditions significantly affect the costs of performing portable x-rays because harsh weather adds to total transportation time and significantly increases the costs of maintaining vans.

In the case of physicians' services, on the other hand, the differences from one locality to another are determined by differences in the costs of malpractice insurance—a cost category that does not play the same role in the portable x-ray business—and cost of living conditions. Geography and weather conditions play no role in differentiating localities for purposes of physicians' services.

Additionally, the GPCI methodology used in the RBRVS could not be applied to portable x-rays because of the very limited role of malpractice insurance in the portable x-ray industry and the very different allocation of costs among overhead and other items in the portable x-ray service as compared to physicians' services. Thus, the entire GPCI methodology would be inappropriate for portable x-rays.

In short, portable x-rays should not be included in the proposed physicians' fee schedule because the entire methodology for the new fee schedule was designed for physicians, *not* nonphysician technologists, and there has been no study of the portable x-ray industry or the relationship between portable x-rays and physicians' services upon which to base incorporation of portable x-rays into the fee schedule.

CONCLUSION

For the foregoing reasons, the NAPXP seeks the support of Congress in persuading HCFA either to use its discretion to exempt portable x-rays from the physicians' fee schedule—at least until such time as there has been adequate study of the portable x-ray industry for this puprose—or, at a minimum, to maintain budget neutrality with respect to portable x-ray payments in 1991 to avoid decimating this valuable industry.

Attachment.

ATTACHMENT 1

IMPACT OF THE PROPOSED PHYSICIANS' FEE SCHEDULE
ON PRE-TAX PORTABLE X-RAY PROFITABILITY*

Company Locality	1991 $ Profit	1991 % Profit	1992 $ Profit**	1992 % Profit	1991-1992 % Change ($ Profit)
CA_1	15,543	?	(124,957)	(?)	(?)
CA_2	171,430	3.22%	(162,292)	(3.25%)	(200.9%)
CN_1	24,700	9.5%	(246,485)	(?)	(?)
CN_2	(733)	(.001%)	(40,399)	(?)	(?)
DE/PA	4,505	0.13%	(1,280,495)	(56.44%)	(28,523.86%)
FL_1	50,000	9.16%	(32,200)	(6.44%)	(170.3%)
FL_2	132,340	9.1%	(137,380)	(9.44%)	(203.81%)
FL_3	(150,600)	(4.8%)	(1,051,632)	(30.71%)	(598.29%)
FL_4	21,670	2.8%	(354,580)	(?)	(?)
GA	32,710	4.2%	(8,953)	(1.17%)	(127.37%)
MA/NH/ME	658,204	6.86%	(6,056,796)	(209.90%)	(1,020.2%)
NE	(12,990)	(3.42%)	(53,655)	(14.14%)	(313.05%)
OH_1	267,300	9.27%	(67,738)	(2.35%)	(125.34%)
OH_2	2,040	0.18%	(107,802)	(9.75%)	(5384.41%)
OH_3	91,050	9.37%	(9,618)	(0.99%)	(110.56%)
OH_4	14,800	3.44%	(61,377)	(?)	(?)
OH_5	11,390	4.61%	(16,632)	(6.73%)	(246.02%)
OK_1	4,320	1.33%	(79,828)	(24.49%)	(1947.87%)
OK_2	(72,015)	(22.98%)	(130,777)	(41.74%)	(81.60%)
PA	228,693	5.45%	(1,270,179)	(47.10%)	(655.41%)
TX_1	(337,921)	(26.5%)	(499,075)	(44.80%)	(69.0%)
TX_2	23,250	(2.06%)	(50,704)	(4.5%)	(318.08%)
MA	35,262	?	(71,888)	(?)	(?)
Total Cos.: 23					

Simple average 1991 profit margin (total 1991 profit margin ÷ 17 companies): 1.98%
Simple average 1992 profit margin (total 1992 profit margin ÷ 17 companies): (30.23%)
Simple average profit margin decrease (total 1992 profit margin decrease ÷ 17 companies): (2,316%)

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* Assumes no transition rules, i.e., full impact of new fee schedule in 1992.

** Assumes 1992 global/technical payments are computed per proposed physicians' fee schedule; 1992 transportation payments are the same as 1991 transportation payments; 1992 costs are the same as 1991 costs.

ATTACHMENT 2

METHODOLOGY USED IN ESTIMATING IMPACT OF PROPOSED PHYSICIANS' FEE SCHEDULE ON PORTABLE X-RAY PROFITABILITY

The methodology used by the National Association of Portable X-Ray Providers ("NAPXP") in assessing the impact of the proposed physicians' fee schedule on portable x-ray profitability was as follows.

Sample selection: The sample of portable x-ray companies for this calculation was chosen in effect randomly, by requesting members of the NAPXP Board of Directors and Legislative Committee to perform the calculation described below for each company they own and/or control. The resulting sample of 23 companies is varied in size and geographically, representing 14 states and 7 regions.

Assumptions: For purposes of this calculation, two assumptions were made: 1) that no transition rules would be in effect, i.e., that the full impact of the proposed physicians' fee schedule would be felt in 1992 (this assumption was simply made for purposes of simplification); 2) that technical component and professional component (if applicable) payments to portable x-ray suppliers would be calculated pursuant to the RVUs and conversion factor in the proposed physicians' fee schedule, but transportation component payments for portable x-ray suppliers would remain the same as they are in 1991; and 3) that each company's costs in 1992 would be the same as in 1991.

Calculation steps: The following steps were used in the calculation:

1. Identify those codes representing 75%-80% of technical and/or professional component procedures.

2. For each code, list the 1991 technical/global payment.

3. Calculate the estimated 1992 fee schedule payment by multiplying the geographically adjusted RVUs for the procedure times the $26.87 conversion factor.

4. Determine the decrease per procedure by subtracting (3) from (2).

5. Determine the total decrease for each code by multiplying the results of (4) by the 1991 annual frequency for the procedure.

6. Sum the results in (5) to obtain the total 1992 decrease for the identified procedures.

7. Estimate the company's total revenue decrease for 1992 by "grossing up" the total in (6) by dividing that number by the percentage of total technical/global procedures represented by the identified codes.

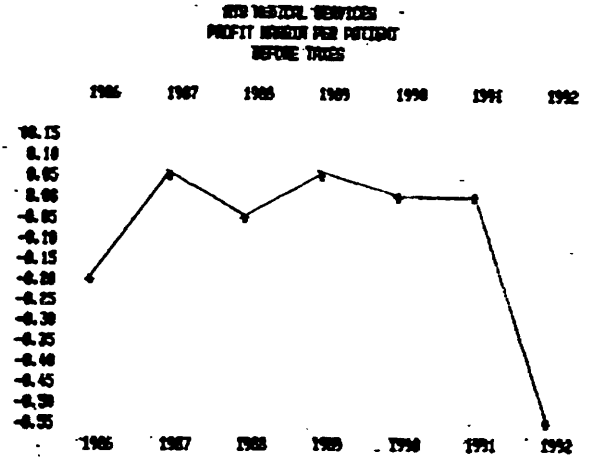
8. Subtract the total in (7) from 1991 gross revenues to obtain estimated 1992 gross revenues.

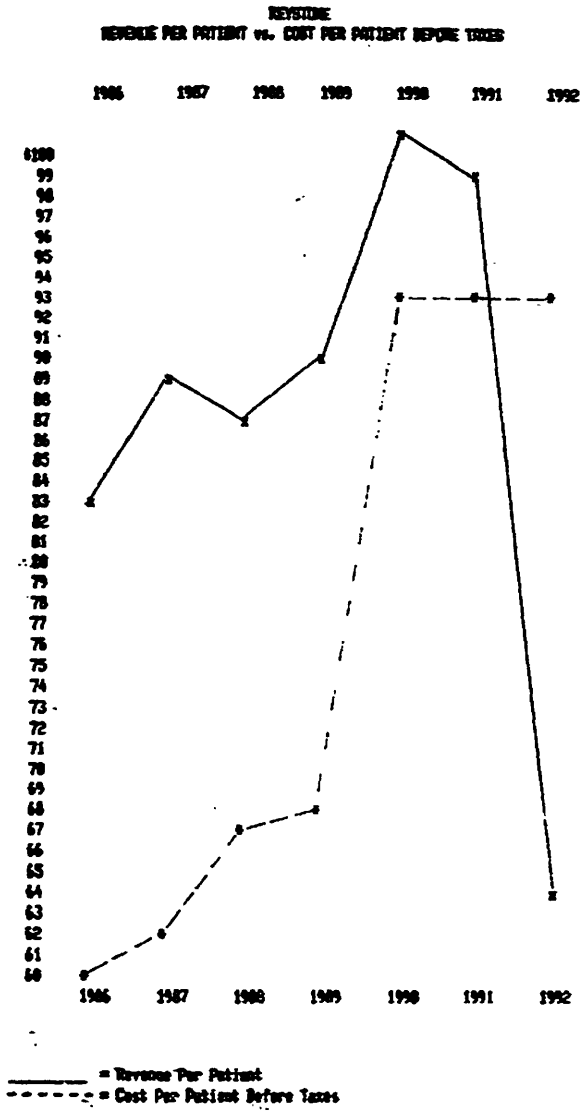
9. Using the 1992 estimated gross revenue figure in (8) and total costs from 1991, calculate dollar profit and % profit margin for 1992.

10. Calculate the decrease in profit margin from 1991 to 1992.

Aggregation procedure: Estimates of aggregate impacts of the proposed physicians' fee schedule on the entire industry were made by taking a simple average of the 1991 profit margins, a simple average of the 1992 profit margins, and a simple average of the profit margin decreases.

Attachment 3




REVISION
REVENUE PER PATIENT vs. COST PER PATIENT BEFORE TAXES
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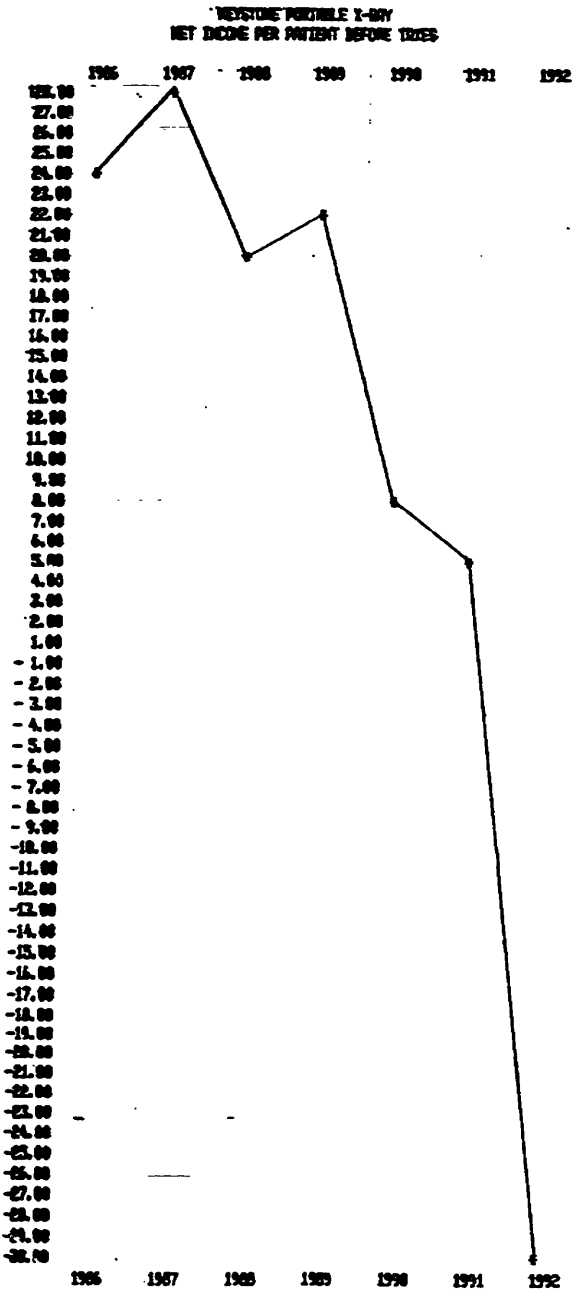
1987
1988
1989
1990
1991
1992
= Revenue Per Patient
= Cost Per Patient Before Taxes


KEYSTONE PORTABLE X-RAY
NET INCOME PER PATIENT BEFORE TAXES
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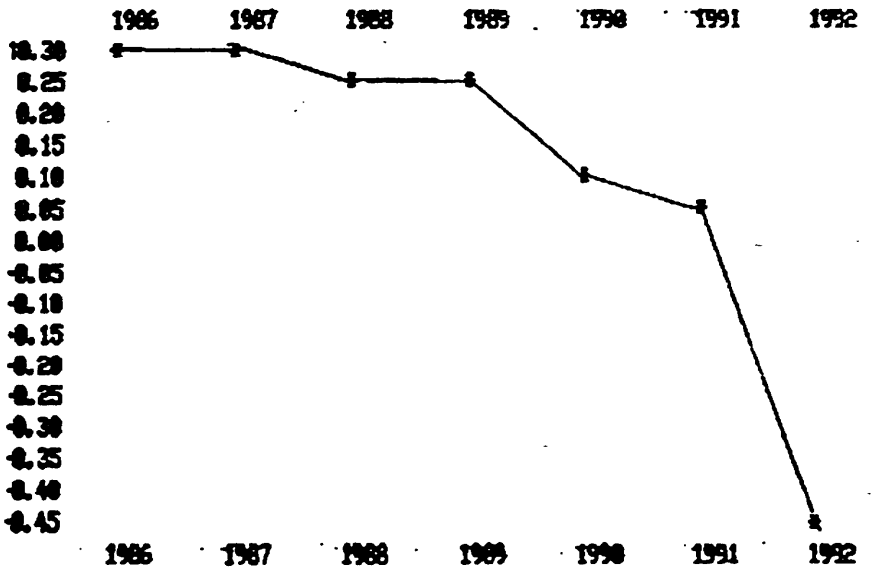
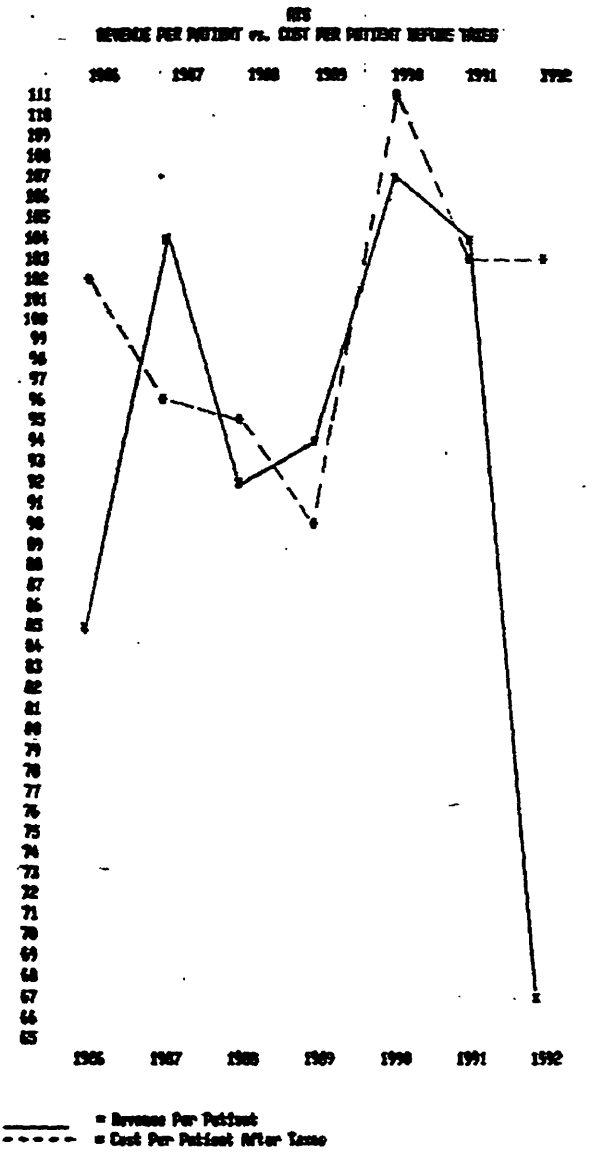
1987
1988
1989
1990
1991
1992

KEYSTONE PORTABLE X-RAY
PROFIT MARGIN BEFORE TAXES




1986
1987
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1990
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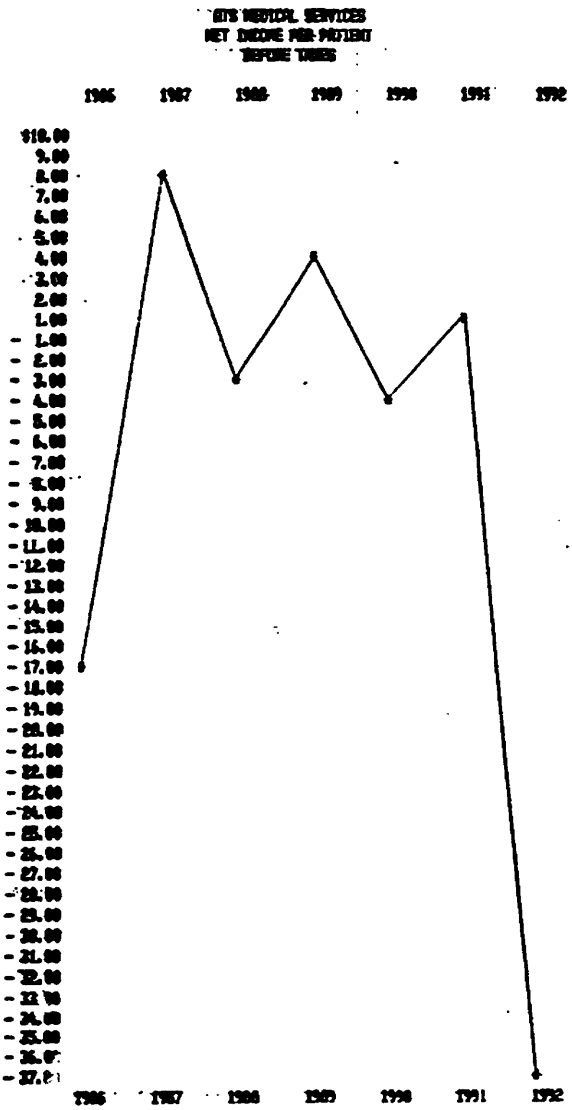
= Revenue Per Patient
= Cost Per Patient After Taxes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1991
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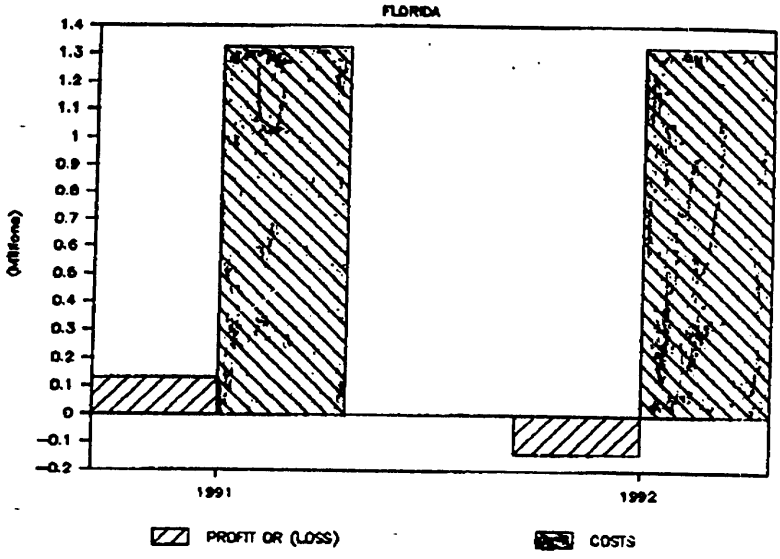
EFFECT OF PHYSICIAN PAYMENT REFORM



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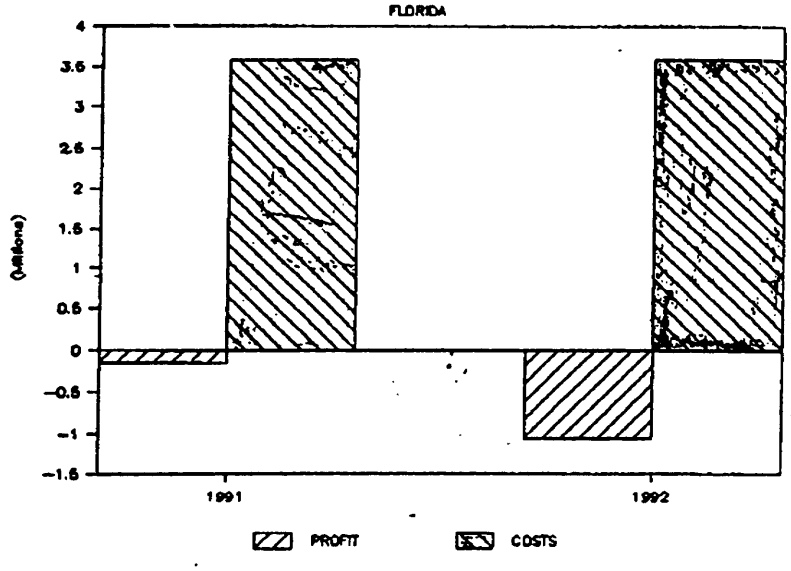

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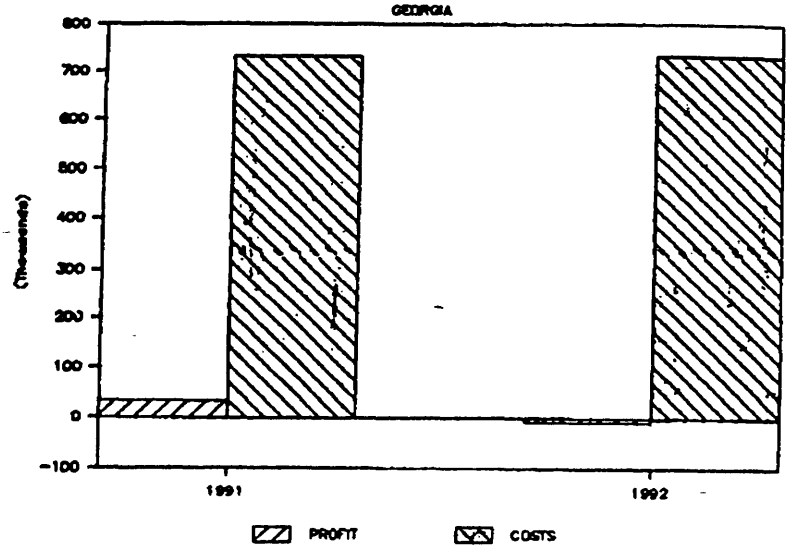

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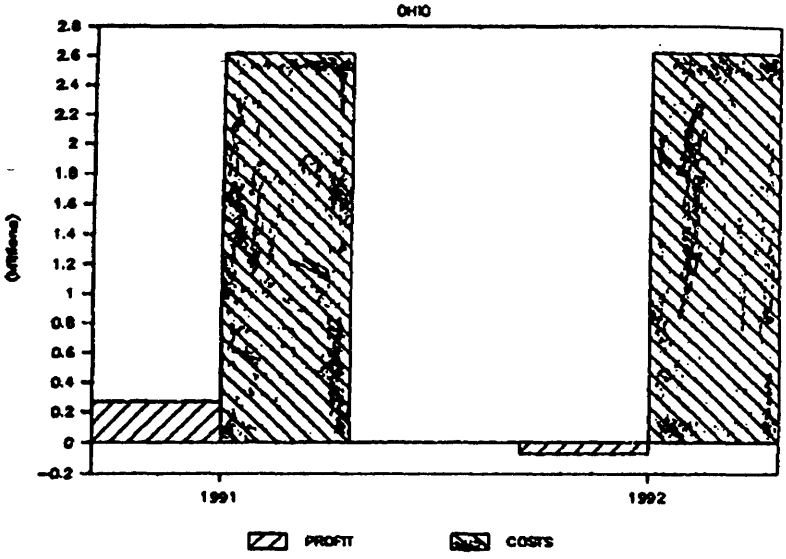

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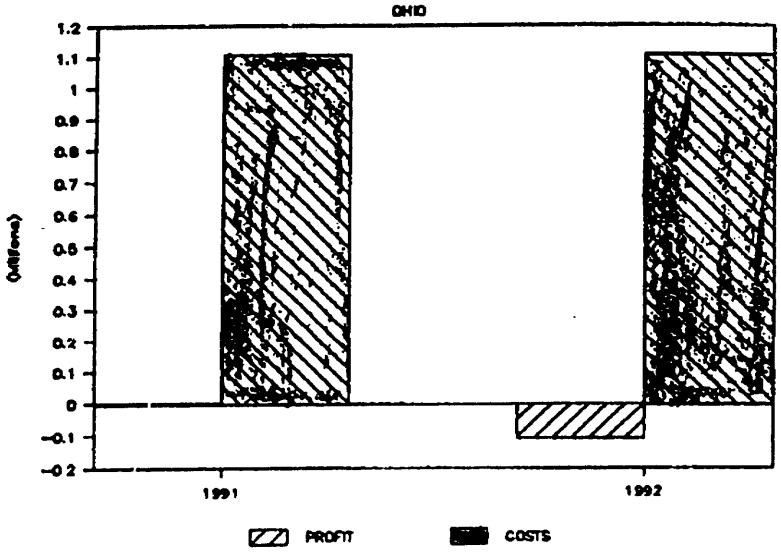

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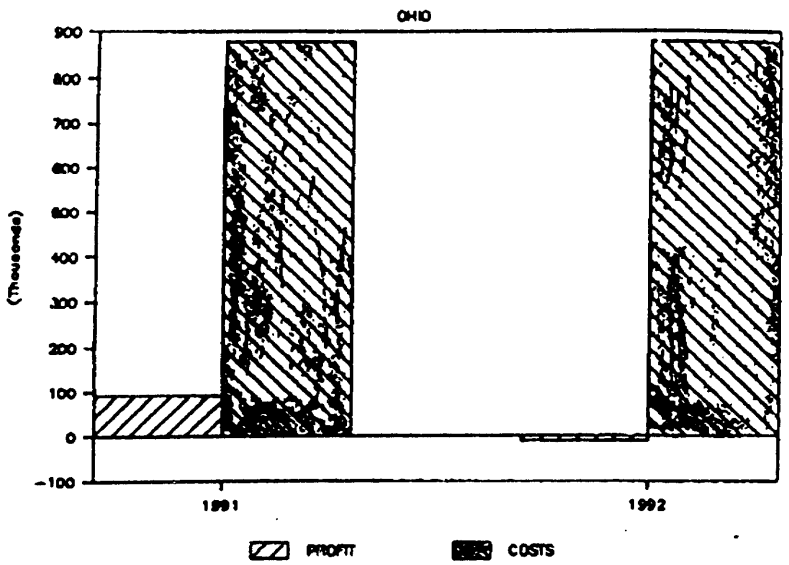

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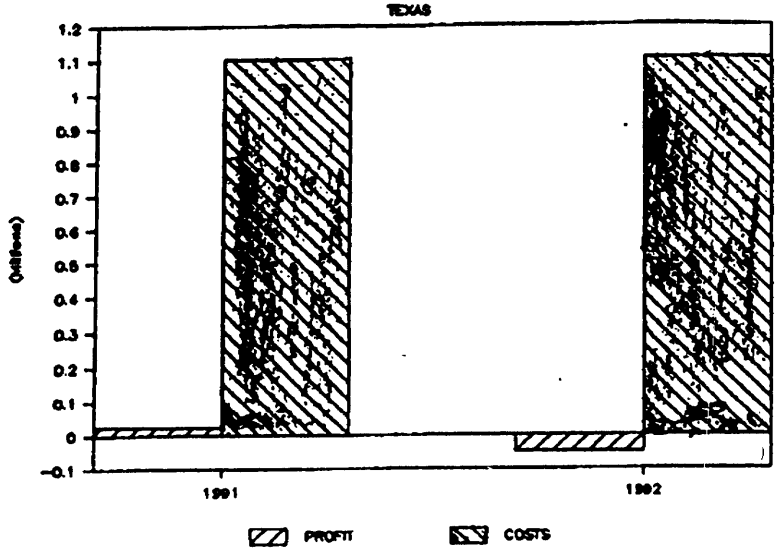

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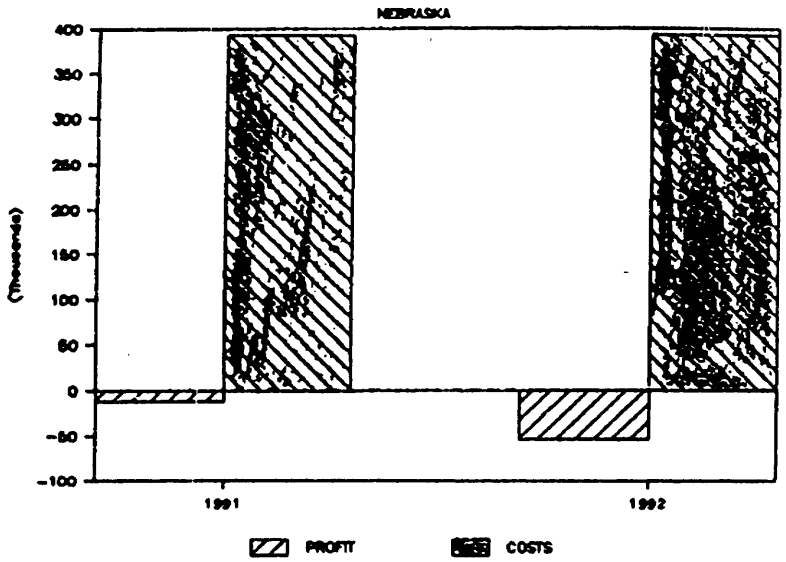

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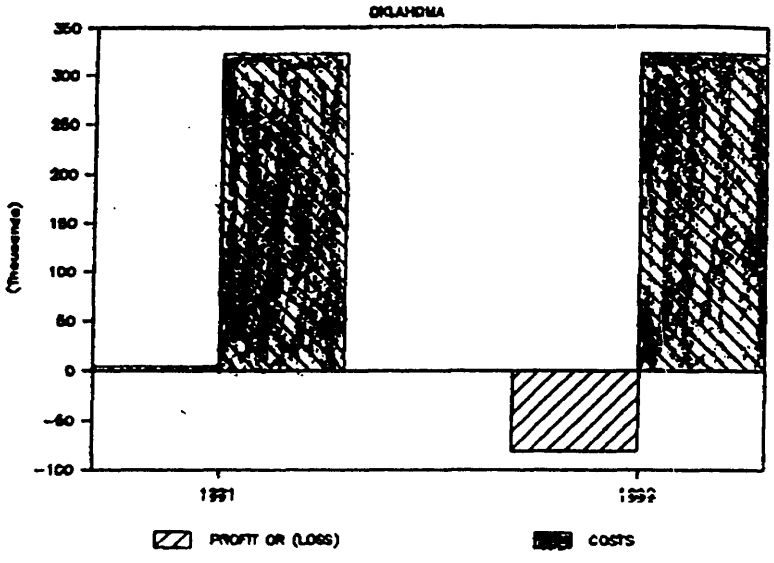

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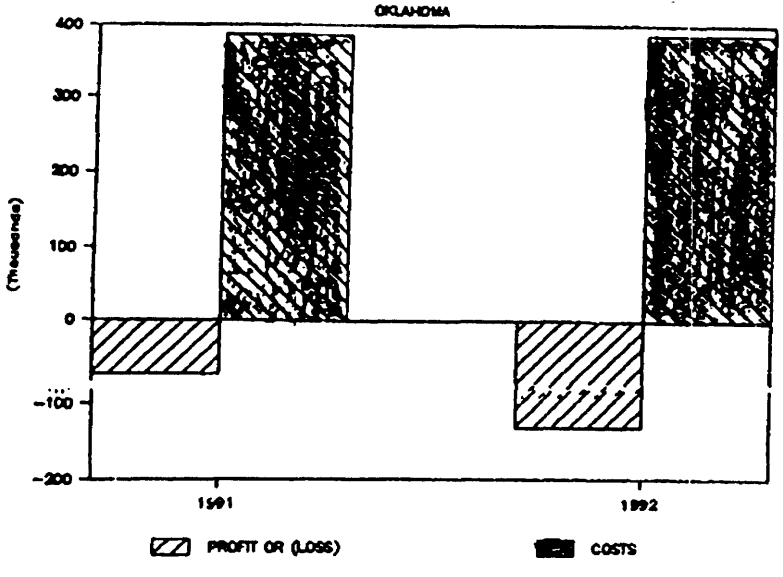

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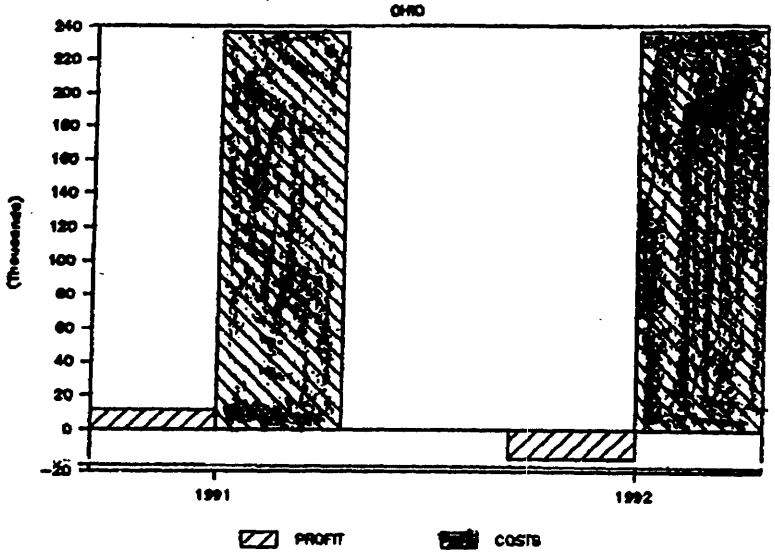

COMPARISON OF MEDICARE PORTABLE X-RAY PAYMENTS & AMBULANCE/HOSPITAL X-RAY CHARGES SELECTED LOCALITIES 1990

LOCALITY	ROUNDTRIP AMBULANCE[c]	EMERG. ROOM	RAD. DEPT. (X-RAY)	PHYS.FEES (RAD.AND/OR EMERG.RM.)	TOTAL HOSP.	PORTABLE X-RAY	PORT. X-RAY INTERP.	TOTAL PORT. X-RAY	AMB.-PORT. X-RAY
Tarzana, CA	302.00	135.00	86.50[a]	150.00	673.50	104.16[a],[g]	N/A	104.16	6.47
Plantation, FL	400.00	59.00	90.00[a]	50.00	599.00	90.25[a]	13.74	103.99	5.76
Tamarac, Davie, Plantation, Coral Springs, Hollywood, Margate, Sunrise, Hallandale, Cooper City and Lauder Hill, FL (2 hospitals)	306.00	59.50	120.00[b]	65.00	550.50	90.25[b]	13.74	103.99	5.29
	306.00	102.65	115.00[b]	115.00	638.65	90.25[b]	13.74	103.99	6.14
Clearwater, FL	270.00	96.50	80.15[a]	83.15	529.80	85.99[a]	13.14	99.13	5.34
St. Petersburg/ Tampa, FL	314.40	31.07[d]	98.72[a],[d]	N/A	444.19	98.09[a]	N/A	98.09	4.53
Miami, FL	352.00	156.67[d]	99.00[a],[d]	N/A	607.67	98.09[a]	N/A	98.09	6.19
Boston, MA	299.00	100.00	127.00[a]	13.64	539.64	163.64[a]	11.18	174.82	3.09
Quincy, MA	318.12	84.00	61.75[a]	13.74	477.61	163.64[a]	11.18	174.82	2.73
Lima, OH	318.00	75.00[d]	64.85[a],[d]	N/A	457.85	97.46[a]	N/A	97.46	4.70
Cleveland, OH	268.00	93.80[d]	68.28[a],[d]	N/A	430.08	97.01[a]	N/A	97.01	4.43
Central OH	226.00	54.95[d]	65.50[a],[d]	N/A	346.45	95.28[a]	N/A	95.28	3.64
Dayton, OH	238.00	32.18	55.63[a],[d]	N/A	325.81	98.04[a]	N/A	98.04	3.32
Newport, RI	176.38	69.00	13.09[a]	12.44	271.11	99.44[a],[g]	N/A	99.44	2.73

[a] Chest x-ray
[b] Hip x-ray
[c] Excludes oxygen fee; assumes 6-mi. round trip
[d] Average of area hospitals
[g] Global billing

STATEMENT OF THE PATHOLOGY PRACTICE ASSOCIATION

The Pathology Practice Association is a national association of pathologists from private practice, hospitals, independent laboratories, and academia. We appreciate the opportunity to comment on the proposed Medicare fee schedule, published in the June 5, 1991 Federal Register.

The proposed fee schedule is a disaster for many in the pathology profession. By the time cuts based on the relative value assigned to pathology services are combined with additional cuts based on budget neutrality as well as on expected changes in volume and intensity of service, the impact on pathologists is devastating.

Although the proposed rule estimates average cuts in pathology fees starting at 6% the first year and rising to 30% by 1996, pathologists in some localities report they would face reductions of up to 60%.

Historically, Medicaid reimbursement rates have been among the lowest in the country. In California, those Medicaid (MediCal) rates have not changed in ten years. Yet, reimbursement rates proposed in the Medicare fee schedule will be even lower than decade-old MediCal rates for some pathology services. For example, the proposed fee for code 88300 (Surg,Path,Gross) in the state of California is approximately $6.27 for the professional component. That is 32% below MediCal's $9.12 payment rate for the last ten years for the same service. For code 88304 (Surg,Path,Gross and Micro), MediCal has paid a rate of $30.40 for the last ten years. In contrast, the proposed fee schedule contemplates a payment of $18.03 for the professional component, 41% less than the MediCal rate. Only transition rules which phase in the cuts would soften the devastating impact.

We cannot believe Congress intended cuts of this magnitude. The RBRVS was intended to provide an equitable redistribution of payments for services among the various medical specialties. However, if one examines the effect of HCFA's proposed changes on pathologists' net income, based on HCFA's assumptions and on published income data, the shifts are dramatic and inequitable.

We believe that the inherent unreasonableness and inequitability of the RBRVS is illustrated by examining the effects of the payment changes on net income for pathologists and family physicians if all payors adopted the proposed Medicare payments. For example, 1988 data, attributed to the Medical Group Management Association, reported that the median net income for pathologists was $139,000. (Median net income is not the same as mean net income in HCFA tables, but for purposes of general analysis is used below.) Using HCFA's assumptions on overhead expenses, a pathologist making that median income would have to gross $199,000. If pathologists are to expect a 30% cut in payments when the RBRVS is fully implemented, then their median gross income should be expected to drop to approximately $139,000, out of which they must still pay some $60,000 in overhead. That would leave a median net income of only $79,000 for pathologists, a 43.1% reduction from the 1988 median net income figure.

Contrast that outcome with a family practitioner who, according to the same source in 1988, was making a net median income of $90,000. Because of high overhead expenses (as demonstrated in HCFA's tables), a family practitioner with that median net income would have to gross $205,000. According to the new fee schedule, family practitioners can expect an ultimate 15% increase in their fees which would bring the gross income figure up to $236,000. Family practitioners' overhead, as before, would remain about $115,000 which, when deducted from the new median gross income level, leaves a net income of $121,000, a 33% increase in net income.

This analysis suggests a staggering shift in net income among medical specialties, leaving pathology at the bottom. We fear that if implemented, these radical changes will drive future physicians away from pathology and lead to shortages in pathology manpower to the detriment of medical colleagues and Medicare beneficiaries alike.

We join many of our colleagues in the medical profession in protesting the formula for determining the proposed fees. Our concerns are two-fold: the conversion factor and the relative value scale.

With respect to the conversion factor, we must oppose the 10.5% cut based on HCFA's judgments on anticipated changes in volume and intensity of services. Pathologists as a specialty should be excluded from this cut since they do not control the frequency of their services. Rather, volume and intensity of service is determined by how often surgeons and other physicians operate or request a biopsy. That is beyond our control and thus is an inappropriate basis on which to penalize pathologists with additional cuts to already reduced fees.

Similarly, we join with many in the medical profession in protesting the across-the-board 6% cut to the conversion factor which HCFA has proposed to ensure

budget neutrality. We encourage HCFA to work with Congress and the various interested parties to find an alternative to meet budget goals without the arbitrary effects of the current approach.

Although pathology values were restudied, the new fee schedule is more detrimental than the model schedule published last year. While Harvard researchers have demonstrated reproducibility of some of the results, they cannot verify that the results are accurate and reasonable. In particular, HCFA should reexamine the data on which it bases overhead expenses relating to practice and malpractice costs. These costs can run significantly higher than HCFA's tables would suggest.

In general, it is our view that the proposed Medicare fee system is inherently unreasonable for all medical services. For example, a pathologist would receive $5.64 in reimbursement from Medicare for examining a gross specimen, making a diagnosis, and dictating and reviewing a report. What service, provided by any profession, is reimbursed at such a low rate? Further, why should a plumber in Alexandria VA who makes a nighttime service call be able to charge $67.50 for a half hour when a pathologist in that community who makes a nighttime consultation during surgery (88331) will be paid approximately $46.79 or 30% less than a plumber?

We welcome HCFA's statement in the proposed rule that it will look at RVUs on an annual rather than five-year basis. Clearly, further work needs to be done on the RVUs for pathology services before those in the profession have confidence in its fairness.

We also take note of HCFA's proposal to use 15% of the 1991 adjusted historical charge as the basis for the technical component of pathology services pending receipt of more definitive data from Abt Associates. We view a 15% level of technical reimbursement as inadequate and urge HCFA to adopt a more flexible approach than a flat 15% for technical costs for all services.

It is not possible to determine, based solely on site of service, whether a pathologist is paying for technical costs. For example, while it is commonly assumed that charges from hospital-based pathologists are for the professional component only, some hospital-based as well as independent laboratory-based pathologists bear the technical cost for inpatient pathology. Some hospitals demand that pathologists pay for inpatient technical costs in order to maintain their hospital contract, even though these costs for Medicare patients are being reimbursed to the hospital through the DRG payment.

The technical costs of providing pathology services also vary significantly for different CPT codes, and case mix depends heavily on site of service. For that reason, technical costs cannot be expressed as a fixed percentage of total charge for the different CPT codes. Furthermore, case mix may be considerably different even within one type of service site. For example, the mix of services provided in a 50-bed rural hospital will be dramatically different than that at a tertiary care center with an emphasis in oncology. Thus, a fixed percentage factor for technical costs applied uniformly to all CPT codes would be unfair.

The technical component is a significant cost that must be recognized and reimbursed fairly. It must be distinguished from practice overhead as the latter is applied to both the professional and technical component. It should also be paid directly to the provider bearing the cost of the technical services.

We appreciate the opportunity to share our views on the proposed fee schedule and hope HCFA will make appropriate adjustments in implementing the final rule.

STATEMENT OF THE RENAL PHYSICIANS ASSOCIATION

The Renal Physicians Association (RPA) is pleased to provide a statement to the Committee on Finance, Subcommittee on Medicare and Long-Term Care, on Medicare payments to physicians under the resource-based relative value scale (RBRVS) and the Administration's Notice of Proposed Rulemaking to implement the new Medicare physician fee schedule.

RPA appreciates Chairman Rockefeller's and the Subcommittee's commitment to ameliorate the problems inherent in the Notice of Proposed Rulemaking (NPRM) on the RBRVS while moving forward with a Medicare Fee Schedule which is both fair and equitable. While RPA will provide comments to HCFA on several areas of concern, we will focus our comments here on the most problematic to all of organized medicine -- the reductions to the conversion factor.

REDUCTIONS TO THE CONVERSION FACTOR

If the proposed rule were implemented as written, drastic, unnecessary and unanticipated reductions in physician fees of over $12 billion would be realized by 1996, due to conversion factor reductions of 16 to 22 percent, despite Congress' clear intent that transition to the new MFS be budget neutral and that Medicare physician payment reform not be used as a budget cutting device. It is because of these reductions to the dollar conversion factor, more than any other reason, that physician payments will be so much lower than originally intended by Congress. For some of these reductions, we realize that HCFA is constrained to the letter of OBRA '89, and therefore call upon the Congress to correct for them through legislative action. But, Congress need also mandate HCFA in other areas to reverse all of the unnecessary reductions to the dollar conversion factor proposed by HCFA which threaten the budget neutrality upon which physician payment reform was based.

The following briefly describes the conversion factor (CF) reductions proposed by HCFA:

Behavioral offset adjustment: By assuming that physicians will offset 50% of every dollar in lost revenue due to fee reductions, HCFA proposes to lower the conversion factor by 10.5 percent. HCFA does not attribute any dollar savings to the offset since they claim that the offset is required to prevent any increase in overall outlays under the fee schedule. However, HCFA staff have estimated that without this offset, $4.5 to $5 billion would remain within the Medicare physician expenditure pie by 1996.

RPA maintains that no behavioral offset assumption be employed by HCFA because we believe that the Volume Performance Standards will take care of any unanticipated increase in volume as they provided a mechanism for HCFA to recommend lesser updates if expenditures exceed the target. Regarding HCFA's arguments against having the VPS take care of all unanticipated volume increases, if problematic, Congress could simply recommend greater reductions in updates if merited, or change the default formula. Additionally, given the great uncertainty admitted by HCFA, the Congressional Budget Office (CBO), and the Physician Payment Review Commission (PPRC) as to physician responses to the new payment system, and the lack of substantial data on the subject (even the most relevant data employed by HCFA on this issue (Christensen) is severely limited -- it is outdated (1976), only general practitioners and internists were studied, the data was gathered from a single state, etc.), Congress should legislate that HCFA be prohibited from using a behavioral offset assumption in its calculation of the conversion factor. Anything less will fall short of the goals of physician payment reform should physicians be penalized unnecessarily.

Transition rules adjustment: Because of an unintended consequence of the transition rules for phasing in the new fee schedule (the fact that more services will receive full increases to the RBRVS rates in 1992 than will receive reductions to the full final RBRVS rates), HCFA believes that overall outlays in 1992 would be two percent in excess of budget neutrality. To "correct" for this, HCFA proposes a 6.2 percent reduction in the CF. In the proposed rule, HCFA acknowledged that this will result in outlays of physician services being $3 billion less than if the transition adjustment was not made; but HCFA staff now say that by 1996 a total of $7 billion would be saved in order to make the MFS budget neutral in 1992.

The reductions in the conversion factor appear larger than would be required to adjust for budget neutrality. For example, a 6.2 percent reduction to the CF to adjust for a predicted initial increase of outlays of 2 percent due to the transition rules seems inflated. This results in a threefold reduction in the CF to offset expected increases in outlays, an effect known as the "tripling" effect.

Crosswalk to the new visit codes: It is likely that the transition/behavior adjustments actually understate how much that HCFA has reduced the conversion factor. The staff of the Physician Payment Review Commission believe, based on a preliminary estimate, that HCFA's assumptions on the frequency that new visit codes will be billed (called the "crosswalk" by HCFA) may have reduced the CF by another 3-5 percent from what would have been the case if different assumptions were used. Instead of an almost 17 percent reduction in the CF, the reductions made by HCFA may be as great as 22 percent when the "crosswalk" assumptions are also taken into consideration.

SUMMARY OF HCFA'S CONVERSION FACTOR REDUCTIONS

-10.5%	behavioral offset – no "savings" estimated by HCFA, but physicians fees would be reduced $4.5 to $5 billion by 1996
+ -6.2%	transition adjustment – $7 billion in savings by 1996
-16.7%	total conversion factor reduction due to these two factors alone – $12 billion in reductions by 1996
+ -5.0%	preliminary PPRC estimate of possible additional cut due to visit code crosswalk – no savings estimated by HCFA, but would translate into additional reductions in fees by 1996
-21.7%	possible total HCFA conversion factor reduction as opposed to true "budget neutral" CF – would translate into over $12 billion (plus savings due to an inaccurate projection in the "crosswalk" due to the new visit coding system) in reductions during the transition to the new MFS, despite Congress' intent that Medicare physician payment reform be budget neutral and not be used as a budget cutting devise.

Physician payment reform will be undermined if Congress does not act to reverse these cuts. Physician trust and faith in Congress and the Administration is at stake. RPA urges Congress to enact legislation which would return physician payment reform to the budget neutral basis on which is was intended. Congress should specifically:

(1) prohibit HCFA from employing a behavioral offset;

(2) correct the transition asymmetry problem and eliminate the "tripling effect" of applying all adjustments to the conversion factor and;

(3) correct for HCFA's "crosswalk" to the new visit codes if budget impacts show that it will further unnecessarily reduce the conversion factor.

RPA is sensitive to the pay-as-you-go budget rules passed last year, and would prefer alternatives that would not trigger it. However, we cannot stand by and watch physician payment reform be brutalized by HCFA and by technical drafting errors. RPA would be pleased to assist in the drafting legislative language which achieves the ends outlined above.

STATEMENT OF THE RURAL REFERRAL CENTER COALITION

The Rural Referral Center Coalition (the "Coalition") is pleased to submit these comments regarding hospital capital-related costs. The Coalition is an informal Coalition of approximately 80 hospitals which currently are designated as rural referral centers ("RRCs") under Medicare's prospective payment system ("PPS").

A CAPITAL PROSPECTIVE PAYMENT SYSTEM SHOULD NOT BE IMPLEMENTED

The Coalition strongly urges Congress to withdraw its mandate that Medicare payments for hospital capital costs become payable through PPS.

First, the PPS approach exposes many hospitals to a severe and potentially devastating reduction in capital reimbursement based on no evidence that the PPS fold-in is necessary towards cost containment of capital. American Hospital Association ("AHA") data, as well as preliminary data supplied to the Coalition by the health care consulting firm Lewin/ICF, contradicts Congress' and the Health Care Financing Administration's ("HCFA") position that a PPS fold-in is necessary to contain capital costs. Indeed, AHA's data reveals that capital has not grown as a percent of operating costs since the inception of PPS. For instance, AHA has found that annual increases in capital costs have averaged 10.5% since 1986 and that capital costs as a percentage of operating costs have remained at about 9% since PPS was implemented. See American Medical News, April 8, 1991, page 5. Lewin/ICF's data is consistent, finding an average yearly rate of increase in capital costs of 9.6% since Fiscal Year 1985 for all hospital groups and capital costs as a percentage of total Medicare costs and as a percentage of total Medicare revenues remaining at approximately 10% since Fiscal Year 1985 for all hospital groups. See attached charts. Accordingly, one can conclude that the present PPS system effectively contains hospitals' expenditures in general; it is not necessary to move to a capital PPS rule to achieve this end.

Second, RRCs as a class perhaps are exposed to a disproportionate risk that their capital reimbursement will be inadequate under the capital PPS fold-in since RRCs are being looked upon to assume an increasing burden in the rural health care marketplace which will necessitate possibly disproportionate investment in capital. For instance, Congress established the Essential Access Community Hospital ("EACH") Program in the Omnibus Budget Reconciliation Act of 1989 ("OBRA '89") which calls for the reorganization and centralization of the rural health care system. HCFA presently is implementing this program in seven states. Grants are being awarded to assist states in creating rural health care networks comprised of EACHs or RRCs as the central providers of inpatient health services with rural primary care hospitals as the providers of short-term (i.e., no longer than 72 hours) inpatient care. As such, RRCs are among those institutions which will provide the bulk of inpatient care to rural populations. As the transition to this type of system proceeds, RRCs' experience with capital costs likely will change. We are not presently able to predict exactly how these costs will evolve. However, we can surmise that a PPS approach will jeopardize the financial strength of many of these institutions. Further, the capital PPS rule perhaps erroneously assumes that capital expenditures result in excess capacity. Instead, capital investments frequently are

made to keep pace with technological advancement. Hospitals, and RRCs in particular which must provide state-of-the-art-services to rural communities, should not be put at risk for being able to maintain state-of-the-art-technology; indeed, the overall quality of health care is put at risk by this approach.

Third, the Coalition understands that institution of this system will expose all hospitals to greater credit worthiness scrutiny by lending institutions. Hospitals magazine recently reported that "the proposed capital fold-in regulations may harm hospitals' credit worthiness...'We can say that the effect on credit quality won't be positive; it'll be negative or neutral.'" Hospitals, April 20, 1991, page 38. Given the absence of any factual data to support the need for the capital PPS system in order to contain hospitals' capital expenditures, it would be entirely inappropriate to expose all hospitals to greater credit worthiness scrutiny and thereby risk their ability to maintain state-of-the-art capital.

Finally, the proposal would result in the redistribution of revenue from "high cost" providers to "low cost" providers without consideration of whether the low cost providers would make more effective use of the resources. In some cases, this proposal could move funds from a successful organization to one which is failing and which would continue to fail even with additional capital payments. This result would be contrary to the public interest. It also is an incorrect assumption that "high cost" hospitals have historically made imprudent investment decisions.

Specific Changes Requested

In the event that HCFA proceeds to implement the capital PPS rule, the Coalition specifically requests that Congress ensure that the following changes be incorporated:

1. The applicable geographic adjustment factor described in proposed 42 C.F.R. §412.316 should explicitly recognize that hospitals which are reclassified by the Medicare Geographic Classification Review Board ("MGCRB") for purposes of their wage index are entitled to application of this reclassification for purposes of the capital PPS calculation. The preamble to the proposal references this concept (55 Fed. Reg. at 8485), but the regulations do not specifically address the issue. Accordingly, the Coalition submits that the regulations should be amended to make it clear that hospitals which have had their wage indices reclassified under Social Security Act Section 1886(d)(8)(B) or (d)(10) should use the geographic adjustment factor from Table 2 for the Metropolitan Statistical Area ("MSA") to which the hospital has been reclassified. From an administrative standpoint, this would be the simplest approach. Use of the existing values in Table 2 would avoid the need to (i) calculate new geographic adjustment factors for those MSAs for which an alternative wage index will result from the reclassification of hospitals into those MSAs and (ii) determine to which of these new factors it would be appropriate to apply the 1.6% increase which HCFA has found to be applicable to certain large urban MSAs. Alternatively, HCFA could develop another set of geographic adjustment factors specifically appropriate to reclassified hospitals; these factors would be based on the revised set of wage indices which HCFA plans to publish to reflect changes necessitated by MGCRB determinations. At the very least, these are the indices upon which reclassified hospitals' geographic adjustment factors should be

based. Indeed, these new indices will serve as the wage indices for reclassified hospitals and HCFA explicitly states in the preamble to the proposed rule that the geographic adjustment factor is to be based on the wage index "that is applicable to hospitals under" PPS. 55 Fed. Reg. at 8484.

2. The definition of "old capital costs" under proposed 42 C.F.R. §412.300(b) should be revised to include any capital commitments (i.e., those listed in the definition of "new capital costs") which were entered into prior to October 1, 1991 instead of prior to October 1, 1990. Indeed, many hospitals currently are involved in construction efforts, debt issues, or capital acquisitions which were entered into prior to release of the proposed capital PPS rule; it would be unfair to penalize these institutions which made necessary capital investment decisions pending promulgation of the proposal.

Should you have any questions or require any further information, please do not hesitate to contact the Coalition's Washington Counsel, Wendy L. Krasner at 202/778-8064 or Sally A. Rosenberg at 202/778-8056.

4047C

Attachment

PPS-2 TO PPS-5 MEDICARE CAPITAL COSTS

Type Hospital	Capital Costs Per Case				Yearly Increase			Avg. Yearly Rate of Increase
	PPS-2	PPS-3	PPS-4	PPS-5	PPS2-3	PPS3-4	PPS4-5	
Total	$411	$470	$506	$541	14%	8%	7%	9.6%
Other Rural	260	301	324	338	16%	8%	4%	9.1%
Rural Referral Centers	326	378	405	436	16%	7%	8%	10.2%
Urban Small MSA	414	468	510	548	13%	9%	7%	9.8%
Urban Large MSA	496	566	604	646	14%	7%	7%	9.2%

PPS-2 TO PPS-5 TRENDS IN MEDICARE CAPITAL COSTS PATTERNS

Type Hospital	Capital Payments Proportion of Total Revenues				Capital Costs Proportion of Total Costs			
	PPS-2	PPS-3	PPS-4	PPS-5	PPS-2	PPS-3	PPS-4	PPS-5
Total	.093	.101	.100	.094	.106	.111	.109	.108
Other Rural	.106	.118	.116	.104	.112	.119	.119	.114
Rural Referral Centers	.100	.110	.107	.100	.113	.118	.115	.113
Urban Small MSA	.094	.101	.100	.093	.109	.112	.111	.108
Urban Large MSA	.089	.097	.096	.092	.102	.107	.106	.105