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RECOMMENDATIONS REGARDING MEDICARE HOSPITAL AND PHYSICIAN PAYMENT POLICIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

MARCH 20, 1997

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RECOMMENDATIONS REGARDING MEDICARE HOSPITAL AND PHYSICIAN PAYMENT POLICIES

THURSDAY, MARCH 20, 1997

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

The Subcommittee met, pursuant to notice, at 1:07 p.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 13, 1997
No. HL–7

CONTACT: (202) 225–3943

Thomas Announces Hearing on Recommendations Regarding Medicare Hospital and Physician Payment Policies

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on recommendations regarding medicare hospital and physician payment policies. The hearing will take place on Thursday, March 20, 1997, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include Dr. Joseph Newhouse, Chairman of the Prospective Payment Assessment Commission (ProPAC), and Dr. Gail Wilensky, Chairman of the Physician Payment Review Commission (PPRC). However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Medicare hospital and physician payments dominate the fee-for-service portion of the Medicare program. The Congressional Budget Office estimates that hospital payments will total $483 billion between fiscal years 1998 and 2002—about 68 percent of Part A fee-for-service payments. Physician fee schedule payments will total $372 billion during this same period, or about 46 percent of Part B fee-for-service payments. The President's fiscal year 1998 budget includes several provisions relating to these areas. These proposals will be examined in light of the recommendations from ProPAC and PPRC.

Since 1984, Medicare has paid for inpatient hospital services using a prospective payment system (PPS). This system offers incentives for hospitals to provide care in an efficient manner. At the same time, the inpatient hospital PPS recognizes the higher costs incurred by some institutions. The President's fiscal year 1998 budget includes several provisions related to hospitals including reducing the inpatient operating and capital payment rate updates, reducing the amount of additional payments to teaching and disproportionate share hospitals, and reducing payments for outlier cases. In addition, the President proposes to establish a PPS for outpatient services. In its March Report to Congress, ProPAC made several recommendations regarding these and other hospital payment issues.

In 1992, Medicare began reimbursing physicians using a resource-based relative value scale (RBRVS) system. At the same time, Medicare began to set annual volume performance standards for the rates of increase in Medicare physician expenditures and began to limit the amount of copayments that non-participating physicians could charge beneficiaries. Under the RBRVS system, each physician procedure has a work, malpractice, and practice expense component. The Health Care Financing Administration will be issuing a notice of proposed rule making this Spring

to change the method for reimbursing physicians for their practice expenses. The new system will result in substantial changes for some medical specialties. In addition, the President's fiscal year 1998 budget includes several provisions related to physician services including moving to a single-conversion factor and reducing payments to high-cost hospital-based medical staffs. The Subcommittee will examine these and other physician issues as they compare to PPRC's recommendations.

In announcing the hearing, Chairman Thomas stated: Both the Prospective Payment Assessment Commission and the Physician Payment Review Commission have made significant recommendations, which this Subcommittee should give careful consideration to as we examine the President's budget and develop policy for the future of fee-for-service Medicare.

FOCUS OF THE HEARING:

This hearing will focus on the provisions in the President's fiscal year 1998 budget proposal regarding Medicare payments for hospitals and physicians. These proposals will be addressed in light of the recommendations developed by the Congress, by ProPAC and PPRC, as well as the policies contained in the Medicare Preservation Act of 1995 and the Balanced Budget Act of 1995.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement and a 3.5-inch diskette in WordPerfect or ASCII format, with their address and date of hearing noted, by the close of business, Thursday, April 3, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

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

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.

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

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

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

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

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

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–225–1904 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

*****NOTICE—CHANGE IN TIME*****

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE Contact: (202) 225–3943
March 18, 1997
No. HL–7-Revised

Time Change for Subcommittee Hearing on Thursday, March 20, 1997, on Recommendations Regarding Medicare Hospital and Physician Payment Policies

Congressman Bill Thomas (R–CA), Chairman of the Subcommittee on Health, Committee on Ways and Means, today announced that the Subcommittee hearing on recommendations regarding medicare hospital and physician payment policies previously scheduled for Thursday, March 20, 1997, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, will begin instead at 1:00 p.m.

All other details for the hearing remain the same. (See Subcommittee press release No. HL–7, dated March 13, 1997.)

Chairman THOMAS. The Subcommittee will come to order.

Today the Subcommittee will examine two of the largest contributors to the Medicare fee-for-service spending. We have been spending some time on some of the newer approaches, cutting edge, if you will, and we sometimes tend to forget that there are areas in which most of the money continues to be spent.

Although we have yet to receive legislative language, we understand the President's fiscal year 1998 budget contains several provisions regarding the services. The Congressional Budget Office estimates that the President's plan, as best they are able to estimate, would reduce projected payments for inpatient hospital services by $14.2 billion between fiscal year 1998 and fiscal year 2002. Physician payments would be reduced from projected spending by $6.2 billion.

To assist us in examining the President's proposal, a return engagement for the Chairman of the Prospective Payment Assessment Commission, Dr. Joseph Newhouse, and the Chair of the Physician Payment Review Commission, Dr. Gail Wilensky.

Each March these nonpartisan Commissions have reported to the Congress their recommendations for ways to improve the Medicare Program. It is March, and they are here to provide us with their recommendations.

Over the last few weeks, we have heard from both ProPAC and PhysPRC on several Medicare issues, including, as I said, HMO payment policies and other areas. While this is a growing area, these topics for today's Subcommittee hearing are where the money is.

We have also invited representatives from the hospital and physician communities to provide us with their feedback on the President's budget and the Commissions' recommendations. We need to find out ways to make Medicare a more prudent purchaser on the fee-for-service side of the program.

Personally, I would like to welcome Tom Johnson, who is the chief executive officer of the Kaweah Delta Health Care District Hospital, which is located in the city of Visalia. The question of who is buried in Grant's Tomb is appropriate here. Guess which district Visalia is in. I look forward to hearing, however, from all the witnesses, and with that, I would call on my Ranking Member.

Mr. STARK. Well, Mr. Chairman, I was not going to have an opening statement today. I have met all the witnesses and, indeed, known them for some time, and I look forward to their enlightening us.

But yesterday there was an event in El Paso in which a group of FBI, IRS, and, I presume, HHS agents from the Office of the Inspector General, raided the Columbia HCA facility in El Paso "as part of a long-term investigation." I would be less than modest if I did not suggest that that was an investigation which I requested several years ago.

I have been expressing concerns that Columbia is not good for the health of America, and we are constantly presented with conflicting studies on what profit and nonprofit facilities do and who is more efficient. And I would presume we will soon have the benefit of a grand jury indictment or a jury trial transcript where we can get some hard data which ProPAC and, indeed, PhysPRC can use to see how the exchange of funds between the physicians and the hospitals, if in fact there was any, affected the cost and quality.

Now, there may be nothing to this raid. It occurs to me, with all of the information I have had from Columbia Hospital about the quality awards they have won, Vladeck may have really wanted to get some proprietary information about how they got to be so good, and they would not tell them; so he raided the hospital to get this information so he could have all the other hospitals be as good as Columbia.

That is a possibility. But for those of you who were thinking of going to the reception for Members tonight at the National Air and Space Museum hosted by Columbia, I would urge you to think about whether you have some concern for the propriety of attending this in view of the ongoing investigation.

Mr. Chairman, thank you for indulging me, and I look forward to our first panel's enlightenment.

Chairman THOMAS. Thank you, Mr. Stark.

The gentleman from Louisiana.

Mr. MCCRERY. I thank the Chairman. In light of the opening statement of Mr. Stark, I feel compelled to say that it was a cheap shot. There have been not-for-profit hospitals and any number of other hospitals investigated and found guilty of improprieties. And to single out one institution, I think, is probably inappropriate. It was, in fact, a single institution in a single city, not a network-wide investigation or raid. I would just like to make the record clear on that.

Mr. STARK. Would the gentleman yield?

Mr. MCCRERY. Surely.

Mr. STARK. It is my understanding further that the idea that it was a single institution will not be the case for long, at which point I would be glad to inform the gentleman further as to the extent of this investigation.

Mr. MCCRERY. Well, at this point, it is a single institution.

Mr. STARK. It is.

Mr. MCCRERY. And the gentleman is well aware that the University of Pennsylvania had $30 million in fines. Would he suggest that the University of Pennsylvania go away? I think not. But we should continue, certainly, to investigate any institution, for-profit or not-for-profit, that violates the law and attempts to bilk this system that many have created over the years that is ripe for bilking.

Chairman THOMAS. I thank the gentlemen for their comments. I was going to try to smooth the waters by saying that the preceding was a paid vindictive announcement, but apparently that would not be appropriate at this time.

If you have heard this before, stop me. Your written testimony will be made a part of the record. [Laughter.]

But you can inform this Subcommittee in any way you see fit on what you folks have been doing and are going to report to us today about Medicare hospital and physician payment policies.

Dr. Newhouse, did you want to start?

STATEMENT OF JOSEPH P. NEWHOUSE, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION; ACCOMPANIED BY DONALD YOUNG, M.D., EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. NEWHOUSE. Thank you very much, Mr. Chairman. It is a pleasure to be back here with you. I would like to focus most of my remarks today on the hospital operating cost update recommendation and then come to hospital outpatient services.

I would like to just walk you through some of the charts that are attached to the testimony. Chart 1 I think tells a fairly remarkable tale. It shows the change in operating costs for the past 12 years since we have had the Prospective Payment System, and you will notice that for the first several years, the costs are going up around 9 percent or so a year. But in 1994, they actually go down 1 percent in nominal terms, and the information we have for 1995 and

1996 suggests that trend is continuing—that is, costs are continuing to go down.

Now, one of the reasons they are going down is shown in the next chart, chart 2. You will notice that in 1994 the length of stay fell a whole half a day. That is larger than at any time since PPS started. And in 1995 it fell another half a day—again, a large change in length of stay. It is related, of course, to the increase in postacute care, skilled nursing facilities, and home health facilities that we have talked about before.

Now, in part because of this fall in the length of stay, the margins for prospective payment systems have increased to all-time recent highs. That is in chart 3. They are as high as they have been since the first couple of years of prospective payment.

Total margins are also fairly robust. If you move on to chart 4, you will see that they are also the highest they have been since the first 2 years of prospective payment, around 5.5 percent.

Now, these figures were in part responsible for our recommendation to you that the update factor for 1998 be zero.

Now, if we move on to chart 5, however, you will see that even though the update factor is zero, that does not mean Medicare payments will not increase. Chart 5 shows at the top the increase over time in payments per discharge and costs per discharge, and you will see those two lines have diverged quite markedly in the last few years. That difference, of course, reflects the margins we were looking at before.

If you look down, you will see the update factor has gone up over time considerably less than payments per discharge, and that is because there is an increased case mix complexity at hospitals.

To sum up, Mr. Chairman, we believe hospital costs are going down, margins are high, and a zero update would be a prudent move on the part of Medicare as a purchaser.

Let me make two quick remarks on hospital outpatient department payments. To use a technically precise term, they are a bit of a mess. We do believe there is a problem with beneficiary copayment that needs to be addressed. It is very high for many outpatient services. Doing that will require money, and we believe part of the money can be found by correcting a flaw in the payment formula, the so-called formula-driven overpayment.

Thank you, Mr. Chairman, and I will await your questions.

[The prepared statement follows:]

Statement of Joseph P. Newhouse, Ph.D., Chairman, Prospective Payment Assessment Commission

Good afternoon, Mr. Chairman. I am Joseph Newhouse, Ph.D., Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., the Commission's Executive Director. We are pleased to be here to discuss the Commission's recommendations to improve the Medicare program. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

Over the past several weeks, we have testified before this Subcommittee about the Commission's recommendations on Medicare's risk program, post-acute care, and teaching and disproportionate share payment policies. These recommendations are published in our recently released *Report and Recommendations to the Congress.* This afternoon, I would like to discuss other recommendations that we make in our report. These include our views on payment updates for hospitals, hospital outpatient services, and the end-stage renal disease (ESRD) program.

Mr. Chairman, as this Subcommittee's hearings have demonstrated, the Medicare program is at an important crossroads. Never before have beneficiaries had so many

choices among providers, sites of care, and delivery options. At the same time, however, Medicare spending is growing at a rate that is unsustainable. Without any intervention, the Medicare Trustees estimate that the Part A Hospital Insurance Trust Fund will be depleted by the year 2001. The challenge is to enact policies that maintain quality care for Medicare beneficiaries while at the same time ensuring the fiscal viability of the program for future generations.

The Commission believes that Medicare must take advantage of the invigorated heath care marketplace and tailor its payments to correspond to providers' lower costs in delivering services. At the same time, Medicare must reevaluate its payment methodologies for certain services where increasing utilization is a major reason for rising expenditures.

While the bulk of our recommendations focus on payment methods, our first recommendation emphasizes the need for the Medicare program to be vigilant in monitoring and improving the quality of care delivered to beneficiaries who receive services under both the fee-for-service and capitation options. This is increasingly important given the cost-containment pressures and the rapid structural changes occurring in the health care financing and delivery systems. In our report, the Commission recommends that the Secretary pursue a comprehensive approach to quality assurance that includes not only analyzing patterns of care to raise quality standards, but also reviewing individual cases to identify poor performers.

MEDICARE PAYMENTS TO PPS HOSPITALS

Payments to PPS hospitals represent the largest share of Medicare outlays, about $74 billion in fiscal year 1997. In addition to payments for routine operating and capital costs associated with hospital admissions, Medicare makes additional payments to hospitals that have teaching programs and those that treat a disproportionate share of low-income patients.

In its evaluation of Medicare policies, the Commission annually reviews the financial performance of hospitals. I would like to share with you some of our findings.

Hospital Payments and Costs

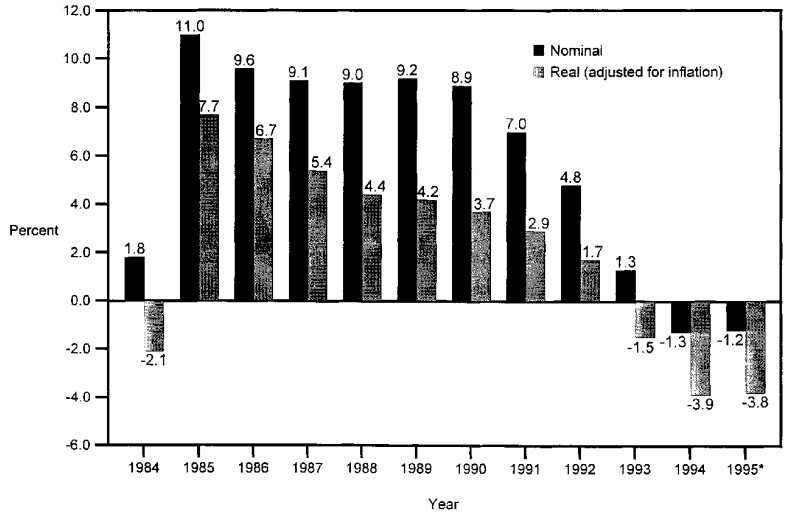
Remarkable changes are occurring in hospitals. Since 1993, the growth in Medicare operating costs per discharge has been less than general inflation. In 1994, these costs actually decreased, in absolute terms, for the first time (see Chart 1). This 1.3 percent decline was 3.9 percent below the overall inflation rate. Preliminary data for 1995 indicate that costs fell an additional 1.2 percent in that year, or 3.8 percent relative to general inflation. Data from the American Hospital Association through October 1996 indicate this trend is continuing.

Reduced cost growth partly reflects changes in the amount and timing of services furnished during inpatient stays. The average length of stay for Medicare beneficiaries in PPS hospitals dropped nearly 20 percent between 1990 and 1995 (see Chart 2). Shorter stays are due to a combination of earlier discharges to post-acute care settings and improvements in hospital productivity.

The rapid drop in hospital cost growth has enabled hospitals to make a profit on Medicare patients despite payment updates that have been as low as at any time since PPS began. Through the late 1980s, PPS margins—which compare Medicare capital and operating payments to costs—dropped steadily, to a low of −2.4 percent in 1991 (see Chart 3). With slower cost growth, this trend began to reverse, and in 1994 PPS margins jumped to 5.0 percent with a further jump to 7.9 percent estimated for 1995. Assuming cost growth continues at the current level, ProPAC projects that PPS margins continued to rise in 1996 to 10.3 percent, and will be 11.7 percent this year.

The dramatic decline in hospital costs also enabled hospitals to improve their overall financial position despite the financial pressures imposed by Medicare and private payers. Total margins—which reflect gains and losses from all payers on inpatient and outpatient services as well as non-patient care activities—increased from 4.4 percent in 1993 to 5.0 percent in 1994; preliminary data for 1995 indicate continued improvement to 5.6 percent (see Chart 4). These margins were the highest in the past 10 years, and higher than at any time prior to the implementation of the Prospective Payment System.

Chart 1. Annual Change in Medicare Operating Costs Per Discharge, First 12 Years of PPS (In Percent)



* Based on preliminary data and subject to revision.

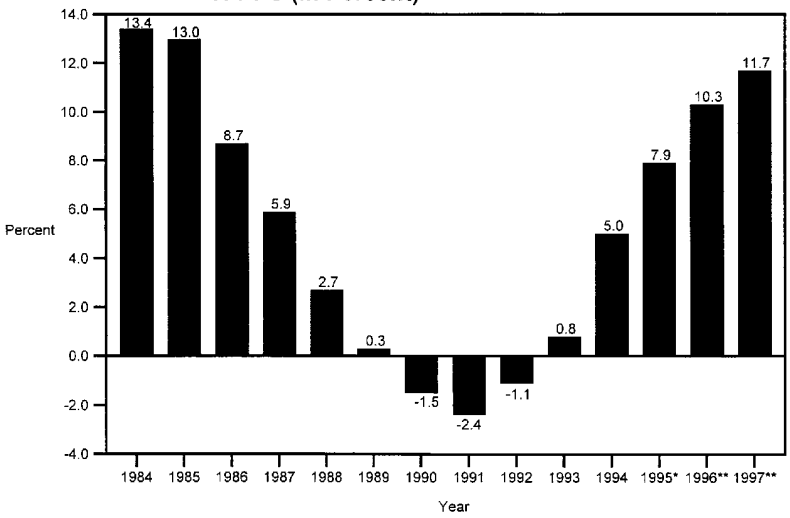
SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 2. Change in Average Medicare Hospital Length of Stay, Fiscal Years 1984-1995

Fiscal Year	Length of Stay
1984	8.8
1985	8.4
1986	8.2
1987	8.3
1988	8.4
1989	8.3
1990	8.4
1991	8.2
1992	8.0
1993	7.7
1994	7.2
1995	6.7

SOURCE: MedPAR summary statistics

Chart 3. PPS Margins for All Hospitals, First 14 Years of PPS (In Percent)

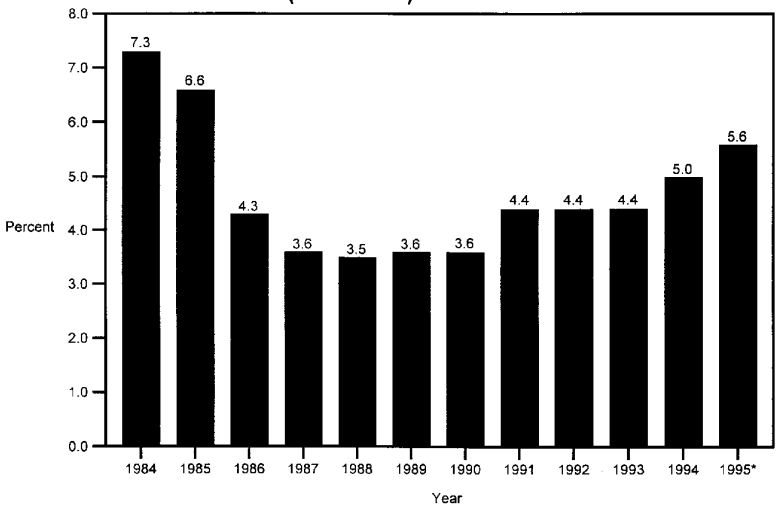


* Based on preliminary data and subject to revision.

** Projected.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 4. Total Margins for All Hospitals, First 12 Years of PPS (In Percent)



* Based on preliminary data and subject to revision.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

PPS Operating Update

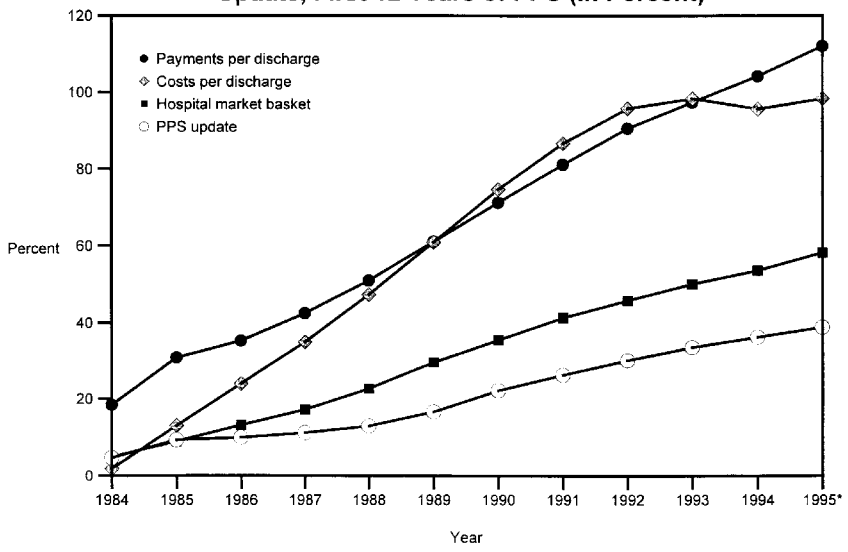
Mr. Chairman, the trends I have just described portray a hospital industry that is adapting rapidly to a more price-competitive environment. The Commission considered the declines in hospital cost growth as it developed its fiscal year 1998 update recommendation for operating payments paid to PPS hospitals. The formula-based approach we have used is the same one we have used over the years. It takes into account the effects of inflation on hospital costs, changes in the mix and complexity of admissions, added costs of new technologies, and hospital productivity improvements.

This year, our recommendation also reflects the effects of changes in the services provided by hospitals. Some of the recent declines in hospitals' inpatient operating costs may be because patient stays are shorter. This may be due to improvements in technology, the availability of less invasive procedures, and an increased use of post-acute care providers. While these changes may reflect improvements in patient care, they also indicate a discrepancy between the services provided in the inpatient setting and those included in the Medicare payment rate. The Commission believes that Medicare payments should be adjusted to reflect the reduced service content of Medicare discharges.

ProPAC recommends a zero operating update for fiscal year 1998. We believe a zero update fulfills Medicare's responsibility to act as a prudent purchaser while allowing hospitals sufficient funds to furnish quality care. I should add, Mr. Chairman, that if the Commission's recommendation is adopted, per case payments will still increase next year. This is because PPS payments grow in proportion to the complexity of patients that hospitals treat, and this complexity has increased each year.

In fact, because of case-mix increases and other policy changes, Medicare payments to PPS hospitals historically have risen substantially more than increases in the hospital market basket, despite PPS updates that have been less than the market basket (see Chart 5). And, as I mentioned earlier, the slowdown in cost growth is resulting in a widening gap between payments and costs.

Chart 5. Cumulative Increases in PPS Operating Payments and Costs Per Discharge, Market Basket, and Update, First 12 Years of PPS (In Percent)



SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Mr. Chairman, the Commission believes that the PPS operating update can be constrained for the upcoming fiscal year. Hospitals currently are receiving PPS payments that are higher than those proposed by either the President or the Congress during last year's budget negotiations. If no legislation is passed this year, hospitals will receive an update in fiscal year 1998 equal to the rise in the market basket—the largest increase relative to the market basket since 1985. Such a large increase would come at a time when hospital costs have been falling and hospital margins are high.

Although the Commission believes that PPS rates should not be increased for fiscal year 1998, we emphasize that our recommendation applies for only one year. ProPAC will continue to monitor changes in hospital costs and financial condition to ensure that quality of and access to care do not suffer.

Capital Payment Rates

Mr. Chairman, Medicare's current capital payment rates are 15 to 17 percent too high. The Commission believes that flaws in the current rates must be corrected to avoid overpaying capital costs in future years. We also believe that there should be no capital update for fiscal year 1998.

Medicare payments for inpatient capital currently reflect a transition from a cost-based to a fully prospective system which began in fiscal year 1992 and will be completed in 2001. Hospitals' capital payments are based on 1992 capital costs, updated to reflect subsequent costs increases. The data used to estimate the 1992 costs were flawed, however, resulting in inflated base payment rates. Moreover, the update applied to the 1992 base rates in 1993 through 1995 was based on historical costs increases, rather than an update framework. (Such a framework has been used to set capital payment updates since fiscal year 1996.) These flaws had little effect on Medicare payments for fiscal years 1992 through 1995 because capital payments were subject to a budget neutrality adjustment that limited total capital payments to 90 percent of hospitals' projected capital costs, regardless of the base payment rates. In fiscal year 1996, though, the budget neutrality adjustment expired and the Federal capital payment rate jumped 23 percent.

The Commission is recommending that the current base rates be adjusted to achieve more appropriate payment levels so that the current overpayments will not be carried into future years. There are several ways this could be done. One approach, which the President has incorporated into his budget proposal, would be to replace the current base rates with the rates in effect in 1995, updated to the present. Alternatively, the 1992 base rates could be recalculated using actual cost data and then updated to the present year by an appropriate update factor. This would correct for errors that helped to cause the current distorted higher rates. Another option would be to reimpose a budget neutrality adjustment. This approach, however, would fail to break the link between capital payments and hospitals' costs, which is inconsistent with the goal of prospective payment.

Hospital Outpatient Services

The Commission has several major concerns with current Medicare policies related to hospital outpatient services. These focus on the methods used to pay hospital outpatient departments and the cost-sharing amounts beneficiaries must pay to receive services in the hospital outpatient setting.

Payment for hospital outpatient services is extremely fragmented. While some services are paid using prospective rates, most are still paid on the basis of costs or charges, or a blend of costs or charges and prospective rates. Cost and charge-based payment methodologies contribute to growth in Medicare spending because they provide few financial incentives for hospitals to furnish services efficiently. Other factors that contribute to the growth in outpatient spending are the volume and complexity of services delivered, as providers shift more care historically delivered in an inpatient setting to the ambulatory arena.

The payment system for hospital outpatient services needs to be revised. Medicare payments for all outpatient facility services have been growing, on average, about 14 percent annually since 1983. In 1995, payments were about $16.3 billion; HCFA estimates that about 70 percent of these payments, or $11 billion, were made to hospitals for outpatient services.

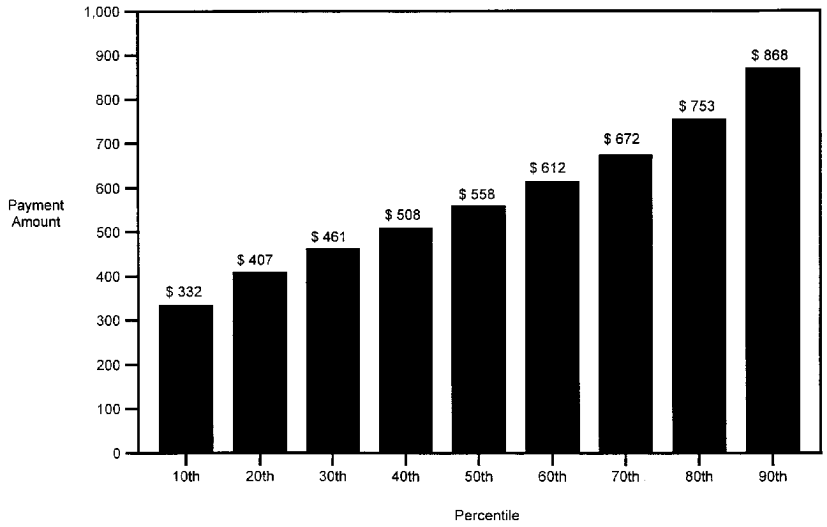
The Commission believes a prospective payment system should be implemented for hospital outpatient services. Such a system should include both per service rates and a mechanism to control volume. Part of the difficulty in constraining spending in the ambulatory arena, however, is that almost all services provided in the hospital outpatient department can be obtained in other settings. Thus, payment methods and constraints that apply to the hospital outpatient setting only may result in services being shifted to other sites that receive more generous payments. Con-

sequently, the Commission believes that Medicare should move towards a payment system that is consistent across all facilities.

To the extent that prospective payment cannot be implemented immediately, the Congress should address a flaw in the current payment formula for most outpatient surgeries, radiology procedures, and selected diagnostic services that systematically pays hospitals more than Congress intended. Medicare's payments for these services are supposed to be the amount that remains after subtracting the beneficiaries' copayments from the total service payments due the hospital. The current payment formula, however, does not take into account the full amount of the beneficiaries' copayments. Consequently, Medicare ends up paying hospitals more than intended. This formula-driven overpayment should be corrected immediately.

The Commission also recommends reducing beneficiaries' over-inflated liability for hospital outpatient services. Under the current system, beneficiary coinsurance is set at 20 percent of the hospital's charges. However, because these charges are higher than Medicare payments, beneficiaries end up paying substantially more than 20 percent of the total payment. For certain surgical, radiological, and diagnostic procedures, the average beneficiary copayment is more than half of the entire payment. In addition, the amounts that beneficiaries pay vary widely, depending upon hospitals' charges. For example, 10 percent of beneficiaries who received a cataract procedure in 1995 paid coinsurance amounts of $332 or less, while another 10 percent paid at least two and a half times that amount, or $868 (see Chart 6).

Chart 6. Beneficiary Coinsurance Payments for Cataract Surgery in Hospital Outpatient Departments, 1995



SOURCE: ProPAC analysis of a 5 percent sample of hospital outpatient department claims from the Health Care Financing Administration.

The Commission believes that hospital outpatient coinsurance should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. We recognize that reducing beneficiary coinsurance requirements would increase Medicare outlays. This increase should be offset in part by correcting the flaw in the hospital outpatient payment formula. If necessary, the reduction in beneficiary liability could be phased in over several years.

Update to the Composite Rate for Dialysis Services

Medicare payments for end-stage renal disease (ESRD) beneficiaries are growing rapidly. Between fiscal years 1986 and 1994, spending grew at an average annual rate of 13 percent, to $8.4 billion. A large part of this increase is due to an expanding ESRD population. The number of recipients increased, on average, nearly 9 percent per year over the same period. While these enrollees represent only 0.6 percent

of the Medicare population, they account for about 5 percent of total program expenditures.

The Omnibus Budget Reconciliation Act of 1990 requires ProPAC to recommend an annual update to the prospective payment—called the composite rate—that Medicare pays to covers all of the services routinely required for a dialysis treatment. Unlike Medicare payments to other providers, the composite rate has not been updated since 1983; it is $126 per treatment for hospital-based providers and $122 for independent facilities. While their payment to cost ratios have declined, independent dialysis facilities—which account for about two-thirds of dialysis providers—have consistently received payments that are higher than their costs. Payment-to-cost ratios for hospital-based facilities are considerably lower, but this may be related to their overhead allocation practices (see Chart 7).

Chart 7. Payment to Cost Ratios for Hospital-Based and Independent Dialysis Providers, Fiscal Years 1991-1995

Type of Provider	1991	1992	1993	1994	1995
Hospital-based	0.80	0.78	0.77	0.77	0.74
Independent	1.13	1.12	1.11	1.04	1.03

Note: Includes both hemodialysis and peritoneal dialysis treatments.

SOURCE: ProPAC analysis of unaudited Medicare Cost Report data from the Health Care Financing Administration.

Because Medicare is the dominant payer for chronic dialysis, it has a unique responsibility to monitor the quality of these services. While there is no conclusive evidence indicating that quality of care has actually declined, recent studies suggest that almost half of all U.S. hemodialysis patients are underdialyzed, which raises the risk of morbidity and mortality. The Commission is concerned that maintaining the current level of payments may adversely affect the quality of care provided to dialysis patients. Therefore, we recommend that the composite rate be increased by 2.8 percent in fiscal year 1998. Further, the Commission recommends that HCFA regularly audit dialysis cost reports and track quality indicators for these providers to monitor the relationship between dialysis payments and quality of care. Future recommendations to increase the composite rate will depend upon whether the Commission finds that higher payments raise the standard of care.

CONCLUSION

The Commission believes that important reforms are needed in the areas I have just discussed. The Commission's recommendations would help to preserve the Medicare program while maintaining quality care for Medicare beneficiaries.

This concludes my formal statement, Mr. Chairman. I would be pleased to answer any questions you or members of the Subcommittee may have.

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

Dr. Wilensky.

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., CHAIR, PHYSICIAN PAYMENT REVIEW COMMISSION; ACCOMPANIED BY LAUREN B. LEROY, PH.D., EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION

Ms. WILENSKY. Thank you, Mr. Chairman. It is a pleasure to be here and to report on some of the recommendations for this year's annual report.

As you indicated, we have already discussed in earlier hearings issues relating to risk adjustment and payments to risk plans. I

would like to focus my comments primarily on two issues: Implementing the resource-based practice expense and improving the volume performance standard. If I have time, I would like to touch on a couple of other areas that PPRC is working on that we think are also very important.

With regard to implementing the resource-based practice expense relative value, as you know, legislation was passed in 1994 that requires implementation in January 1998. There is currently a controversy on two major issues. The first has to do with the accuracy of values that are being developed by HCFA, and the second has to do with the anticipated size of payment change.

What we are urging at PPRC is that the process of moving to a practice expense relative value system begin as scheduled in January 1998, but that it be phased in over a 3-year period. The reason is the following: There will not be any new information in another year's time, and we do know the direction that the system needs to go to.

Before the relative value scale was introduced, we started with cuts in overvalued procedures because, again, we knew the right direction to start. What we are recommending is that HCFA develop a process to refine the initial values and that they get input from the interested parties and that when HCFA announces in its proposed rule, which is expected in May, they provide information about the refinement process at that time so physicians understand what will happen with the refinement process and how they can participate.

With regard to the anticipated size of the payment changes, we agree there is some concern. In table 1 of the handout, we indicate the estimated size of these changes. Briefly, about 35 percent of the services could go up by more than 25 percent, and 39 percent of the services could go down by more than 25 percent based on the numbers we now have.

In any case, what this means is that practices are at risk for seeing large changes. The way to handle that is to have a transition period, and it is why PPRC recommends there be a 3-year transition. Not only does that allow you time for a refinement process as you proceed, but it clearly dampens the effect that would occur if it was entirely introduced in 1 year. This, of course, should sound familiar. It is the concept that the Congress has included in all of the legislation about major changes that have occurred with regard to the Medicare Program.

So we would recommend there be movement forward starting in January, that the refinement process be made more clear, and that there be a transition. We also think it would be helpful if HCFA would be clearer on the kinds of budget-neutral assumptions it will make—that is, the volume offset. This is an issue that I actually painfully recall when the first round was occurring. I think it is fair to ask HCFA and to indicate what actually happened during the first round, whether they should have symmetric changes, and whether the health care environment has changed so much that it is really not relevant.

Let me briefly touch on improving the volume performance standard. There are two problems right now: One, that there are three separate performance standards. That means you are intro-

ducing distortions. Figure 3 and table 3 show what some of those distortions are. And, second, by law there is a deduction of 4 percentage points to the 5-year historical trend which is beginning to make the growth rate that is included quite unreasonable.

We recommend the concept of a sustainable growth rate. It is one Congress has raised. It is one the administration has raised. It would mean a single conversion factor and a target linked to the GDP. PPRC recommends 1 or 2 percent above GDP, but something linked to it, and to have a system that fully recoups both the excess and shortfall payments that may occur.

Just let me mention the areas in which we are also doing work. They have to do with monitoring access in managed care, access for vulnerable populations, the use of performance measures, the use of data for health plans and PSOs. These are areas we would be glad to speak about either here or in any other hearings or in private that you may wish to have.

Thank you.

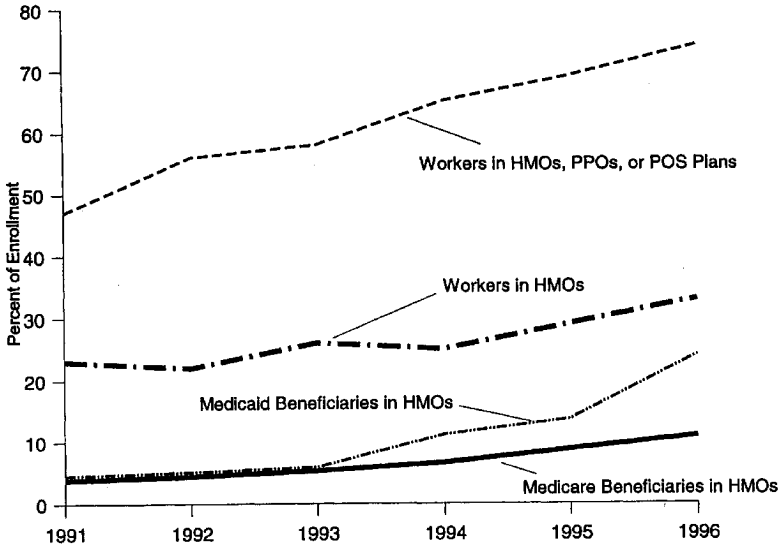
[The prepared statement follows:]

Statement of Hon. Gail R. Wilensky, Ph.D., Chair, Physician Payment Review Commission

Mr. Chairman and members of the subcommittee, I am pleased to be here today to present key recommendations and analyses from the Physician Payment Review Commission's 1997 annual report to Congress. Reflecting the Commission's mandate, our 1997 report considers a wide range of issues affecting Medicare, Medicaid, and the broader health system. Throughout, we have looked to see how these public programs can benefit from the tremendous changes that are occurring in how Americans pay for and receive health care. The number of individuals covered by traditional indemnity insurance is shrinking. Managed-care plans are evolving toward more integrated systems and closer relationships with their provider networks, while physicians and hospitals are joining together in new types of organizations. In response to rising premiums, leading corporate purchasers of health care are changing the way they pay for health services, potentially affecting both the costs and quality of care.

Medicare can learn from these experiences. In fact, as commercial managed-care penetration grows and managed-care enrollees age into Medicare, it is inevitable that more and more beneficiaries will select this option within Medicare. The beginning of this trend is reflected in the recent growth in Medicare managed-care enrollment (Figure 1). Moreover, changes can be made in the traditional program that can help contain costs and improve quality. The challenge is to develop reforms that ensure both Medicare's financial solvency and beneficiary access to timely, appropriate health care services.

Figure 1. Trends in Managed-Care Enrollment, 1991-1996 (percentage)



SOURCE: Physician Payment Review Commission analysis of data from Health Care Financing Administration and KPMG Peat Marwick (1996).

NOTE: Enrollment data for workers refers to workers in large firms. HMO is healith maintenance organizations. PPO is prefered provider organization. POS is point-of-service plan.

Because previous hearings of this subcommittee focused on other important aspects of the Commission's report including payment policy under Medicare managed-care, risk adjustment, and graduate medical education, my comments today primarily focus on issues affecting Medicare physician payment. The Commission also has some advice to provide in a number of other areas including:

- access to care under Medicare managed-care;
- Medicare's use of quality and performance measures;
- the capabilities of health plans to provide data useful for risk adjustment, access and quality monitoring;
- consumer protection under managed care; and
- managing health care for those individuals who are both Medicare and Medicaid beneficiaries.

While I will touch upon these issues at the end of my statement, time will not permit more substantial discussion today. We would welcome the opportunity to discuss them later. In addition, the Commission has made recommendations concerning the rules under which provider-sponsored organizations (PSOs) may participate in Medicare. Since I understand that the subcommittee may devote an entire hearing to this issue, we would be happy to provide a more comprehensive review of our work at that time.

PHYSICIAN PAYMENT UNDER THE MEDICARE FEE SCHEDULE

When the Congress enacted physician payment reform in 1989, it called for the Medicare Fee Schedule to be phased in over five years, beginning in 1992. With the completion of that transition in 1996, the fee schedule is now the sole basis for Medicare payments to physicians. Many of the concerns that led to adoption of physician payment reforms have been addressed:

- the pattern of relative payments for physicians' services has been significantly realigned;
- physician fee updates are now linked to performance in slowing volume growth, giving Medicare a tool to hold down growth in spending for physicians' services;
- balance billing—the practice of charging patients more than Medicare's allowed charge—has decreased dramatically; and

• access remains good for most beneficiaries. There have been decreases in use of some types of services but these changes appear to reflect changes in treatment modalities or other factors, rather than changes in payment policy. Moreover, beneficiaries report no increases in problems obtaining care and their satisfaction with care continues to be high.

Still important challenges remain, in part due to inconsistencies within physician payment policy that resulted from lack of data or compromises made to gain support for the 1989 reforms. My remarks today will focus on several of these critical issues:

• implementing resource-based practice expense relative values,
• refining other aspects of the Medicare Fee Schedule, and
• improving the system of Volume Performance Standards.

Implementing Resource-based Practice Expense Relative Values

The most controversial of refinements to the fee schedule continues to be the development of resource-based practice expense relative values, required by legislation passed in 1994 to be implemented in 1998. When the fee schedule was enacted, data were not available to develop these values. The Congress acknowledged this gap by asking the Commission to study the issue. The Commission has considered the current charge-based values to be inconsistent with the goals and intent of a resource-based fee schedule. And its research demonstrated that it is feasible to develop resource-based values for practice expense.

No Need for Delay. The current controversy concerns two issues: the accuracy of the values the Health Care Financing Administration (HCFA) and its contractors are developing, and the anticipated size of the payment changes projected to occur. With respect to the accuracy of the values, a number of specialty societies have questioned HCFA's data and methods for developing values. They argue that acceptable values cannot be derived for implementation next January.

The Commission disagrees. No new information will be available to HCFA with another year that would produce "better" relative values. In fact, enough is known about the direction and magnitude of changing to a resource-based method that it makes sense to proceed. This is the approach that was taken even before the fee schedule was implemented when payment cuts were mandated for those "overvalued procedures" predicted to be reduced under a resource-based approach. Further delay in implementing new practice expense values is unwarranted, given how much time has already passed since implementation of the fee schedule with its flawed charge-based practice expense values.

Refinement Process. Any inaccuracies in relative values could be resolved in a refinement process similar to that used to refine physician work values. The Commission recommends that HCFA develop a process to refine initial values with input from interested parties. Announcement of this process should be made when proposed practice expense values are released for public comment.

Phase In New Values. With respect to concerns that some physicians will experience more extreme payment reductions than they had anticipated, the Commission has long maintained that new values be phased in over a three years, rather than all at once as required by current law. This is because of the disruption that could occur if substantial changes in payment for individual services were implemented in a single step. For example, the Commission's analyses suggest that when resource-based practice expense values are introduced, practice expense relative values for about 36 percent of services will increase by more than 24 percent; 39 percent of services will experience a decrease in practice expense relative values of more than 25 percent (Table 1).

HCFA's Practicing Physicians Advisory Council recently concurred with the Commission by recommending a transition. A three-year transition would help mitigate the effect of any errors before they are corrected in the refinement process. If the implementation of new values is delayed contrary to the Commission's recommendations, the length of the phase-in should be shortened accordingly. Providers who will experience large payment reductions can use the delay to prepare for changes so a full three-year phase-in would not be necessary.

Budget Neutrality Assumptions. Finally, there are concerns about whether HCFA will apply a volume offset to maintain budget neutrality when implementing the new values. When the fee schedule was first implemented, HCFA's actuaries assumed that physicians experiencing payment declines would increase services to offset half of their lost revenues. To account for this volume offset, the conversion factor was lowered, resulting in lower increases in physician fees than had been anticipated. The Commission recommended then that the volume offset should have been symmetrical: that is, it should have been structured to recognize that physicians experiencing payment gains may reduce the number of services they provide.

In implementing new practice expense values, HCFA should consider three issues: whether physicians actually responded to fee changes as the volume offset anticipated, whether an offset should be symmetric, and whether increased penetration of managed care has affected physicians' ability to increase service volumes in response to payment reductions.

Table 1. Distribution of Changes in Relative Value Units under Resource-Based Practice Expense Estimates (percentage)

Change in Relative Value Units*	Percent of Services: Practice Expense Relative Value Units	Percent of Services: Total Relative Value Units
Reductions		
More than 25 percent	39.3%	27.7
16 percent to 25 percent	13.5	7.1
6 percent to 15 percent	3.2	18.3
Change Within 5 Percent	5.7	9.4
Increases		
5 percent to 14 percent	1.0	6.0
15 percent to 24 percent	1.4	22.7
More than 24 percent	35.9	8.9
Total	100.0	100.0

SOURCE: PPRC, *Practice Expenses under the Medicare Fee Schedule: A Resource-Based Approach*, 1992.

* Reductions and increases reflect a comparison of Physician Payment Review Commission estimates of relative value units with 1992 relative value units.

Refining Other Aspects of the Medicare Fee Schedule

Other important refinements to the fee schedule are still taking place that are improving the accuracy with which it measures the relative resources required to provide each service. In the past year, HCFA has completed two substantial efforts to improve the fee schedule:

- the first review of the relative value scale, and
- changes in fee schedule payment areas.

The Five-Year Review. The 1989 legislation which created the fee schedule also directed HCFA to review all relative values every five years to ensure their accuracy. The first review was completed last November; revised values were reflected in physician payments as of January 1. This review focused exclusively on physician work values, because they comprise the only fee schedule component that is currently resource-based. Future reviews will look at practice expense values; malpractice values remain charge-based.

With input from multiple physician specialty societies and the American Medical Association's Relative Value Update Committee, HCFA conducted a two-year process that reviewed values for over 1,000 services. In the Commission's view, this process was successful in improving the accuracy of work relative values. Its decisionmaking mechanisms were consistent, its methods were fair, and it was accountable to all interested parties. In addition, the review identified overvalued as well as undervalued services.

Several issues remain to be addressed in 1997. These include such questions as whether surgical global services should be increased to reflect the increase given to values for evaluation and management services. (Global services encompass both the surgical procedure and visits before and after surgery). The Commission will monitor HCFA's response to this and other unresolved issues in the coming year. Along with others, it is also beginning work on how to improve the process for the next review and how to incorporate the review of practice expense relative values into the process.

Fee Schedule Payment Areas. The Commission was less pleased with changes made in the fee schedule payment areas. These areas exist so that payments under the fee schedule can be adjusted for variations in local prices. Currently, every state has one or more geographic payment areas. Medicare payments are the same within each area, but vary from area to area. For example, physicians in Manhattan are paid 34 percent more than physicians in South Dakota for a level 3 established patient office visit.

Payment areas must be drawn carefully to be equitable and to ensure that risk-plan payments are tied accurately to local fee-for-service expenditures. Changes made by HCFA reduced the number of payment areas from 210 to 89 (Table 2).

Table 2. Effect of Payment Area Revision on Number of Payment Areas by State

	Number of Payment Areas	
	1996	1997
Alabama	6	1
Alaska	1	1
Arizona	6	1
Arkansas	1	1
California	28	9
Colorado	1	1
Connecticut	4	1
Delaware	1	1
District of Columbia	1	1
Florida	4	3
Georgia	4	2
Hawaii	1	1
Idaho	2	1
Illinois	16	4
Indiana	3	1
Iowa	1	1
Kansas	3	1
Kentucky	3	1
Louisiana	8	2
Maine	3	2
Maryland	3	2
Massachusetts	2	2
Michigan	2	2
Minnesota	1	1
Mississippi	2	1
Missouri	7	3
Montana	1	1
Nebraska	1	1
Nevada	4	1
New Hampshire	1	1
New Jersey	3	2
New Mexico	1	1
New York	8	5
North Carolina	1	1
North Dakota	1	1
Ohio	1	1
Oklahoma	1	1
Oregon	5	2
Pennsylvania	4	2
Rhode Island	1	1
South Carolina	1	1
South Dakota	1	1
Tennessee	1	1
Texas	32	8
Utah	1	1
Vermont	1	1
Virginia	4	1
Washington	3	2
West Virginia	5	1
Wisconsin	11	1
Wyoming	1	1
TOTAL	210	89

SOURCE: HCFA *Federal Register* notice, July 2, 1996.

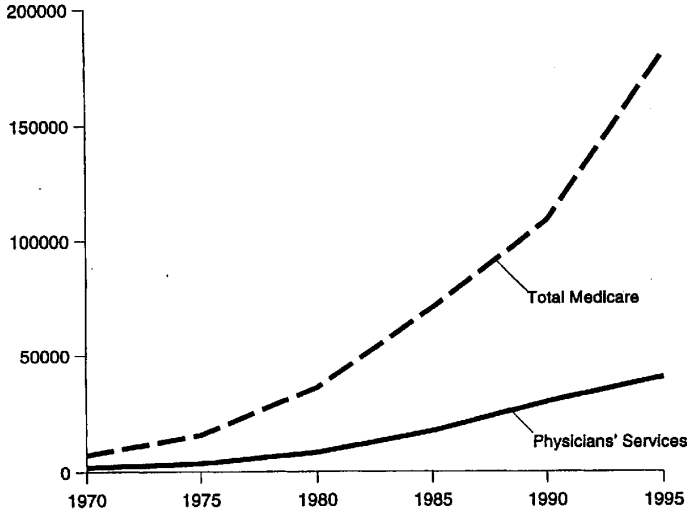
NOTE: Maryland and Virginia payment areas do not include the two counties in Maryland and two counties and one independent city in Virginia that are part of the Washington, DC payment area.

These new areas represent an improvement over previous policy. First, in many cases, areas were combined when input prices were similar. Second, all areas now conform to county boundaries. Even so, the Commission is concerned about certain limitations of HCFA's method. First, under the new configuration, there may be significant payment differentials within a market. Second, HCFA has indicated that it will not divide statewide areas into smaller areas even if demographic and economic changes result in large differences in input prices.

IMPROVING THE SYSTEM OF VOLUME PERFORMANCE STANDARDS

Despite progress in slowing the rate of growth in physicians' services, overall Medicare expenditures continue to increase at a rate many consider unaffordable (Figure 2). The Congressional Budget Office projects that Medicare spending will continue growing at rates of 8 percent to 9 percent annually.

Figure 2. Medicare Expenditures, 1970-1995 (dollars)



SOURCE: HCFA Office of the Actuary.

NOTE: Does not include administrative or peer review organzation expenses.

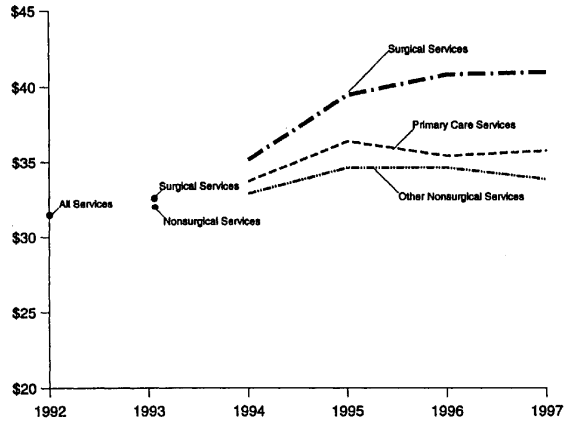
Because of similar high rates of spending growth for physicians' services in the late 1980s, the Volume Performance Standard (VPS) system was introduced to curb further increases in spending growth for physicians' services. The VPS system sets target rates of spending growth, and then adjusts payment levels depending on whether those targets were met. The target rates of spending growth are called performance standards; adjustments to payment levels based on these standards are called conversion factor updates.

Problems with the VPS. The Commission has long held that a budgeting tool like the VPS system is necessary to constrain spending for physicians' services, But it has also warned that methodological flaws keep the system from working as intended. The current system is flawed for two reasons:

- there are separate performance standards and conversion factor updates for primary care services, surgical services, and other services.
- in setting spending targets, it applies a 4 percentage point deduction to the five-year historical trend for volume and intensity growth of physicians' services.

The existence of three performance standards is introducing serious distortions in the patterns of relative payment, the very problem the Medicare Fee Schedule was intended to correct (Figure 3). Conversion factors for 1997 are: $40.96 for surgical services, $35.77 for primary care services, and $33.85 for nonsurgical services (Table 3). Shifts in relative payments accomplished over the past several years will likely be reversed unless further legislative changes are made.

Figure 3. Conversion Factors for Different Types of Services, 1992-1997



SOURCE: PPRC compilation of conversion factors as reported in the *Federal Register.*

Table 3. Conversion Factors, by Category of Service, 1992-1997 (dollars)

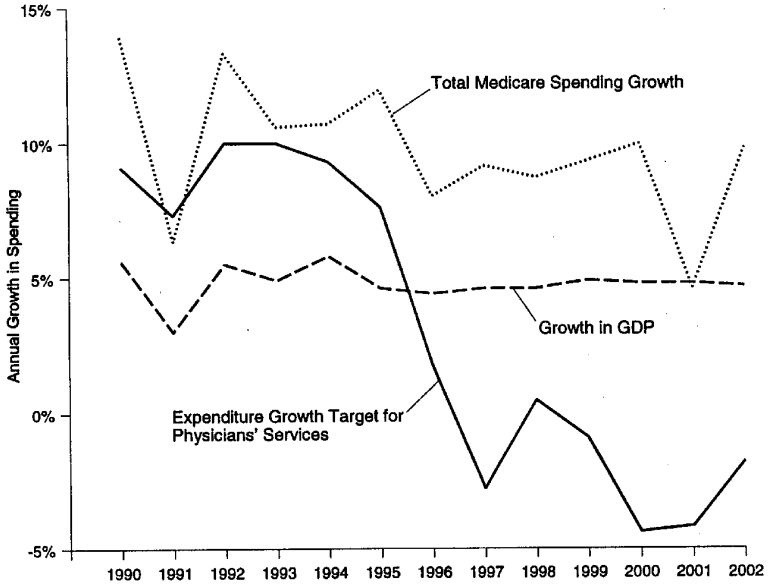
Category of Service	1992	1993	1994	1995	1996	1997
All Services	$31.00	-	-	-	-	
Surgical Services	-	$31.96	-	-	-	
Nonsurgical Services	-	31.25	-	-	-	
Surgical Services	-	-	$35.16	$39.45	$40.80*	$40.96*
Primary Care Services	-	-	33.72	36.38	35.42*	$35.77*
Other Nonsurgical Services	-	-	32.90	34.62	34.63*	$33.85*

SOURCE: Physician Payment Review Commission compilation of conversion factors as reported in the *Federal Register.*

* These conversion factors include an additional budget-neutrality adjustment that offsets increases in spending from changes to the relative value units and other payment policy changes.

Basing updates on historical trends less a legislated deduction will result in increasingly unrealistic target rates of spending growth. When the first performance standards were calculated, the historical trend was high and only a small deduction was taken. At that time, it was expected that volume and intensity growth would remain high. In fact, the five-year trend for volume and intensity growth has fallen from about 8 percent in 1992 to about 4 percent in 1996. Even so, the legislated deduction has increased over time from 0.5 percentage points initially to its current 4.0 percentage points. As a result, the performance standards that were originally well above GDP growth, are now projected to fall well below growth in the Medicare program as a whole or the national economy (Figure 4).

Figure 4. Projected Spending Targets for Physicians' Services Compared to Growth in GDP and Total Medicare Spending, 1990-2002



SOURCE: Physician Payment Review Commission analyses of data from the Congressional Budget Office, January 1997 baseline.

The Sustainable Growth Rate System. During the last session, this committee, others in Congress, and the Administration proposed changes to correct these problems, referred to as the sustainable growth rate system. This system would incorporate many of the Commission's recommendations, including:

- establishing a single conversion factor update, and performance standard for all physicians' services covered by the Medicare Fee Schedule;
- setting a target linked to growth in gross domestic product (GDP); and
- structuring the system to fully recoup excess spending or return shortfalls.

Single Performance Standard and Update. Adopting a single performance standard and update would eliminate distortions in payment. Changing to a single budget-neutral conversion factor now, however, would require a large reduction in payment for surgical services which are also likely to reduced with implementation of new practice expense relative values. The Commission recommends that a transition to a single conversion factor should occur over a three-year period. This transition should be coordinated with the implementation of resource-based practice expense values to prevent large payment reductions for any category of service in a single year.

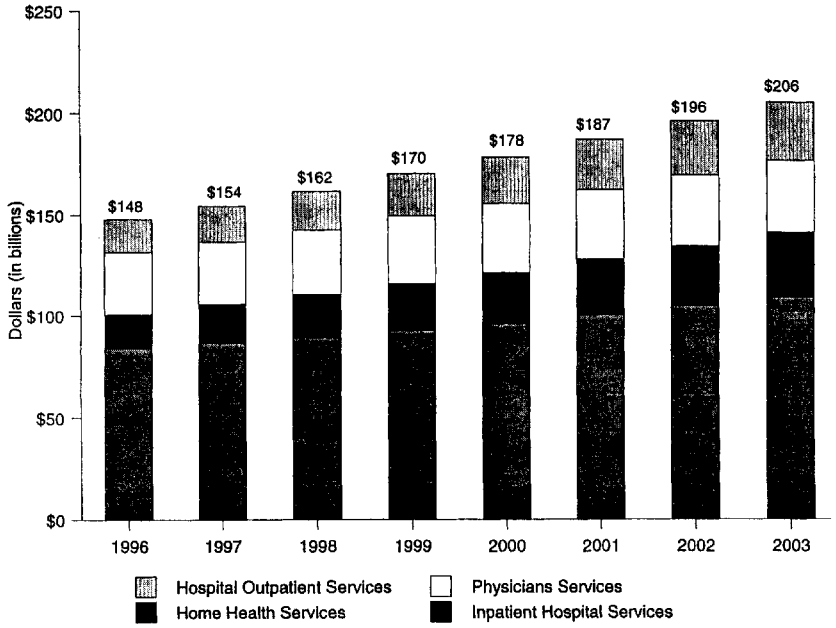
Standards Linked to GDP Growth. Linking performance standards to projected growth of real gross domestic product per capita would provide a realistic and affordable goal that links targets to what the economy as a whole can afford. The Commission has also recommended that targets be set to exceed GDP growth by 1 or 2 percentage points to allow for advancements in medical capabilities.

Symmetrical Limits on Updates. Finally, the sustainable growth rate system will recoup excess spending or return shortfalls within one year. This can lead to substantial fluctuations in the conversion factor from year to year, because of the inherent volatility of annual spending growth. Limits on the size of annual updates are therefore critical for preventing undue changes in payment levels. The mechanism allows any excess spending or surplus beyond these limits to be recovered in subsequent years. The Administration has proposed limiting updates to 3 percentage points above the Medicare Economic Index (MEI) to 8.25 percentage points below. The Commission recommends a more narrow and symmetric range, restricting the size of annual reductions and increases from the MEI to 5 percentage points.

Constraining Total Medicare Spending. The Commission also has some views on how to develop mechanisms for constraining spending in the Medicare program.

While spending growth for physicians' services has slowed, other services, such as outpatient hospital and home health services, continue to grow unabated (Figure 5). There are no mechanisms linking payment levels for these services to volume and intensity growth. While prospective payment for inpatient hospital services does curb price, it does not rein in overall spending growth because there are no constraints on the number of admissions. Developing constraints for spending growth in sectors other than physicians' services is difficult, however. Although it is physicians that determine the number and intensity of these services, they would not be directly affected by reductions in other providers' payment levels.

Figure 5. Projections of Spending by Health Care Sector, 1996-2003 (in billions of dollars)



SOURCE: Physician Payment Review Commission analysis of data from the Congressional Budget Office, January 1997 baseline.

Fee-for-service spending can be constrained through either expenditure targets or expenditure limits. An expenditure target system (like the VPS) establishes a level of spending, and then adjusts payments up or down so that, on average over time, spending matches the planned budget trajectory. An expenditure limit system sets a ceiling for spending and only adjusts payments downward as needed when spending exceeds the limit. If spending falls below the limit, payments are not affected and the shortfall results in budget savings. The failsafe budget mechanism proposed in the last year's Medicare restructuring legislation is an example of an expenditure limit system.

There are several challenges in designing a Medicare expenditure limit system. First, it should achieve the desired rate of growth without producing large annual fluctuations in payment levels. Second, decisions must be made about allocating spending to individual sectors. Third, the implications on different geographic areas must be weighed. Finally, any new system must be consistent with current payment mechanisms, such as the expenditure target system already in place for physicians' services.

OTHER WORK

As I mentioned earlier, the 1997 annual report also considers a number of other issues we have not yet shared with this committee. I would like to take just a few moments to outline some of the Commission's recommendations in these areas.

Several weeks ago, I testified on issues related to payment and risk adjustment in Medicare's managed-care program. In our 1996 report, the Commission addressed a number of other important policy issues relevant to Medicare managed care. These included which types of plans should be made available, standards for plan participation, and mechanisms for facilitating beneficiary choice.

This year, we have moved forward with work on access to care in Medicare risk plans (both for the typical Medicare beneficiary and for vulnerable subgroups), use of quality and performance measures, consumer protection initiatives, and the treatment of provider-sponsored organizations.

Access in Medicare Managed Care

Although monitoring access under Medicare managed care could alert policymakers to any adverse effects of program changes, there is now no system for doing so. Since, both the Secretary of Health and Human Services and the Commission are required to monitor beneficiary access to care in Medicare fee for service, the Commission recommends that a similar requirement be created to monitor managed-care access. Its recently completed survey on beneficiary access in Medicare managed care shows the feasibility of this method for monitoring access. (See attached *PPRC Update* describing the results of this survey). Monitoring efforts should be designed to permit comparisons, where possible, of access between Medicare managed care and fee for service. In addition, these should include analyses designed to explain access barriers for vulnerable groups and to determine the relationship between access and outcomes.

PPRC Update

No. 4, October 1996

Physician Payment Review Commission

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How Do Medicare Beneficiaries Fare in HMOs?

Preliminary Results from PPRC Access Survey

Medicare beneficiaries increasingly get health care through HMOs. Enrollment now totals 12 percent of beneficiaries, up from 9 percent at the end of 1994. Rapid enrollment growth is expected to continue.

One of the key questions emerging with the growth of Medicare managed care is how these arrangements affect access. Access is not determined by a single measure, but is the sum of such factors as experience in obtaining care, perceived barriers to care, clinical aspects of care, and satisfaction.

The Issue

Policymakers are focusing on the rules, processes, and incentives associated with managed care. Do these promote improved access or restrict it in undesirable ways? Answering these questions requires collecting new data and developing access monitoring strategies. A PPRC survey of more than 3,000 Medicare risk plan enrollees and disenrollees provides a starting point.

The Evidence

Access to care in Medicare HMOs is good for most beneficiaries, although disenrollees and certain vulnerable subgroups of enrollees experience more problems (Table 1).

- Twelve percent of enrollees and 22 percent of disenrollees reported at least one of the access problems included in the survey questionnaire.
- The nonelderly disabled, those over age 85, and those with functional impairments experienced a higher rate of access problems than others.

Measure	Enrollees	Disenrollees
Reported any access problems	12	22
Not referred for wanted specialty care	6	14
Felt discharged too soon if hospitalized	6	14
Wanted more home health services, if had used any	17	36
Had trouble making appointments	8	15
Gave up due to trouble*	25	52
Rated overall health care covered by plan		
Excellent	44	25
Very good/good	53	51
Fair/poor	4	24
Would recommend plan to family/friends		
Generally	88	50
With serious/chronic health problems	75	44

Table 1. Selected Measures of Access and Satisfaction (percentage)

Although various access problems were found, none were widespread.

- A small minority perceived problems with access to specialty care or hospital care. Home health users had more problems obtaining these services.
- Only a modest proportion had trouble making appointments. Of those who had trouble, however, many gave up trying to make an appointment.

Across a range of measures, most beneficiaries are satisfied with their HMOs.

- Nearly nine in ten enrollees would recommend their HMO to others. Three-quarters would recommend their plan to those with a chronic or serious illness. Fewer disenrollees would do so.
- Nearly half of enrollees rated their plan's health care as excellent. Many more

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disenrollees than enrollees rated their HMO's care as either fair or poor.

Access issues motivated many HMO joiners; other motives varied by enrollment status.

- Nearly half of all enrollments were due to increased benefits or reduced costs (Figure 1).
- Enrollees were more likely than disenrollees to have joined because of the HMO's providers. Disenrollees were more than twice as likely to have been motivated by a salesperson.

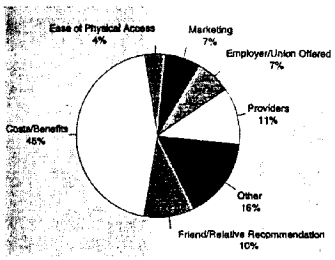

Figure 1. Reasons for Enrolling in Medicare Risk Plans

Although only a small percentage of enrollees leave their HMOs, their experiences provide valuable policy information. Those who switched HMOs differed from disenrollees to fee for service.

- Problems with physicians and access concerns motivated 40 percent of disenrollments to fee for service (Figure 2). More than a quarter disenrolled because they moved or for other involuntary reasons.
- Plan switchers were more likely than disenrollees to have left because their doctor left, died, or retired, and less likely to have left because of access problems.

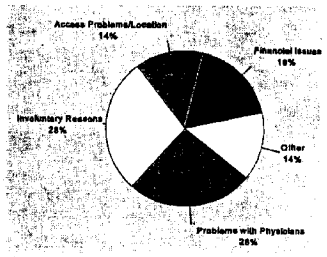

Figure 2. Reasons for Disenrolling from Risk Plans to Medicare Fee for Service

Conclusions

As Congress considers broadening choices and facilitating further growth in Medicare HMO enrollment, a key consideration will be the monitoring strategies set up to evaluate effects of program changes. PPRC's survey shows that surveying beneficiaries is a feasible method for gathering information on access.

Methodology

A telephone survey of 3,080 Medicare beneficiaries enrolled in a risk HMO for at least one month during the year ending February 1996 was conducted for PPRC by Mathematica Policy Research, Inc., in the spring of 1996. Enrollees constituted 92 percent of the study population. Plan switchers, those enrollees who had disenrolled from another plan that year, made up 5 percent. Three percent were disenrollees, in fee for service at year-end but enrolled in a risk HMO at some point during the year. The study achieved a 64 percent response rate.

Staff Contact:
Beth Docteur

Findings presented are preliminary. A full report on the survey's results and methods will be available from PPRC in November.

PPRC is a nonpartisan congressional advisory body, charged with providing policy advice and technical assistance concerning Medicare, Medicaid, and other aspects of the health system. It conducts independent research, analyzes legislation, and makes recommendations to the Congress on program design and implementation issues.

Gail Wilensky, Chair
Lauren LeRoy, Executive Director

Access for Vulnerable Populations

To promote access for vulnerable populations in Medicare managed care, the Commission recommends that the Congress direct HCFA to pursue demonstrations of a broad range of innovative and effective health delivery approaches for vulnerable groups in managed care. It should also direct an agency such as the Agency for Health Care Policy and Research to develop a research framework for promoting access for vulnerable groups in Medicare managed care, and to coordinate public and private efforts to evaluate and disseminate innovative health care delivery strategies.

Medicare's Use of Performance Measures

With private-sector purchasers increasingly using information on health plans' performance in administering their benefits programs, use of quality and performance information in Medicare looks promising for the future. Performance measures should now be used in Medicare to provide beneficiaries with information on partici-

pating health plans and, where comparable information can be obtained, on fee for service. The measures should also be used in Medicare's quality improvement program and in program monitoring. In addition, HCFA should proceed in its use of Medicare performance measures as guided by advances in methodology and by considerations of public acceptance and private-sector use. It should also seek to promote efficiency and minimize duplication of effort by continued collaboration with others to identify core measures.

Implementing an enhanced quality assurance system that incorporates health plan performance measures would also permit dropping the so-called 50–50 rule. This rule, which prohibits a Medicare risk-contracting plan from exceeding a 50 percent cap on publicly insured (i.e., Medicare and Medicaid) enrollees is arguably no longer needed in a Medicare program where more direct measures of health plan quality and performance are being implemented. Retaining this rule presents a barrier to plans' specializing in the elderly and disabled and restricts Medicare participation or market expansion of health plans.

Health Plan Data

As policymakers seek to improve Medicare fee for service and expand the range of plan options available to beneficiaries, the need for data will likely increase. The Commission recommends that HCFA define a standard core health data set useful for risk assessment and adjustment, quality improvement, access monitoring, and other performance measures. The cost of providing data should be weighed against the value of expected use. The data set should be as consistent as possible with health plans' other internal and external data needs. Once the core data set is well-defined, HCFA should require health plans and their contractors to provide the necessary data.

Provider-Sponsored Organizations

In 1995, the Congress proposed allowing PSOs to contract directly with Medicare. Different legislative proposals would have treated PSOs differently from other managed-care plans by waiving state licensure requirements and applying federal solvency standards. Since then the environment has changed. New PSOs have emerged in many markets, states are revising their laws, and the National Association of Insurance Commissioners is developing new regulatory approaches that could be adopted by the states. These trends seem to reduce the urgency of special treatment for PSOs under Medicare.

For that reason, the Commission recommends that provider-sponsored organizations that participate as risk contractors in the Medicare program should be required to meet the same standards as other plans. Flexibility should be used in developing and enforcing standards and rules as appropriate given differences in plan design. Plan participation in Medicare should be monitored to ensure that state or federal requirements do not impose unreasonable barriers to market entry for PSOs or other health plans seeking to participate in Medicare.

Federal Premium Contribution

Over the past few years, the congressional debate on Medicare has primarily focused on how to offer beneficiaries a broader choice of health plans. Some have argued that focusing only on expanding the risk-contracting program is too narrow. They advocate a more fundamental change of providing a contribution that beneficiaries would use toward purchase of health insurance from a variety of approved plans, including Medicare fee for service. Because such a system would be a significant departure from the current program, the Commission has begun to analyze these issues and their implications for Medicare.

In considering how a Medicare premium contribution system might work, the Commission looked to see what lessons could be learned from two existing premium contribution systems: the Federal Employees Health Benefits Program and the California Public Employees' Retirement System. These programs have made quite different decisions on key design issues such as the structure of the premium contribution, how competition among plans is managed, and benefit package design. Another issue that would confront Medicare would be how to integrate current and future beneficiaries into a new system. We have looked at the advantages and disadvantages of various approaches, considering whether these are administratively feasibly, how they might effect competition on premium prices, their potential impact on adverse selection, and their potential for controlling programs costs. The Commission will continue to analyze these issues in the months ahead to provide for an informed discussion should Congress consider such a proposal.

Secondary Insurance for Medicare Beneficiaries

For the second consecutive year, the Commission has devoted time to considering issues related to private secondary insurance for Medicare beneficiaries. These include the impact of secondary insurance on Medicare spending, expanding portability, and how to evaluate the impact of program innovations. To facilitate future evaluations, the Commission recommends that insurers and employers that provide supplemental insurance be required to report information to HCFA about beneficiaries' purchase or receipt of such insurance.

Dually Eligible Beneficiaries

Finally, given that more than five million elderly and disabled persons (nearly 15 percent of Medicare beneficiaries) are entitled to receive benefits from both Medicare and Medicaid (Table 4). Proposals to restructure Medicare and Medicaid should explicitly take into account their implications for these dually eligible individuals. Proposed changes should be assessed in terms of their effect on the potential for coordinating the financing and delivery of care.

Table 4. Characteristics of Dually Eligible Beneficiaries and Other Medicare Beneficiaries, 1995 (percentage)

Characteristic	All Beneficiaries	Dually Eligible	Other
Percentage of Medicare Population	100.0	14.6	85.4
Percent Female	56.9	64.1	55.7
Age			
Under 65 (disabled)	11.0	30.6	7.6
65 to 84	78.1	54.3	82.2
85 or older	10.9	15.1	10.2
Race			
Black	9.1	24.2	6.7
White	89.0	71.0	91.9
Other	1.9	4.8	1.4
Covered Under Part B Buy-In	14.1	81.5	2.6
With Private Insurance	72.7	16.8	82.2
With at Least One Month HMO Enrollment	10.4	4.2	11.5
Institutionalized	5.6	16.8	4.1
Functionally Impaired	18.8	35.7	15.9
Health Status			
Excellent	16.2	7.2	17.7
Very good	25.8	13.3	27.9
Good	29.5	29.2	29.6
Fair	19.4	31.8	17.3
Poor	9.1	18.5	7.5

SOURCE: Physician Payment Review Commission analysis of 1995 Medicare Current Beneficiary Survey.

NOTE: Dual eligibles are defined as beneficiaries who reported being covered by Medicaid at any time during the year prior to the interview.

Chairman THOMAS. Thank you very much. Let me talk to you in reverse order because I have a couple of fairly specific questions for you, Dr. Wilensky, and then, Dr. Newhouse, I want to take you through some of your charts and some of the things you said since the idea of a zero-based update has gotten some folks' attention. And I want to make sure I understand everything you said and that your charts show.

Dr. Wilensky, you talked about the update, the conversion to a single factor. We did visit that and dealt with it and came up with a phase-in period, and it just seems to me that when you are dealing with any significant number up or down and that number deals with someone's income, 30 to 40 percent in a 12-month period is a fairly tough shift. If, in fact, that were to occur, I assume the Full Committee would be besieged to examine income averaging as a change in the Tax Code, and so we clearly agree with a phase-in procedure. Everybody seems to think 3 years is appropriate. Two might be OK; 4 years is probably too long, so 3 years sounds good.

I am more interested in what has occurred with HCFA in their attempt to get a handle on the one component which is supposed to be a real-world check, which was the practice expense, and they had set up a fairly elaborate procedure to get that data which, in terms of polling, was not returned in any kind of a number to give you any degree of confidence.

When folks do that, there are ways to statistically manipulate what you have to get it to look a bit random. What they did was to choose something else, and that was go to a formula structure. I know that was also different than your suggestions earlier.

I frankly am less concerned how you do it than whether or not what they do has some degree of validity that allows us to have a comfort level, notwithstanding, I think, a clear sentiment to do it over several years rather than one.

Ms. WILENSKY. Well, there has been a lot of controversy raised. Now, there are two components. There is a direct and an indirect allocation of the practice expense, and the concern has been for the indirect costs.

There are some standard accounting procedures that can be used that are either allocating according to time or according to work. Again, we think that while there is some arbitrariness that will inevitably occur and we wish there had been some different procedures or studies used during the time they had available, we still think it is possible to proceed now by indicating clearly that changes will be made in the refinement process and how physicians will be involved during that process. It is better to move ahead.

There is concern being raised, but there is or should be equal concern for people who have been being paid on a historical charge basis for the last 7 years.

Chairman THOMAS. Thank you. Also in the President's proposal on the physician performance standards, you folks proposed a GDP plus a kind of——

Ms. WILENSKY. Two.

Chairman THOMAS. Two—it was 1 or 2. But let's take the hard number, the 2 percent. It would be gross domestic product plus 2 percentage points. The President's was just GDP; right?

Ms. WILENSKY. Yes.

Chairman THOMAS. Why the 2-percentage-point bump? How significant is it, and how strong are your feelings about it in comparison to what the President offered?

Ms. WILENSKY. The concern of the Commission was that the GDP period would not allow for some of the advantages of new technology that at least initially may be cost increasing. I do not think there are strong feelings about the number 2. I think there

was some concern that GDP plus zero was very stringent. It would especially be an issue of concern were it to last very long.

In some ways, it is like the minus 4 that is now attached to the volume performance standard. When it was first introduced, it did not have nearly the draconian effect that it will have if it stays on. This is not something we explicitly discussed, but my own sense would be GDP plus zero probably would not cause too much harm if limited to a very short period. It would not allow for the adoption of new technologies if it were for more than a couple of years.

So we would feel comfortable with GDP plus something small.

Chairman THOMAS. Thank you.

Dr. Newhouse, in terms of ProPAC's recommendation for a zero update, there has been some, if not criticism, at least concern, and you walked us through a number of areas. And in your report on page 21 and your table 1.1 in that report, it kind of sets out the components of the hospital update taken into consideration by the Commission. And it is a series of items rather than just a single one. I want you to go over the list there, especially the scientific, technological advances in medicine, the productivity case mix and so on. Just give us a flavor for how you wound up with the decision that you got.

Mr. NEWHOUSE. I would be happy to do that, Mr. Chairman. Take the top two items. We start with the forecast of the market basket increase for the following year. That is just a forecast or a guess. For this year, we started with the HCFA estimate of 2.8 percent, and it has been the Commission's custom to correct for any errors in past forecasts—if the forecast has been too high, to take that back, in effect, and if it has been too low, to give it back. And the 1996 forecast error, as you see, was eight-tenths of 1 percent negative, meaning from the government's point of view hospitals were overpaid, so we are taking that back. That gets us down to 2 percent.

Now, the next item, scientific and technological advance, the rationale for it is really the same rationale that Dr. Wilensky just gave you for the plus on the GDP factor; that is, historically, innovation and technological change in medicine has increased capabilities and increased costs.

The Commission has historically added about three-tenths of 1 percent to a full percent for this factor. This year, because of the increased price competitiveness of the medical care sector, we thought there might be more cost reducing innovation. And so we went toward the lower end of that range and came out at four-tenths of 1 percent.

I should add that this whole procedure, going through this step by step, is the procedure that the Commission has customarily used every year, so it is really—the only thing to supply this year is why we came out at the numbers we came out at.

Now, the next item, the allowance for productivity and service change, is clearly what is important in getting to our final recommendation of zero. And it is also something of a change from the way we have operated in the past. In the past, we have used a standard of about 1 percentage point for an increase in productivity. That is to say, we felt that hospitals could increase their efficiency, if you will, of doing what they are doing by about 1 percent

a year. You can imagine them on a treadmill with a slight grade of 1 percent. And we have said, therefore, we will knock off 1 percentage point because we think they can improve productivity by that much.

Now, what was different this year and why it comes to minus 3 to minus 1 is that we explicitly considered the fall in length of stay and the increase in postacute care, which, as you know, is paid for separately. And that is why the words "and service change" appear in that line as well as productivity.

As you know, the operating payment pays for the DRG, which is a bundle of services during the admission. And if some of that bundle is shifting out to postacute care and being paid for separately, then it would be appropriate to reduce what we are paying for the DRG. And that is what is going on here. So we took out—we have a range there, minus 3 to minus 1, because the exact amount is not very clear.

Finally, the last component, the net adjustment for case mix change, the case mix change is the average of the DRG weights at a hospital. For example, a coronary bypass operation has a weight of about 5, and a cataract operation has a weight of about 0.5. And Medicare pays in proportion to those weights. So the hospital gets 10 times as much, roughly, for a bypass operation as it does for a cataract operation. And if the average of those weights goes up, Medicare payments go up proportionately.

Now, there has always been an issue about how much of this increase in the weight is so-called true change, that is, more complicated cases being treated, and how much is so-called upcoding, that is, how much is it really the same patient being reclassified to a higher category. And Medicare wants to pay for the former and does not want to pay for the latter.

So this line is in there to say how much in the Commission's view is the latter, is upcoding, and to the degree it is upcoding, we would knock some off. Now, we have been at PPS for quite a long time now, and we think that the upcoding that should be occurring is occurring, and, therefore, we did not deduct anything for upcoding this year. In other words, we think that hospitals are doing it to the degree that they can do it.

So putting that all together, that comes out, as you see at the bottom, to minus six-tenths to plus 1.4 percent, and we just decided to pick zero in the middle and recommend a zero update to you.

Chairman THOMAS. Have you ever done less than zero?

Mr. NEWHOUSE. No. The Commission has never recommended less than zero. In fact, it has never recommended zero, but historically, of course, the market basket increase that we started with way up on top has been higher. So it would have taken quite a bit more to get——

Chairman THOMAS. So, in effect, the Governor on this whole process, even if you were to go zero—we can never go below where you are going to get money back. It is not going to happen. So we are going to go to zero. But if you will look at the correction, even if we are off to a degree, that is a built-in rudder, isn't it, when you do your correction for fiscal year 1996 forecast error?

Mr. NEWHOUSE. Yes, that is just in the market basket—whatever the market basket turns out to be. It is an estimate, and then after

the fact, we know what it turned out to be and we correct for the differences. But that is just the market basket which is the input prices.

Chairman THOMAS. Worst-case scenario, you are wrong, what is the makeup procedure, or do we just do better next time?

Mr. NEWHOUSE. Because all human institutions, including our Commission, can be wrong, we are recommending this update for 1 year only, and then we would take a look in another year to see how it would go or how it is going.

Chairman THOMAS. Everybody wants true productivity improvements. Zero updates to me do not sound like a very good incentive for productivity. Is that false economy, or are there ways in which hospitals would actually have an incentive to increase productivity, notwithstanding a zero?

Mr. NEWHOUSE. Well, Mr. Chairman, the Commission has always had a philosophy of sharing gains in productivity. So when I said there was a 1-percent correction, actually the treadmill was really set at 2 percent and we were going to give half back to the industry. But beyond that, to any individual hospital, because the payment it gets is really independent of what it does—it is the action that you in the Congress take that determines that—any individual hospital, if it can improve productivity, it is still going to save the full amount. If you decided in the aggregate that hospitals are becoming more productive, it is still true that if the individual hospital becomes more productive, it saves the full amount.

I think the incentive to the individual hospital is still quite strong.

Chairman THOMAS. OK. Let's take your chart 5, which I think gives us a number of lines and shows history in terms of payment changes, costs, and the rest.

What would it look like with a zero update if we took your recommendation and plugged it into the chart?

Mr. NEWHOUSE. OK. It may be easier to—I will tell you the answer on chart 5. The divergence up at the top would probably be——

Chairman THOMAS. If you have a better chart, I will look at the better chart.

Mr. NEWHOUSE. Well, why don't you look at chart 3, which is the PPS margins.

Chairman THOMAS. We will do that, but I do like the one that puts them all together.

Mr. NEWHOUSE. OK, fine. We will go back——

Chairman THOMAS. We will do chart 3. Go ahead.

Mr. NEWHOUSE. Chart 5 I think would be the gap between the top line and the next to top line, that is, between payments and costs, would be roughly unchanged. Our estimate is it would shrink slightly. To go back to chart 3——

Chairman THOMAS. Well, to project current trends, they would obviously continue to separate, which is why you are telling us that they wouldn't. But you wouldn't get a corrective factor with the 1 year zero.

Mr. NEWHOUSE.The number the Commission used for the estimates actually goes beyond the zero update on operating costs and also includes a minus 15 percent on the capital cost side, which we

have not come to yet. Those two together, doing both, we estimate would reduce the PPS margin to 10.4 percent. And current law has a 2-percent update, so that would be roughly 12.4 percent. So we are still talking double-digit margins on the PPS side, and if you decided not to adopt the capital cost reduction, of course, the margins would be even higher than our 10.4.

Chairman THOMAS. And if we were not to adopt your zero percentage, you believe the current trends and the way in which we have been looking at it, your argument in all likelihood, all things being equal, would be much stronger next year.

Mr. NEWHOUSE. Yes, I do. I think that if you do not adopt our recommendations—say for the sake of argument you went with a 1-percent increase, the margin would be approximately—that would translate into approximately an additional 1-percentage-point increase in the margin.

Chairman THOMAS. And that if we decided to go with your recommendation of zero and what we got—and I will just use chart 5—instead of a continued separation, a kind of a stabilizing of the relationship that would encourage us perhaps to then take a look at the next year to see if it stabilizes and we might be able to deal with a Greenspan-esque approach to closing the gap, is that——

Mr. NEWHOUSE. I would think that would be prudent, yes, Mr. Chairman.

Chairman THOMAS. But you believe the prudent step now, as per your recommendation, is to, at least for the year, try zero.

Mr. NEWHOUSE. Yes.

Chairman THOMAS. The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman.

Concerning the zero update recommendation, Joe, there are a wide variety of recommendations. The national public hospitals will testify that their overall margins are less than 1 percent, seven-tenths, while their Medicare margins are pretty high. The President is recommending minus 1, the blue dogs are minus 2, you are minus 2.8. I presume it is at 2.8. So do you take into account the other revenues, or do you just focus on Medicare and what the margin on Medicare will be after your update?

Mr. NEWHOUSE. We have looked at both PPS margins and total margins by subgroup. Now, we can do better, clearly, at forecasting PPS margins than total margins because it is much harder to forecast what will happen to private revenues.

Mr. STARK. Yes. The question is: We now pay a higher amount for hospital-based SNFs and home health care agencies. Is that not correct?

Mr. NEWHOUSE. I am sorry. I did not fully understand.

Mr. STARK. We pay extra or higher reimbursement to SNFs and home health agencies that are hospital based.

Mr. NEWHOUSE. We pay higher for SNFs.

Mr. STARK. And home health——

Mr. NEWHOUSE. Not for home health.

Mr. STARK. Not for home health? You are sure?

In any event, why should we pay more for SNFs? What is to suggest they are any different? Just because it is hospital based, why should we pay that particular SNF more than one with equally

good quality care, which I presume is licensed by the same body that licenses the hospital-based one?

Mr. NEWHOUSE. I think that question is a difficult one for the purposes of formulating policy. What we know is that costs are higher in hospital-based SNFs.

Mr. STARK. Well, yes, but that is because they are loading a lot of overhead that other SNFs——

Mr. NEWHOUSE. You took the words out of my mouth. That was why it was difficult——

Mr. STARK. But from the standpoint of our getting a better bargain in quality care, you cannot give me some built-in reason that we ought to do that. Is that correct?

Mr. NEWHOUSE. Well, the built-in reason would have to be that I think that one believed, for example, that the true costs were—true costs as opposed to the accounting costs—were higher and that for some reason or other there was not free-standing SNF in this community, for example.

Mr. STARK. Right up there with boiling seas and flying pigs in the leaps-of-faith department. OK.

Have you ever considered that we are getting less service in review, and out of HHS, and that we ought to perhaps think about having a little higher cost of administration in HCFA? We always brag about the fact that it is only 2 percent or less, but is it time—and have either of you ever considered—Gail might know more about this than the rest—that maybe we ought to think about giving them a little more money?

Ms. WILENSKY. Yes and yes.

Mr. NEWHOUSE. Yes.

Ms. WILENSKY. The answer is yes and yes, I believe that that is correct.

Mr. NEWHOUSE. Yes, I do, too. I also——

Mr. STARK. I wonder if as isues get more complicated and complex and——

Ms. WILENSKY. Particularly with regard to some of the payment safeguards, where I think there would be——

Mr. STARK. Well, to the extent that that is something you all could refer to us as a suggested policy, I would like to share it with my colleagues, because we have spent years and we never have really looked at that. That was just something that might be of interest to us.

The only other question I have for ProPAC is on the outpatient department payments. You want to have a PPS for hospital outpatient as soon as possible. Is that right?

Mr. NEWHOUSE. We would like to shift away from cost-based reimbursement as soon as possible.

Mr. STARK. All right. Now, the administration says we should fix the problem over 10 years. Mr. Coyne and I have a bill that says 1 year. That is a pretty easy scale now for you all to just crank up or down for me. Where should that be? I think 10 years is too long. We will go broke. Or I may not be here to watch you fix it. But is there a better range for phasing in whatever the fix is?

Mr. NEWHOUSE. Just to be clear what we are talking about, my understanding of the 10-year phase-in for the administration is on the beneficiary cost-sharing or copayment side.

Mr. STARK. And not on the whole PPS——

Mr. NEWHOUSE. Not on the whole reimbursement side. But I could be mistaken.

Mr. STARK. What about on the reimbursement side?

Mr. NEWHOUSE. On the reimbursement side, the problem is the integration—or getting a level playingfield, if you will, between what is in physician offices and what is in hospital outpatient departments, which we are not near to doing in my view. It would be nice if we were, but we are not. I would worry about getting the playingfield——

Mr. STARK. All right. Well, let me just finish. In many areas, the ambulatory centers do a safe job for basically half the money that we pay for the outpatient department. Right?

Mr. NEWHOUSE. As far as I know.

Mr. STARK. Let's put it this way: Where ambulatory surgical centers do procedures that are safe and——

Mr. NEWHOUSE. Yes.

Mr. STARK [continuing]. Considered routine, we pay about half of what we would pay for the same procedure in the same town when it is done in an outpatient setting. Ought we not look at that and ask you for some recommendations?

Now, there are people who say we ought to raise payments to the outpatient level. I suggest that we might look a little more toward bringing it down to the ambulatory surgical center level. Could you give us some advice on that?

Mr. NEWHOUSE. Yes. In our next year's report, we would be happy to take a look at that. I suspect personally that some of this may be the same kind of issue we were talking about with the SNFs, that we are talking about allocation of overhead on the part of the hospital.

Mr. STARK. I just have one request for Gail. We have heard a lot from many physicians lately about whatever we wrought many years ago when we implemented this payment system. I know you can attest to the fact that I warned the surgeons that, while they liked it the year we passed it, there would be some years in the future when they would not think we were such good guys here and would complain about the fact they were getting reduced in payment as opposed to, say, primary care who were getting an increase.

Well, that time seems to have come. Many people have warned us not to deal with anecdotes, but what I am hearing is, Gee whiz, I am going broke. We all know that physicians' incomes I guess on average went from 160 to 195, but averages do not mean much.

Could you provide to the Subcommittee in a sanitized version some examples, maybe going back a few years, and then estimating what would happen in these practice adjustments. So you could say here is Physician A in California or Physician B in New York who over these years has had this much Medicare revenue, this much per procedure, whether it is back surgery or whatever, and here is what will happen under these scenarios. We are talking about aggregate information, and it does not mean much when you say the physician is only going to move from $6,000 a procedure to $5,725—then I am not as concerned. If the physician is going from $6,000 to $2,000 in 1 year, then we ought to look at it.

I am sure you can get that information from HCFA, and give us some anecdotes, if you will, so we can get a feel for what these ranges would do, both phasing-in and the amount. I would find that helpful, and I think my colleagues would as well.

Ms. WILENSKY. We would be very glad to provide that information. Let me make the point that I think there are three things going on right now that are causing so much attention from the physician community.

First, there are two different kinds of changes that have strong interactive kinds of effects; that is, the movement to a single conversion factor and the use of the relative value practice expense. It is pushing the same people in a downward direction.

The other thing that is happening is that I think you are getting a response from the surgeon community about questioning whether working with the government is working with a fair business partner. The reason their higher conversion factors have been occurring over the last few years is that their volumes have been lowered.

Now, there is a lot of debate about whether they caused it or whether the internists and generalists were responsible. But I think you are also——

Mr. STARK. But we agreed to reward them, in any event.

Ms. WILENSKY. But the reward that was built into the law was that if you spend less, you get a higher conversion factor. And I think you are hearing, with some legitimacy, complaints: We played the game as you said; now we are getting hit. When you go to a single conversion factor, we are taking it on the chin.

Mr. STARK. If I could respond, I am not so excited about the single conversion factor, but I do feel the practice expense is something that a good accountant could consider. That is empirical. What is the rent? What is the salary? What is the cost of insurance? That is what it is, and we ought to be able to get that more easily.

Thank you very much for indulging me.

Chairman THOMAS. Certainly, and I want to assure my friend that in this new atmosphere of civility, anything that occurred on his watch, he is going to get full credit. [Laughter.]

Chairman THOMAS. The gentleman from Louisiana.

Mr. MCCRERY. Dr. Newhouse, in the President's proposal for Medicare, he would limit the definition of a hospital discharge to only those patients that go from the Medicare hospital to home and would define as a transfer a patient going from the hospital to a PPS-exempt facility or a SNF.

Are you familiar with that proposal?

Mr. NEWHOUSE. Yes.

Mr. MCCRERY. Do you think that might have the effect of hospitals keeping patients longer?

Mr. NEWHOUSE. It might, Mr. McCrery. But I personally favor this proposal, but I think it will have a fairly limited impact. So let me try to explain all of that to you.

The limited impact part is that we know from the ProPAC work that most patients that go to SNFs actually have longer than average stays. That is not terribly surprising. They are probably the sicker patients. And the transfer payment only really comes into

play if you stay past the so-called geometric mean, or you can think of it as the average stay.

So since these patients are sicker, actually for relatively few of them is it going to matter, because the hospitals—once they get past the mean, the hospital is going to get the standard DRG payment either way. But for some patients it will matter; that is, for the patients that are staying relatively short times in the hospital. So let's focus on that where it does matter.

The Commission did not take this up, which is why I am giving you my personal view. The reason I personally like it is that it somewhat levels the playingfield; that is, right now for these patients, if the hospital discharges the patient to the SNF, which may just be another floor of the hospital, the hospital is going to start to collect a per diem payment and it still keeps the entire DRG payment. So there is a fairly strong incentive to get the patient out to the SNF, financial incentive.

Under this scheme, things would be somewhat more balanced. The hospital would actually keep more money if it kept the patient in the hospital per se, and that would somewhat play against the additional money it would get if it transferred the patient to the SNF.

Now, you could also make it neutral by linking the hospital payment with the SNF payment or the entire postacute payment, as we recommended that you do a demonstration of that in our recommendations to you. That would also be a way of keeping things neutral. But that is why I think this would be relatively limited but probably a step in the right direction.

Mr. McCrery. Do you all recommend anything else to deal with the increasing number of postacute care services?

Mr. Newhouse. Do we recommend anything else? We have a number of recommendations to you on postacute care for SNF. They kind of divide into short-run changes and longer run, more visionary kinds of changes.

The short-run changes are to impose cost limits on ancillary services for SNF care, and on the home health side to think about some kind of reduced payment for high users and also some copayment for home health. The more visionary refers to linking the acute and postacute services that I mentioned. That we would do by demonstration first.

Mr. McCrery. Thank you.

Thank you, Mr. Chairman.

Chairman Thomas. Does the gentlewoman from Connecticut wish to inquire?

Mrs. Johnson. Thank you. It is a pleasure to have you here today and begin the process or move it one step further along of understanding the challenge of all of these numbers that have to be laid out there for the next year.

I am interested in your recommendation in terms of hospital updates and particularly the zero update, because in recent years, in my experience, these recommendations have very different impacts on different kinds of hospitals. And we have seen in our charts, for instance, that the margin will be very low or negative in the big teaching hospitals. And then when you add the IME and the DME and the DSH in, they come back up.

Well, the medium-sized hospitals that do not get teaching reimbursement or DSH payments and yet have a high Medicare hospital census in my experience suffer the most when we press down on Medicare reimbursement rates. The other institutions have other sources of money that tend to compensate for zero updates or low adjustments, a lowering of the market basket change.

Have you played out these rates to look at how they will affect different kinds of hospitals, and particularly the sort of midsized hospitals that will serve a region of small towns but are not teaching hospitals and are not DSH hospitals and do not even have a particularly high level of uncompensated care?

Mr. NEWHOUSE. As best I can recall, we have not cut it quite that finely. We have looked at teaching and DSH against nonteaching and DSH. Naturally, as with any industry, there is a spread across the industry in how profitable firms and what their margins are and so forth. We see the stock market going up and down all the time in response to that news.

Our estimates are that the hospitals with negative PPS margins will be at an all-time recent low, even with our proposal; that they will be about 20 percent of hospitals with such margins, down from about 60 percent of such hospitals a few years ago.

The other point I would make is that some analysis the Commission did a few years ago suggested that, as you would expect, hospitals with negative margins in one year are not necessarily the same hospitals with negative margins the next year; that negative margins get the attention of the board and some steps are done to address the problem, and margins become positive.

So as far as we know, there are probably relatively few hospitals—but there surely are some—that go year after year with negative margins. Those hospitals, of course, are the ones that over time will merge or close. But I think that is a relatively limited problem, as opposed to, say, a large class of hospitals. In any event, things are certainly getting better for the hospital industry as a whole.

Mrs. JOHNSON. Any help you could give me in looking at those hospitals or refining down your view, Dr. Newhouse, would be helpful, because smaller hospitals that are really critical to the quality of health care in large, rather rural areas but not carried as rural hospitals are very important, and they carry—those are areas where the population is also aging. So they have an increasingly high percentage of Medicare patients. And I do see them having a lot of trouble, and they have already downsized costs a couple of successive times that are significant enough to hit the papers, involve all the staff—really be an institutional response to cost cutting.

But you can only do that so many times and still have decent service capability. I would hope you would look at that more carefully. Dr. Young and I spent a good deal of time on this issue last year, and it is true your data does not go deeply to the issue that I am raising.

I would be happy to have you comment in 1 minute, Dr. Young. I do want to get on to my other question, because in teaching hospitals, you are recommending that we encourage training in settings outside the hospital. I absolutely agree with that. But that is

going to be money that used to flow to the teaching hospital that is going to flow now outside the teaching hospital. If at the same time we base IME payments only on volume of Medicare patients, then what are we going to do to the ability of teaching centers to survive?

This is my thought. If you base reimbursements only on volume of Medicare patients and the hospital only has residents in, say, three areas, then that is one thing. But if they are a really sophisticated medical center, and they are trying to train not only specialists in a lot of areas but sub-subspecialists as well, then they are going to have the same reimbursement for their Medicare patients as a teaching hospital, whether they have 10 residents or 50 residents. At least, that is the way I read your recommendation. And while we do not want to encourage them to hire more residents—and I understand you are trying to get rid of that resident/bed ratio and all those things that drive institutions to hire more residents whether we need the doctors or not, nonetheless doing it only on volume, I think, could have a significant and concerning impact on teaching institutions.

Mr. NEWHOUSE. Well, in terms of the first question on giving the hospital flexibility; that is, teaching hospitals being able to send it elsewhere, that still is primarily at the option of the hospital. That is, we want to give the hospital the ability to do that, which it does not now have. If it chooses not to do that, well, that is its business. But we think it should have the option to do that.

On the remainder of the question, the most important thing, in our view, is to disassociate the payment to the teaching hospital from the number of residents that it has, which would have the effect then of ending the subsidy to the hospital of hiring another resident.

How, then, any teaching moneys are distributed would have to be addressed, because one would need a replacement formula. The Commission recommended that at least at the outset that be done historically to avoid major disruptions. But one would have to—if the delinking were done, one would have to come to an issue of how any teaching moneys would be distributed among hospitals over time as the number of residents changes.

Mrs. JOHNSON. Just to conclude, we also did a historic performance for 2 years, but I do not think just patient volume is going to be an adequate basis on which to distribute. I think we also have to look at, in a sense, the teaching burden of that hospital, how many disciplines it is responsible for, and how many levels of—how intense their teaching responsibilities are.

Mr. NEWHOUSE. I agree with that, Mrs. Johnson, yes.

Mrs. JOHNSON. OK. Thank you.

Chairman THOMAS. I thank the gentle lady.

Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Thank you, Mr. Chairman.

I have two questions. This is a pretty technical discussion, and I do not understand it all. But these are two questions which I have.

First of all, a specific one. In terms of the information which was distributed by you, Dr. Young, at one of the briefings, I have a list here that talks about the urban and the rural hospital PPS mar-

gins, and the rural are very distinctly lower for Medicare than the urban. Maybe you could explain that to me.

The next question is really for both Dr. Young and Dr. Newhouse. If I understand it correctly, you are saying that there should be zero adjustment for the hospitals for a 1-year period. However, the administration has suggested a market basket minus 1 percent for a 5-year period.

Now, we have got to produce a budget for a 5-year period. We have to look ahead. So what happens to the other 4 years?

Mr. NEWHOUSE. Which one do you want to take first?

Mr. HOUGHTON. You choose it.

Dr. YOUNG. On the information that I distributed, in 1995 the PPS margins for rural hospitals were 3 percent. That is substantially lower than the average. On the other hand, the total margins for rural hospitals were 7 percent. That is substantially higher than the average.

We think in part what we are seeing on the margins today is a result of declining cost growth and, as Dr. Newhouse pointed out, even actually negative cost growth. Costs in some areas are lower this year than they were last year.

We are not seeing that declining cost growth nearly to the same extent in rural areas as in urban, and that in part is what is accounting for and driving the lower PPS margins in rural areas. Part of that may well be due to the fact that these hospitals are still able to generate substantial added revenues from their private payers, and that is why their total margins are so high. They have not had the same financial pressure that urban hospitals have as a result of managed care and changes in the private market. They therefore have not lowered their cost growth. Their PPS margins are lower, but overall they are still doing fine. In fact, they are doing a lot better on average than the urban hospitals.

Mr. HOUGHTON. Because of the private?

Dr. YOUNG. I am sorry?

Mr. HOUGHTON. Because of the private?

Dr. YOUNG. Because their ability to generate revenues substantially in excess of their costs from their private business.

Mr. NEWHOUSE. On the question of the years 2 through 5, I think the Commission was just uncomfortable in trying to forecast. If you look at my chart 3, the margins for the last 5 years, we have gone from 1 to 5 to 8 to 10 to 12 percent. I do not think anybody sitting back in 1991 or 1992 would have been able to have guessed that that was what was going to happen. Certainly, I do not know anybody that thought that hospital costs would actually fall after they had been going up kind of 9 percent a year for years and years.

So we were just uncomfortable. I think you will have to make a decision about——

Mr. HOUGHTON. In your uncomfortableness, can you give us sort of a guesstimate?

Mr. NEWHOUSE. A guesstimate. Well, there is the issue of the guesstimate and then how much of a margin of error you build in around the guesstimate. If I had to guess—and it really is a guess—I am skeptical that costs are actually going to continue to fall, at least in nominal terms. They might fall in real terms some. I think a lot depends on how much additional pressure is going to

be brought to bear on the private side on hospitals. Medicare, after all, still is only—although it is the biggest single payer, it still is only a minority of hospital dollars for many hospitals and all hospitals in the aggregate.

So I think hospital costs—it is also going to depend on what inflation is, obviously. We start with our market basket forecast. It is probably reasonable to forecast around 3 percent inflation a year, but that has got to have a lot of uncertainty around it, too.

So that is the best I can do for you.

Mr. HOUGHTON. Well, if you forecast 3 percent a year, that is approximately what the White House has done, 2.8 percent, I think, and then a minus 1 percent from that. Would you agree with that philosophy?

Mr. NEWHOUSE. Well, that would certainly be within a range of my comfort zone. There are other numbers that would be in that range, too; particularly by the time you get out 3, 4, and 5 years, it gets to be a fairly wide range, I think, about what actually might happen.

Mr. HOUGHTON. Thank you very much.

Chairman THOMAS. I thank the gentleman from New York and thank once again our stalwarts, and my guess is we will see you before the summer solstice.

Thank you very much.

The next panel, as advertised: Thomas Johnson, who is the chief executive officer of Kaweah Delta Health Care District Hospital; actually, he is here on behalf of the American Hospital Association; Tom Scully, Federation of American Health Systems; and Larry Gage, president, National Association of Public Hospitals and Health Systems.

When you get settled, I will tell all of you that any written statements you may have for the record will be made a part of the record without objection, and you may proceed to inform the Subcommittee in any way you see fit. We will begin with Mr. Johnson and then move across the panel.

Welcome, Tom.

STATEMENT OF TOM JOHNSON, CHIEF EXECUTIVE OFFICER, KAWEAH DELTA HEALTH CARE DISTRICT, VISALIA, CALIFORNIA; ON BEHALF OF AMERICAN HOSPITAL ASSOCIATION

Mr. JOHNSON. Thank you, Mr. Chairman. I am Tom Johnson, chief executive officer of the Kaweah Delta Health Care District. The district is a public agency in Visalia, California, a community of 92,000 people in the heart of the south San Joaquin Valley. The district includes three hospital campuses: One devoted to rehabilitative care, another devoted to senior care and ambulatory services, and a large campus with a full array of outpatient, nursing care, and acute-care services. We also operate a wellness center, a childcare center, and a community benefit program with outreach and clinic services to the underserved population.

Fully, 24 percent of the population in our county is on public assistance, and the unemployment rate in our county is 17 percent. Without a county hospital, our district plays a lead role serving the

needs of people on Medicare and Medicaid, as well as the uninsured.

I am pleased to appear today on behalf of the AHA and its 5,000 hospitals, health systems, networks, and other providers of care. We appreciate this opportunity to present our views on Medicare's hospital payment policies, especially ProPAC's recommendations, as well as some of the President's budget proposals.

Many of ProPAC's recommendations for fiscal year 1998 are long-term suggestions that would move Medicare into the future in a progressive and constructive manner. However, a few of the short-term recommendations would present significant difficulties for hospitals and health systems like mine that are trying to serve today's seniors, cope with the volatile health care market, and at the same time strengthen our ability to serve the Medicare beneficiaries of tomorrow.

One of our concerns is the recommended PPS update for operating rates. Throughout the eighties, the Commission recommended PPS update amounts that were less than the full market basket increase. In part, this was done to spur hospitals to improve efficiency. Over the last year, hospitals have improved productivity significantly, but it seems that the Commission's approach for productivity gains and losses is the same: Lower recommended payment updates, more specifically, as we have heard, a zero update for fiscal year 1998.

ProPAC's recommendation was based on a finding that, due in large part to increased efficiency, hospital margins have improved for Medicare inpatient services. This improvement may encourage the belief that reductions in payments to hospitals can be achieved without pain. This is not true. In fact, when ProPAC reported these margins, they also estimated that 40 percent of the Nation's hospitals lose money when they treat Medicare inpatients.

More important, 20 percent of the hospitals have negative total margins. Overall, they are losing money. The reason: Medicare pays less than costs—only 97 cents on the dollar, according to ProPAC—and Medicaid is an even worse payer, and managed care ratchets down the commercial payment, which means we can no longer cost shift to make up the difference.

For about 1,000 hospitals, one in five of the Nation's community hospitals, Medicare and Medicaid combined represent more than two-thirds of total revenues. In our hospital, it is 70 percent. These hospitals are vital resources in their communities. Many serve a large number of the elderly. Update or no update, hospitals like these still must meet market price increases as measured by the hospital market basket index.

We urge Congress to reject ProPAC's recommendation and enact a positive PPS update. It is the best way to ensure that Medicare can continue to purchase high-quality services for our seniors. On this issue, the President's budget proposal is far more preferable and reasonable than ProPAC's recommendation.

Mr. Chairman, some of ProPAC's other recommendations are reasonable long-term improvements, such as the expanded use of prospective payment systems for skilled nursing, home health, and outpatient services. However, while promoting this move for outpatient services, the Commission also suggests a budget-driven re-

duction in outpatient reimbursement for certain surgical, diagnostic, and radiology services. It makes little policy sense to tinker in the short term with the formula-based outpatient payments while also embracing prospective payment and the incentive for efficiency it brings. AHA asks Congress to implement PPS for outpatient services quickly, as proposed by the administration, and forgo short-term contradictory changes in payment, as suggested by the Commission.

ProPAC also calls for implementation of PPS for skilled nursing and home health care, and, again, we agree. We recommend, however, that Medicare's payment policies reflect several differences in the cost of providing these types of care. These differences include the intensity of services provided, geographic differences in cost, and additional costs associated with hospital-based facilities.

Finally, in conclusion, the AHA strongly supports changing the way Medicare pays managed care plans. The President, ProPAC, and PPRC have suggested ways to reduce variations in managed care payments across the country. We urge Congress to support these efforts. We also support carving out GME and DSH funding from these payments to ensure that hospitals and others providing the services, not the managed care plans receiving the payments, are appropriately reimbursed.

Mr. Chairman, Medicare was a good idea 30 years ago when I entered into this field, and it is a good idea today. We look forward to working with you to ensure that hospitals and health systems can continue serving America's seniors for generations to come.

Thank you.

[The prepared statement follows:]

Statement of Tom Johnson, Chief Executive Officer, Kaweah Delta Health Care District, Visalia, California; on Behalf of American Hospital Association

Mr. Chairman, I am Tom Johnson, chief executive officer of the Kaweah Delta Health Care District, a public agency in Visalia, CA. Visalia is a community of 92,000 people. The district consists of three hospital campuses—one devoted to rehabilitative care, another devoted to senior care and ambulatory services, and a large campus which has a full array of outpatient, distinct-part nursing care and acute care services such as open heart surgery. The district also operates a wellness center, a child care center and a community benefit program with outreach and clinic services to the underserved population in the district.

I am pleased today to appear on behalf of the American Hospital Association (AHA) and the nearly 5,000 hospitals, health systems, networks, and other providers of care that the AHA represents. Medicare plays a major role in the everyday efforts of hospitals and health systems like mine to deliver care in our communities, and we appreciate this opportunity to present our views on Medicare's hospital payment policies, particularly the Prospective Payment Assessment Commission's (ProPAC) recommendations, as well as the President's budget proposals.

I would like to begin, Mr. Chairman, by commending ProPAC's commissioners and staff. The issues that surround Medicare have been influenced by the same dramatic change that is buffeting the health care environment itself. Keeping up with and sifting through those issues is a difficult and complicated task, and we appreciate the diligence and determination with which the commissioners and staff get the job done.

In its March 1 report to Congress, ProPAC made 43 recommendations for Fiscal Year 1998. Many of these are long-term suggestions that would move Medicare into the future in a progressive and constructive manner, and we support those concepts. However, a few of the more short-term recommendations would present *significant difficulties* for hospitals and health systems like mine that are trying to serve today's seniors, cope with a volatile health care environment and, at the same time, strengthen our ability to serve the Medicare beneficiaries of tomorrow.

SHORT-TERM ISSUES—I will start by noting our concerns about recommendations that we believe are ill-advised. Then I will move on to comments about some of the recommendations that we support.

Update for operating rates—The Prospective Payment System (PPS) was developed to provide hospitals with an incentive for efficiency and, by setting a fixed rate with an update factor for inflation, protect the Medicare program from the costs of inefficiency that could occur when hospitals provided inpatient services. Throughout the 1980s, the commission recommended PPS update amounts that were less than the full market basket increase, in part to give hospitals an incentive for improved efficiency. In the last year, hospitals have been successful in improving productivity significantly. But it appears that the commission's approach for productivity gains and losses is the same: lower recommended payment updates—more specifically, a zero update for Fiscal Year 1998. *We urge Congress not to penalize hospitals for the efficiencies they have achieved.*

ProPAC's recommendation, in part, was based on its finding that hospitals' margins, in the aggregate, have improved for Medicare inpatient services. The fact that hospitals have become more efficient may encourage the belief that reductions in payments to hospitals can be achieved without inflicting pain. This is not true. First, it is important to note that ProPAC's findings about hospitals' financial status apply *solely to Medicare inpatient services*. Second, at the same time ProPAC reported these Medicare PPS inpatient margins, it also estimated that *approximately 40 percent of the nation's hospitals lose money when they treat Medicare inpatients.*

More important, *20 percent of hospitals have negative total margins,* meaning that, overall, they are losing money on all patients served. Government payment sources pay less than the cost of providing care. In the aggregate (including both inpatient and outpatient services), Medicare pays less than costs (only 97 cents on the dollar, according to ProPAC) and Medicaid is an even worse payer—a critical difference for hospitals that do not have a level of private-pay patients to make up the difference.

For roughly 1,000 hospitals, representing one in five of the nation's community hospitals, Medicare and Medicaid combined represent more than two-thirds of total revenue. Seventeen percent of these hospitals are sole community providers; another 16 percent are located in the core city of metropolitan areas. Many are already in weakened financial positions, with roughly 10 percent of these hospitals experiencing bottom-line losses for three years in a row, considering all sources of revenue.

These hospitals are vital resources to their communities; many serve a large number of elderly citizens. While it is true we need to rationally reduce our excess hospital capacity, placing at risk many hospitals in rural and inner-city areas with high Medicare and Medicaid populations does not qualify as a rational approach.

In addition, the Medicare program has already shared in the savings that resulted from PPS isolating the program from the effects of the high cost inflation that occurred in the 1980s. Now that cost inflation has slowed, the commission's recommendation seeks to have Medicare share again—this time in hospital-produced savings. Regardless of the Medicare program update, hospitals must still meet market price increases as measured by the hospital market basket index. As a result, *we urge Congress to reject ProPAC's recommendations and enact a positive PPS update—the most appropriate policy to ensure that Medicare can continue purchasing high-quality services for seniors.* In that regard, the Administration's budget proposal is a far more preferable and reasonable approach than the commission's recommendation.

Reducing capital payment rates—The commission recommends revising current payment rates for capital and then applying an update factor, which, it predicts, would result in a reduction in payments of between 15 and 17 percent. We have several concerns about suggested reductions in capital payments, including:

- The commission claims that there were flaws in the data and updating methods in prior years, which are responsible for capital payment rates being between 15 and 17 percent too high. In fact, higher-than-anticipated payments for capital costs likely resulted from a change in HCFA's policy regarding the treatment of allowable interest for payment purposes (published in the Federal Register on August 30, 1991), which increased payments for capital—not from an "overstatement" of payment rates.
- One of the reasons for changing Medicare's method of paying for capital costs several years ago was to slow the growth of capital costs, and it has worked. The capital PPS system was designed to reward hospitals for slowing cost growth, and they have responded to that incentive. Yet in the face of hospitals' success in significantly slowing capital cost growth, ProPAC proposes not a reward, but a penalty, in the form of further payment reductions. PPS should not be turned on its ear and used to penalize hospitals when they achieve or exceed cost control goals.

Capital payments should be reasonable and predictable for hospitals and for the Medicare program—that's fair. But after several years of prospective payment, it is unfair to look back now and suggest that cost-based reimbursement, not PPS, might have produced a better outcome for the Medicare program. *We urge Congress not to penalize hospitals for the efficiencies they have achieved and to reject ProPAC's justification for capital payment reductions.*

Reducing the level of IME payments—The commission recommends reducing the indirect medical education (IME) adjustment from its current level of 7.7 percent to 7 percent. This amounts to "double jeopardy" for teaching hospitals when added to proposed reductions in the PPS update. That is because when the PPS update amount is reduced, additional amounts paid by Medicare to teaching hospitals for IME are also automatically reduced. Lowering the IME adjustment to 7 percent means that hospitals will be receiving a smaller payment for Medicare's share of teaching costs on top of an already smaller teaching and base payment amount.

Moreover, reductions like this have an impact far beyond just Medicare's payments to teaching hospitals. The marketplace for medical care is changing: from competing on the basis of service to competing on price; from fee-for-service to capitation; and from inpatient care to ambulatory and community care. Each change has affected the structures that support clinical education. In addition to federal budget constraints, these marketplace trends will continue to undermine historical private sector support for the important community service role that teaching hospitals play.

If the Medicare program were to reduce its historic commitment to support hospital costs for physicians-in-training, other payers might use the Medicare policy as justification for reducing or eliminating support for these costs. Therefore, *we urge Congress to reject this proposal, continue to provide a benchmark for support of the educational and uncompensated care costs of teaching hospitals, and continue Medicare's long-standing commitment to fund its share of teaching hospitals' costs.*

LONG-TERM ISSUES—Mr. Chairman, let me be clear: Hospitals and health systems support efforts to balance the federal budget. We also understand that some reductions in Medicare payments to hospitals are likely to be part of any balanced budget proposal. However, we believe that the ProPAC recommendations I've just discussed would do more harm than good.

Critical congressional decisions must focus not just on fiscal policy, but on sound health policy—issues such as the long-term financial viability of Medicare and the future of the health care delivery system. That is why we support the general long-term direction outlined by many of the commission's recommendations, including the following.

Improving distribution of IME payments, and establishing a broader-based financing mechanism for GME and teaching hospitals—The commission states that IME payments should reflect the historical relationship between hospital costs and teaching intensity, and should continue to be based on the volume of Medicare patients treated. The commission adds that IME payments no longer should change in proportion to annual variations in the number of residents or beds, and that they should allow and support training in settings outside the hospital. And the commission calls for a broader-based financing mechanism that is not limited to the Medicare program. We wholeheartedly agree.

Like ProPAC, the AHA believes that a broad-based financing mechanism—a trust fund for graduate medical education—is an appropriate vehicle for supporting clinical education. A federal trust fund for graduate medical education should be supported by all public and private payers. Unless such a fund is established and adequately supported, teaching hospitals will have to choose between being price-competitive by reducing their educational responsibilities, or retaining their responsibilities and being priced out of the market.

In addition, a broader array of training sites are better suited to contemporary needs of residency programs. Residency programs began in the inpatient units of teaching hospitals. Over the past two decades, an increasing amount of residency training has moved to ambulatory training sites, both hospital-based and elsewhere within a community. Medicare has recognized hospital-based training, both inpatient and outpatient. It has also recognized hospital-supported programs in non-hospital sites. Nevertheless, there is a need to expand support for residencies in ambulatory training sites, home and community service sites, and long-term care sites. In addition, the training provided under such a fund should be broadened to include not just physicians, but nurses and other health care practitioners.

Improving Medicare's DSH adjustment and distribution—The commission calls for protecting access to hospital care for beneficiaries, and disproportionate share hospital (DSH) payments based on each hospital's share of low-income patient care and

volume of Medicare cases. The commission also calls for concentrating DSH payments among the hospitals that serve the highest number of poor patients.

A decade ago, Congress mandated an explicit PPS payment adjustment for hospitals that serve large numbers of low-income patients. One rationale was to compensate hospitals for the costs of treating poor patients, who often lack access to routine care or early intervention and, as a result, are sicker when they reach the hospital.

Another rationale for the adjustment: Congress had become increasingly concerned that certain hospitals were at risk of closing as a result of treating large shares of low-income patients, and began to view the DSH payment as a way to mitigate that concern. The payments were seen as helping to maintain access to care for low-income Medicare beneficiaries and other patients.

Policy changes in Medicaid and welfare, along with more health care being provided on an outpatient basis, raise the question of whether the DSH adjustment itself be reviewed. *AHA believes a re-examination of the mechanics of the adjustment may help ensure that the adjustment continues to meet its mission in light of the many dramatic changes health care is going through. We urge Congress to consider two issues in particular.*

First, the AHA believes that the Medicare DSH payment should continue to reflect the higher cost of caring for low-income people, and of maintaining access to health care for these people. But HCFA's interpretation of the current formula used to calculate these payments takes into account a hospital's Medicare inpatient days, and only the number of Medicaid inpatient days for which Medicaid has *paid* a hospital, as proxies for the number of low-income people served by a hospital.

AHA believes that the DSH payment should be based on the number of patient days actually *furnished* to Medicaid recipients—known as Medicaid-eligible days—and not on the number of Medicaid inpatient days that Medicaid actually *pays* a hospital—known as Medicaid-paid days. The number of days a hospital furnishes to Medicaid patients—which, especially as managed care grows, is often greater than the number of days Medicaid actually pays for—is the appropriate measure.

Federal courts have backed our view. Current law states simply that Medicaid days should be used in the DSH calculation. The Health Care Financing Administration (HCFA) has interpreted this to mean that the Medicare DSH payment should be based on the inpatient days Medicaid pays for—which is defined differently in each state. However, the Department of Health and Human Services has lost in four federal appeals courts—the Ninth, the Eighth, the Sixth, and the Fourth circuits—on HCFA's interpretation. In each case the court has sided with hospitals, determining that the Medicare DSH adjustment should be based on the number of days *provided* to Medicaid patients.

The Ninth Circuit was particularly pointed, saying that "Patients meeting the statutory requirements for Medicaid do not cease to be low-income patients on days that the state does not pay Medicaid inpatient hospital benefits. Thus it is illogical to conclude that Congress intended that only Medicaid-paid days serve as proxy for low-income patient days." *The AHA urges this subcommittee to clarify current law so that it requires the calculation of the Medicare DSH payment to be based on Medicaid-eligible days.*

Second, in the current environment of managed care, keeping track of hospital inpatient Medicaid days has become more difficult—resulting in often understated Medicaid burdens for hospitals. Under Medicaid managed care many hospitals do not know whether the patient seeking care is a Medicaid recipient. Also, state-based Medicaid waiver programs have changed certain eligibility rules, bringing new population groups into the program. And discussions about restructuring Medicaid add uncertainty to a hospital's ability to track Medicaid inpatient days when calculating Medicare DSH.

Therefore, we believe that keeping track of which patients are covered by Medicaid should be the responsibility of the managed care plan that has contracted with Medicaid to provide care for those patients. Because the plan receives payment directly from Medicaid for Medicaid-eligible patients, and then pays the hospital for that recipient's care, it seems logical that the plan would be more easily able to track those Medicaid-eligible patients than the hospital. ProPAC, in its March 1 report to Congress, agrees.

Expanding Prospective Payment to Outpatient Services—The commission recommends using prospective payment methods for hospital outpatient departments. The AHA has been and remains a proponent of an appropriately structured prospective payment system. We support improved payment arrangements like PPS that are simple to understand, easy to administer, and promote cost-effective utilization of appropriate patient care services.

However, while promoting a rapid move to prospective payment, the commission at the same time suggests an arbitrary budget-driven reduction in current outpatient reimbursement for certain surgical, diagnostic and radiology services. The commission suggests that hospitals have been "overpaid" for these services because of an error in the formula used to calculate payments. Hospitals are not "overpaid" for outpatient services. In fact, Medicare pays hospitals less than the cost of actually providing outpatient care to seniors. But, more important, we believe the combination of first lowering formula-based payments and then moving to prospective payment would create conflicting incentives for hospitals. It makes little policy sense to tinker in the short term with the formula-based payments, which may encourage an increase in services provided, while at the same time embracing prospective payment and the incentives for efficiency it brings. *AHA asks that Congress implement PPS for outpatient services as quickly as possible as proposed by the Administration, and forego short term, contradictory changes in payment as suggested by the commission.*

Reducing beneficiary liability for outpatient services—The commission also recommends that beneficiary liability for hospital outpatient services should be reduced, from 20 percent of *charges,* as set by Congress, to 20 percent of the allowed *payment*. Beneficiaries have been paying a greater share of the bill each year while Medicare's share has declined. Reducing seniors' liability for the cost of their care is a legitimate concern and an issue appropriately resolved between the Medicare program and its beneficiaries. We disagree with the commission's suggested use of short-term hospital outpatient payment savings to remedy this long-standing problem. Instead, we support a proposal like the President's, which would gradually increase the government share of payments so that, ultimately, beneficiaries will pay only the 20 percent coinsurance the law intended to be applied.

Expanding Prospective Payment to Skilled Nursing and Home Health Services—The commission calls for implementation of PPS for skilled nursing and home health services as well. As stated above, the AHA favors prospective payment. We strongly recommend, however, that Medicare's home health and skilled nursing services payment policies reflect several justifiable differences in the cost of furnishing care.

• Medicare should recognize, at a minimum, differences in levels of physical functioning, cognitive capabilities and behavior of the patient, and intensity of rehabilitation and therapy services. A clear variation in costs results from the different nursing and rehabilitation needs of each patient. As a result, some facilities provide more intensive nursing and therapy; some admit more severely ill or more disruptive patients; some are more capable of responding to medical episodes. These differences need to be recognized in payment. Otherwise, low intensity nursing facilities would receive a windfall and high intensity facilities would be penalized.

These differences in patients needs and costs are known as case mix costs. They are recognized in the Medicare hospital inpatient PPS system through a combination of the Diagnosis-Related Groups (DRG) classification system, supplemental payments for outlier cases, and other payments for the higher costs associated with indirect medical education and treating large numbers of low-income people. While the hospital inpatient PPS system is inappropriate for long-term care and home care patients, the underlying principle of recognizing patient-related cost differences is the same and should be recognized in any prospective payment system for skilled nursing or home health care.

• Medicare should recognize geographic differences in costs, which are beyond the control of the health care system. Providers serve Medicare patients in communities with different costs of delivering care. Some communities have higher wage rates than others; some have higher supply or operational costs than others. While PPS and the Resource-Based Relative Value Scale (RBRVS) revealed the difficulty of drawing geographic boundaries for payment purposes, the difficulties are minor compared to the inequities that would result from failing to recognize geographic cost differences.

• Medicare should recognize the added operational costs associated with hospital-based skilled nursing and home health services. Hospital-based services are provided by delivery systems that have a broad array of services and responsibilities. As a result, additional costs arise from: a hospital's ability to provide service on demand (standby services) that are not available from limited service providers; greater availability of laboratory and x-ray services that support hospital-based and free-standing providers; and requirements imposed on the hospital by licensure and accreditation.

• Medicare should incorporate accounting costs that result from government-mandated cost-finding practices, which historically allocated hospital overhead from inpatient care units to ambulatory, community-based, and nursing home units. Or,

Medicare should increase inpatient PPS payments to adjust for prior accounting requirements. Under Medicare's original policies, services provided under Medicare Part A were reimbursed on a cost basis using accounting procedures prescribed by Medicare. While there were many concerns with these procedures, they were equitable because they applied to all Medicare Part A services. Because Medicare accounting procedures require allocation of all general service and administrative costs among the various Part A facilities and units, any over-allocation of costs in one area would result in under-allocation in another.

When Medicare hospital inpatient PPS was established, it based inpatient payments on the level of costs determined using the accounting practices that had been used for cost-based reimbursement. Nevertheless, equity was preserved in part by continuing to recognize the consequences of Medicare's accounting requirements through the payment differential for hospital-based facilities and services.

• Medicare payments should provide clear public recognition of the uncompensated care missions that hospitals and hospital-based services fulfill in our nation. Hospitals, by legislation (Emergency Medical Treatment and Active Labor Act—EMTALA) and commitment to community service, provide emergency services that evaluate and treat all individuals regardless of ability to pay. Once admitted and treated, the patient may be reassigned to a hospital-based home health or nursing home service that is medically appropriate and lower in cost than an inpatient unit.

However, uncompensated care patients bring no revenue, regardless of where they receive care. Unlike freestanding home health agencies and nursing home facilities that have no emergency room for uninsured or underinsured people, the hospital-based facility bears a disproportionate share of the costs of uncompensated care.

Changing Medicare payments to health plans—When beneficiaries join managed care plans, Medicare pays an up-front, monthly, per-person amount based on the adjusted average per capita cost (AAPCC). The AAPCC is a formula by which Medicare determines the average cost of providing care to beneficiaries in a particular area.

The commission calls for reducing the variation in Medicare payments to health plans across the country and for setting a minimum payment amount. AHA agrees. The current system, based on Medicare's fee-for-service payments, is flawed and inequitable. Given the wide variations in historic fee-for-service utilization patterns, there is a resulting wide variation in health plan payments—more than 300 percent among counties across the United States.

We advocate Medicare health plan payments that are uniform across the country, with an adjustment that reflects regional differences in the cost of delivering care due to the fact that some areas may care for less-healthy, more costly Medicare beneficiaries. To achieve this, *the current AAPCC should be blended with a new payment rate that eliminates differences in historical patterns of use across counties. And a payment floor should be quickly established to raise payments in the lowest-rate areas.*

The AAPCC payment also includes what Medicare traditionally spends on DGME, IME and DSH. However, the rates that a plan negotiates with a hospital do not necessarily include these direct graduate medical education (DGME), IME or DSH payments that the hospital would traditionally receive. In addition, the plan may direct patients away from the hospitals to a lower-cost site of care—because the plan receives the same AAPCC amount regardless of the provider it contracts with. In either case, there is no requirement that the plan use the portion of the AAPCC that results from clinical education and uncompensated care payments to support these provider costs. As a result, the health plan often benefits financially if it can avoid using hospitals that support medical education.

The hospital—which is directly incurring the costs of providing clinical education or uncompensated care—does not receive the funds that Medicare intends to help pay for those costs. *The AHA strongly supports the commission's recommendation to remove the clinical education and DSH payment amounts included in the AAPCC and to make those payments directly to the entities that incur the costs of these important missions.*

CONCLUSION

Mr. Chairman, Medicare has, in some way, touched the lives of every American. It was a good idea 30 years ago, when it was created, and it is a good idea today. But, in order for Medicare to continue its mission of caring for America's seniors for another 30 years, it has to be brought up to date so that it can adapt to the dramatic changes health care has experienced. We believe that many of the commission's recommendations can help get that job done. We look forward to working with

you to ensure that hospitals and health systems can continue serving America's seniors for generations to come.

Mrs. JOHNSON [presiding]. Thank you, Mr. Johnson.

Mr. Scully.

STATEMENT OF THOMAS SCULLY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FEDERATION OF AMERICAN HEALTH SYSTEMS

Mr. SCULLY. Mrs. Johnson, Mr. McCrery, I am Tom Scully with the Federation of American Health Systems. The federation represents 1,700 hospitals across the country, approximately 780 acute-care hospitals, 600 specialty hospitals, and a little over 300 hospitals that are nonprofit that are managed primarily by Quorum Health Care. Our members are Mr. Stark's favorite company, Columbia; Tenant Health Care; HealthSouth, the largest rehab provider in the country; Vencor, the largest long-term care hospital in the country; Community Health and Health Management Associates, both very large, primarily rural providers, mostly in the South and the West; Magellan, the largest psychiatric provider in the country; and Horizon CMS, also a rehab and specialty care provider.

Overall, the federation's members have 820,000 employees nationwide, primarily in the South and the West. Columbia alone has 295,000, is the ninth largest private employer in the United States. Tenant is among the largest employers in Florida, California, Louisiana, and Texas.

We support virtually everything that the AHA has in their testimony and most of what Larry with the public hospitals would probably support. We have some minor differences. The major thing you might find in the differences is we represent the majority of the PPS-exempt providers, most of which, I think, are not included in the other two groups.

I would like to make two quick general points first, and then hit on a few specific reimbursement issues.

First, the reason I put that lovely budget chart up is to show that I think there is a perception that this is a very easy year in Medicare. The fact is, the numbers are much tougher than you think. Two years ago, we were talking about $270 billion of cuts. That was over 7 years. This year we are talking about $100 billion. That is over 5 years. The comparable number with 7 is more like 180. A lot of people do not realize that the baseline, because health inflation has dropped, has dropped a lot.

When you look at the absolute numbers 2 years ago in the vetoed budget bill, the capped spending numbers that were in your bill, and then you look at where the President's budget is as far as his target for spending, I think the numbers are much closer than people realize. They are remarkably close. If you look at the bottom two lines, you see that by the year 2000, 2001, 2002, the targets the President is talking about spending are extremely close, and almost identical to what you had in your 1995 bill 2 years ago, which was perceived as being very harsh. So I am not here to whine. I am just here to say as a matter of course, the policies in here, we

are looking at still a very tough year on Medicare. And I think when you look at——

Mrs. JOHNSON. Excuse me, Mr. Scully. Are you talking about the two top lines?

Mr. SCULLY. The two bottom lines. The two top lines—the top three lines are CBO baselines from 1995, 1996, and 1997. The bottom two lines, the further down are the absolute targets that were written into OBRA 1995, and the next line up is the projected spending in the President's budget that he would like to see in Medicare for the next 5 years.

My point is when you look at what you would like to spend on Medicare for the next 5 years, we are still looking at pretty close to where you were 2 years ago. And, again, I am not complaining. I am just saying the numbers have dropped significantly, and the baselines are closer together than people might think.

Second, when you look at the payments, 2 years ago when we came and met with most of you in the leadership, we basically said we would be happy to see one-third out of hospitals, one-third out of physicians and other providers, and one-third out of beneficiaries. We would like to see a fair spread among the different categories of Medicare. No matter how you slice it this year, you can estimate between 60 and 70 percent, but 60 to 70 percent is coming out of hospitals. So when you look at it, it is a very, very tough year by any reasonable measure for hospitals.

In the 1995 bill, we may not have liked the 270 number, but as most of you remember, we very much liked almost all the reforms. The federation is for the ultimate PPS reform, which is capitation for everything. We would like to see you do that. We would be very happy with slightly lower reduction numbers, but we would like to see many of the 1995 reforms repeated. We supported most of them. We still support most of them, especially in the original House bill.

Going to some of the specifics, we are obviously very concerned about the market basket update. Growth in hospital spending is down to 3 or 4 percent per year. We have reacted to all the incentives you have created. We have reduced costs massively. Our wages next year are going to go up by 3.3 percent, yet we are looking at very small increases. Even if you assume all of the ProPAC assumptions, which are pretty tough, all the ProPAC assumptions, they say that they would look at between 0.6 and 1.4. Splitting the difference does not come to zero. I think a zero update is very, very harsh.

Second, on capital payments, there is a 15- to 17-percent cut. That is a very steep cut, especially tough on providers in the South and the West. Hospitals in the South and the West tend to be newer, have higher capital costs. The Federal Government as a partner in capital is a rollercoaster. We may have had a reasonably good payment last year, but 17 percent is very dramatic.

Disproportionate share I am sure Larry will get into, so I will get back to that.

Outpatient payment reform, I have tortured Mr. Thomas over the years trying to explain FIDO. It is a very complicated payment issue, but it is $11 billion off budget that is not counted that we get reduced in payments to hospitals for copayments. It is $8 bil-

lion on budget. We happen to very much support the administration's proposal. We think it is a very good proposal, but it is an enormous cut to providers and it is going to have a big impact on every outpatient department across the country.

I see the red light is on. That is as fast as I can talk. I have a lot of other issues I would like to cover. I know there is a later hearing on PPS-exempt facilities. We have a lot of very major concerns about psychiatric, rehab, long-term care hospitals. But I would state again that the federation in the long run is for the ultimate PPS reform, which is capitating everything.

We are happy to work with you to try to get reductions out of the existing program, but as long as we keep tinkering with the existing program, you are going to have the structural problems we all live with, and eventually going to capitation is the only way you are going to eventually really fix the Medicare Program.

[The prepared statement follows:]

Statement of Thomas Scully, President and Chief Executive Officer, Federation of American Health Systems

My name is Thomas Scully, President and CEO of the Federation of American Health Systems and I am pleased to be here today to testify on behalf of the nation's 1700 investor-owned and managed hospitals. Nationwide, there are approximately 780 acute care hospitals and almost 600 specialty hospitals that are investor-owned. Our companies also manage over 300 nonprofit hospitals.

This committee will be considering many issues this year that will have a profound impact on hospitals and other providers of care and, consequently, on the quality of health care in this country, particularly for Medicare beneficiaries. The recommendations of the Physician Payment Review Commission and of the Prospective Payment Assessment Commission are likely to have a significant impact on your deliberations, so I am especially grateful to be here today to offer our views on their recommendations.

This is a time of great challenge and change in our nation's health care delivery. We are seeing continued steady growth in managed care. Health care providers are merging and integrating to form systems that can provide improved care over the full course of an illness. And these provider-sponsored systems are contracting with employers, insurers and plans to provide a comprehensive range of health care services for their insured beneficiaries, often on a capitated, at-risk basis. Our member hospitals and health systems are leaders in driving these fundamental changes in health care. Whether it is in Texas, Florida, Louisiana, or right here in Washington, DC, our hospitals are leading the way in revitalizing aging systems or developing new systems that are creating efficient, high quality, low cost health care for consumers. The trends toward lower costs, with continued excellence in quality, offer considerable promise to make access to affordable, quality health care available to all Americans. We are proud that our hospitals and health systems are on the forefront of the creation of a new dynamic market for health care.

This is also a time when major Federal health-financing programs face significant pressures as we seek to balance the Federal budget and restructure the Medicare program. Congress must proceed carefully to ensure that the changes made in these programs preserve access to high quality care and that they begin to develop the groundwork for the kind of long term structural changes that are needed for the future.

ProPAC has made many detailed recommendations for changes in Medicare payments rendered on a fee-for-service basis that will significantly impact hospitals. One of the biggest issues for hospitals is ProPAC's recommendation, made only by a very divided Commission after a long and contentious debate, to provide a zero market basket update for FY98. This recommendation may encourage the perception that reductions in payments to hospitals can be achieved without inflicting pain. This is absolutely not true! Many hospitals of all capital structures are struggling financially and reductions of this magnitude in Medicare payments would hurt and hurt a lot.

It is important to remember that ProPAC reports *average* hospital margins. At the same time that it shows hospitals with what appear to be relatively healthy Medicare margins, on average, about 40 percent of the nation's hospitals are losing money when they treat Medicare patients. In the past these hospitals have been

able to stay in business by shifting unmet Medicare costs to other payers. Increasingly, however, this is becoming an impossible strategy as competitive pressures increase throughout the health care sector. In fact, 20 percent of hospitals have negative total margins, meaning that, overall, they are losing money on all patients served. There is a reason for all the recent hospital mergers and consolidations. It is a tough business. This is no picnic.

Under any scenario, government payment sources still pay less than the cost of providing care. Including both inpatient and outpatient services, Medicare pays only 97 cents on a dollar for the cost of care, according to ProPAC, and Medicaid pays even less. This is a very serious situation for hospitals that do not have a sufficient level of private-pay patients to make up the difference, or who are unable to do so due to competition. Many hospitals are already in weakened financial position, with roughly 10 percent of high Medicare/Medicaid hospitals experiencing bottom line losses three years in a row, considering all sources of revenue.

All hospitals are vital resources to their communities; many serve a large number of elderly citizens. While it is true that the hospital "squeeze" is working to find a rational way to reduce our country's excess hospital capacity, unnecessarily placing at risk many in rural and inner-city communities does not seem to be the prudent strategy. Medicare reductions of the magnitude being discussed will have an adverse impact on a significant number of hospitals and on the beneficiaries they serve.

In the context of these concerns, it is hard to fathom ProPAC's recommendations to provide a zero update for Medicare payment rates for FY98. The cost of doing business increases each year for hospitals, which are labor intensive, at least as much as for other enterprises, and when these increases are not recognized by Medicare, unfair financial pressure is placed on hospitals already struggling with all the issues discussed above. Perhaps that is why the Commission was divided in their vote on this recommendation.

In addition, our member hospitals and health systems are especially concerned about the deep cut in Medicare payment for hospitals' capital expenditures. These cuts would fall disproportionately on hospital systems, a growing segment of the industry that is important to the future delivery of health care services in the country and to the growth of networks with the capacity to provide coordinated care and to offer managed care options to beneficiaries. It is troubling that the Commission would recommend such deep reductions, nearly 17 percent, in Medicare's capital payments given the multi-year commitments that hospitals make in this area. Hospitals, like other businesses, need to have a reasonable expectation of what their future revenue will be when they undertake capital planning and make major financial investments. To be a reliable business partner, Medicare must ensure a reasonable level of continuity in these payments from year to year.

ProPAC also recommends that improvements be made in the Medicare formula for allocating payments to hospitals serving a large number of low-income patients (disproportionate share or DSH). These additional payments have become important for many hospitals and can be significant in maintaining access to care for low-income patients. We are concerned about the recommendation to establish a new minimum threshold and to not make any disproportionate share payments to hospitals whose percentage of low-income patients falls below the threshold. Our members are the biggest care providers in Texas, Florida, California and other border states with high levels of low income patients. They may not meet the levels of some inner city teaching hospitals, but they—and their patients—will be adversely impacted by inappropriate DSH reforms. Finally, any proposed changes in disproportionate share payments should be reviewed carefully for their effect on all hospitals, and their possible effect on access to care for low-income Americans. I would strongly urge that our hospital associations be fully involved and consulted in making these formula changes.

ProPAC also includes several recommendations affecting both Medicare outpatient payments and beneficiary coinsurance for hospital outpatient services. These would be extremely significant changes given the huge effect they would have on hospital revenues, the amount of beneficiary coinsurance assessed and the level of Medicare spending. We strongly support one of the proposals, the adoption of a prospective payment system for hospital outpatient services. We are very concerned, however, about the suggestion to eliminate the so-called "formula-driven" overpayment (FIDO). We do not understand how hospitals can be considered "overpaid" for the outpatient services they provide to Medicare beneficiaries when they are paid considerably less than the cost of providing those services. We would strongly oppose the reductions that are caused by eliminating FIDO, unless they are accompanied by implementation of a reasonable outpatient prospective payment system for all outpatient services. A fixed rate prospective system allows hospitals to know in ad-

vance what they will be paid and encourages them to adjust to reductions by becoming more efficient in providing care.

Finally, we would urge Congress to adopt the principle of shared responsibility for the burden of program changes needed to balance the Federal budget and restore solvency to the hospital trust fund. In this context, Congress might consider to what extent the Federal budget can help to absorb the large reductions in beneficiary coinsurance for outpatient services that ProPAC and the Administration have recommended. Alternatively, you might consider whether these reductions might be part of a package that would include increased beneficiary payments in other areas. For example, ProPAC recommends that some copayment should be introduced for home health services.

Finally, ProPAC makes eighteen separate recommendations concerning Medicare payment for post-acute and psychiatric services, an area of enormous importance to our member hospitals and systems. As mentioned earlier, most of the specialty hospitals in the U.S. are FAHS members. In particular, HealthSouth, the dominant rehab provider, Vencor, by far the largest long term care hospital system, and Magellan, the nation's largest psychiatric health provider, are all active FAHS members.

ProPAC recommends that case-mix adjusted prospective payment systems be implemented as soon as possible for skilled nursing facility services, home health, rehabilitation services and long-term care hospitals, and it recommends that interim payment reforms be adopted immediately in each of these areas until an appropriate prospective payment system is implemented. Our member hospitals and systems support the development of case-mix adjusted prospective systems, but they are especially concerned about possible interim changes to the current TEFRA payment system that is the basis of payment for rehabilitation, psychiatric and long-term care hospital services. ProPAC supports interim changes to address perceived disparities in payments between new and old providers. But the Commission itself acknowledges, and I quote from its report, that several "... methods to correct for the payment disparity between new and old providers have been considered in the past. Each one has strengths and weaknesses and may raise additional equity issues if implemented." I would add the thought that many of the changes being considered would create serious equity problems.

One frequently discussed approach, and the one recommended by the Administration, is to rebase the TEFRA facility-specific cost limits. We have *very* serious concerns about this proposal. As ProPAC also observes, *rebasing would penalize hospitals that have constrained their costs* (often our hospitals) by paying them less. At the same time, facilities that had not become more efficient would be rewarded with higher payments. I assume Congress wants to encourage efficiency—as PPS would—not penalize it. We hope the Committee would not adopt a proposal with such perverse effects.

We also must emphasize that our support for case-mix adjusted prospective payment systems for post-acute services is conceptual support at this time. Although we believe this is the appropriate direction for reform, neither the Congress nor the industry, (nor apparently HCFA) has seen any of the crucial elements of such systems spelled out. How would payments be adjusted for case-mix? Would payment be on a per-day or per-episode basis? What exceptions and special payment rules would apply? How would it be phased in? How would the prospective systems vary across the different provider types: skilled nursing, rehab, long term hospital, and home health? Given the need to resolve such large issues, we are extremely concerned that the Health Care Financing Administration is proposing that it be given the authority to implement prospective payment using interim final rulemaking authority. This would mean that HCFA could implement major program change, affecting a significant portion of the health care sector, without the opportunity for Congress, the industry or the beneficiaries to have any input. While we are very supportive of HCFA and have enjoyed a good working relationship with the Administrator and the staff, I would certainly hope that this Committee would not agree with such an unprecedented approach. Such a "blind" delegation of policymaking would set the stage for a potential policy debacle that will end up back in Congress' lap.

ProPAC makes numerous other recommendations that we are interested in working with ProPAC and the Committee to address, but I wish to conclude by encouraging Committee support for broader structural reforms, some of which are touched upon by the Physician Payment Review Commission in its report.

It is imperative that the inevitable Medicare reductions that Congress requires to achieve a balanced budget be combined with a broader restructuring of the program that firmly places it on a long-term road toward greater efficiency, cost-effectiveness and high quality care. One important step would be to allow seniors to choose to

receive care from a variety of private health plan options, similar to the design of the Federal Employees Health Benefit Program (FEHBP). One of the essential options in such a new system would be the purchase of care directly from local provider-sponsored organizations (PSOs). These community-based, integrated networks of physicians, hospitals and other caregivers can directly provide the full Medicare benefit package. PSOs achieve the cost efficiency necessary to hold down health care costs by managing both the utilization and the cost of producing those services. And they do it by providing services through the same hospitals and physicians many patients, including the elderly, are already familiar with. The PSOs we seek would provide services to *Medicare beneficiaries only* and would be federally approved, with appropriate solvency, accountability and quality standards in place. This approach is embodied in H.R. 475/S. 146, bipartisan legislation introduced by Congressmen Greenwood and Stenholm on the House side and Senators Frist and Rockefeller on the Senate side.

Why should PSOs be certified by the federal government? The simple answer is that without federal certification they will never happen. Hospitals, for the most part do not want to be in the commercial insurance business. The under 65 year old commercial market is saturated with commercial plans and HMOs. It is very tough and very expensive to enter that market. You have to market door-to-door to every small business and retailer in a community. Yet the Medicare market (over 65) is only 10% penetrated by managed care and offers a wide open market for new entrants. Insurers and HMOs see this as their growth market and they want to keep new competitors, especially local providers, out. It is greatly in the interest of the Congress, and seniors, to let new qualified competitors in.

If we are forced to get a commercially insured life for every Medicare covered senior, we will *never* be in the market. If providers have to go to Richmond or Austin to get a license *and* meet the 50/50 rule, it will be a cold day in hell before you see a significant provider-based plan take Medicare capitation. That is the insurers strategy. It is very smart. It is also called *Protectionism*.

Our health sytems are extremely solvent and practice the highest quality medicine. Give us fair federal rules and we'll give you quality Medicare capitated coverage.

The real question is why not have federal certification? Medicare is a federal program. Insurance commissioners have no historical jurisdiction over Medicare. They do have jurisdiction over commercial plans, and if we want to do commercial insurance we will get a state license. And you can establish federal rules *without* a new bureaucracy. Create federal guidelines and let the states implement them under contract—as they have for three decades with hospital survey and certification standards. A competitive Medicare market is *long* overdue. Let local providers compete—and we'll deliver competition in big doses of *high* quality and low costs.

Hospitals have enjoyed a strong working relationship with the Committee and its staff. The ProPAC and PPRC recommendations have led off yet another year of complex and difficult policy decisions for the Committee and Congress. We appreciate the opportunity to add our input and look forward to working with you again to ensure quality results for America's seniors and America's taxpayers.

Chairman THOMAS [presiding]. Notwithstanding the gentleman's concern about the light, he does understand that any written testimony has already been made a part of the record, and that anything he might want to submit for us to better understand the workings of the operation——

Mr. SCULLY. I had a tortuously detailed written statement that you probably do not want to read. But it is submitted. Thank you.

Chairman THOMAS. It may shock the gentleman when I tell him I have read it.

Mr. Gage.

STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

Mr. GAGE. Thank you very much, Mr. Chairman, Members of the Subcommittee. I am Larry Gage, president of the National Associa-

tion of Public Hospitals and Health Systems, and I am afraid I cannot talk as fast as Tom, but I will do my best.

NAPH represents over 100 of America's metropolitan area public and some nonprofit safety net hospitals. These hospitals uniquely rely on governmental sources of financing to support their care to Medicare, Medicaid, uninsured, and low-income patients.

I am pleased to have this opportunity to testify today on a range of issues of concern to safety net providers, with particular emphasis on Medicare payments for hospital and physician services. I do have a prepared statement which I have submitted for the record. Also, last week NAPH board member Jerry Starr, who is the chief executive officer of the Kern Medical Center in Bakersfield, did testify before the Subcommittee on the specific issues of disproportionate share hospital and graduate medical education payments. I will not repeat what he said here. I am certainly happy to answer any questions about these issues.

I do want to emphasize, to reemphasize, however, that DSH funding and graduate medical education will continue to be essential sources of funding for safety net health systems, and we strongly support the ProPAC recommendations regarding the restructuring of Medicare DSH.

My additional comments can be summarized in several areas. First, I do want to take the opportunity to describe in a little more detail the situation of safety net hospitals nationally today using new data which we gathered from 1995 that is being released today for the first time. This data is included at some length in my prepared statement, but let me call your attention to just two key facts represented by two charts. Not to be outdone by the federation, we have two charts, but they are smaller and undoubtedly less costly to produce. [Laughter.]

Mr. GAGE. The first chart indicates with two colorful pies that over 70 percent of inpatient care and——

Chairman THOMAS. Mr. Gage, our concern is not what the charts cost you, but what your conclusions cost the taxpayers.

Mr. GAGE. Very good. You will be happy on both fronts, I am sure, sir.

It shows that over 70 percent of all inpatient care and over 77 percent of the 22 million outpatient visits provided by NAPH members in 1995 were for Medicaid and so-called self-pay individuals. And if you add Medicare to those numbers, the proportion jumps to 90 percent for both inpatient and outpatient. These are uniquely governmental institutions.

Second, on the second chart, I want to point out that State and local subsidies only cover about half of the cost of uncompensated care provided at urban public hospitals. To make up the difference, member hospitals rely on Medicaid disproportionate share payments for 40 percent of the funding and Medicare disproportionate share payments for 9 percent. And while that may sound small, that 9 percent is an essential component of uncompensated care. Medicare is a key player in the fragile partnership of Federal, State, and local governments that currently finances uncompensated care.

I also wanted to comment briefly on the issue of margins. While the average inpatient margin for all hospitals in 1995, as reported

by ProPAC, was 5.6 percent, the average overall margin for NAPH hospitals was a meager 0.7 percent, which is lower by far than any individual group of hospitals looked at by ProPAC, and many individual NAPH members experienced negative margins. This finding, I believe, is consistent with the New England Journal study released last week which showed that public hospitals as a group have the lowest administrative costs in the industry.

Now, because of the unique role of safety net providers in the health care delivery system, the impact of changes in Medicare policy must be fully considered before reforms are implemented. In particular, the freeze in PPS rates urged by ProPAC would be likely to disproportionately affect safety net institutions, and I join Tom and the AHA and others in strongly opposing such a freeze.

Similarly, these hospitals and health systems, which already face unique challenges in financing capital improvement projects, will be further disadvantaged by reductions in capital payment rates. We also want to take this opportunity to urge you to support legislation to provide additional capital financing assistance to safety net health systems, such as the assistance that would be provided in H.R. 735, recently reintroduced by Representative Stark. These systems require access to capital, not necessary for major construction projects, but to enable them to downsize appropriately, to decentralize, to form broader networks and systems, and to improve access for low-income and elderly patients.

Finally, in conclusion, even though it is not in the jurisdiction of this Subcommittee, I want to urge you again as you participate in broader budget discussions to reject further Medicaid cuts as part of any budget package you consider this year. Medicaid Program growth has slowed considerably in the last year. Due to the implementation of welfare reform, safety net hospitals are faced with significant losses of Medicaid revenues as legal immigrants lose Medicaid and Medicare SSI eligibility. Further, States' delinking of the enrollment process from welfare and Medicaid is going to result in fewer healthy Medicaid recipients in the risk pool as States move to managed care.

Thank you very much. I would be happy to answer any questions you may have.

[The prepared statement follows:]

Statement of Larry S. Gage, President, National Association of Public Hospitals and Health Systems

I am Larry Gage, President of the National Association of Public Hospitals & Health Systems (NAPH), which represents over 100 of America's metropolitan area safety net hospitals. These hospitals and systems are uniquely reliant on governmental sources of financing to support care to Medicare, Medicaid, and uninsured, low income patients. They also provide many preventive, primary and costly tertiary services to their entire communities, not just to the poor and elderly. These services include a wide variety of around-the-clock standby services such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, and crisis response units for both natural and man-made disasters.

I am pleased to have the opportunity to testify before the Subcommittee today on a range of issues of concern to safety net providers with relation to Medicare payments for hospital and physician services. As the health care market undergoes revolutionary change in how it delivers and pays for health care services, safety net institutions will continue to be called upon to meet certain unique needs within their communities, such as training physicians, ensuring health care access for low income, uninsured individuals and providing the types of round-the-clock specialty services mentioned earlier. Governmental payers, like Medicare, have long recog-

nized the importance of these missions and the need to support them through the overall Medicare hospital reimbursement methodology, including DSH and GME payments. As the health care market becomes more competitive—as the number of uninsured continue to increase—and as payment rates increasingly reflect whatever plans or payers can negotiate with providers of care, the importance of explicit, adequately-financed funding streams for safety net providers will be essential to the stability of many urban and rural health systems.

Last week, NAPH Board Member Jerry Starr, CEO of Kern Medical Center in Bakersfield, California, testified before this subcommittee on the specific issues of disproportionate share hospital (DSH) and medical education payments. I will not repeat his testimony here today. However, I want to re-emphasize that DSH and GME funding will continue to be essential sources of funding for safety net health systems. NAPH strongly supports the ProPAC recommendations regarding the restructuring of Medicare DSH.

My additional comments today can be summarized in four areas:

First, because your first hearing focused mainly on DSH and GME, I want to take this opportunity to describe for you in more detail the situation of safety net hospitals, using new data being publicly released today for the first time. This data is from NAPH's 1995 annual survey and highlights the important mission of these hospitals and how their ability to meet that mission is being impacted by changes in the health industry. We also have information to present about the relative margins of these hospitals and their current source of funding for uncompensated care. Recent market trends have indicated increasing competition for Medicaid business (particularly low cost Medicaid business) while an ever-shrinking group of safety net providers shoulder most of the uncompensated care burden—a burden that is growing steadily.

Second, because of the unique role of safety net providers in the health care delivery system and the fragility of the funding sources on which they rely, the impact of any changes in Medicare payment policy on these institutions must be fully considered before reforms are implemented. In particular, changes in prospective payment system (PPS) rates are likely to disproportionately affect safety net institutions. Similarly, these hospitals and health systems, which already face unique challenges in financing capital improvement projects, will be further disadvantaged by reductions in capital payment rates. Finally, while we support the idea of an outpatient prospective payment system, as recommended by ProPAC, we caution that it must be designed carefully, taking into account unique costs incurred by safety net providers. We also want to take this opportunity to urge you to support legislation to provide additional capital financing assistance to safety net health systems, such as the assistance that would be provided by H.R. 735 recently introduced by Rep. Stark, and to consider permitting broader use of a global fee structure for hospital and physician services. Safety net systems presently require access to capital, not necessarily for major construction projects, but to enable them to downsize appropriately, decentralize, and form broader networks and systems to improve access for the low income and elderly patients they serve.

Third, I have included in my prepared testimony a further discussion of Medicare disproportionate share hospital (DSH) and medical education payments, which are essential to the continued viability of safety net hospitals and health systems. Although the focus of this hearing is not on DSH or GME, I nevertheless want to reiterate the importance of these two payment streams and to suggest certain changes in them to better tailor the payments to sound health care policy. Specifically, NAPH urges you to revise the DSH payment formula to account for uncompensated care, and to adopt a "shared responsibility" or all-payer approach to financing graduate medical education. We also urge the Subcommittee to carve DSH and GME payments out of capitated payments to Medicare risk contractors and pay them directly to hospitals. Finally, we want to strongly urge you to accept the ProPAC's recommendation to authorize the Secretary to collect additional data on the provision of inpatient and outpatient services to uninsured and underinsured patients.

Fourth, even though it is not in the jurisdiction of this Committee, we ask that Medicaid cuts not be part of any budget package you consider this year. Medicaid program growth has slowed considerably in the last year. Due to the implementation of welfare reform legislation, safety net hospitals are faced with significant losses of Medicaid revenues as legal immigrants lose Medicaid and Medicare SSI eligibility. Further, states' de-linking of the enrollment process for welfare and Medicaid is going to result in fewer healthy Medicaid recipients in the risk pool in states with Medicaid managed care. The impact of further cuts in the program or a shift to per capita caps would be devastating. At a minimum, we ask that a targeted group of hospitals treating the highest volumes of low income patients be protected from cuts in the Medicaid DSH program.

NAPH Members Provide Remarkable Levels of Both Inpatient And Outpatient Care

Perhaps the most striking characteristic of safety net hospitals and health systems is the tremendous volume of both inpatient and outpatient services they provide. On the inpatient side, in NAPH's most recent member survey, 90 hospitals reported total staffed beds of almost 40,000 for an average of 442 per hospital, total admissions of 1.4 million and total inpatient days of 10.9 million. To place this volume of care in perspective, in comparison to the average hospital in the 100 largest cities in the U.S., the average NAPH member reported 30 percent more admissions, 9 percent more inpatient days, and an occupancy rate (75 percent) that was 11 percent higher.[1]

Contrary to a sometimes-held misconception of safety net hospitals as primarily inpatient facilities, these institutions have always been the family doctor for large numbers of low income and uninsured patients, providing large amounts of primary and preventive care. In 1995, just 67 NAPH members provided an astounding total of 22 million outpatient visits, only 4 million of which were emergency room visits. Compared to the average hospital in the 100 largest cities, NAPH members provide a full 68 percent more outpatient visits.

Care to Low Income And Uninsured Patients Is on the Rise in Safety Net Institutions

In addition to providing large volumes of care generally, safety net hospitals and health systems tend to provide a huge proportion of care to Medicaid, Medicare and uninsured patients in particular. Over 70 percent of inpatient care provided in NAPH member hospitals in 1995 was for Medicaid and so-called "selfpay" individuals. For safety net institutions, these patients are for the most part medically indigent individuals who cannot afford to pay for the services they receive.[2] When Medicare patients are added, the proportion jumps to 90 percent. For outpatient and emergency care, the proportion is the same: 90 percent of visits were for Medicare, Medicaid and selfpay (Figure 1) and only 10 percent from commercial payers.

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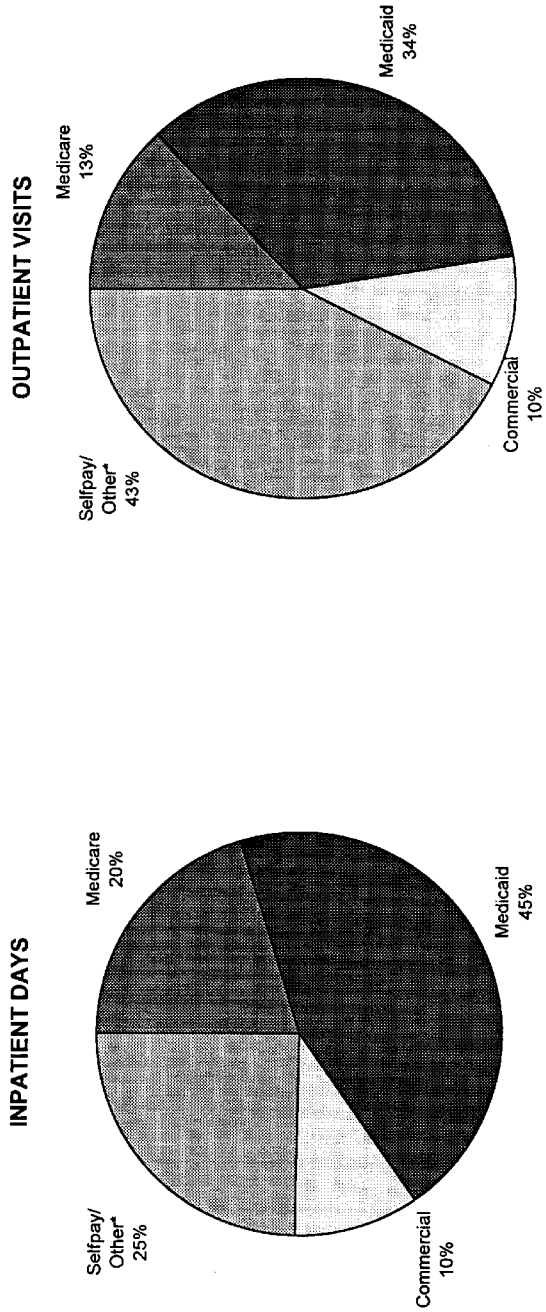
[1] The 100 largest cities are ranked according to population and defined as central cities, not MSAs. The analysis was conducted using data from the 1994 AHA Annual Survey.

[2] Self-pay patients typically include both uninsured patients who can afford to pay some or all of their hospital bills out-of-pocket, as well as uninsured patients who can or do not. So, for NAPH members, "selfpay" patients are the equivalent of "no-pay" patients.

Figure 1
Payer Source for NAPH Member Hospitals, 1995



* Typically, selfpay patients in NAPH member hospitals are the indigent who cannot afford to pay for services.

As safety net providers, NAPH members have historically provided large amounts of uncompensated care in their communities and their share of the uncompensated care burden is steadily increasing. In 1995, 67 hospitals reported incurring $5.8 bil-

lion in uncompensated care (defined as bad debt and charity care) for an average of just over $86 million per hospital. For these institutions, bad debt and charity care charges represented a full 25 percent of total gross charges. According to data from AHA, all hospitals nationwide provided $28.1 billion in bad debt and charity care. While NAPH member hospitals represent less than two percent of hospitals, they provide over 20 percent of bad debt and charity care.

Moreover, in a trend with sobering implications for safety net institutions, uncompensated care is increasingly concentrated among an ever-shrinking number of providers. AHA data on public general hospitals in the 100 largest cities (a subset of total NAPH members) from 1980 and 1993 indicate that the category of selfpay (or no-pay) patients increased from 16.8 percent of gross charges to 22.2 percent, or an increase of over 30 percent. Among private general hospitals during the same period, the proportion of patients with no insurance decreased from 7.4 percent of gross charges to 5.5 percent, a 26 percent decrease. At the same time, private hospitals' share of Medicaid patients grew by 15 percent, reflecting increasing competition for less costly Medicaid patients, such as healthy pregnant women and children.[3]

Further, the number of uninsured Americans continues to rise. The passage of welfare reform legislation in the last Congress is the single most sweeping rollback in Medicaid coverage since the program's establishment. The bill eliminated Medicaid and SSI coverage for substantial numbers of legal immigrants, thereby not only significantly increasing the rolls of the uninsured, but placing a particular burden on safety net providers and the state and local governments that support them. Legal immigrants will continue to need medical care in times of sickness or accident, and will seek that care in safety net hospitals who treat all regardless of ability to pay. Many of these hospitals in high immigrant states, like California, will be overwhelmed by the burden of providing yet more uncompensated care.

Safety Net Providers Depend on Medicaid and Medicare to Finance Uncompensated Care

Unlike most community hospitals that can tap commercial patient revenues to subsidize uncompensated care, urban safety net hospitals rely on Medicare and Medicaid revenues to subsidize the huge amounts of uncompensated care they provide. While Medicaid and Medicare combined represented 55 percent of the overall care provided by NAPH members in 1995, they accounted for 71 percent of net patient revenues.[4]

Appropriations from local government and other revenues intended to cover indigent care costs amounted to 12.3 percent of total revenues. In effect, state and local subsidies cover just over half of the cost of uncompensated care provided at NAPH member hospitals. To make up the difference, these hospitals rely on Medicaid disproportionate share hospital (DSH) payments (40 percent) and Medicare DSH payments (9 percent) (Figure 2). While Medicare DSH payments may not appear significant by comparison, Medicare is a key payer in the fragile partnership of federal/state and local governments that currently finances uncompensated care, particularly in the face of serious proposals to cut Medicaid DSH and declining support by state and local governments (local subsidies have decreased 46 percent over the last eight years). In 1995, 53 NAPH hospitals received a total of $316 million in Medicare DSH payments, roughly 8 percent of the $3.8 billion DSH payments nationwide. Medicare DSH has been and will continue to be an essential piece of the patchwork funding that enables NAPH members to provide critical health services to the elderly, disabled and poor.

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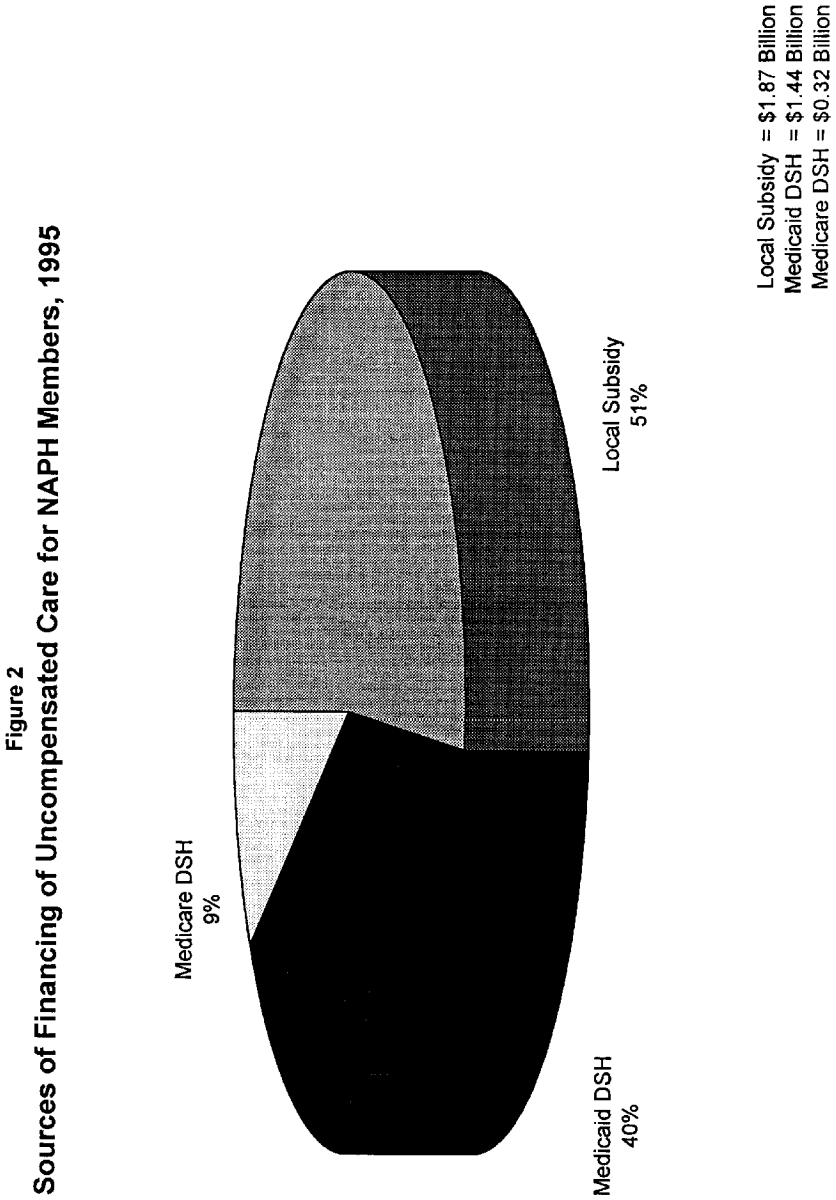
[3] National Public Health and Hospital Institute. *Urban Social Health: A Chart Book Profiling the Nation's 100 Largest Cities.* Washington, DC:1995.

[4] Since much of the overall care provided by NAPH members (as measured by their "gross revenues") is to uninsured patients who cannot afford to pay for their care, the actual revenues received (as measured by their "net revenues") that is represented by Medicaid and Medicare revenues is higher than the proportion of care provided to these patient populations.



CHANGES IN PPS PAYMENT RATES ARE LIKELY TO HAVE A DISPROPORTIONATE IMPACT ON SAFETY NET INSTITUTIONS.

The recently released report of the Prospective Payment Assessment Commission (ProPAC) makes a number of recommendations with regards to Medicare payments for acute care hospitals. In particular, the Commission recommends no update for prospective payment system (PPS) operating rates.

Although NAPH members are most concerned about DSH and GME payment policies, the underlying prospective reimbursement rate upon which those additional adjustments are made is obviously of concern as well. In particular, the effect of any changes (including a freeze) of PPS rates is compounded for NAPH members since the DSH and indirect medical education (IME) payments on which they depend are calculated as percentage add-ons to the PPS rate. Therefore, an inadequate PPS update is magnified for safety net teaching institutions because it means that their DSH and IME payments will also be lower.

In addition, safety net institutions in general tend to incur above average costs in treating Medicare (and other) patients because they generally serve a sicker, poorer and needier population. Although PPS rates are adjusted to account for variables such as case mix indices, they are nevertheless based on averages across all Medicare hospitals. Safety net hospitals will always be on the higher end of the spectrum with regard to costs, and therefore payment rates based on average costs across hospitals will always place these institutions at a disadvantage.

This reality is reflected in NAPH member margins. While the average inpatient margin for all hospitals in 1995, according to ProPAC, was 5.6 percent, the average margin for NAPH hospitals and health systems was a meager 0.7 percent. These margins are lower by far than any of the various groups of hospitals looked at by ProPAC. (Major teaching hospitals had the lowest margin, at 3.7 percent, while propriety hospitals enjoyed margins of 8.8 percent.) Many individual NAPH members actually experienced negative margins.

To the extent that NAPH members have been successful in maintaining positive—albeit relatively small—margins, it is reflective of their success in holding down costs and increasing their efficiency. In fact, an article in last week's *New England Journal of Medicine* reported that public hospitals have lower costs per discharge ($6,507) than either for-profit ($8,115) or private nonprofit ($7,490) institutions, and that they experienced a dramatically smaller rise in administrative costs between 1990 and 1994—0.6 percent as compared to 2.2 percent for for-profit hospitals and 1.2 percent for nonprofit hospitals. NAPH members have also worked hard to shift the focus of care from predominantly inpatient-based to providing an ever-increasing portion of care on an outpatient basis in more cost-effective and community-based settings. To the extent that their margins have improved based on these cost-saving measures, hospitals should not be penalized. Such behavior is precisely what Congress intended to encourage in enacting and refining the PPS system in the first place. So while it is appropriate for the Medicare program to share in some of those savings, it is not appropriate to penalize hospitals for achieving them.

Safety net hospitals face unique challenges in financing capital improvement projects and are likely to be particularly impacted by changes in Medicare capital payment policy.

With respect to capital payment rates, ProPAC recommends revising the current payment rates and applying a zero update factor for fiscal year 1998. NAPH member institutions have traditionally been particularly disadvantaged with respect to capital improvements. Unlike their private counterparts, they do not have ready access to financing to support renovation or rebuilding projects, for a variety of reasons. Their large indigent care burdens and uncertain revenue streams make them a too-risky proposition for private investors. Moreover, federal, state and local government assistance for capital expenses has become scarcer and tighter. As a result, NAPH member institutions have physical plants that are on average 29 years old, as compared to an average lifespan of 7 years for hospitals as a whole. Changes in Medicare capital payment policies that make it harder to cover the costs of capital improvement projects are therefore likely to place a particular burden on safety net institutions.

For these reasons, NAPH is greatly indebted to Mr. Stark for his persistent efforts over the years to establish a federal trust fund to provide limited capital financing assistance to safety net providers. He has again this year introduced legislation to achieve this goal, H.R. 735, the Essential Health Facilities Investment Act, and we are grateful for his understanding of the critical need to assist safety net hospitals in this regard in order to ensure that they are able to compete in a changing health care marketplace.

A HOSPITAL OUTPATIENT PROSPECTIVE REIMBURSEMENT SYSTEM SHOULD BE DESIGNED WITH SENSITIVITY TO ITS IMPACT ON SAFETY NET PROVIDERS.

ProPAC also recommends implementation of a prospective payment system for hospital outpatient services, including some mechanism to control for the volume of services. NAPH certainly supports this approach in general as a means of adopting appropriate incentives on the outpatient side to match those measures long estab-

lished for inpatient care. Although the ProPAC report does not specify exactly how the system should be set up, NAPH urges Congress to ensure that however it is designed, it is sensitive to the particular situation of safety net institutions. Again, we emphasize that safety net institutions often incur costs that are higher than the average, and as a prospective rate is developed it should both provide for appropriate outliers, and take into account the justifiably higher costs that certain hospitals with particularly vulnerable patient bases are likely to incur.

Finally, with respect to physician payments, we note that the ProPAC report calls attention to the relative incentives inherent in two different approaches to Medicare expenditures: traditional unbundled fee-for-service reimbursement and managed care. We would like to urge you to consider a third option, based on the experience of a number of urban safety net hospitals with largely salaried medical staffs. While salaried physicians may have once been considered at an economic disadvantage in a fee-for-service era, we are finding increasingly that this system can be an advantage under other reimbursement methodologies. These include managed care, and we certainly support the AHA and Administration's recommendations to open up the Medicare program to managed care products offered by provider-sponsored organizations. There is another model to which we would like to call your attention, however—one that is already in use in a number of urban safety net systems with salaried medical staffs. That is the "global fee" arrangement, whereby a system is paid a single, bundled fee for hospital and physician services to a patient. We are aware that HCFA has experimented with such global fees in areas like cardiac surgery, and we strongly urge the Committee to consider making broader use of such global fee options.

THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL FORMULA SHOULD BE CHANGED TO REFLECT UNCOMPENSATED CARE AND HCFA SHOULD BE AUTHORIZED TO BEGIN COLLECTING THE DATA TO DO SO AS SOON AS POSSIBLE.

Although this hearing is focused primarily on non-DSH and non-GME payment policies, there are a few recommendations in ProPAC's report in these areas which I would nevertheless like to take a few moments to address. In particular, I want to emphasize NAPH's support for ProPAC's suggested reform of the Medicare DSH formula to account for uncompensated care. We wholeheartedly endorse the approach they have developed using costs of care for low income populations, and in fact have used it as the basis for our proposed reform of the Medicaid DSH program.

Nevertheless, in order to implement this kind of a measure of low income care, additional data collection will be necessary, as ProPAC points out. No accurate or consistent data on hospitals' costs for these populations currently exist in any usable form. While we are in the process of modeling our Medicaid DSH proposal using proxies for some of these costs, it may be desirable for HCFA to do so more systematically in the manner outlined in the ProPAC report. As ProPAC observes, data necessary to develop a reasonably accurate estimate of these costs could be collected with relatively little additional burden on hospitals. Because this information would be invaluable for both Medicare and Medicaid DSH reform, we urge Congress to authorize and direct HCFA to begin collecting such data as soon as possible, without waiting for a Medicare or Medicaid bill to be adopted to get this ball rolling.

To summarize NAPH's concern about the current DSH formula, it is based on a hospital's "disproportionate share patient percentage," which is a measure of the proportion of care provided to Supplemental Security Income (SSI) and Medicaid patients.

There are a number of serious problems with this formula that warrant reexamination.

- In relying on measures of SSI and Medicaid populations, the statutory low income proxy does not include the significant uncompensated patient care load that some hospitals are currently bearing.[5] This problem will be exacerbated as the impact of welfare reform legislation begins to reduce Medicaid eligibility in states with high numbers of immigrants or in states that choose to de-link Medicaid and welfare eligibility.
- Many hospitals are finding it difficult, if not impossible, to identify Medicaid patients in states that have moved to implement Medicaid managed care—Medicaid patients show up with an insurance card from a managed care plan, which may not identify them to be Medicaid recipients. To the extent the Medicare DSH formula

[5] Uncompensated care is accommodated in the formula only indirectly, because payments are made to hospitals with at least 100 beds that receive at least 30 percent of their net revenues from state or local government payments for indigent care.

relies on Medicaid utilization, the inability to account for all Medicaid patients translates into reduced Medicare DSH dollars.

• Hospitals with significant uncompensated care burdens are finding it increasingly difficult to retain their share of the less costly Medicaid populations (for example, healthy mothers and children) as market competition intensifies. Their burden of uncompensated care and care to high risk chronically ill populations is increasing while their ability to cross-subsidize that care with lower risk Medicaid volume is diminishing.

• The DSH formula needs to reflect the change in health care delivery from inpatient to outpatient services. As hospitals reorient to provide more preventive and primary outpatient care and less episodic, acute inpatient care, the DSH formula should include inpatient and outpatient services as part of its measure of low income costs.

For all of these reasons, changing the Medicare DSH low income proxy is imperative to protecting access in hospitals that serve large numbers of low income patients. ProPAC has recognized this need and proposes a change in the low income proxy to include all of the elements of low income care. Their proposed low income cost variable includes Medicare SSI patients, Medicaid patients, care to patients supported by local indigent care programs, and uncompensated care. NAPH strongly supports this approach to incorporating all of the components of low income care and to targeting Medicare DSH funds on the highest volume providers of low income care.

GME is a Public Good Which Should Be Financed By All Parts of the Health Care System

NAPH member hospitals play a significant role in training residents and health professionals. Over 85 percent of NAPH members are teaching hospitals, and they trained nearly 18 percent of all residents in 1994. In 1994, 62 NAPH hospitals trained 12,531 residents, or an average of 202. In 1995, 63 NAPH members received $158 million in direct GME (DGME) payments from Medicare and nearly double that or $261 million in indirect medical education (IME) payments.

NAPH supports a "shared responsibility" approach to financing graduate medical education which treats GME as a public good. This approach would require contributions from all payers of health care, not just Medicare, and, thus, should distribute GME funding based on all patient care volume. Alternatively a trust fund approach could be financed with general revenue contributions or a broad-based tax. ProPAC's report includes just such a recommendation for a broader-based financing mechanism for GME payments.

The level of financing for GME is critical. As other payers negotiate ever lower rates, teaching hospitals are losing their ability to cross-subsidize medical education costs. In addition, as more Medicare patients move to managed care, GME funds, which are currently based on the volume of Medicare fee-for-service patients, will diminish considerably. These trends threaten to undermine the viability of our nation's teaching hospitals and their ability to train physicians.

Medicare GME and DSH Funds Should Be Carved Out of the AAPCC and Made Directly to Hospitals

The current methodology for distributing DGME, IME and DSH payments is seriously flawed in the Medicare managed care context. For Medicare patients enrolled in managed care, these supplemental payments are incorporated into the average adjusted per capita cost (AAPCC) which is the capitation payment made to managed care plans. The plans do not necessarily pass these payments along to the hospitals which incur the costs that justify the payments. In fact, some plans receive the payments and do not even contract with such hospitals. As Medicare increases the use of capitated risk contracting, the amount of DGME, IME and DSH funds that go to teaching hospitals will diminish considerably unless this payment policy is changed. In essence, payments intended to support the costs of teaching or low income care are being diverted from the hospitals that provide the care to managed care plans that are not fulfilling this mission. For this reason, ProPAC has recommended, and NAPH strongly agrees, that the GME and DSH payments be carved out of the AAPCC rate and paid directly to the hospitals that incur those costs.

Physician Workforce Reforms Must Be Balanced With Maintaining Access to Care in Underserved Communities

ProPAC also recommends restructuring DGME and IME payments to remove disincentives for hospitals to reduce the size of their residency programs. NAPH sup-

ports this notion. Our members have been making significant efforts in recent years to decrease the size of their resident population.

It is important to keep in mind, however, that safety net teaching institutions face particular challenges in reducing their reliance on residents. In general, these institutions depend on residents and supervising attending physicians to provide otherwise unavailable care to underserved communities. Replacing these physicians is costly—NAPH members estimate that it would cost two to three times more to replace a resident with some combination of physicians and non-physician providers—and difficult, since replacements are not easily found. Therefore, while we support proposals such as ProPAC's to restructure the physician workforce, we urge that such measures be implemented carefully, with sensitivity to the patient care role that residents play in underserved communities.

PROPOSALS TO REMOVE DSH AND GME PAYMENTS FROM MEDICARE SHOULD BE UNDERTAKEN WITH EXTREME CARE NOT TO UNDERMINE THE SAFETY NET AND TEACHING INSTITUTIONS THAT THESE PAYMENT STREAMS SUPPORT

Finally, I would like to comment briefly on recent informal suggestions from both House and Senate members that we examine the possibility of removing DSH and GME payments from Medicare and finance them with general revenue funds. In theory, NAPH agrees that providing care to low income populations and training physicians are "public goods" that should be financed by a broader base than just Medicare. However, without having seen any details about how such a move would be implemented, we do have a number of concerns about these suggestions.

First, under the current system DSH and GME are part of the Part A Trust Fund, and as such the funding for them is protected through a dedicated revenue stream. We would certainly be concerned about any approach that did not set up a similar trust fund mechanism and provide protection for these payments similar to that currently accorded them.

Second it is imperative that these payments be adequately funded. At a bare minimum they should receive funding in at least the same amounts as under current law. We would not support any such structural move that had the effect—intended or otherwise—of cutting the overall funding for these programs.

On the other hand, as I indicated earlier, conceptually a broader base of funding for these services is certainly justifiable. An approach that would set up multiple funding streams for a new GME/DSH trust fund would certainly be worth considering. For example, Senator Moynihan and Representative Lowey have introduced bills to establish a very broad financing base for GME, including Medicare, Medicaid, and private insurance (through a premium tax). This may be an approach worth further exploration.

Chairman THOMAS. Thank you, Mr. Gage. I wonder how much you did pay for the charts. I am looking at the one, and if I read it correctly, the local subsidy is 51 percent, and 51 percent of that pie starts about 12 o'clock and stops somewhere around 7 to 8 o'clock.

Mr. GAGE. We obviously did not pay enough to get the segments of the pie looking quite proportional. [Laughter.]

Chairman THOMAS. Well, you know, you get what you pay for.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Mr. Scully—and others can chime in on this if they want—you mentioned that you were willing to have one-third of the cuts come out of hospital reimbursements, and yet—I mean, you point to the impact of the steep 15-percent cut, 17-percent cut in capital costs, the impact of the outpatient cuts, and the low update on top of all of the economies that hospitals have already adopted and imply that these three sets of cuts are really going to be unbearable.

If we are to get one-third of the savings out of the hospital sector, then how would you do it?

Mr. SCULLY. Well, that adds up—for instance, if you look at the AAPCC, which you haven't gotten to yet, but the President did, a lot of people do not—when they see the number that says managed care was cut by $34 billion, 50 percent of that is a passthrough. That money goes—60 percent of all money in Medicare goes to hospitals. So if you are going to say you are going to reduce the AAPCC, that is going to have an impact on us as well. The money goes through us.

So when you add up the $102 billion net, for instance, in the President's budget and you look at how much it affects hospitals—and a lot of the part B stuff, other outpatient payments also affect hospitals—it goes far beyond just the market basket and outpatient and outpatient reform. There are a lot of these components that people do not think of as hospital hits that hit hospitals, and by my calculations, I think very credible calculations, it got up as high as $72 billion out of the $102 billion. But I think a reasonable number is certainly 60 to 70 of it goes directly to hospitals, depending on the chunks of the pot you look at.

Now, there are a lot of reasons for that. We can look at the physician side. There is only 7 percent that comes out of physicians. The physician baseline is very low. Growth is 2, 3, 4 percent per year for the next 5 years in physicians. But it is roughly the same for hospitals. It is about 3.5 percent for hospitals.

I guess our argument is, I am not saying—we have—23 percent of our hospitals have negative margins. We have 24 percent that are losing money on Medicare. I am not going to say that hospitals are going to shut their doors and say which ones are. The fact is we are adapting to a squeeze. I think we have reacted very well to market pressures from managed care and from fairly low repayment in Medicare. And I think it is just a matter of equity.

The fact is in past budgets—and I have done a few of them—it is a lot easier to go out and take a lot of money out of the market basket update or big chunks of part A with hospitals than it is from any place else. And for 15 years, we have been the victims, I would say, of the fact that it is a lot easier for somebody at OMB or CBO or ProPAC to say let's take half a point off the market basket instead of taking 25 little nicks out of physician updates. It is just easier as a budgeteer to do that. And I think when you look back at the history——

Mrs. JOHNSON. I guess what I was getting at is you mentioned that only capitation payments would fix Medicare. Could you sort of apply that to the current situation? In other words, if we are going to constrain the growth in health care costs, in Medicare costs, since the hospital payments are such a big part of that, we are going to have to do something.

Now, constraining the update factor at least is not a cut below the line. The capital cuts are below the line, and they have a quite variable effect on different types of institutions. The outpatient cuts are also going to be extremely heavy and vary a lot from institution to institution. At least, I would guess that. I am not sure about that.

But I understand the problems with the proposals, but on the other hand, we have to have some input on what would be a less

destructive way to at least constrain the growth in hospital costs, preserving to the best of our ability a healthy hospital system.

Mr. SCULLY. Well, I think we are more than happy to contribute our fair share, and I think there are a lot of ways to do that. The President did market basket minus 1. I think a freeze is probably not, I do not think, rational policy. I think somewhere between a freeze and market basket minus 1 is probably where we will end up, but I think freeze is pretty harsh. And I think it is not equitable compared to where you are looking at other places in Medicare. Are you going to have masses of hospitals across the country closing? I doubt that. But it is going to add to the squeeze, and it is very hard to find a hospital in this country right now that is not feeling the squeeze, staffwise, patient carewise, every place.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. The gentleman from Maryland.

Mr. CARDIN. Thank you.

Mr. Johnson, let me ask you a question on the beneficiary's liability on outpatient services. I notice in your testimony that you support the change so that their liability would be 20 percent of the allowed payment rather than the current arrangement.

I am curious, though, that you do not want to do this immediately. You believe it should be phased in over time. I am just curious as to why there is an overpayment by beneficiaries now. I understand the revenue issue. Why wouldn't you be more anxious to get this corrected on a faster time schedule?

Mr. JOHNSON. Mr. Cardin, the beneficiary liability we believe is really a matter between Medicare and the beneficiaries. I think there is a misconception that the hospital is somehow gaining a great amount of revenue because of the higher charges and the beneficiary copayment based on those higher charges, when, in fact, that is not the case at all. The Medicare outpatient rates are what Medicare pays hospitals. And I think there is a similar misconception out there in the senior community about what hospital charges are, related to inpatient services. When there is a DRG payment and they see a bill that is exceeding that, they think somehow there is more money coming to the hospitals.

I think this matter needs to be addressed between Medicare and the beneficiary.

Mr. CARDIN. Well, why not then correct it immediately? Would you support correcting it immediately?

Mr. JOHNSON. I think whatever Medicare and the beneficiary plan is immediately, or as it is explained, these things do take explanations, and I think how it is explained to the senior citizens and the complex relationship it is between the increased Medicare costs that could result. If you are basing a copayment on a different point, if it is on the payment instead of on the charges, it could increase the Medicare Program's costs. I think that all has to be balanced, and I think that is a balancing act that does take a little careful work.

Mr. CARDIN. I am not sure I follow you or agree with your point. I guess my point is that if there is an overcharge, regardless of who is benefiting from that overcharge—and we all acknowledge that the beneficiaries are paying too much—why shouldn't we move more rapidly to correct it?

Mr. JOHNSON. If the government wants to move rapidly to correct that, that is great. But it will cost the government more money, probably, in their share.

Mr. CARDIN. Mr. Scully.

Mr. SCULLY. I think it is fair to say the outpatient payment system is a mess and has been for a long time, and this problem has built up over 10 to 15 years. What you have really is that HCFA, OMB, everybody in the budget over the years, we have gotten to the point that we are being paid in the outpatient area far less than our costs. And the whole system, basically—I can explain it in detail, if you would like some day, but we are basically being paid about 50 to 60 percent of our cost. Beneficiaries—and it is usually paid by their Medigap plan—are getting hit. There is no question they are paying excessively high copayments.

If the government just went out and fixed it tomorrow and said the beneficiary tomorrow is going to pay a 20-percent copayment, hospitals would take an enormous hit. And I think you can see that, HCFA, Medicare is paying far, far less than their share of the actual costs in outpatient. I think the administration—this is a very tough issue. I think they happen to have come up with an extremely rational phased-in policy over 10 years that will keep—the hospitals will get paid a little less. Beneficiary copayments will drop. It is a very good long-term policy.

Mr. CARDIN. I understand that, and I understand your point. I am not so sure I would agree with you that we are reimbursing the hospitals too low and, therefore, allowing you to recoup some of the costs from the beneficiaries. I am not sure that is the rationale for the current mistake in law where our beneficiaries are overpaying. I believe there was a good-faith effort to reimburse what we believe to be a reasonable reimbursement for outpatient services. We may have missed, but there was at least an effort.

Mr. SCULLY. I would be happy to sit down with ProPAC and go through it with you, but I think there is a lot of evidence going way back, as far back as 7, 8 years ago when I first got involved in this, that the HCFA rate of payment for outpatient is significantly less than cost by any measure. There is no doubt there is a problem here, and there is no doubt the beneficiaries have been paying more than they should for a long period of time.

Mr. CARDIN. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Just one quick followup to that. According to our charts and CBO's estimate of the President's plan to correct it now, it is about $48.8 billion. Does the gentleman have any idea what it would have cost to correct it—oh, let's pick a period, 1983, 1985, somewhere around in there?

Mr. SCULLY. I am not sure I want to touch that one. [Laughter.]

Chairman THOMAS. Any idea what it would have cost to correct it at that time, Mr. Scully.

Mr. SCULLY. Well, there were periods probably from 1989 to 1993 where it probably could have been corrected, too, and it was not. So it probably would have been cheaper to correct it at the time.

Chairman THOMAS. The old business of a stitch in time applies to this as well, and since it was the beneficiary that was left holding the bag, it was the easiest route to go, although totally unac-

ceptable, and taking the easy way out now costs us, I guess, $48 billion to correct. It would have been $10 billion, $5 billion, $3 billion had we done it when it became apparent.

Mr. SCULLY. Also, one of the reasons it was done was it created an awful lot of budget savings at the time in the baseline for people that were trying to do balanced budget nips and tucks here and there. So there are a lot of things that contributed to it, but it certainly would have been cheaper.

Chairman THOMAS. I appreciate your reference to cheating the beneficiary in terms of explaining to them what their actual costs are versus what their costs should have been as nips and tucks in terms of a balanced budget structure. We probably should stop this conversation right here. Because if you are going to give me those answers—what else should I say?—I am going to keep responding a little more pointedly. So we probably just ought to stop right there.

Mr. SCULLY. OK.

Chairman THOMAS. Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Mr. Johnson, let's talk about taxes paid by for-profits and sometimes not-for-profits paying in lieu of taxes, and they are being reimbursed directly for those expenses by Medicare rather than including those costs in the base for the calculation of capital reimbursement for all hospitals.

Do you have an opinion on that, or does AHA have a position on that?

Mr. JOHNSON. I do not know if AHA has an opinion on it, Mr. McCrery, but we can certainly get back to you on that. I can tell you from my experience or our experience, we do receive taxes from our local—the public. All of those are put toward what we call our community benefit plan, so they go back into the community for services that are needed and directed by the elected board. But I do not know if there is a position by the AHA on your question, but we will certainly get back to you on that.

Mr. MCCRERY. OK. Well, let me rephrase the question so you will know exactly what I am looking for. I would like to know what AHA's position on it is.

I want to know if AHA supports allowing investor-owned hospitals, which incur local property taxes, and not-for-profits, which make payments in lieu of taxes, to be reimbursed by Medicare for their share of those costs. That is the question.

Mr. JOHNSON. OK. I have been informed that AHA supports a specific adjustment for property taxes.

Mr. MCCRERY. OK. Thank you.

Mr. JOHNSON. OK.

Mr. MCCRERY. Do either of the other two witnesses want to address that?

Mr. SCULLY. I am not sure Larry and I would agree on this one. If you want us to, we probably could, if you want us to. [Laughter.]

Mr. MCCRERY. I would like for you to agree, but——

Mr. SCULLY. Well, we certainly support it. It is basically the federation's proposal, and the AHA—it has been somewhat controversial within the different segments of the hospital field.

Just to give you a brief history behind it, there was a long negotiation, which I was involved in when I was in the government, in 1991 when hospital capital was folded into PPS and essentially all hospitals got paid the same for capital. Some nonprofits pay payments in lieu of taxes locally. Most for-profits pay taxes locally. And an agreement was done at the time where HCFA was going to go off and write a separate regulations, which they did over the course of 2 years, that everybody agreed to in 1991, and then it finally came out almost 3 years later. It was in the NPRM exactly as it was agreed to, and it was yanked at the last minute for a variety of reasons.

The provision was fixed in the 1995 budget bill in the House and the Senate, and that bill was vetoed. Our view has been and always has been—I think it is very similar to the IME argument. We pay the property taxes; the nonprofits who pay the payments in lieu of taxes pay them. There are costs. Nonprofits do not pay them. The nonprofits that do not pay those fees, and that we should be reimbursed for those capital costs. And as it is now, they go into the pot, and everybody splits them up.

It is similar—there are very few in IME. We do not have as many teaching hospitals. We have a number of them. Our view is that the people who do the teaching hospital payments should get paid for teaching hospital costs. There are very specific costs. This was negotiated in great detail in 1991 when the PPS—Gail Wilensky was then the HCFA Administrator, and I was at OMB, and I was intensely involved on the government side then. This was a very long negotiated agreement between all the hospitals as to how it was done, and when the regulations came out, at the last minute it was not fixed.

So it has a long history to it.

Mr. MCCRERY. Mr. Gage, do you have any comment on this?

Mr. GAGE. We do not as an organization have an official position. We have discussed the issue from time to time. It is not directly relevant to most of our members, although some of them feel pretty strongly, and as Tom indicated, on the other side of the issue, mainly because they see capital reimbursement as a zero sum game. And if you have capital funds flowing out in one direction—and that clearly does not include most of the Nation's public hospitals—you have to take it away from somewhere else. If it were not a zero sum game, I am not sure we would have the same level of concern with it.

Mr. MCCRERY. Yes. Well, there does seem to me to be some inequity there since those costs are fixed, they are mandatory, they cannot be avoided, and so maybe we will try to work something out again.

Thank you.

Chairman THOMAS.I want to thank the panel very much. Obviously, we will be visiting again as we move forward with this. Tom, it is good to see you.

Our next panel consists of Dr. Thomas Reardon, who is vice chair of the American Medical Association; Alan R. Nelson, Dr. Nelson, executive vice president of the American Society of Internal Medicine; Dr. Michael Maves, who is the executive director of the American Academy of Otolaryngology-Head and Neck Surgery, Alexan-

dria, Virginia; and Patrick Harr, Dr. Harr, president, American Academy of Family Physicians.

I want to thank you all for coming. Any written testimony that you may have will be made a part of the record, and you may inform the Subcommittee about your interests and concerns in any way you see fit.

Dr. Reardon, why don't we start with you and then we will just move right across the panel. I will warn you. These microphones are very unidirectional, so you are going to have to speak directly into them. Thank you.

STATEMENT OF THOMAS R. REARDON, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. REARDON. Thank you, Mr. Chairman. My name is Dr. Thomas Reardon. I am a general practitioner from Boring, Oregon, and vice chair of the AMA's board of trustees. I appreciate this opportunity to testify today on physician payment issues.

It is clear that Medicare has been extremely successful in improving the health of our Nation's seniors. It is also obvious that the current Medicare Program cannot be sustained. The Hospital Insurance Trust Fund faces bankruptcy in 5 years or less, and the future looks even bleaker with the aging of the babyboomers.

In contrast, Medicare's physician spending is below the growth rate for any other major sector of Medicare and well below Medicare's overall growth rate. The AMA is pleased that the administration's 1998 budget proposal recognizes this fact. Unfortunately, the administration's approach to Medicare reform relies primarily on payment reductions in hopes of getting more services for less money. We believe this approach threatens seniors' access to quality care, while also postponing the major restructuring needed for Medicare's long-term survival.

The administration's budget targets $5 billion in savings over 5 years from physicians by moving to a single conversion factor and revising the physician payment update formula. The AMA has consistently sought a return to a single conversion factor. Because of the impact on certain specialties, we support a transition of as close to 3 years as possible, with a single conversion factor fully phased in by January 2000.

The administration also proposes replacing the current Medicare volume performance standard update formula with a sustainable growth rate formula. The volume allowance in the administration's formula was initially set at growth in real capita GDP plus 1 percentage point. CBO apparently failed to score $5 billion in savings from the administration's proposal, and the volume allowance has been reportedly reduced to GDP plus zero. Under GDP plus zero, physician payments would continue to fall well below medical inflation and could even fall below current payment levels as they are projected to do under the current system. We believe policymakers must set spending growth for physician services that best balances patient care needs and the Federal budget. Physicians are only asking for the opportunity to have Medicare payments keep up with the cost of providing care to their patients.

The AMA could support the new payment update formula set at a minimum of GDP plus 2 as provided in the 1995 Balanced Budg-

et Act, with assurances that this would be increased as necessary to cover medical inflation. Physicians have been doing their part to keep Medicare costs under control. Budget resolution should not penalize them with further reductions.

Many physicians face additional extreme payment reductions due to the implementation of a resource-based practice expense component of the Medicare fee schedule by January 1998. However, preliminary data released by HCFA earlier this year suggests that there are problems with HCFA's practice expense data and methodology. The AMA supports resource-based practice expenses so long as they reflect actual practice expenses, but we are seeking a 1-year extension of the implementation date. We believe that with an additional year, there would be time to correct the data, develop better methodologies, and collect missing data. It is extremely important HCFA get this right the first time because practice expenses represent over 40 percent of Medicare's payment to physicians. The cuts HCFA projected earlier this year would nearly eliminate practice cost reimbursement for some procedures and some specialties.

The AMA urges Congress to: One, extend the implementation date by 1 year; two, give physicians the opportunity to review HCFA's data 6 months before issuing a rule; and, three, ensure that the new practice expense values do not reduce physicians' ability to provide high-quality medical services to the Medicare beneficiaries.

The AMA opposes the administration's proposal to eliminate payments to assistants at surgery and reduce the payments for so-called high-cost medical staffs. We also have concerns with the proposal to expand the Centers of Excellence demonstration project. In addition, the AMA strongly opposes the administration's effort to repeal fraud and abuse safeguards included in last year's health insurance legislation.

We look forward to working with you and the entire Congress in enacting reforms needed to protect Medicare for seniors and save it for our children. We thank you again for this opportunity to present.

[The prepared statement follows:]

Statement of Thomas R. Reardon, M.D., Member, Board of Trustees, American Medical Association

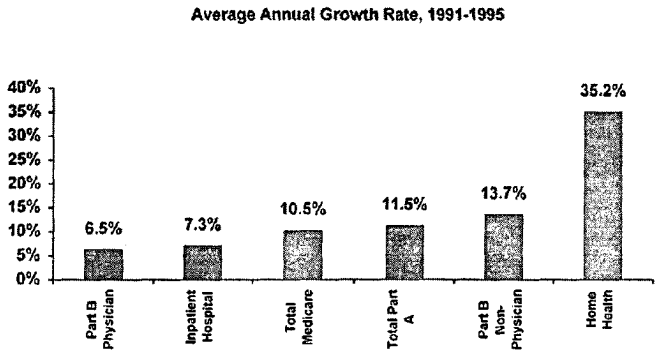
Mr. Chairman, my name is Thomas R. Reardon, MD. I am a general practitioner from Boring, Oregon, and a member of the Board of Trustees for the American Medical Association (AMA). On behalf of the 300,000 physician and medical student members of the AMA, I thank you for this opportunity to testify before the Subcommittee today regarding Medicare physician payment issues.

A wide range of experts have independently concluded that, despite Medicare's clear success in improving the health status of our elderly and disabled citizens, the program cannot be sustained without fundamental restructuring. The Hospital Insurance Trust Fund faces bankruptcy in five years or less, and Medicare's current overall expenditure growth cannot be sustained. Medicare faces a much more serious long-term problem as the "baby boom" generation ages and the number of workers paying taxes for every Medicare beneficiaries will decline from 3.9 currently to only 2.2 in the year 2030.

The high growth rates for many of the services are due to a combination of factors, including increased beneficiary demand for new services, flaws in payment rules which encourage high volume growth in some categories of service, insulation of most beneficiaries from cost considerations, and ineffective approaches to cost control. However, as the chart below indicates, physician spending growth is well

below the rate for any other major sector of Medicare, and well below overall Medicare growth. The AMA is pleased that the President's 1998 budget proposal explicitly recognizes this fact.

- Part B physician spending growth was 6.5% from 1991-1995.
- Part B non-physician spending grew at 13.7% over the same period.
- Physician spending growth was well below the rate for any other major sector of Medicare, and well below overall Medicare Growth



Source: Health Care Financing Administration Office of the Actuary

We are also pleased that the Administration's budget supports the development of innovative provider sponsored organizations in order to offer greater choice to Medicare beneficiaries. We believe these types of options hold the promise of enhancing beneficiary choice while controlling Medicare's costs. The AMA also supports the President's investment in preventive health care to improve seniors' health status by covering colorectal screening, diabetes management, and annual mammograms without copayments, and by increasing reimbursement rates for immunizations to ensure that Medicare beneficiaries are protected from pneumonia, influenza and hepatitis.

Unfortunately, the Administration's budget primarily adopts the strategy of cutting physician and other provider payments in hopes of getting more services for less money. We believe this approach will ultimately divorce the Medicare system and its beneficiaries from the mainstream of American medical care, while postponing the major restructuring needed for Medicare's long-term survival. In the meantime, the long-term problems will only grow larger, requiring more draconian and expensive solutions.

AMA'S PROPOSAL FOR MEDICARE TRANSFORMATION

The AMA has a plan which addresses both the short and long-term problems with Medicare, while preserving the bond of trust between a patient and physician that makes medicine unique. The AMA's Transforming Medicare proposal is based on the idea of a competitive market-driven system as the best option for the future of the Medicare program because it offers more choice to senior citizens and the disabled. We must give the patient both the opportunity and the responsibility to make wise prospective choices of physician and health plan, with the reasonable opportunity to change either if they prove unsatisfactory.

Our plan would modernize traditional Medicare, eliminating the need for Medigap, while preserving the security and quality of care beneficiaries now receive. It would create a new MediChoice option, which would provide a broad menu of health plan choices for Medicare beneficiaries to choose from, including medical savings accounts and provider sponsored organizations. And finally, it would ensure that a healthy Medicare is available for future generations. The AMA would welcome the opportunity to discuss our Transforming Medicare proposal with the Subcommittee in greater detail at an appropriate forum.

IMPROVING THE PHYSICIAN PAYMENT SYSTEM

The Administration's 1998 budget proposal targets $5 billion in savings over five years from refinements to the Medicare physician payment schedule. In particular, the Administration proposes moving to a single conversion factor (CF) for the payment schedule, and replacing the current Medicare Volume Performance Standard (MVPS) update formula with a Sustainable Growth Rate (SGR) formula.

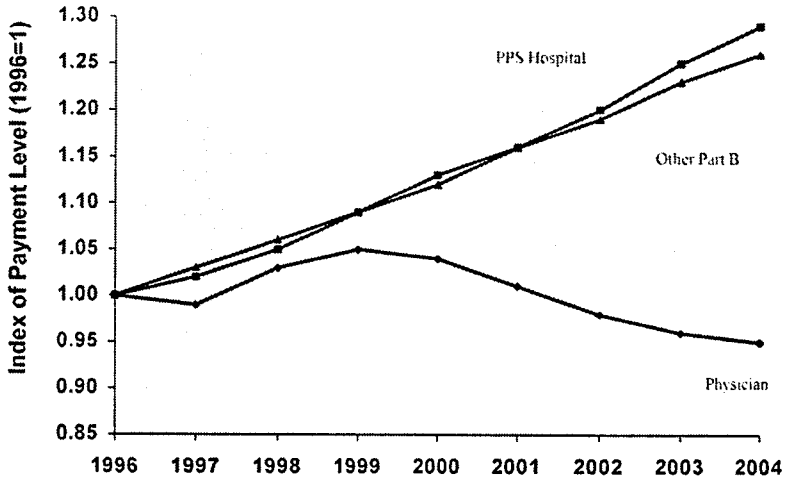
Under the Administration's budget proposal, the overall payment update for 1998 would be set at 1.9%, yielding an overall CF of $36.63 in 1998. With the move to a single CF of $36.63, surgical service payments would fall by 10.6% compared to 1997 levels, while primary care payments would increase by 2.4% and other service payments would increase by 8.2%. The payment reductions for surgical services are further exacerbated by the implementation of resource-based practice expense relative value units scheduled for 1998, as discussed below.

The AMA has consistently sought a return to a single growth standard and conversion factor for physician services. We adopted this position well before any indication of which services would benefit from multiple standards. At our Annual House of Delegates meeting in 1996, AMA policy was modified to adopt a compromise that responds to two realties. First, because moving to a single conversion factor could lead to large single year cuts for some services and specialties, we support a transition of as close to three years as possible. Second, because we also recognize that one of the purposes of a transition is to allow those who face cuts time to adjust, and that there has been "fair notice" of a shift to a single conversion factor, our House of Delegates voted that the "clock should start running" on such a transition on January 1, 1997.

In addition to moving to a single conversion factor, the AMA supports replacing the MVPS system of updating physician payments. There is widespread agreement that the current method of updating physician payments, the MVPS system, is fundamentally flawed. The Congress, the Administration, and the Physician Payment Review Commission (PPRC) have all proposed replacing the current MVPS update formula with a sustainable growth rate (SGR) formula, which uses real per capita gross domestic product (GDP) to adjust for volume and intensity.

The Administration's fiscal year 1998 budget proposes implementing an SGR formula, with the volume target in the SGR formula initially set at growth in real per-capita GDP plus one percentage point. However, the Congressional Budget Office (CBO) scoring of the proposal apparently failed to yield the targeted savings of $5 billion in savings from the Medicare fee schedule, and the volume allowance in the SGR was reportedly reduced to GDP+0.

In general, the AMA supports implementing the SGR approach as a needed correction for the MVPS. Fundamentally, the question for policymakers is determining the level of annual spending growth for physician services that best balances patient care needs and the federal budget. Under the current MVPS physician update formula, the projected Medicare payment level for physicians is a steep actual decline, while hospital and other provider payment rates go up, as the chart below indicates. Although these non-physician services are unlikely to see their full projected increases, their budget savings will be charged against this rising baseline, while further savings from physicians require even steeper cuts.



Source: CBO January 1997 Baseline Medicare

Budget reconciliation for Medicare should reflect the fact that physician spending is under better control than any other major Medicare segment, and that the budget baseline already assumes steep annual payment cuts. Physician practice costs, as measured by the Medicare Economic Index (MEI), continue to rise while physician reimbursement under Medicare is projected to fall. Physicians are only asking for the opportunity to have Medicare payments keep up with the costs of providing care to Medicare beneficiaries, and are willing to accept the challenge of maintaining volume growth at current low levels.

While we believe that MEI is the appropriate goal for physician updates, we understand that budgetary constraints may not presently allow for a full MEI update for physicians. Physicians are willing to do their part to put Medicare's fiscal house in order, as we have repeatedly done in the past. Physicians, who accounted for 32% of combined physician and hospital Medicare spending from 1987 to 1993, absorbed 43% of Medicare provider cuts over the same time. We would be willing to accept GDP+2 under an SGR system as a temporary measure, if there were assurances that this could be increased to cover MEI once the necessary Medicare savings were obtained. In contrast, under GDP+0 as the Administration proposes, physician payments would continue to fall well below MEI, as they are projected to do under the current MVPS system.

Given a new SGR, with a realistic growth allowance, we could also support a new ceiling on positive MVPS adjustments, which would provide direct financial benefits to the federal budget if actual volume is below target. Moreover, the federal government receives a very real additional benefit—the ability to pay for the payment rates needed to maintain the viability of Medicare fee-for-service out of reduced service volume. At the same time, like the PPRC, we believe it essential to maintain the current 5% maximum payment reduction from the MEI (increased from 3% by OBRA 93) and to reject Administration proposals to lower the floor to MEI minus 8.25%.

Resource-Based Practice Expense

As mentioned above, many physicians face additional extreme payment reductions due to the implementation of the resource-based practice expense in 1998. The Social Security Act Amendments of 1994 requires the Health Care Financing Administration (HCFA) to implement a "resource-based" practice expense component of the Medicare fee schedule by January 1, 1998. That is, the payment for this component—which represents over 40 percent of the payment for physician services—is to be based on the actual expenses incurred in delivering each service. Currently, the practice expense allowance is derived from a formula based on the prior reasonable charge payment system.

The AMA supports resource-based practice expenses so long as they reflect actual practice expenses, but is seeking a one-year extension of the implementation date. The 1994 legislation said that HCFA should "recognize the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings." HCFA contracted with Abt Associates to conduct a two-part study of 3,000 physician practices expenses. When the survey was pulled back due to poor response rates, HCFA was left without adequate data to meet the intent of the law.

HCFA is relying primarily on data derived from clinical practice expert panels, or CPEPs. Early review of the recently-released CPEP findings suggest that they contain a number of errors. HCFA has even rejected certain direct costs that its expert panels found were part of the cost of surgery when doctors supply their own staff and supplies in hospital operating rooms. The AMA and medical specialties are working to identify and correct those flaws but more time is needed.

Those who want to adhere to the current January 1, 1998, deadline argue that any problems can be corrected later through a refinement process similar to the one used when new work values were implemented in 1992. The AMA believes this is an inappropriate comparison. HCFA invested nearly three times as much time and money on the design of new work values as it has spent to revise practice expense values. Whereas thousands of doctors were surveyed to come up with the work values, in the end, there was no broad survey of practice expenses. Simply put, with work values, the product being tested was much further along in the development process than is now the case with practice expense values.

Opponents of an extension also maintain that there is no point in waiting another year because the demise of the indirect cost survey shows that it will never be possible to collect this information independently. We believe that with another year, HCFA could develop alternative relative values that bear some relationship to actual practice expenses. There would be adequate time to validate and correct the CPEP data. Better indirect cost allocation methodologies could be developed and tested. Missing data could be collected, perhaps through an expansion of existing surveys.

The cuts HCFA projected in January are so extreme that they would nearly eliminate practice cost reimbursement for some procedures and specialties. Many inpatient surgical procedures and two specialties could suffer cuts of more than 80% in their practice expense values, and at least 40% in their total payments. Under HCFA's projections, payments for many surgical procedures would fall below Medicaid levels. Thus, there is good reason to fear that if Medicare makes deep cuts in its payments for complex procedures, doctors performing these services may find that they can no longer afford to accept Medicare patients.

In addition, even some of the specialties which seem relatively unscathed in HCFA's projections could actually experience significant cuts if other payers pick up the new Medicare values because the projections do not show the impact of cuts in procedures usually done on patients under age 65. To impose such deep payment cuts based on such spotty research seems certain to undermine physician support for the RBRVS.

The AMA urges Congress to: (1) extend the resource-based practice expense implementation date by one year to January 1, 1999, in order for HCFA to incorporate data on physicians' actual practice expenses into the new relative values; (2) direct HCFA to give physicians the opportunity to review the practice expense data and assumptions six months prior to issuing the proposed rule; and (3) instruct HCFA to take whatever steps may be necessary to ensure that implementation of the new values will not have a negative effect on physicians' ability to provide high quality medical services to Medicare beneficiaries.

OTHER PHYSICIAN PAYMENT ISSUES

Assistants at Surgery

The Administration is proposing to save $400 million over the next five years by making a single payment for surgery. This means that the additional payment Medicare now makes for a physician assisting the principal surgeon in performing an operation would no longer be made. Instead, the payment amount for the operation would have to be split between the principal surgeon and the assistant at surgery. We believe this provision dangerously imposes financial disincentives for the use of an assistant at surgery. The AMA supports efforts to develop guidelines for the appropriate use of assistants at surgery, but believes that patient care should not be compromised in search of Medicare savings. The professional judgment of surgeons regarding the need for an assistant at surgery for a specific patient must be recognized, even for operations in which an assistant ordinarily may not be re-

quired. Congress has considered and rejected this proposal in the past, and we urge the Subcommittee to reject it again.

High Cost Medical Staff

The Administration proposes to reduce Medicare payments for so-called high cost hospital medical staffs. This proposal is not new. In its 1994 Annual Report to Congress, the PPRC concluded that such a "provision's disadvantages ... outweigh its advantages." The Commission went on to note that such a provision:

may have unintended effects on physician behavior, including a shifting of admissions away from hospitals with the high-cost designation. The provision would also increase the cost and complexity [of] administering the Medicare program.

In some cases, the physicians responsible for a hospital's medical staff being designated "high cost" for a given year might simply take their patients elsewhere, leaving the remaining physicians on staff to bear the financial consequences, with potentially serious repercussions for the affected hospital. Finally, the proposal could have the effect of inappropriately reducing payments to physicians who treat a sicker patient population. In the absence of a sound methodology to measure differences in the severity of illness of the patient population being treated by the medical staff, it is too risky to put in place a formula-driven process that could inappropriately lower payments for treating patients who are more expensive to treat because they are sicker.

Centers of Excellence

The Administration proposes to expand what it calls the "Centers of Excellence" demonstration project, under which Medicare makes a bundled payment to participating entities covering both physician and facility services for selected conditions, such as coronary artery bypass operations. We are concerned that these demonstration projects do not offer a potential increase in quality and cost-effectiveness, and that these "centers of excellence" in fact emphasize cost-cutting rather than excellence. We also find the name "centers of excellence" inappropriate in that it implies that institutions participating in this payment arrangement provide higher quality services than non-participating institutions.

Fraud and Abuse

The AMA strongly opposes the Administration's efforts to repeal the fraud and abuse safeguards included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which would eliminate the obligation of the Departments of Justice and Health and Human Services to issue advisory opinions on the anti-kickback statute, reduce the government's burden of proof for civil monetary penalties, and repeal the risk sharing exception to the anti-kickback statute.

Fraud and abuse has no place in medical practice and the AMA is committed to setting the highest ethical standards for the profession. For those who wish to comply with the law, the incidence of misconduct can be greatly reduced by setting standards of appropriate behavior, disseminating this information widely, and designing and implementing programs to facilitate compliance. HIPAA provides new and much needed guidance by requiring HHS to establish mechanisms to modify existing safe harbors, create new safe harbors, issue advisory opinions, and issue special fraud alerts. This guidance will allow physicians, hospitals and insurers to develop efficient and effective integrated delivery systems that will benefit Medicare, Medicaid and the private health care marketplace.

In the area of civil monetary penalties (CMPs), HIPAA requires that the Inspector General establish that the physician either acted "in deliberate ignorance of the truth or falsity of the information," or acted "in reckless disregard of the truth or falsity of the information." The AMA fought long and hard to preserve this clarified standard in the face of huge opposition. This standard makes the burden of proof for imposing CMPs under HIPAA identical to the standard used in the Federal False Claims Act, and there is no reason that two enforcement tools designed to address the same fraudulent behavior should have different standards of proof. Moreover, this section provides important protection for physicians who may unwittingly engage in behavior that is impermissible.

Finally, the AMA strongly opposes the Administration's proposal to eliminate the new risk sharing exception to the anti-kickback law provided in HIPAA. The expansion of managed care in today's health care market requires additional exceptions to the anti-kickback laws so that more flexibility in marketing practices and contractual arrangements is afforded. The future of the Medicare and Medicaid programs depends upon the ability of competing plans to offer quality alternatives to the existing program. HIPAA provides a much needed exception to the anti-kickback

law for certain risk-sharing arrangements which will facilitate the development of innovative and cost-effective integrated delivery systems.

CONCLUSION

Americans can no longer postpone tackling fundamental reform of the Medicare program. Failure to do so is certain to prove even more costly for the millions of Americans who expect to be able to rely on this program in the future, as well as those working Americans who are called upon to help finance it. Simplistic budget-cutting has not resulted in cost-control over recent years; on the contrary, price controls have had the perverse effect of exacerbating Medicare's fiscal crisis and severely threatening the promised access of beneficiaries to medical care.

However Medicare is reformed, it will be our overriding goal to ensure that the change not damage the essential elements of the patient-physician relationship. Above all, reform should not break the bond of trust between a patient and physician that makes medicine unique. By that we mean:

- All patients must remain free to choose the physician they feel is best qualified to treat them or individually elect any restrictions on choice;
- All patients, including those with chronic conditions and special health or financial needs, must have access to any needed service covered by Medicare;
- No restrictions on information about treatment options and no financial incentive program can be allowed to interfere with the physician's role as patient advocate;
- Both patients and physicians must have complete, easily understood information about the Medicare program, and a right to raise questions, voice grievances, and to have them responded to in a fair, effective process; and
- Patients must be protected from unscrupulous or inept health plans, physicians, and other providers.

Americans who depend on the Medicare program for their medical and health care, as well as those who will rely on it in the future, should not have to worry about whether benefits promised them will be forthcoming. The AMA looks forward to working with the Subcommittee and the 105th Congress in protecting Medicare for our seniors and saving it for our children.

Mrs. JOHNSON [presiding]. Thank you very much, Dr. Reardon. Dr. Nelson.

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

Dr. NELSON. Thank you. I am Alan Nelson, executive vice president of the American Society of Internal Medicine. My request today is a simple one: That Congress do what is required to make 1998 the year when Medicare payments become truly resource based by doing two things—first, Congress should mandate implementation of a single dollar conversion factor, which would be fully implemented on January 1, 1998; and, second, Congress should not grant an extension of the date when resource-based practice expenses will be implemented unless—and I want to emphasize the "unless"—a review of the proposed rule shows that it is not possible to implement sound resource-based practice expenses on January 1 of next year.

You will recall that this Subcommittee included a single conversion factor in the Balanced Budget Act of 1995. We appreciate your past support, but we must now ask that you once again enact legislation to mandate a single conversion factor. ASIM supports the administration's proposal to establish the conversion factor at the dollar amount of the current primary care conversion factor updated for inflation. Given that the Balanced Budget Act approved by this Subcommittee would have mandated implementation of a single

conversion factor on January 1, 1996, surgeons will already have had several years of de facto transition under the administration's proposal to implement a single conversion factor of January 1 next year.

There is no reason to believe that access to surgical procedures will suffer under a single conversion factor. Even with the one-time reduction in payments that would be required under a single conversion factor, the average annual updates for surgical procedures between 1993 and 1998 will have kept pace with inflation.

ASIM also urges this Subcommittee to withhold judgment on changing the timetable for implementation of resource-based practice expenses until after the proposed rule is published and until HCFA explains the process that will be used to refine the initial resource-based practice expenses. In today's testimony on behalf of PPRC, Dr. Wilensky explained that the Commission recently concluded that sufficient data are available to develop resource-based practice expenses and that no better data would be forthcoming should a delay be granted by Congress. We agree with the Commission's view that the unfairness inherent in the current system demands that methodologically sound RBPEs be implemented as soon as possible.

Most of the groups that are calling for a delay are basing their assessment on highly preliminary data that HCFA released in January. ASIM agrees that improvements are needed in HCFA's preliminary approach, but there is no basis now for concluding that HCFA will be unable to make the improvements needed so that implementation cannot still occur on January 1.

We question the assumption that access to surgical procedures will suffer if resource-based practice expenses were implemented next year. Under a valid resource-based practice expense methodology, all physician services would be paid on data on how much it costs to provide the service. As long as these costs are appropriately recognized, there is no reason for access to suffer. The income estimates that are being cited by some to make the case that access could suffer are based on the most extreme numbers from only one of the options that HCFA presented in January. It is likely that the actual impact of the proposed rule will differ substantially from those preliminary numbers.

Now, let me make it absolutely clear that ASIM is not saying that we automatically will sign off on anything that HCFA proposes as long as it is implemented on January 1, 1998. We have offered HCFA constructive criticism on the preliminary data and methodology. We will continue to work to influence the process so that the proposed rule is one that had credibility with physicians. We also believe it is essential that there be a fair process for refining the initial practice expense RVUs.

When the proposed rule is published, we will determine if it meets reasonable standards for methodological soundness. If it does not, then it would be appropriate to reexamine the timetable for implementation. But doesn't it make sense for Congress to not pull the plug on the process that may yet result in implementation on January 1, 1998, of a credible and defensible resource-based practice expense methodology that is more fair than the current charge-based system?

So, in conclusion, 8 years ago Congress, with bipartisan support, concluded that beneficiaries would benefit from a resource-based system for determining Medicare payments to physicians. Congress was right in 1994 when it decided to complete the job by mandating implementation of RBPEs, and the 104th Congress, under the leadership of this Subcommittee, was right when it included a single conversion factor for the Medicare fee schedule for the Balanced Budget Act of 1995. We believe now is the time to complete the process.

[The prepared statement follows:]

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

INTRODUCTION

The American Society of Internal Medicine (ASIM) represents physicians who specialize in internal medicine, the nation's largest medical specialty. Internists provide both primary and consultative care to more Medicare patients than any other physician specialty. Consequently, Medicare payment policies have a direct and disproportionate impact on the ability of internists to provide their elderly and disabled patients with the best care possible. ASIM's testimony today will address the impact of two important Medicare fee schedule payment reforms—resource-based practice expenses and a single conversion factor—on internists and their patients. The testimony will also address other reforms that are needed in Medicare payment policy.

MAKING MEDICARE PAYMENTS RESOURCE-BASED

Congress has an opportunity to make 1998 the year that Medicare payments *truly* become resource-base—a full nine years since Congress first said that it wanted Medicare payments to be based on the resources required to provide each physician service. Or it can accept the arguments of those who say that further delay is needed—even though this means continuing highly inequitable payment policies. ASIM believes that Congress should assure that the 1998 budget allows for correction of two distinct flaws in the Medicare fee schedule that have resulted in payments not being truly resource based:

1. Separate volume performance standards, conversion factors, and updates have resulted in surgical procedures being paid at a much higher rate than primary care and other nonsurgical services that require the same resources to perform.
2. Medicare payments for practice expenses continue to be based on historical charges, not resource costs. As a result, services that historically were overvalued prior to implementation of the resource based relative value scale (RBRVS) continue to be overpaid for their overhead expenses, while services that were undervalued continue to be underpaid for their practice expenses. Concern about the inequities created by the current charge-based formula led Congress to enact a technical corrects act in 1994 that mandates implementation of resource-based practice expenses on January 1, 1998.

SINGLE CONVERSION FACTOR

ASIM strongly supports the administration's proposal to enact a single dollar conversion factor for the Medicare fee schedule, effective 1/1/98, and to establish the single conversion factor at a level that is no less than the current primary care conversion factor, updated for inflation. We appreciate this subcommittee's support in the past for enactment of a single conversion factor—particularly, the decision by the subcommittee to include a single conversion factor during mark-up of the Balanced Budget Act of 1995.

Under the 1997 default conversion factors, surgical procedures are reimbursed at a rate that is 14% higher than primary care services, and 21% higher than other nonsurgical services, that involve the same amount of physician work. In an effort to correct this inequity, Congress included a single CF in the Balanced Budget Act of 1995. The single CF would have been effective on January 1, 1996. As the committee is well aware, however, President Clinton vetoed the BBA, with the result that the policy of separate conversion factors and updates remains in effect. There continues to be strong bipartisan support for enacting a single CF, however, as evidenced by the fact that it not only was included in the BBA and in the President's

current budget, but it has also been included in other proposals such as the recently-unveiled "Blue Dog" budget proposal.

Current Law Requirements

Current law requires that separate target rates of increase in expenditures—or volume performance standards (VPSs)—be established for surgical procedures, primary care services, and nonsurgical services. If actual spending is below the applicable VPS, the services in that category get a bonus increase (the Medicare economic index plus the percentage that actual spending came in under the VPS). If spending exceeded the applicable VPS, the Medicare economic index (MEI) is reduced by the percentage that spending exceeded the VPS unless Congress specifies otherwise. After adjustment for demographic changes and changes in law that may affect annual growth in expenditures on physician services, the VPSs represent a target rate of growth that is equal to the previous five year historical average growth in expenditures for the category of services, minus a performance standard adjustment factor.

Congress' original intent in mandating separate volume performance standards in the 1989 authorizing legislation was to create incentives for physicians to reduce the rate of increase in the volume of services that they provide. Some surgical groups argued at that time that the volume performance standards would have a greater impact on physician behavior if a separate VPS was created for surgical procedures. Congress responded by creating separate VPSs for surgical procedures and all other non-surgical services. In 1993, an additional category—for primary care services (office, nursing home, home, and emergency room services) was added—resulting in the three separate VPS categories.

The evidence now shows that the policy of having three separate VPSs has done great damage to the concept of resource-based payments—without achieving the intended objective of increasing incentives for physicians to control the volume of services within their own specialty. Surgical volume growth has slowed not because surgeons responded to the separate VPS by being more diligent in reducing unnecessary care, *but because of changes in practice patterns—specifically, the substitution of non-surgical treatments for surgical procedures—that would have occurred anyway and that are outside of a surgeon's control.* In many cases, it is effective medical management by internists and other non-surgeons that have resulted in fewer surgical procedures being performed.

To illustrate, many heart patients that in the past may have eventually required coronary bypass surgery can now be treated through medication and careful management by an internist of their diets and lifestyles, and when necessary, by a procedure called angioplasty that can clear blocked arteries without resorting to more invasive (and costly) bypass surgery. Under the current VPS methods, internists and cardiologists are penalized because substituting visits and less invasive nonsurgical treatments for surgery increases the "volume" of primary care and nonsurgical services. Cardiac surgeons receive a reward for the reduction in the number of coronary bypass procedures, even though the reduction in volume was due to changes in practice patterns over which they had no control.

The Physician Payment Review Commission, citing the Agency for Health Care Policy and Research, reported in 1994 that "Reductions in the volume of prostate-related procedures mostly reflect changes in treatment through increased use of drugs, less invasive surgical procedures, and watchful waiting" (PPRC, Fee Update and Medicare Volume Performance Standards for 1995, May 15, 1994). The evidence also suggests that much of the reduction in surgical volume is due to an inevitable "bottoming out" of the number of patients who have a need for cataract surgery and several other surgical procedures that experienced explosive growth in the mid-1980s. In the same 1994 report from the PPRC that is cited above, the Commission noted that:

"The period of greatest growth in volume for a new medical procedure or technology is often the first few years following introduction, largely because it is during this period of diffusion that patients with existing indications are treated along with those newly identified. In the mid-1980s, the volume of new technologies such as cataract surgery was growing at double-digit rates, because there were tens of millions of patients who needed—and could benefit—from those treatments. As time has passed, however, the demand for such procedures has naturally declined . . . Cataract lens replacement surgery provides an illustration [of how the demand for technology can decrease over time because fewer patients require the procedure]. Lens implant improvements and new surgical techniques transformed cataract surgery in the 1980s into a safe, rapid, and convenient cure for cataracts. In 1988, however, the volume of cataract surgery began to decline on a per person basis . . . this decline may have indicated that the backlog of potential lens implant recipients cre-

ated by the improved surgical technology had largely been depleted. In its 1990 report, the Commission noted that if this hypothesis were correct, the volume of cataract surgery should be expected to be level or possibly decline over the next few years. Noting the large percentage of total surgical volume associated with cataract surgery, the Commission observed that such a reduction in growth of this surgery, if not offset by increases in other types of surgery, would substantially reduce the growth of total surgical volume. Analysis of Medicare claims data supports the validity of the Commission's prediction. Volume of cataract lens replacement services declined by 7.0 percent from 1992 to 1993. These procedures, along with other eye-related surgical procedures, continue to account for a substantial portion of Medicare expenditures for surgery—currently about 30 percent. This decline in cataract surgery has had a substantial impact on growth in total surgical volume."

It is time for Congress to recognize that separate volume performance standards have not had the intended effect of motivating physicians to more carefully control the volume of services within their own specialty. What separate VPSs have done, however, is create inequities that are in direct conflict with the principle of paying the same amount for service involving the same resource costs.

Timing, Amount of the Conversion Factor

Eliminating the inequities created by separate VPSs and conversion factors requires that a single CF be implemented on January 1, 1998—without any additional transition or delay. Given that Balanced Budget Act of 1995 would have mandated that a single conversion factor go into effect on January 1, 1996, physicians will already have had two years of a de facto transition to a single conversion factor under the administration's proposal for implementation on January 1, 1998. Unlike a true transition, which would have lowered the surgical CF each year, surgeons have actually benefited from higher updates in the meantime. Further, in 1995 many surgical groups advocated a transition of "as close to three years as possible"; had their advice been followed by Congress and signed into law by the President, the single CF would have become fully implemented on January 1, 1998. If a 1998 implementation date was acceptable to them in 1995, there is no reason for Congress to grant a request this year by the same groups to delay it further. As noted later in our testimony, there is no basis for concluding the implementation of a single CF on January 1, 1998 will reduce access, given that the average per annum update for surgical procedures from 1993–1998 will have kept pace with inflation, even with the one-time reduction that will be required in the surgical CF.

We also urge Congress to support the administration's proposal to establish the single conversion factor at a level that is no lower than the current primary care conversion factor, updated for inflation. Payments for primary care services, which have been undervalued in the fee schedule updates for most of the past five years, should not be rolled back below current levels. Establishing the conversion factor at anything less than the primary care conversion factor, as updated for inflation, would also require deeper cuts in payments for surgical procedures, and provide less relief for the other nonsurgical services that have been most disadvantaged under the current update formula. A transition would also reduce the savings that the administration projects from a single CF by easing the reductions in payments for overvalued surgical procedures.

IMPLEMENTATION OF RESOURCE-BASED PRACTICE EXPENSES

ASIM continues to strongly support implementation of methodologically sound resource-based practice expenses as Congress mandated in 1994. Because current practice expense payments are not truly resource-based, some services remain grossly overvalued while others remain substantially undervalued. An internist who provides 115 level 3 established patient office visits—typically requiring 29 hours of face-to-face time with patients—receives the amount of practice expense reimbursement that a surgeon gets for one bypass graft that takes only a few hours to perform. *Medicare also ends up paying surgeons for operating room overhead expenses that the hospital, not the physician, incurs and that are already paid under Part A.* In 1992, the Physician Payment Review Commission noted that "54% of the Medicare fee schedule payment for a coronary bypass graft in the final rule represents payments for practice expenses. However, this service is provided in hospital operating theaters that are equipped and staffed by the hospital, not the physician. In this case, the Medicare Part A payment includes the costs of virtually all of the expense payment for this service besides the physician work."

Preliminary Data and Methodology

Research on the development of resource-based practice expenses has been underway for most of this decade. The current congressionally-mandated study builds upon work by Harvard University, the Physician Payment Review Commission, and several other notable experts in the field. Several studies have looked at the use of existing data sources to develop indirect practice expense relative value units (RVUs), and concluded that results can be obtained using existing data that mirror those that would be obtained from cost accounting surveys. Attached to this testimony is a chronology of the work that has been done on RBPEs. It is therefore not correct to suggest, as some have, that HCFA's efforts to develop a methodology for implementation on January 1, 1998 are based on only two years of research.

In late January, HCFA released some highly preliminary data—and a range of possible methodological options—for comment and review by specialty societies and the American Medical Association. Because the data released by HCFA in January indicate that major redistribution of income may occur under resource-based practice expenses, some have concluded that the Health Care Financing Administration's approach to this issue is fundamentally flawed.

ASIM does not believe that the test of HCFA's proposed methodology should be the degree that it does or does not redistribute payments. Rather, it should be whether or not the methodology that HCFA will propose is methodologically sound and more fair than the existing charge-based methodology. HCFA project staff have repeatedly stated that the data, methodological options, and specialty-impact estimates released in January for review and comments are "highly preliminary" and meant only to be "illustrative" of the impact of a range of approaches to determining RBPEs—and that none of the specific options presented will be adopted by HCFA to develop the proposed rule. Given the preliminary nature of the information that was released, we do not believe that it is appropriate to conclude now that implementation of RBPEs needs to be delayed. ASIM has provided HCFA with detailed recommendations for making improvements in the methodology and data that will be used to develop resource-based practice expenses.

We urge this Committee to withhold judgment on changing the timetable for implementation of resource-based practice expenses until a proposed rule is published, and until HCFA explains the process that will be used to refine the initial resource-based practice expenses. The Physician Payment Review Commission will likely present testimony today that explains the reasons why it rejects any delay in implementation of RBPEs, a view that will be reflected in its upcoming report to Congress. Dr. Gail Wilensky, chair of the PPRC, recently told your colleagues on the Senate Finance Committee that sufficient data are available and that no better data would be forthcoming should a delay be granted by Congress. We agree with the Commission's view that the unfairness inherent in the current system demands that methodologically sound RBPEs be implemented as soon as possible, and that there is no reason to conclude now that this can't be accomplished on January 1, 1998.

We don't understand why some other physician groups have concluded that it is not possible for HCFA to develop a sound resource-based proposal within the current time frame mandated by Congress. Certainly, it makes more sense to wait until the proposed rule is out to make an informed decision—rather than reacting (or overreacting) to some highly preliminary data and options.

This does not mean that ASIM is fully satisfied with the work done by HCFA to date. We have offered our own suggestions for improvement in the methodology. But we are willing to wait and see if the proposed rule meets our standards for methodologically soundness before making a premature judgment based on data that HCFA itself said was highly preliminary. *If* the published methodology isn't sound, then Congress can always reexamine the timetable for implementation at a later date. But given that correction of the existing inequities is long overdue, Congress should want HCFA to continue to work toward implementation on January 1, 1998, rather than pulling the plug on the current process and timetable. Congress should also insist that HCFA establish an adequate refinement process for the interim RBPEs that will be implemented on January 1, 1998. The *only* circumstance that would justify a delay in implementation is if it turns out that HCFA is unable to develop a sound and defensible methodology—a conclusion that is not warranted at this time.

Behavioral Offset

ASIM also strongly supports the Physician Payment Review Commission's view, as explained in its upcoming report to Congress, that unproven assumptions of a behavioral offset should not be incorporated into the RBPEs. A behavioral offset will magnify the reductions for overvalued services and reduce the gains for undervalued

ones. The Commission correctly points out that the administration's contention that physicians offset 50 cents of every dollar that is lost when payments are reduced was not borne out when the RBRVS was implemented. HCFA should learn from its experience with the RBRVS, rather than repeating the same mistakes. If necessary, Congress should consider enacting legislation that would limit HCFA's ability to apply a behavioral offset. ASIM recalls that Rep. Fortney (Pete) Stark, the ranking minority member of this subcommittee, led a bipartisan effort in 1991 to prohibit HCFA from applying a behavioral offset when resource-based *work* relative value units were first implemented. ASIM appreciated Mr. Stark's efforts at that time, and asks that the subcommittee members consider pre-empting HCFA's efforts to again apply a behavioral offset in implementing resource-based practice expense RVUs.

Refinement Process

We also agree with the Commission's view that HCFA should propose a refinement process—allowing for sufficient input from practicing physicians and other experts on practice expenses—to permit reexamination of the proposed practice expense RVUs prior to implementation of the final rule. Such refinement panels should be used to address major areas of disagreement with the proposed RBPEs for specific codes or families of codes, if a specialty has compelling evidence to suggest that the proposed RBPEs may be incorrect. The practice expense RVUs that HCFA will implement in January 1998 will be interim final RVUs, allowing parties to provide additional input and comments in 1998.

Because all of the interim RVUs will be subject to further refinement, ASIM has urged HCFA to exercise caution in implementing the interim practice expense RVUs to avoid the problems that would be created by "overshooting" or "undershooting" in the interim RVUs. "Overshooting" would occur if HCFA implements interim practice expense RVUs that call for major reductions in payments that are later found upon refinement to have been set too low. This can be avoided if HCFA errs on the side of being cautious in the magnitude of the reductions required for services that will undergo refinement.

ASIM is not persuaded that a three-year transition to RBPEs is merited, as the Commission recommends. A transition not only would perpetuate current inequities for several more years, but it also makes the process of implementation far more complex, with the potential for creating the same kinds of unintended budget-neutrality problems that occurred with the transition to the RBRVS. When the proposed rule on implementation of the RBRVS was published in 1991, HCFA proposed a much larger budget neutrality adjustment than otherwise would have been necessary because the transition formula specified by Congress resulted in an asymmetrical transition (more services initially experienced gains in payments than received reduced payments, thereby creating a larger budget-neutrality offset). The result was that the reductions for some services were much greater than was appropriate, while the gains for others were less than intended. Expressions of concern by Congress ultimately led HCFA to apply a lesser offset to deal with the asymmetrical transition. The complexity of developing a transition that would not have unintended consequences supports the wisdom of Congress' original plan to implement RBPEs on January 1, 1998 without further delay or transition.

If Not Now . . . When?

Most of the organizations that advocate a delay in implementation of RBPEs imply that their concern is limited to making sure that HCFA has the best data available, and that more time is simply needed for HCFA to do the job right. Congress should consider the possibility that some of those who are calling for a one-year delay *may never support implementation, no matter how much time is granted to study the issue or the process and methodology that is used.* Some of the groups advocating a "delay" have essentially said as much. One member of the surgeon-dominated Practice Expense Coalition, the American Society of General Surgeons, has explicitly stated that it seeks repeal, not just a delay, of resource based practice expenses. The March 5 testimony of the American College of Surgeons (ACS) to the Senate Finance Committee suggests that it is opposed to the concept of basing practice expenses on resource costs, not just to the current methodology and timetable. Their testimony stated that "on an even more fundamental level, the preliminary impact analysis confirms that a *purely resource-based approach yields inappropriate results."* The ACS witness, when questioned by a member of the Finance Committee, refused to commit to any date when the College would agree that RBPEs should be implemented.

The specialty societies who are opposed to basing payments on resource costs because they will yield "inappropriate" results—i.e., that they will reduce payments

for some of their specialty's services—are not likely to be satisfied with a one year delay. It can be expected that even if a one-year delay was granted, those same groups would likely be back again next year seeking repeal of resource based practice expenses, or absent that, continued delay in implementation. Their request for an extension may have less to do with the ostensible purpose of assuring that the methodology is valid and more with putting off as long as possible (which would be forever, if some of them had their way) any resource based methodology that will redistribute Medicare dollars from surgical procedures to primary care and other physician services.

This is not to suggest that all of the groups asking for an extension are fundamentally opposed to resource-based payments. Some may in fact be motivated principally by concerns about the adequacy of the data. But Congress needs to be aware that there are other groups that will never accept resource-based payments, no matter how much time is granted to develop the methodology.

IMPACT ON ACCESS OF SINGLE CF, RBPEs

Those who are opposing implementation of RBPEs and a single CF argue that the "extreme" reductions that it may be required would reduce access to surgical procedures. In March 5 testimony to the Senate Finance Committee, the American College of Surgeons stated that "The combined payment effect from adoption of a single conversion factor, refusal to pay fairly for medically necessary assistant at surgery services, and implementation of flawed practice expenses is simply too much . . . To be frank, we sometimes get the feeling that Medicare would simply prefer to stop providing surgical services to its beneficiaries. We presume this also means that the administration expects that Medicare beneficiaries requiring radical mastectomies, cataract extractions, kidney transplants, hip replacements, brain surgery and a few thousand other types of operations, will soon be forced to obtain them from someone other than a qualified surgeon, or to be offered some unproven alternative treatment by less-trained health care providers."

ASIM does not believe that our surgical colleagues would refuse to perform needed surgery on their Medicare patients, as the above statement unfortunately implies. Under a single CF, surgeons would be paid at the same dollar rate as an internist or a family physician gets paid for a service that requires the same amount of physician work. If internists are able and willing to provide needed services to their Medicare patients at this rate, why would a surgeon by unable or unwilling to do so? The conversion factor for surgical procedures was increased by almost 30% from 1993 through 1997. A 10.6% reduction in the current CF for surgical procedures would be required in 1998 under the administration's proposal for a single CF. This means that the surgical CF still will have increased by 14.6% from 1993 through 1998, assuming that Congress enacts the administration's proposal—or by an average of almost 3 percent per year. *Since the average annual updates for surgical procedures will have kept pace with inflation, there is absolutely no basis for suggesting that implementation of a single CF, at the dollar amount recommended by the administration, will reduce access to surgical procedures.* Some of the loss to surgeons in payments for their surgical procedures will also be offset by increases in the "other nonsurgery" and primary care services category. Surgeons don't just provide surgery; they also provide consultations, hospital visits and diagnostic procedures in the "other nonsurgery" category, which will gain 8.2% under the administration's proposal.

Under methodologically sound resource based practices, Medicare payments for practice expenses for the first time will be based on the differences in the costs of providing physician services. The payments for the practice expenses of surgeons (and other physicians, for that matter) therefore will be based on their resource costs—no more, and no less than the data show are appropriate. Payments would be reduced for some procedures only by the amount that Medicare now pays *in excess of the resource costs* that are required to provide them (such as the amount that some surgeons are now paid for overhead costs that are actually picked up by the hospital). Some appropriate redistribution of dollars will be required under RBPEs, but there is no reason to conclude now that RBPEs won't be high enough to cover surgeons' true practice expenses. Until HCFA's proposed methodology is published as a proposed rule, there clearly isn't any basis for deciding now that Medicare's practice expense payments would not cover the costs of providing surgical procedures.

There is another dimension to access that also must be considered: access to primary care services. Although most beneficiaries enjoy good access to physician services, it is access to primary care services that is most at risk when Medicare payment policies undervalue the work and practice expenses involved in delivering pri-

mary care. We've heard from many internists who say that Medicare payments barely cover their costs, and some have said they've begun limiting the number of new Medicare patients they can accept into their practice. A single CF and fair, resource-based Medicare payment system should have an overall positive impact on access.

REPLACING THE VPSs WITH A SUSTAINABLE GROWTH RATE

A single conversion factor, and methodologically sound RBPEs, will result in a true resource-based fee schedule. Improvements are also needed in the update formula, however, so that physicians have a reasonable opportunity to obtain CF updates that keep pace with inflation—an opportunity that does not exist under current law.

ASIM agrees with the administration that the current volume performance standards (VPSs) should be replaced by a single sustainable growth rate (SGR). We are concerned, however, that the administration's proposal to establish the SGR at an amount equal to per capita GDP does not allow for sufficient growth in the volume of services that beneficiaries will require. (It is our understanding that the administration, after originally proposing an SGR of per capita GDP plus one percent, is now proposing that the SGR be limited to per capita GDP only). As noted earlier in our testimony, after adjustment for demographic changes and changes in law that may affect annual growth in expenditures on physician services, the VPSs represent a target rate of growth that is equal to the previous annual growth in five year historical average expenditures for the applicable category of services, minus a performance standard adjustment factor. In OBRA 93, Congress increased the performance standard adjustment factor from 2 to 4 percent. To illustrate, if the average growth in expenditures on primary care services in a particular five year period was 4 percent, the VPS would allow for zero growth in volume and intensity of primary care services. No matter how low the growth in expenditures is during a five year period, physicians will always be required to reduce growth by another 4 percent in order to get an update equal to inflation as measured by the Medicare economic index.

It is not reasonable to expect that physicians can continually reduce growth by 4 percent per year from the prior five year average. Because OBRA 93 established an unreasonable and unrealistic target rate of growth, expenditures will in most years exceed the VPSs, resulting in updates that do not keep pace with inflation—and a 21 percent reduction in the weighted conversion factors (in constant dollars) over the next ten years, according to the CBO. It is essential that Congress enact legislation that would replace the VPSs with a single sustainable growth rate that would give physicians a reasonable opportunity to earn inflation updates if volume growth is kept to a reasonable level.

Although a single sustainable growth rate would appear to be better than the current VPS formula, ASIM is concerned that the administration's proposed SGR is too low to give physicians a realistic opportunity to earn updates equal to inflation. Assuming a per capita GDP growth of 1.5%, the add-on would need to be at least GDP plus two percent (or a total of 3.5%) to assure a full inflation update, based on the CBO's projected average per annum increase in expenditures on physician services of 2.4% per year. An SGR of per capita GDP only would require growth to stay within 1.5 percent, which is below the current baseline projections. *Therefore, the administration's proposal for an SGR of per capita GDP growth would not be sufficient to prevent the automatic cuts in the Medicare conversion factor that will occur due to the increase in the performance standard reduction factor mandated by OBRA' 93.* In its upcoming report to Congress, the PPRC will express a preference for the SGR to be set at GDP plus two percent. ASIM urges the subcommittee to support the Commission's preference for replacing the VPSs with a single SGR that is no lower than per capita GDP plus two percent.

ASIM is also concerned that the administration may apply its behavioral offset assumptions in an inconsistent manner for the purposes of calculating the SGR and the single conversion factor as proposed in its budget. The legislative language for the President's budget indicates that the SGR in 1998 and subsequent years will include an allowance for "changes in expenditures for all physicians' services in the fiscal year (compared with the previous year) which will result from changes in the law, *determined without taking into account estimated changes in the expenditures due to changes in the volume and intensity of physicians' services resulting from changes in the update in the conversion factor . . . "* (emphasis added). This would seem to indicate that the administration plans to assume that a behavioral offset will occur as a result of changes in the conversion factor (i.e., in response to the reduction in payments for surgical procedures that would occur under a single con-

version factor), but that it does not intend to incorporate this change in calculations of the SGR. If the administration's baseline projections assume an increase in volume due to a behavioral offset, this should be reflected in the SGR as well as the CF updates. Otherwise, physicians will have no opportunity to recoup the losses triggered by the behavioral offset adjustment to the conversion factor update should volume not increase as assumed by the administration in its behavioral offset. ASIM would prefer, of course, that the administration not incorporate a behavioral offset adjustment at all. But if an offset is assumed for the conversion factor update, then the administration should be consistent in applying this to the SGR.

Reduced Payments to Hospital Medical Staffs

ASIM has concerns about the administration's budget proposal to reduce payments to "high cost medical staffs." This proposal, which has been included in past budgets from this administration, could have the effect of inappropriately reducing payments to hospitals with higher costs because they have a sicker patient population. In the absence of a sound methodology to measure differences in the severity of illness of the patient population being treated by the medical staff, it is too risky to put in place a formula-driven process that could inappropriately lower payments for physicians on hospital medical staffs that are treating patients who are more expensive to treat because they are sicker.

Savings Should Target Higher-Growth Areas

ASIM supports the objective of a balanced budget, and recognizes the need to reform Medicare to keep it solvent and affordable. Given that Medicare fee schedule payments to physicians are already expect to decline under current law, we believe that Congress should focus its attention on higher growth areas, rather than on extracting more savings from payments for physician services. We also believe that structural reforms are preferable to attempting to squeeze more savings out payments to "providers." We would be pleased to provide the subcommittee with our recommendations for short-and long-term structural reforms.

In deciding where savings might be achievable without compromising access and quality, Congress should take into consideration which categories of spending are growing at a rate that may not be sustainable. By the same token, categories of spending that are growing so slowly that they are not contributing to Medicare's fiscal problems are not the place to look for further reductions.

Notwithstanding our concern that the administration's proposed SGR is too low, ASIM is pleased that the administration's proposed budget takes into account the fact that expenditures on physician services are growing slower than any other category of Medicare spending. The January "baseline" projections from the Congressional Budget Office show how much spending on physician services has already been curtailed. According to the CBO, *total* outlays for physician services *will grow by an average of only 2.4% per year* through the year 2002. By comparison, payments to hospital, home health agencies, skilled nursing facilities, and most particularly HMOs will all grow at a rate exceeding that of inflation. The CBO estimates that Medicare fee schedule payments—as expressed by the weighted separate conversion factor updates—will actually *decline* by about one percent over this period of time—or by 21 percent after inflation is taken into account. Fee schedule payments to physicians therefore have the dubious distinction of being the *only* category of outlays whose payment rate is projected to actually drop, in both real (after inflation) and nominal dollars. It is not reasonable to expect that total outlays on physician services—which will now barely keep pace with inflation—can be reduced further without compromising access and quality.

Payments to HMOs

ASIM's interest in payment reform is not limited to the Medicare physician fee schedule. Since increasing numbers of internists are treating their Medicare patients through arrangements with Medicare HMOs and other risk contracts, internists and their patients are directly affected by changes in the way that HMOs are paid by Medicare. The President's budget proposes that the average adjusted per capita cost (AAPCC) be reformed by (1) setting local rates at 90 percent of the prevailing fee-for-service rates, rather than 95 percent under current policy (2) subtracting graduate medical education payments and disproportionate share hospital payments from the AAPCC and instead giving them directly to the institutions incurring the costs and (3) lowering the AAPCC in certain high cost areas and increasing them in low cost areas.

ASIM has no specific policy on the proposal to lower payments from 95 percent to 90 percent of the prevailing fee-for-service rates. Given that the CBO projects that outlays on Medicare HMOs will increase at an average rate of 71 percent per annum, it is reasonable for the Congress and the administration to review ways to achieve savings in this category of spending, especially if this will reduce the need to further slash fee-for-service payments. Although not conclusive, there are some studies that suggest that Medicare HMOs do enroll a healthier patient population than the fee-for-service program, and that the current formula may on average overcompensate HMOs for the care of the healthier patients that they typically enroll. ASIM also supports the goal of reducing geographic inequities in AAPCC payments, but we have not yet determined if the administration's proposal is the best way to correct such inequities.

ASIM is concerned that in the absence of a risk adjustment for the AAPCC payments to HMOs, HMOs that treat a sicker mix of patients will be penalized, especially if the AAPCC rate is lowered to 90 percent from 95 percent. This would increase the disincentive for HMOs to enroll sicker patients. ASIM supports the PPRC's view that:

regardless of how payment rates are set, as long as Medicare beneficiaries can choose among options, improved risk adjustment will be essential. Otherwise, health plans will not be fairly paid for enrollees with better or worse-than-average status (for example those with chronic conditions or functional disability). Without improvements in risk adjustment, plans will continue to have an incentive to avoid enrolling patients who will be expensive to care for. The commission recommends that improved risk adjustment be implemented immediately. (Statement before the Subcommittee on Health, Ways and Means, on Medicare HMO Payment Policy, February 25, 1997)

Because internists tend to treat Medicare patients that are older and sicker than those of other physicians, ASIM believes that it is particularly important that Congress initiate payment reforms—including risk adjustment—for Medicare HMOs that would decrease the likelihood that internists' patients will be discriminated against by HMOs that are trying to limit their own risk.

ASIM also has recommendations on federal consumer protection standards for beneficiaries enrolled in Medicare managed care plans. We are submitting a separate statement for the record of the subcommittee's March 6 hearing on Medicare HMO Regulation and Quality.

CONCLUSION

In conclusion, let's recall some of the reasons why Congress, in 1989, mandated a resource based payment system for Medicare. Congress believed that patients were not well-served by a system that rewarded physicians for providing surgical and technological procedures while penalizing them for providing primary care and other nonsurgical services. Under the charge-based system that existed before, surgical procedures were paid far more for the resources involved than primary care services. Congress wanted to equalize the financial incentives, so that physicians' decisions about what services to order, or what specialty to enter, weren't influenced by biased financial incentives.

By mandating instead that Medicare pay the same amount for all services that involve the same resources to provide, Congress hoped to increase the incentives for physicians to enter, and remain in, primary care, and to encourage physicians to put more emphasis on management of patient care as an alternative to surgical intervention. Although progress has been made, the fact is that surgical procedures are still paid under a much higher conversion factor than primary care and other nonsurgical services. The current charge-based method for paying for practice expenses—which Congress intended as only a temporary measure until a resource-based methodology could be developed—similarly perpetuates the payment inequities that favor procedures done in the hospital over primary care and other services provided in the office.

Eight years ago, Congress—with bipartisan support—concluded that beneficiaries would benefit from a resource based system. Congress was right then, and it was right in 1994 when it mandated resource based practice expenses. The 104th Congress—under the leadership of this subcommittee—was right when it included a single conversion factor for the Medicare fee schedule in the Balanced Budget Act of 1995.

Now is the time to complete the process by once again enacting legislation to mandate a single conversion factor and by rejecting any delay in implementation of sound resource based practice expense. There is no basis for further delay or for requiring a transition to a single CF. Resource-based practice expenses that are *de-*

rived from a valid methodology need to be implemented as soon as is feasible. As the PPRC has stated, there is no basis for concluding now that it is not feasible to implement a valid RBPE methodology on January 1, 1998 as Congress has mandated. Congress can always reexamine the timetable for implementation once the proposed rule is published, although a change in the timetable for implementation would be justified only if the methodology is fundamentally unsound.

ASIM appreciates this subcommittee's long history of support for Medicare physician payment reform, and pledges our support to your efforts to assure that 1998 becomes the year when it will be said that Medicare payments are *truly* resource-based.

Mrs. JOHNSON. Dr. Maves.

STATEMENT OF MICHAEL MAVES, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY, ALEXANDRIA, VIRGINIA; ON BEHALF OF PRACTICE EXPENSE COALITION, AND PATIENT ACCESS TO SPECIALITY CARE COALITION

Dr. MAVES. Thank you. Members of the Subcommittee, I am Dr. Michael Maves, executive vice president of the American Academy of Otolaryngology-Head and Neck Surgery, and a practicing head and neck surgeon at Georgetown University Medical Center. I was also the chair of the Department of Otolaryngology at St. Louis University.

I would like to thank the Subcommittee for this opportunity to testify on behalf of the Practice Expense Coalition with respect to HCFA's proposal to revise the practice expense component of the Medicare fee schedule.

In 1994 Congress directed the Health Care Financing Administration to develop resource-based practice expense relative values for each procedure and service provided under Medicare. In so doing, the statute specifically directs that the relative values "recognize the staff, equipment, and supplies used in the provision of medical and surgical services in various settings." Clearly, congressional intent was for HCFA to construct the practice expense values using data generated by actual resources involved in the provision of physician services.

Unfortunately, HCFA's proposed new practice expense values are not based on a methodology that measured the actual resources consumed in the provision of a Medicare procedure or service. It is inconceivable that a sound practice expense methodology using actual data could produce payment reductions of the magnitude identified by HCFA at its January 22d briefing. In fact, some of the reductions completely eliminate the practice expense values for certain specialties.

For example, cardiac surgeons could experience as much as a 44-percent reduction in total relative value units they received under the Medicare Program in 1995. Contrast this with national data which shows that practice expenses, on average, account for about 41 percent of the total physician revenues. Thus, any proposal that would reduce total payment by 44 percent, such as is the case for cardiac surgeons, we believe is fatally flawed, unrealistic, and not the product of an actual measuring of the resources required to

provide a service, such as nursing staff, clerical staff, rent, utilities, and so on.

While we recognize that HCFA made an effort to collect data through the use of clinical practice expert panels and through the use of a survey of selected physician practices, neither of these tasks were completed.

In fact, the survey instrument was so complex that only about 27 percent of the practices selected responded. It is our understanding that the Office of Management and Budget, when it gave its approval of the survey, indicated that a response rate of at least 70 percent would be required in order to have a representative and sound database.

We understand firsthand the problems of having surveys completed by physicians and offered our assistance to HCFA to help in this regard, but HCFA declined to accept the offer to work with us on this part of the program.

To construct a new set of values, HCFA relies primarily on data derived from the clinical practice expert panels. Early review of the recently released CPEP findings suggest that they contain a number of errors. In addition, HCFA has no indirect cost data and there has been no way to reality test its proposed methodology. Such tests are needed because preliminary projections from HCFA released in January envisioned payment cuts that are far more drastic than had been anticipated in other studies. The 20- to 25-percent cut projected for cardiologists, for example, is double what had been proposed in prior practice cost studies.

This is not just a Medicare problem. As you are aware, many insurance companies utilize the Medicare relative values in developing their own payment schedules. Thus, the true impact of this proposal is really not known at this time. However, it could be very substantial. It seems unwise to cause such a major disruption in the health care delivery system using spotty research.

As someone who has spent essentially my entire career in academic medicine, I am concerned about the impact of such change on academic health centers and their mission to provide community services, such as indigent care and charity hospitals.

The impact on patients also is an unknown, especially in terms of access and quality. No one knows for sure how physicians will adjust to these changes. In surgery, a substantial portion of the preoperative and postoperative care is provided by nursing staff. Currently, the surgery is paid on the basis of a global fee, which covers the preoperative, intraoperative, and postoperative care. If you take away a substantial portion of the relative value units, it would seem to us that the quality of such services in the global fee would have to suffer—as would patient care.

In conclusion, the Practice Expense Coalition urges Congress to, first of all, stop the current rulemaking process and to instruct HCFA to assemble experts in cost accounting to develop the mechanisms for collecting actual data on physician practice expenses.

The project that Congress gave HCFA is one that industries throughout this country deal with every day. U.S. industries have cost accounting systems to assign cost to products and services.

I believe that is the task Congress asked HCFA to do, and if done correctly, it should not result in the type of reduction being proposed.

Thank you.

[The prepared statement and attachment follow:]

Statement of Michael Maves, M.D., Executive Vice President, American Academy of Otalaryngology-Head and Neck Surgery, Alexandria, Virginia; on Behalf of Practice Expense Coalition, and Patient Access to Speciality Care Coalition

Mr. Chairman: This statement is made on behalf of the Patient Access to Specialty Care Coalition (Coalition), consisting of 128 patient, physician, non-physician, health care professional, and senior citizen organizations dedicated to ensuring access to specialists, choice of health care professional, and basic patient protections in this changing health care marketplace.

The Coalition was formed in 1993 in response to President Clinton's comprehensive health care reform proposal. Throughout the last four years, the Coalition has been committed to ensuring that the highest quality health care is maintained no matter what structures are developed for providing this care.

The Coalition has not deviated from its choice and access principles, which include access to specialists in-network, the availability of out-of-network care, a timely appeals process, a ban on financial incentives which result in the withholding of care or the denial of a referral, a consumer information checklist to provide the broadest information to patients, and a prohibition on "gag clauses."

It is the Coalition's firm belief that if these principles are incorporated into Federal legislation, they will go a long way to protect patients in this rapidly changing health care environment, and ensure that they get the highest quality health care they deserve. Contrary to reports in the press, these principles are not "anti-managed care," and the Coalition is not trying to derail or change any mechanism being developed in the marketplace to deliver health care. In fact, the Coalition recognizes that several managed care plans in the country provide quality health care to their patients and embrace these principles. However, there are also many health care plans that do not.

Therefore, for more than four years, the Patient Access to Specialty Care Coalition has been advocating that several simple, nonintrusive steps be taken to ensure that patients receive adequate care in a managed care setting.

For more than four years, the health care insurance industry has denied that there are any problem areas at all that need to be addressed -- either by themselves or through Federal and/or State legislation.

In the last few years, court case after court case, both State and Federal have confirmed the Coalition's concerns about these problems, and have, in fact, proven the industry's assertion to be wrong. Because Congress has not yet been able to address these areas, several States have begun to pass laws of their own to address these real patient concerns. Also, with no "global" approach to this matter, Congress is now witnessing the introduction of several bills addressing specific procedures or conditions.

At present, as the public outcry has become so loud, the industry has responded by proposing certain voluntary standards to address "problems" that they have for so long denied as even existing. While these voluntary standards are a step in the right direction, they fall far short of what is needed to ensure patients receive timely access to quality care in a managed care environment.

The Coalition has been a strong advocate of applying its principles to all health care plans and providers. However, in the past, there has not been widespread support in Congress for any comprehensive approach to health care delivery. Also, there has been a concern about "too much regulation" or interference in the marketplace. Consequently, most recently, the Coalition has concentrated its efforts on applying these principles to the Medicare program.

Inasmuch as the Federal government is paying for the health care received by Medicare enrollees, it is fiscally responsible for the government to determine that it is getting value for its payments to managed care plans.

Therefore, in this 105th Congress, the Coalition has strongly endorsed H.R. 66, the Medicare Patient Choice and Access Act of 1997. This legislation currently has 43 cosponsors -- both Democrats and Republicans -- and is a modest approach for providing needed protections for patients participating in the Medicare program. All of these Medicare provisions are entirely budget neutral, and some have already been scored as such by the Congressional Budget Office.

ASSURING ADEQUATE IN-NETWORK ACCESS

Current Federal law (Paragraph 4 of Subsection (c) of Section 1876 of the Social Security Act) already requires that managed care health plans provide access to the full range of Medicare health care benefits. The provisions of H.R. 66 clarify these provisions and contain more specificity about the care which must be provided.

OUT-OF-NETWORK ACCESS

The provisions of H.R. 66 require that if, at the time of enrollment, a managed care (closed-panel) plan is offered to a Medicare enrollee, a point-of-service plan must also be offered which allows the patient to go out-of-network.

As Congress explores the role of managed care in controlling health care costs, it also has the opportunity to give Medicare enrollees more choices, and more security in knowing that the health care provider of their own choice can always be there if they choose a point-of-service plan. If Congress is committed to moving more seniors into managed care plans, it makes sense to increase the comfort-level of the elderly by having point-of-service plans available when offering a managed care product.

In addition, making out-of-network treatment available to Medicare enrollees is a very good quality assurance check. If too many Medicare enrollees in a plan are going outside of the plan to seek care, this is an early warning signal to the Health Care Financing Administration that there is something wrong with the managed care plan.

The provisions of H.R. 66 do not require any copayment amounts or place any requirements on what type of plans must be provided. The marketplace can decide this.

Allowing the option of point-of-service at the time of enrollment does not affect the health care plans' ability to be aggressive in their cost containment activities, nor does it limit their efforts to encourage providers and consumers to use health care resources wisely. It will simply put pressure on health plans to keep the patient's welfare uppermost on their agenda, ahead of dividends and the bottom line.

The health insurance industry has consistently claimed that a point-of-service feature would greatly increase the cost of doing business. This is not true. The Coalition previously has shared with your Subcommittee the 1995 *Milliman and Robertson Actuarial Analysis* which demonstrated that a point-of-service feature can actually save a health care plan money. Moreover, point-of-service continues to be the fastest growing insurance product.

GRIEVANCE AND APPEALS PROCESS

Current Federal law requires that Medicare managed care beneficiaries have access to a meaningful and timely appeals process (Paragraph 5 of Subsection (c) of Section 1876 of the Social Security Act. (However, Federal Court cases, as well as an investigation by the Office of the Inspector General of the Department of Health and Human Services, have identified many instances where Medicare beneficiaries are not receiving a timely resolution of a grievance concerning a denial of care, treatment, or testing in managed care plans. The appeals process provisions of H.R. 66 are modeled after the one described by a Federal District Court Judge in *Grijalva v. Shalala*, 946 F.Supp. 747 (D. Ariz. 1996).

The health care insurance industry has also called for a timely resolution of disputes concerning treatment determinations. However, the problem with the industry's approach is that there are concerns raised by patients that go much further than just a determination of treatment. In the past, many disputes have dealt with the failure to order a test, or the delay in referral to a specialist. Consequently, the provisions of H.R. 66 permit the patient to seek timely review, at any time, for any actions taken or not taken by the health plan, and call for a 30 day resolution of the grievance.

NOTICE OF ENROLLEE RIGHTS AND ENROLLEE INFORMATION CHECKLIST

Current Federal law requires that managed care health plans disclose certain information about the rights and benefits to which Medicare enrollees are entitled (Paragraph (E) of Subsection (c)(3) of Section 1876 of the Social Security Act.) The provisions of H.R. 66 expand upon the information which must be provided to Medicare beneficiaries.

RESTRICTIONS ON PROVIDER INCENTIVES

Currently, Federal law places certain restrictions on financial incentives to physicians (Paragraph (8) of Subsection (1) of Section 1876 of the Social Security Act). The provisions of H.R. 66 simply expand this current law to all health care professionals and providers who receive payment under Part A and B of Medicare, not just physicians.

PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS ("GAG CLAUSES")

A few months ago, the Health Care Financing Administration sent a letter to all managed care plans participating in the Medicare program, requiring them to remove from their contracts any restrictions on the physicians' ability to discuss with the patient medical treatment options. This requirement was not instituted by regulatory action. It only applied to physicians and it took a very narrow definition of medical communications (i.e. treatment options). Recently, the American Association of Health Plans (AAHP) listed a number of communications which it considered to be appropriate to convey between the provider and the patient -- but this was voluntary and only at the patient's request.

The provisions of H.R. 66 include a broad definition of medical communications, specifically taken from the AAHP's own literature, and state that all health care professionals (not just physicians) cannot be prohibited from making such communications.

Mr. Chairman, the Patient Access to Specialty Care Coalition firmly believes that the enactment into law of these six principles will help to ensure that Medicare patients continue to have real choice and access to quality health care. The Coalition's approach is simple, it is comprehensive and it places reasonable requirements on the industry.

In your continuing deliberations on the expansion of managed care in the Medicare program, and on the need for quality assurances, we urge this Subcommittee to consider H.R. 66, the Medicare Patient Choice and Access Act, as a model and comprehensive approach to address these important patient concerns.

A listing of the current membership of the Patient Access to Specialty Care Coalition follows.

MEMBERS OF THE PRACTICE EXPENSE COALITION

American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgeons
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology—Head and Neck Surgery, Inc.
American Association of Clinical Urologists
American Association of Neurological Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Nuclear Physicians
American College of Osteopathic Surgeons
American Gastroenterological Association
American Psychiatric Association
American Society for Dermatologic Surgery
American Society for Gastrointestinal Endoscopy
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of General Surgeons
American Society of Plastic and Reconstructive Surgeons
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons
International Society for Cardiovascular Surgery
Society for Vascular Surgery
Society of Cardiovascular and Interventional Radiology
Society of Nuclear Medicine
Society of Thoracic Surgeons

Mrs. JOHNSON. Thank you, Dr. Maves.

Dr. Harr.

STATEMENT OF PATRICK B. HARR, M.D., PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. HARR. Thank you, Madam Chair.

My name is Patrick Harr, M.D. I am a practicing family physician from Maryville, Missouri, and president of the American Academy of Family Physicians, the largest primary care specialty group in the Nation, representing over 84,000 members. The administration's budget offers a reasonable basis upon which Congress could develop a bipartisan Medicare reform package that advances primary care, restores trust fund solvency, and lowers the budget deficit. I would like to turn first to something that is not in the budget: The resource-based practice expense project that HCFA is currently working on.

Several medical specialty groups have asked you to delay implementation of the practice expense project. The academy believes it would be inappropriate to delay the project at this time. Instead, we urge you to first review the proposed rulemaking that will be published this spring. Weigh for yourself the soundness and fairness of the proposal, and then decide if the project should move forward as scheduled or be sent back to the drawing board for further work.

Under the flawed system now in place, a family physician must perform 115 intermediate-level office visits to receive the practice expense payments received by a surgeon for one coronary artery bypass graft procedure, although the hospital and not the surgeon

assumes most of the overhead costs for the procedure. The new practice expense method will hopefully correct such glaring inequities and be more sound and defensible than the current method.

We support the administration's proposal to establish a single conversion factor in the Medicare physician fee schedule with no transition. It should be no less than the 1997 conversion factor amount for primary care services, updated for inflation. A single conversion factor would guarantee that physician services involving the same amount of work are paid at the same rates as originally intended by Congress. Given that private sector plans are relying more and more upon the Medicare fee schedule for setting their own fees, it is essential that a single conversion factor become law. Otherwise, the flawed system will be duplicated on the private sector side, thus creating a snowball effect of undervalued and miscalculated payments for primary care services.

We agree with the proposal to use the sustainable growth rate method for calculating annual physician fee updates, but urge you to support at least a 2-percent adjustment. We support modifying the AAPCC formula by establishing a $350 base payment for Medicare HMO plans. This would level the playingfield by reducing geographic disparities in the current formula, which today vary from $221 to $767. The $350 floor would help attract managed care plans to underserved areas, especially rural communities, and make the HMO option available to these beneficiaries.

Given the magnitude of the problems with Medicare GME payments, the administration's GME proposal is modest at best. We support the idea of shifting GME and IME payments to ambulatory training sites where the majority of family practice training occurs. This part of the budget could have gone much further. My written statement contains a 10-point plan for completely restructuring Medicare GME. Unlike the current system, the academy's plan would achieve the appropriate distribution of physicians in the work force by geographic location and specialty.

We strongly oppose the idea of repealing the clarified "should have known" standard adopted last year as part of HIPAA. Congress was correct in HIPAA by insisting that physicians should not be subject to civil monetary penalties for making an honest mistake. We also oppose efforts to repeal the HIPAA requirement that the HHS inspector general furnish physicians with advisory opinions on whether a proposed health care business venture violates Medicare laws and regulations. Eleven other Federal agencies provide such opinions and are not overwhelmed by the process.

A major shortcoming of the Medicare Program is the virtual absence of coverage for preventive services. We are very encouraged by the introduction of H.R. 15, the bill to expand Medicare coverage for preventive services. The academy fully supports the recommendations of the U.S. Preventive Services Task Force and believes they should be fully incorporated into Medicare. My written statement includes an extensive recommendation for modernizing the Medicare Program, and I would like to share just a few highlights with you.

First, public funding for Medicare should come from one source by combining part A and B funding into a single funding pool.

Second, Medicare should be a program with a defined contribution with a minimum defined benefit. The defined contribution should be means tested—"means" meaning both income and assets. And, further, Medicare and Social Security reform should be linked, since both programs financially affect the same populations.

The academy also believes that a telemedicine policy fully covering physician consultations is a critical part of any Medicare reform effort. Interested members and their staff may refer to my written statement for more information about our ideas for telemedicine in Medicare.

In closing, I thank you for this opportunity to appear before you and look forward to your questions.

[The prepared statement follows:]

Statement of Patrick B. Harr, M.D., President, American Academy of Family Physicians

My name is Patrick B. Harr, M.D., and I am a practicing family physician from rural Maryville, Missouri. It is my honor to serve as the President of the American Academy of Family Physicians. The Academy is the single largest primary care medical specialty organization in the United States. On behalf of the 84,000 members of the Academy, I would like to thank you for the invitation to present our views today on the Medicare provisions in the administration's fiscal year 1998 budget proposal that are of importance to family practice. My remarks also include recommendations for reform of the Medicare program that were recently approved by the Academy's Board of Directors.

THE ADMINISTRATION'S FISCAL YEAR 1998 MEDICARE PLAN

The Academy supports a number of the Medicare provisions in the administration's budget plan. Overall, we believe that this plan offers a reasonable basis upon which Congress could develop a bipartisan Medicare reform package that would advance primary care, restore solvency to the trust funds, and achieve a balanced budget.

The budget plan is worth consideration not only for the provisions it includes, but also for the provisions it does not. We are referring specifically to the plan's omission of any delay in the Health Care Financing Administration (HCFA) project to develop resource-based practice expense values as part of the Medicare physician fee schedule.

The RBPE Project. The Academy believes it would be inappropriate to consider legislating a delay in the resource-based practice expense (RBPE) project at this time. We urge concerned lawmakers to first review the proposed rule on resource-based practice expenses that is scheduled for publication this spring, weigh carefully the soundness and fairness of this proposal, and then determine whether the practice expense project deserves to continue or else be delayed and "sent back to the drawing board" for further work.

It is true that the family practice specialty would post "gains" of 9 to 19 percent in practice expense values according to preliminary data released by HCFA on January 22. However, it must be emphasized that we, like many other medical specialties, have concerns with this preliminary data. For example, the volatility of the estimated impacts by specialty, the validity of redistributing practice expense relative value units (RVUs) to non-physician providers, and the application of a 2 to 4 percent behavioral offset in the calculation of practice expenses are of concern to the Academy. Especially puzzling is that under one of the preliminary options reported by HCFA, the in-office practice expense RVUs for CPT codes 99211 through 99213 would receive the same practice expense RVUs (.90 in all three cases) despite the fact that these codes involve increasing complexity and increasing professional and staff time allocations.

Let us emphasize that we support a new practice expense method that is methodologically sound and defensible. However, preliminary data released January 22 are not the final word on this matter. All stakeholders will have an opportunity to suggest improvements to the practice expense method during a 60-day comment period following the NPRM that will be released this spring. We feel it is wholly appropriate during that time period to formulate decisions as to whether the project should continue as scheduled toward a January 1, 1998 effective date. It should also be noted that HCFA staff plan to convene a multispecialty panel later this year to

assist the agency with evaluating the comments and refining the proposed new practice expense method before the implementation date.

The Academy believes that as interested parties continue to discuss the numbers in the HCFA proposal it is important to keep a sense of perspective about the practice expense project. For example, some specialties favoring a delay claim that access to their services would be adversely affected in rural and underserved areas and yet it is primary care providers, especially family physicians, who disproportionately serve these areas, at lower Medicare payment rates. Under the flawed system now used for determining practice expense payments, a family physician must typically perform 115 intermediate-level office visits to receive the practice expense payments equivalent to one coronary artery bypass graft (CABG) procedure—despite the fact that the hospital, and not the surgeon, assumes most of the overhead costs for such a procedure. Such glaring inequities in the Medicare program's method of reimbursing physicians for their overhead expenses is unfair to all primary care physicians and also is contributing greatly to problems in rural and underserved communities with access to needed medical services—including primary care and other non-surgical services.

The HCFA project mandated by Congress to develop a new method for reimbursing physician practice expenses is the only effort to date attempting to rectify this long-standing problem. For these reasons, the Academy simply asks the members of this subcommittee not to rush to judgment on the project before the proposed rule for the new RBPE method is available for review.

A Single Conversion Factor. We support the administration's proposal to "fix" long-standing problems with the formula for calculating annual updates in the Medicare physician fee schedule through the establishment of a single conversion factor. Correcting existing flaws in the update formula is absolutely essential not only to restore the original intent of the Medicare physician fee schedule, but also because the effects of the fee schedule reach far beyond the Medicare program itself. Private sector health plans are relying increasingly upon the Medicare physician fee schedule to determine the fees for physicians participating in their plans. Correcting the inequities in the present Medicare fee schedule is necessary to ensure that these flaws are not duplicated on the private sector side of a physician's practice, creating a snowball effect of undervalued and miscalculated payments for primary care services.

The administration's plan would eliminate the three individual conversion factors for primary care services, surgical services, and other non-surgical services by replacing them with a single conversion factor equivalent to the FY'97 amount for primary care services ($35.7671). This new conversion factor would be adjusted each year by the Medicare economic index. The Academy is a strong advocate for the implementation of a single conversion factor for all medical services that would be no less than the current primary care conversion factor amount. The single conversion factor should take effect January 1, 1998—without a transition period—as proposed in the administration's budget.

Such a policy would guarantee that physician services involving the same amount of work are paid at the same rates—as intended by the drafters of the resource-based relative-value schedule (RBRVS) that serves as the basis for the Medicare physician fee schedule. Surgical and primary care services with exactly the same work values are reimbursed at significantly different rates, as the numbers illustrate. Both a diagnostic laryngoscopy (CPT code 31575) and a level 4 established patient office visit (CPT code 99214) are assigned 1.10 work relative value units by the Medicare physician fee schedule. However, despite the fact that each service involves the same amount of physician work, the surgical service receives $45.0563 while the primary care service receives only $39.3438. Both an incision and drainage of an abscess (simple or single, CPT code 10060) and a mid-level established patient home visit (CPT code 99352) are assigned 1.12 work relative value units by the fee schedule. Yet, the surgical service receives $45.8755 while the primary care service receives only $40.0591.

The Academy is not alone in believing that a single conversion factor would bring greater consistency and fairness to the Medicare physician fee schedule. The policy is also supported by the Physician Payment Review Commission.

A Sustainable Growth Rate Measure. The Academy also favors switching from the current Medicare Volume Performance Standard (MVPS) formula to a single target based on Gross Domestic Product (GDP), such as the sustained growth rate (SGR) formula in the administration's FY'98 budget. The current MVPS system is based in part on a rolling five-year historical average of growth in the volume and intensity of Medicare services. As such, it has the perverse effect of rewarding poor performance, defined as actual expenditure growth exceeding the target rate of increase, with higher future targets. Meanwhile, good performance results in lower fu-

ture targets. This flawed method does not adequately take into account the influence of changing medical practices or efficiencies. However, the change to GDP and a cumulative measure—such as the SGR method favored by the administration, the PPRC, and the Academy—would eliminate this perverse incentive. Under the SGR system, a single target would be established for growth in the volume and intensity of Medicare services, based in part on the growth in GDP. Given the SGR system's cumulative nature, it measures spending on physician services in a base year against a target level of spending. This feature of the SGR system is more equitable to primary care providers than the current MVPS system based on rolling averages. The SGR system also eliminates the 4-percent behavioral offset from calculations of annual fee updates that makes it impossible for physicians to achieve the performance targets required by the MVPS formula.

While the Academy favors switching to the SGR method for calculating annual physician fee updates, we are concerned that the proposed 1 percent adjustment for volume and intensity proposed by the administration is insufficient. We recommend a volume and intensity adjustment of at least 2 percent to ensure that fee schedule updates come closer to matching inflation changes.

The AAPCC Formula. The administration's budget proposes to alter the method by which Medicare reimburses participating managed care plans. Under the current method, Medicare HMO plans are paid 95 percent of the average annual per capita cost (AAPCC) provided for fee-for-service care in a county. Under this method, monthly payment rates for Medicare HMO services vary greatly across geographic areas, from $221 to $767. The administration budget would establish a $350 minimum HMO payment for areas with below-average payment rates, effective in 1998, so that more Medicare beneficiaries could select a managed care option. Leveling the playing field is especially important so that managed care plans would be attracted to rural areas where HMO penetration is currently very low, and rural beneficiaries would be able to choose from at least one managed care option in their community.

A recent study based on HCFA data and distributed by the Fairness Coalition demonstrates clearly that enrollment in Medicare managed care plans is lowest in those areas where the AAPCC payment rate is below $350. For example, less than 1 percent of Medicare beneficiaries in counties with an AAPCC payment rate below $300 per member per month are enrolled in managed care plans. Most of the counties are in rural areas. By contrast, 76 percent of Medicare beneficiaries are enrolled in managed care plans in counties where the AAPCC payment rate exceeds $400 per member per month. While the Academy has not endorsed a particular method for adjusting the AAPCC, we do support the idea of adjusting it toward a national average amount that would apply in all counties. Given that the AAPCC rate in most counties is below the national average at this time, bringing up the floor would be beneficial for the growth and development of most existing Medicare HMO plans. The Academy believes that consumers would benefit from the ability to select between fee-for-service and viable managed care options in their communities as a result of normalizing the AAPCC payment rate.

Some observers have expressed concerns that the AAPCC modifications in the budget plan might diminish quality and harm consumers in the areas in which payments to HMOs are highest by forcing the plans serving those areas to cut back on their supplemental benefit packages, as their payments are lowered to raise the floor in other areas. These supplemental packages typically include low-cost prevention services, prescription drugs, eyeglasses and hearing aids. The Academy is sensitive to these concerns and believes changes ought to be carefully considered and monitored with equal care as they are implemented. We believe it is equally important to modify the AAPCC formula so as to reduce geographic disparity in payment rates and attract managed care to counties where this option is currently unavailable.

We are concerned, however, that the proposal to reduce the AAPCC from 95 percent to 90 percent of the county-level fee-for-service payment rate without an adequate risk adjustment mechanism could jeopardize the prospects for normalizing the AAPCC payment rate nationwide. Accordingly, we urge Congress to examine fully the implications of a reduction in the AAPCC rate upon efforts to establish a $350 minimum national payment floor for Medicare HMO services. Support for an adequate and accurate risk adjustment mechanism should be carefully considered in any AAPCC modification that Congress may adopt this session.

Graduate Medical Education. The budget proposal includes some of the GME reform measures that the Academy has advocated for years. For example, the budget plan would carve out the portions of the AAPCC payment attributable to GME and indirect medical education (IME) payments. The GME and IME payments would instead be distributed directly to the teaching facilities. Given that a substantial portion of family practice training occurs in non-hospital, ambulatory settings, the

Academy urges Congress to guarantee that GME and IME payments would follow the medical resident, so that ambulatory training sites, and not just academic medical centers, would receive support for the instructional services they provide. In addition, we agree with the budget plan's provision to count work in non-hospital training settings for IME payments.

However, given the magnitude of the GME problem, the administration could have gone much further with its proposal to restructure GME. Medicare GME policies are largely responsible for the over-specialization of the physician workforce. At this time, GME is subsidized by the Medicare program without reference to ensuring the appropriate distribution of physicians by geographic location or specialty. Reforming the financing of GME should address these and other policy issues.

The Academy urges Congress to adopt a comprehensive Medicare GME reform policy based on the following recommendations:

• National physician workforce policy, including but not limited to allocation of the total GME financing support pool and the weighting of per-resident capitation payments, should be developed by a public-private commission, the recommendations of which can only be accepted or rejected without modification by Congress;

• The amount of federal GME financial support should initially include no less than the full amount of payments currently included in DME, IME, and the GME component of the AAPCC. The portion of federal support historically identified as IME should decrease over a five year transition period to 75 percent of the current amount;

• All payors of health care services, in addition to the federal government, should share in contributing to a total GME pool;

• GME financial support should be provided in a per-resident capitation amount to the entity legally responsible for paying the costs of training the resident;

• GME financial support to the institution sponsoring residency training must be used to pay the direct and indirect costs of training that occur in any site authorized by an ACGME accredited or AOA approved residency program;

• Full GME capitation payments should be made to support the training of individual residents for the minimum number of months necessary to meet the training requirements of only one certifying board, regardless of the number of months actually experienced by the resident during training;

• Per-resident capitation payments should reflect national physician workforce policy, i.e. increased payments should be made to support the training of residents in undersupplied specialties or geographic areas;

• GME financing policy should limit the total number of funded first-year post-graduate residency positions to 110 percent of the annual number of U.S. MD and DO graduates, phased in from current levels over a five year period;

• Sponsoring institutions should receive GME capitation payments based on the number of residents enrolled in the training program(s) through a national program (such as the National Resident Matching Program) determined by the public-private commission, regardless of the school of graduation of the resident, as long as the resident is eligible for post-graduate residency training in an ACGME accredited or AOA approved residency program in the U.S.; and

• The National Health Service Corps (NHSC) should be used to provide service to populations that would have been served by previously funded residency positions. Disproportionate share payments should continue to support training institutions serving vulnerable populations.

Fraud and Abuse Provisions. The Academy opposes the provisions in the budget plan that would eliminate the "knowing and willful" standard enacted last year as part of the Health Insurance Portability and Accountability Act of 1997 (HIPAA). We believe the Congress was correct in HIPAA in insisting that no physician should be held liable for criminal penalties if that physician did not intend to defraud the government but simply made honest mistakes. Repealing the knowing and willful standard for conviction of health care crimes would, we are convinced, increase the chance that physicians will be penalized for "human error," such as unintentional coding errors.

We also oppose the budget plan's proposed repeal of the advisory opinion requirement. By seeking to eliminate this provision, the administration is demonstrating its continued unwillingness to abide by the spirit and intent of the HIPAA law requiring that advisory opinions be furnished to physicians considering health care business ventures that might or might not conflict with Medicare law and regulations. It is precisely these sort of advisory opinions that would help physicians (and the health care delivery system as a whole) to avoid costly and unintentional violations of the fraud and abuse laws. The administration has claimed that the Inspector General of the Department of Health and Human Services may be deluged with an unmanageable flood of physician-generated requests for advisory opinions. How-

ever, at least 11 other federal agencies, including the Federal Elections Commission (FEC) and the Internal Revenue Service (IRS) provide advisory opinions. Furnishing advisory opinions is a common government practice. It should be further noted that these agencies have not been overwhelmed by such requests. Given that the advisory opinion process is operating well within these agencies, we recommend that the HHS Inspector General contact these agencies, learn from their experiences, and proceed without delay to implement the advisory opinion requirement in HIPAA.

The knowing and willfull standard and the advisory opinion requirements enacted last year are reasonable and widely-supported within the physician community. For these reasons, we urge Congress to oppose the administration's effort to eliminate these provisions of HIPAA.

Preventive Services. A major shortcoming of the present Medicare program is the virtual absence of coverage for clinical preventive services. The Academy strongly supports adding clinical preventive services to the benefits package for Medicare beneficiaries. We are pleased, therefore, with the administration's intent to extend Medicare coverage to preventive health care services such as diabetes management, colorectal screening, annual mammograms without copayments, and reasonable payment rates for administering immunizations to protect beneficiaries from pneumonia, influenza, and hepatitis B. We strongly support efforts to include preventive services in the basic benefit package as long as these services are based on scientific evidence and outcomes, and are consistent with the recommendations of the U.S. Preventive Services Task Force (USPSTF).

In a related matter, the Academy is greatly encouraged by the introduction of the *Medicare Preventive Benefit Improvement Act of 1997 (H.R. 15).* The majority of the standards in H.R. 15 are long overdue. House Ways and Means Subcommittee on Health Chairman Thomas, Representative Ben Cardin, and House Commerce Subcommittee on Health and the Environment Chairman Michael Bilirakis are to be commended for the introduction of this measure and their obvious commitment to updating the Medicare benefits package. This bill is an opportune vehicle for creating a mechanism to implement the science-based recommendations of the USPSTF, which does not rely on "old-style" consensus medicine that has been medicine's usual recourse. We know a great deal more now about what tests are effective, which monitoring activities provide the physician with accurate data and what interventions are likely to result in further productive years for the patient. This medical knowledge should be reflected in both public and private insurance benefit packages.

The Academy urges all health-related committees of Congress to begin implementation of all the recommendations of the USPSTF in federal health programs. Let these recommendations be reviewed and updated as outcomes-based medical research sheds additional light on promoting and preserving health.

High-Volume Withhold. The budget plan includes a provision for withholding 15-percent of payment from physicians practicing in hospitals where the volume and intensity of services per admission exceed 125 percent of the national median for urban hospitals (140 percent of the national median for rural hospitals). The projected savings from this policy is $2 billion by the year 2002. Family physicians serving in underserved or rural communities, where the population is characterized by a higher proportion of Medicare beneficiaries with multiple health problems, would be adversely affected by this proposal. The Academy feels that this proposal is insensitive to the demographics that can lead to a higher volume and intensity of services per admission in such settings, and for this reason opposes the high-volume withhold in the budget plan.

Expanded Health Plan Options. Consistent with the intent of past Republican-sponsored Medicare legislation, the administration's budget would increase the choice of health plans available to beneficiaries by offering them the option of enrolling in provider-sponsored organizations (PSOs). Expanding the choice of health plans available to beneficiaries is also consistent with Academy policy. We will monitor closely any developments with this proposal.

MEDICARE REFORM SHOULD EMPHASIZE MODERNIZATION OF PROGRAM

Medicare reform will be a very prominent subject in the legislative and policy arenas in 1997. The Academy believes there are at least three reasons for its prominence. First, as recently as June 1996, trustees for the Medicare trust funds reported that the Hospital Insurance (Part A) trust fund would be exhausted in 2000 or 2001. Second, Medicare expenditure growth continues to spiral out of control. Finally, the Medicare program is encountering a serious problem in that the number of workers contributing payroll taxes to finance the Part A trust fund is declining. Under present constraints, these demographics will necessitate increased payroll

taxes to sustain the Medicare program—a solution that most likely is not politically viable.

Because of these problems, Medicare reform is the subject of intense debate. The Academy believes that:

- Medicare should be a program with a defined-contribution and a minimum defined-benefit;
- Eligibility should remain as it currently is under Medicare;
- Beneficiaries should have a range of Medicare options from which to choose, including traditional fee-for-service Medicare and any other plan that offers the minimum defined-benefit, accompanied by incentives to choose the most cost-effective option;
- The minimum defined-benefit should include the current benefits available under Medicare, clinical preventive services as defined by the U.S. Preventive Services Task Force, and mental health services at parity with medical services;
- Public funding for the Medicare program should come from one source (combined Part A and Part B financing), which covers all of Medicare;
- The defined-contribution should be based on the per capita cost of providing the minimum defined-benefit in a base year plus a market-determined adjustment rate in years beyond the based;
- Beneficiaries should be responsible for all costs beyond the defined-contribution;
- Medigap insurance should remain an option for Medicare beneficiaries;
- Quality should be certified to commonly accepted professional standards; and
- The defined-contribution should be means-tested, where "means" includes both income and assets.

Further, the Academy takes the position that efforts to reform Medicare should be tied to efforts to reform Social Security (e.g., the adjustment to the Consumer Price Index for cost-of-living-allowances, etc.) since both programs financially affect the same populations. To restructure the Medicare program without also addressing Social Security would place a disproportionately heavy burden on Medicare alone, placing the program and its beneficiaries at risk. Such a half-measure would essentially defeat the purpose of overhauling the Medicare program.

The Academy's recommendations reflect our view that reform should change Medicare from strictly a defined-benefit program, in which the costs to the government are essentially open-ended, to a program with a defined-contribution (and thus a defined cost) and a minimum defined-benefit. Our recommendation favoring more choices for Medicare beneficiaries is consistent with long-standing Academy policy that supports providing beneficiaries with a range of health plan choices accompanied by incentives to choose the most cost-effective option. In this case, the incentive is the defined-contribution coupled with the beneficiary's responsibility for all costs beyond the defined-contribution. Likewise, consistent with the notion of beneficiary choice, the Academy believes that the right of beneficiaries to choose Medigap coverage should be retained as part of overall Medicare program reform.

With regard to funding Medicare, the Academy finds the current distinction between Part A and Part B to be an artificial and archaic one that needs to be updated. Given that beneficiaries are automatically enrolled in Part A but may choose not to participate in Part B, questions may arise over whether the resources of these programs could be combined into one funding stream for Medicare. However, separate funding for the different parts of Medicare often creates perverse incentives to shift patients from one sector of the health care system to another without regard to what may be the best clinical practice. It also is contrary to the notion of a "continuum of care," which the Academy supports. Thus, the Academy favors the concept of a single source to fund all of Medicare.

Another improvement that the Academy endorses is an extension of Medicare benefits to include clinical preventive services and mental health services at parity with medical services. This would make the basic benefits package offered under Medicare more responsive to enrollees' health care needs and may actually generate program savings.

Comprehensive Telemedicine Policy Needed as Part of Medicare Reform

The Academy believes that modernization of the Medicare program would not be complete without the establishment of a comprehensive telemedicine policy. We are particularly sensitive to the potential for telemedicine to assist family physicians serving remote and sparsely populated communities. It is with this perspective in mind that the Academy's Board of Directors recently adopted a number of recommendations concerning Medicare reimbursement and support for telemedicine.

Medicare should reimburse physicians for telemedicine consultations independent of the site of service or technology utilized. Referring physicians should be reim-

bursed for the initial encounter(s) leading to the telemedicine referral using standard evaluation and management (E/M) codes. Consulting physicians should be reimbursed for the telemedicine consultation also using standard E/M codes.

A mechanism should be developed to fund telemedicine infrastructure. Telemedicine infrastructure in our view includes, but is not limited to, transmission and reception audio/video equipment, specialized examination equipment, telecommunications lines, electronic transmission costs, operational personnel, protocol development, and organizational support.

Telemedicine is a technology currently available primarily to the entities fortunate enough to have received grant-funded startup costs. Without a mechanism to ensure capital availability for telemedicine, its benefit will be limited. Some populations, especially those that are historically under-served, may never have access to telemedicine unless patients and/or third party payers, such as the Medicare program finance the technology infrastructure. Examples of infrastructure costs include facility fees, technical component fees, copays, or capitation. Sustaining the cost of telemedicine once the initial infrastructure is in place is an equally formidable problem, and once the Academy believes can best be resolved through Medicare reimbursement for telemedicine consultations.

Presently, HCFA recognizes the utility of technical and professional components, as described in CPT, to pay for certain medical procedures or services. Some cardiology and radiological services are routinely billed using modifiers. For example, a −26 CPT modifier is used whenever a professional component is reported separately for a service or procedure that has both technical and professional components. Resource based relative value scale relative value units for CPT codes account separately for the physician work (professional component) and practice expense (technical component) portions of a medical procedure or service. In addition, in the case of cardiovascular stress testing, for example, a series of CPT codes (93015–93018) have been developed to accurately describe the services provided.

Code 93015 is a global code involving physician supervision, the actual test tracing, interpretation, and a report. Code 93016 involves only physician supervision. Code 93017 involves only providing a test tracing (technical component). Code 93018 involves only an interpretation and a report (professional component).

Thus, the Academy believes that HCFA has established mechanisms to pay separately for the telemedicine component of physician services when appropriate. Further, these mechanisms could serve as the basis for Medicare reimbursement for recognized telemedical infrastructure elements, such as the technical components—or telemedicine practice expenses—associated with providing medical services via this medium.

Access to telemedicine consultations should be initiated and recorded by the patient's designated health care provider (attending physician or non-physician provider), rather than by the patient or consultant. The Academy is sensitive to the potential for inappropriate telemedicine utilization and believes that a mechanism should be developed to help ensure that telemedicine consultations are medically indicated. A policy limiting patient self-referral and consultant-generated referral would address HCFA concerns regarding increased Medicare costs generated by telemedicine. Further, such a policy, in our view, would be consistent with good health care management principles.

A mechanism should be developed to ensure that the referring physician is appropriately reimbursed if referring physician presence is medically necessary during a telemedicine consultation. The Academy believes that there will be certain circumstances when it will be necessary for the referring physician to be present during the telemedicine consultation. In such cases, the referring physician should be reimbursed appropriately. This approach would provide concurrent reimbursement for two physicians, which is a departure from current payment policies. However, the Academy notes that telemedicine consultations are different from traditional physician/patient encounters and telemedicine reimbursement policies must reflect such differences. The policy developed should take into consideration the situation, the service complexity, and the patient's comprehension and comfort. For example, a patient with impaired mental capacity may require the presence of his or her health care provider to explain, demonstrate, and comfort during a telemedicine consult. Current HCFA-approved pilot projects are paying for "attending physician" presence during telemedicine consultations using CPT codes 99211–99215 (established patient office visit codes). Potential approaches for referring physician reimbursement might include a fixed fee, use of current E/M codes, a new CPT codes, or a CPT code modifier.

CONCLUSION

The Academy appreciates this opportunity to appear before the subcommittee today. As practicing physicians, Academy members span the political spectrum and support both major parties. It is important to us that both parties work together to build an improved Medicare program that the nation can afford and that will endure well into the 21st Century. I would be happy to entertain any questions from the members at this time.

American Academy of Family Physicians Federal Grants and Contracts

Funder:	National Institute on Drug Abuse
Project:	American Family Physicians (AFP) Monograph on Diagnosis and Treatment of Drug Abuse
Type of Funding:	Contract
Identification #:	NO1DA–3–2400
Funding Period:	9/30/93 to 3/30/95
Award:	$155,265.00
Funder:	Health Resources and Services Administration
Project:	Interdisciplinary Generalist Curriculum Project
Type of Funding:	Subcontract
Identification #:	240–93–0010
Funding Period:	3/11/93 to 3/10/99
Award:	$122,373.00 (to date)
Funder:	Agency for Health Care Policy and Research
Project:	Development of Practice Guide for Otitis Media
Type of Funding:	Contract
Identification #:	282–90–0086
Funding Period:	10/1/91 to 5/30/95
Award:	$79,333.00
Funder:	Office of Disease Prevention and Health Promotion
Project:	Put Prevention into Family Practice
Type of Funding:	Contract
Identification #:	HP 930002–01–0
Funding Period:	10/1/93 to 5/31/97
Award:	$279,933.00
Funder:	Health Care Financing Administration
Project:	Literature Review and Evidence Tables for Type 2 Diabetes
Type of Funding:	Contract
Identification #:	95–0821
Funding Period:	9/28/95 to 11/30/95
Award:	$23,250.00

Mrs. JOHNSON. Thank you for your excellent testimony.

Mr. McCrery, do you have any questions?

Mr. MCCRERY. Madam Chair, I am 10 minutes late to an appointment, and we have a vote on the floor, and so I want to thank these gentlemen for their excellent testimony. I know there are some disagreements among you, and we will take those into consideration as we look at it.

Thanks.

Mrs. JOHNSON. Since I do not have another meeting but only a vote on the floor, I did want to take a couple of minutes to enlarge on what I think is a significant underlying problem.

Dr. Maves, in your statement you mention that the methodology used by HCFA did not measure the actual resources involved in provision of physician services as the law requires. Could you specifically address what resources have not been identified and collected and how you would collect those data?

Dr. MAVES. Yes, ma'am, thank you. The problem with the current system is that there is really no direct data on the indirect cost component. This was to have been collected by a survey in the original proposal from HCFA. This was not completed due to a very low response rate.

In addition, as we have examined the CPEP data, the data from the panels, we find that there are some errors contained within it, and in addition, there is some incomplete data provided by the CPEP panels.

Finally, there are a number of key costs that were eliminated from consideration. One that I am familiar with is surgeons who may take an office nurse to the hospital with them for assistance in surgery, and those were arbitrarily eliminated from the study.

I would be happy to have the staff of the Practice Expense Coalition give you additional information, but there are a substantive number of pieces of information. I think the most critical one is the indirect cost information which is not collected, and instead HCFA has used a mathematical approximation to reach that piece of information.

Mrs. JOHNSON. You mentioned also in your testimony the clinical practice expert panels that were to be used in collecting the direct data. Could you give this Subcommittee a better understanding of the composition of these CPEPs, how they were selected, and what the process was for verification of the data?

Dr. MAVES. The panels were selected both from nominees from the specialty societies and also from individuals selected by HCFA. It was a cooperative venture. It is one that, in fact, the Practice Expense Coalition vigorously supported. All of the specialties involved provided volunteers, in some cases at specialty society expense, to help HCFA go over actual procedures and estimate the direct costs involved in various procedures.

Typically, these panels were interdisciplinary; in other words, for areas where more than one specialty might provide a service, there was a number of different specialties represented at each panel. I think the CPEP process in and of itself was a good one, a rigorous one, but one where we have had really, I think, insufficient time to examine it. We found some errors. There are some pieces of that pie that need to be completed, and so more than a bad start, it has just simply been the job has not been finished at this point in time to our satisfaction or, I believe, to the standard which Congress initially gave HCFA to complete this.

Mrs. JOHNSON. Thank you.

There was a comment also in your testimony that you think that if reimbursement rates are cut too dramatically, the quality of services would suffer.

Dr. MAVES. Yes, ma'am. We are concerned about that. I think one of the things that has to be taken into consideration are what are the downstream effects from this particular proposal. We are concerned about access. We are concerned about quality. Clearly,

as I indicated in my testimony, as an individual who essentially spent his entire career in academic medicine, I am concerned about the research and education components of our academic health centers who obviously—the income from surgical procedures, all procedures, all services increasingly is an important part of their budget. And so, yes, we are concerned about those. We do not know in what fashion those will go.

These are pretty dramatic cuts. In my own instance, we have some cases, such as total laryngectomy, where we remove the voice box for people that have cancer of the larynx, this has been cut by one-third to one-half. So we are worried that in some cases perhaps access will be affected because of the severe and extreme nature of the cuts that have been proposed in the preliminary rule.

Mrs. JOHNSON. Do any of the rest of you have any comments on this issue, either the quality of the data or the possibility that reimbursement rates would sink to a level that would affect access and eventually quality?

Dr. NELSON. Yes, I would like to comment, Madam Chair. The direct cost estimates, as you indicated, were put together by panels, and that includes the equipment that is necessary and the direct staff expenses and so forth.

The part that has been estimated through other kinds of research is the indirect, which is the heat, lights, rent, those kinds of expenses that you cannot directly assign to a procedure. But research has been done that indicates that time is a pretty good surrogate for that, and that is one of the reasons why we supported what Dr. Wilensky said when she indicated that, while the data may not be perfect, it is certainly adequate to proceed. And it is why in our statement we emphasized the fact that we have serious concerns with these preliminary data, but it is too early for us to judge whether or not HCFA will indeed put together data that are perfectly adequate and reassure the medical community.

Mrs. JOHNSON. I do have to go vote, but the reason I raise this issue—and I think you all ought to think about it really seriously, and particularly as this issue advances—is that during our hearing the other day on the preventive services package, the issue came up that if you are going to reimburse for a lot of screening yet the rate for screening is very low, physicians are going to make choices: Do I schedule someone who wants to see me because they are sick and so on and so forth? Or do I schedule this kind of preventive action that reimburses me below costs? And remember, Medicaid went through a period of reimbursing below costs, and for internists, 2 years ago I began to get direct input that reimbursement rates for an office visit were now so low that if you had a primarily Medicare practice, you could not afford to take any more Medicare patients.

So while we do not talk about this much, in fact both Medicaid and Medicare have experienced a reduction in patient access to care as a result of underreimbursement, and we do not like to talk about that because we go out there and we say now these cuts are going to affect the seniors, and that is a lot of you know what. So it does worry me when I hear, on top of our history of reductions, such sharp reductions. And I would certainly want to be clear that they were well—they were based on very good data.

Dr. NELSON. That is exactly what this change that we are proposing would serve to meet. The problem has been that the kinds of services you just described—the careful history, discussing the treatment options—have been undervalued. And the purpose for the payment reform that we are encouraging to be completed is to assign the value that those services require.

Mrs. JOHNSON. Thank you very much for your testimony today. We appreciate it.

[Whereupon, at 3:17 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of American Academy of Otolaryngology-Head and Neck Surgery, Inc., Alexandria, Virginia

The American Academy of Otolaryngology-Head and Neck Surgery (AAO–HNS) is pleased to submit the following statement for the record of the Ways and Means Subcommittee on Health hearing on *Recommendations Regarding Medicare Hospital and Physician Payment Policies* held on March 20, 1997. We appreciate the Committee's consideration of our views on the following issues.

BACKGROUND ON AAO–HNS

The AAO–HNS is a national medical specialty society of physician specialists dedicated to the care of patients with disorders of the ears, nose, throat and related structures of the head and neck. There are approximately 7500 practicing otolaryngologists—head and neck surgeons in the United States. The public commonly refers to otolaryngologists as ears, nose and throat (ENT) specialists. We are a surgical specialty that provides a range of services to the population, including many services that would be considered primary care. Sore throats, ear aches, allergies and stuffy noses are those most commonly treated in both children and adults. We are also trained, however, to perform complex surgeries, including those related to head and neck cancers.

RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUES

The AAO–HNS is extremely concerned about the progress and status of the Health Care Financing Administration's (HCFA) efforts to develop resource-based practice expense relative value units for the Medicare physician fee schedule. HCFA is currently under a statutory obligation to implement the new practice expense relative values by January 1, 1998. Although the preliminary estimates released by HCFA in January indicate that otolaryngology payments would increase anywhere from two to twenty percent, we remain concerned about the validity of the data and methodologies being used. A review of the top 200 service specific winners and losers indicates that there are serious flaws with the HCFA data and methods. The numbers and relationships are beyond reason.

The law stipulates that the methodology utilized should "recognize the staff, equipment and supplies used in the provision of various medical and surgical services in various settings." Unfortunately, HCFA's failure to collect data on the actual resources used is contrary to congressional intent. The AAO–HNS has complied with HCFA's study plans from the beginning. We participated in both HCFA survey data collection efforts and served on the Clinical Practice Expert Panels (CPEPs). However, despite everyone's best efforts, the survey failed and the CPEPs were unable to arrive at direct cost estimates for numerous services. *In particular, we strongly believe that there is not enough time left to assign appropriate values given the cancellation of the survey on indirect costs.* The Office of Management and Budget specified that a response rate of seventy percent was necessary for the data to be valid when it gave approval. There was only a twenty-seven percent response rate when the survey was canceled.

We are also concerned about HCFA's failure to submit a report to Congress by June 30, 1996 on the method and data to be used as was required in the legislation. The mandate stated that the report must specifically include a presentation of the data utilized in developing the methodology and an explanation of that methodology.

The AAO–HNS is gravely concerned about access to quality medical care under this scenario. The current HCFA plan would seem to adversely affect patient access to quality medical care if implemented in 1998 as scheduled. Implementation of the current HCFA data must be stopped and new methodologies evaluated.

The AAO–HNS is a member of the Practice Expense Coalition that testified before the Subcommittee at this hearing. We fully support the Practice Expense Coalition's recommendations that Congress should:

1. stop the current rule making process;
2. instruct HCFA to assemble experts in cost accounting and to develop mechanisms for collecting *actual* data on physician practice expenses.

CONVERSION FACTORS

We continue to be opposed to proposals for a single conversion factor for the Medicare Physician Fee Schedule. We believe that continuation of a separate conversion factor for surgical services is fair public policy. Separate conversion factors provide relevant policy information about physician behavior patterns and cost containment methods.

If a single conversion factor were implemented, it would result in blatantly unfair payment reductions for surgeons. Surgery has not contributed to the problem of Medicare spending growth, but rather has consistently come under the spending targets set for it by the Congress.

In fact, in recent years, Medicare spending for surgical services has dropped in absolute dollars, not just in growth rates. Because surgery has consistently come in under target, it has received rewards in the form of positive updates. However, despite these positive updates, overall payment rates to surgeons have significantly declined in recent years due to the re-distributive effects of the budget neutral relative value scale. The AAO–HNS believes that it is unfair to implement such a change without at least some transition.

President Clinton's FY '98 Medicare budget proposal calls for a single conversion factor in 1998 without a transition period. Under the proposal, all physician services would be paid at the 1997 conversion factor rate for primary care updated to 1998. Even if fees were frozen at 1997 levels, this would mean a real dollar cut in payments to surgical services of 14.5 percent. This comes on top of any relative value changes HCFA might make in 1998.

The AAO–HNS supports maintaining a separate conversion factor for surgical services. However, should Congress be insistent on changing the law to allow for only one conversion factor for all physician services, we would urge that Congress include, at the very minimum, a three-year transition or phase-in.

Statement of American College of Rheumatology, Atlanta, Georgia

The American College of Rheumatology (ACR) is an organization of physicians, health professionals, and scientists that serves its members through programs of education, research and advocacy that foster excellence in the care of people with arthritis and rheumatic and musculoskeletal diseases. The ACR is pleased to provide written testimony to the Ways and Means Committee on two issues pertaining to the Medicare Fee Schedule (MFS): use of a single conversion factor and implementation of resource-based practice expenses by 1/1/98. We believe that achieving these critically important reforms will end the inequities that currently undermine the original intent of the Resource-Based Relative Value Scale (RBRVS)—equal reimbursement for equal work.

SINGLE CONVERSION FACTOR

ACR strongly supports the administration's proposal to enact a single dollar conversion factor for the Medicare fee schedule, effective 1/1/98, and to establish the single conversion factor at a level that is no less than the current primary care conversion factor, updated for inflation. We appreciate this subcommittee's support in the past for enactment of a single conversion factor—particularly, the decision by the subcommittee to include a single conversion factor during mark-up of the Balanced Budget Act of 1995.

Under the 1997 default conversion factors, surgical procedures are reimbursed at a rate that is 14% higher than primary care services, and 21% higher than other nonsurgical services, that involve the same amount of physician work. In an effort to correct this inequity, Congress included a single CF in the Balanced Budget Act of 1995. The single CF would have been effective on January 1, 1996. As the committee is well aware, however, President Clinton vetoed the BBA, with the result that the policy of separate conversion factors and updates remains in effect. There continues to be strong bipartisan support for enacting a single CF, however, as evidenced by the fact that it not only was included in the BBA and in the President's

current budget, but it has also been included in other proposals such as the recently-unveiled "Blue Dog" budget proposal.

The College urges Congress to support the administration's proposal to establish the single conversion factor at a level that is no lower than the current primary care conversion factor, updated for inflation. Payments for primary care services, which have been undervalued in the fee schedule updates for most of the past five years, should not be rolled back below current levels. Establishing the conversion factor at anything less than the primary care conversion factor, as updated for inflation, would also require deeper cuts in payments for surgical procedures, and provide less relief for the other nonsurgical services that have been most disadvantaged under the current update formula. A transition would also reduce the savings that the administration projects from a single CF by easing the reductions in payments for overvalued surgical procedures.

RESOURCE-BASED PRACTICE EXPENSES

Background

As the Committee knows, the Health Care Financing Administration (HCFA) is in the process of fulfilling its legislative mandate of establishing a RBPE methodology for implementation of a resource-based system and for determining equitable practice expense values for each physician service. HCFA's mandate grew from a long standing consensus that the previous, historical charge-based methodology was unsound and biased against the primary care and evaluation and management physicians who most often serve Medicare beneficiaries. The historical-charge methodology of the practice expense component acts as a disincentive against primary care by consistently overvaluing many surgical procedures while evaluation and management services are undervalued. For example, a rheumatologist or other evaluation and management-oriented physician would have to conduct 115 established patient office visits (level 3) to equal the overhead that would be assigned to one coronary triple bypass procedure. This injustice is heightened by the fact that a considerable portion of the surgeon's overhead is assumed by the hospital or surgical center.

Maintaining current law and implementing a resource-based methodology will alleviate these problems by ending payment disparity in the MFS. The RBPE methodology will facilitate the MFS's ability to encourage appropriate usage of increasingly finite health care resources. A resource-based system should provide incentives to explore all available evaluation and management patient care options before proceeding with more costly surgical procedures. Overall, the Medicare Resource Based Relative Value Scale (RBRVS) was implemented to create a more level playing field by removing the financial incentives that encourage physicians to enter highly technical procedure-oriented specialties. Because practice expenses account for approximately 41 percent of the Medicare RBRVS, resource-basing this component will assist in realizing these goals and will increase access to primary care and evaluation and management services that are utilized most often by Medicare beneficiaries.

Suggested Modifications of Preliminary Data

At a January, 1997 briefing, HCFA released *highly preliminary* data which indicated a wider than expected redistribution of RVUs in the MFS. This information has served to heighten the calls for a delay by some affected stakeholders. While we understand the concern of some organizations in the medical professional community regarding the preliminary and undefinitive nature of the data and methodological outlines released at the briefing, ACR feels it is entirely too early to dismiss the current timetable. We believe that it is premature to conclude, at this point, that the data and methodological options cannot be sufficiently improved between now and issuance of a proposed rule (which is scheduled for May, 1997) to allow for implementation on January 1, 1998, as required under current law. Given the recognized unfairness of the current system, it is imperative that methodologically sound RBPEs be implemented as soon as possible. Therefore, it is ACR's opinion that any decision to re-assess the current timetable mandated by Congress must await publication of the proposed rule and a description of HCFA's approach to refining the proposed RBPEs.

ACR believes that now is the time for providing constructive input on how to implement HCFA's proposals according to the Congressionally mandated deadline. In this spirit, last month we offered specific comments on three aspects of the preliminary data issued in January: the undervaluation of higher level evaluation and management (E/M) codes, linking the CPEP data on direct costs, and the refinement process.

1. Higher Level E/M Code Concerns

The ACR raised concerns that some anomalies exist in the E/M code families as preliminarily released. Specifically, ACR believes that there is an incremental progression in the amount of administrative time necessary to provide increasingly complex levels of E/M services that was not reflected in the administrative time estimates. We therefore urged HCFA to review the administrative times for the E/M visit codes, with the purpose of establishing an incremental progression of these estimates within the code families.

2. Linking

The ACR also supported utilization of a methodology that uses the redundant CPT codes reviewed by the Clinical Practice Expert Panels (CPEPs) to link the direct cost estimates generated by the separate CPEPs. Linking refers to the process of using the redundant CPT codes (i.e., codes reviewed by more than one CPEP) to establish relativity among the different CPEPs. While it is difficult to analyze the tangible effects of the linking process without reviewing the mathematical models for linking and potential impacts, the College philosophically supported the concept of establishing a standardized scale in order to retain the relativity inherent in a resource-based relative value scale.

3. Refinement

ACR shares the opinion of the PPRC and others that a well-defined, inclusive and multidisciplinary refinement process is crucial to the success of the resource-based practice expense initiative. We therefore encourage HCFA to provide as specific an outline as possible for refining the proposed values when it publishes the proposed rule in the Spring. HCFA's ability to establish a refinement mechanism that allows the medical professional community opportunity to address any perceived imperfections in the proposed values is vital in gaining physician acceptance of the proposal. We support the concept of utilizing a multispecialty refinement panel to review the relative values proposed in the Spring, the comments submitted in response by the medical professional community, and the updated values as they evolve in the future. For the latter, we believe that the use of a process similar to that of the AMA Relative Value Update Committee (RUC) is the most appropriate method of achieving long-term refinement of the practice expense values.

CONCLUSION

After a full and open legislative debate on the merits of a resource-based practice expense methodology, it is critical to maintain the current schedule (full implementation by January 1, 1998). The ACR is persuaded that HCFA is well equipped to meet the current implementation date required by law. Clearly, Congressional intent is not in doubt, and determining practice expense RVUs is not a new concept. The analytical framework for developing a more fair and rational resource-based methodology for determining practice expenses has been underway for almost a decade. The methodology will be based on more than eight years of work devoted to the development of equitable RBPE relative values. We urge Committee to recommend to HCFA that it devote all necessary resources to developing resource-based practice expenses, while addressing legitimate concerns regarding the preliminary data, in time for the Congressionally mandated implementation schedule.

Statement of American Gastroenterological Association, Bethesda, Maryland

Mr. Chairman and members of the Subcommittee, thank you for the opportunity to provide the views of the American Gastroenterological Association on the Health Care Financing Administration's (HCFA) proposals to revise the practice expense component of the Medicare fee schedule. The American Gastroenterological Association (AGA) serves as an advocate for its more than 8,400 member physicians and scientists and their patients. The AGA is working in close partnership with other GI societies, namely, the American Society for Gastrointestinal Endoscopy (ASGE), the American Association for the Study of Liver Diseases (AASLD) and the American College of Gastroenterology (ACG), as well as all members of the Practice Expense Coalition, to alert Congress to the serious problems posed by the HCFA proposals.

The AGA strongly believes that the HCFA proposals to alter the practice expense rules are based on inaccurate and unreliable data and are contrary to congressional intent. We are deeply concerned that if these changes go into effect as currently proposed, access to quality care for Medicare beneficiaries will suffer, and major disruptions in the entire health care delivery system will occur.

As you know, in 1994 the Congress directed HCFA to develop resource-based practice expense relative values for each procedure and service provided under Medicare. This legislation specifically directs that the new relative values "recognize the staff, equipment, and supplies used in the provision of medical and surgical services in various settings." Earlier this year, HCFA released four options it is proposing as methodologies for developing the new practice expense RVU's. Each of the four options would result in dramatic reductions in Medicare payments for many services and procedures.

HCFA has failed to follow the clear intent of Congress to base changes in the practice expense component of the fee schedule on *actual resources used in the provision of Medicare procedures or services*. Rather, HCFA has proposed sweeping changes in the practice expense values that are based on neither fact nor actual experience. The results of this flawed methodology are dramatic: gastroenterology fees under Medicare will be reduced by 20–24 percent in 1998 and total payments for most procedural and surgical specialties will be reduced by up to 40 percent next year if the HCFA proposals go into effect as scheduled. Allowing the current HCFA proposals to become effective will cause major disruptions in the delivery of quality health care for Medicare beneficiaries nationwide and jeopardize access to care for Medicare patients.

Moreover, the consequences of these HCFA proposals reach far beyond Medicare alone. As you well know, many third party payers now use the Medicare relative values in establishing their own payment schedules for health care procedures and services. It is unfair and unwise to base such major changes in the health care delivery system on flawed and unreliable data.

The deficiencies in the HCFA process are exacerbated by the fact that these changes will, unless altered by Congress, become effective on January 1, 1998. We urge the Congress to direct HCFA to stop its current rulemaking process and to instruct HCFA to develop mechanisms for collecting actual data on physician practice expenses.

The AGA recognizes that over the coming months and years, Congress will be required to make many difficult choices about how to reform Medicare to ensure its long term solvency and how to balance the federal budget. The HCFA rules now being developed, however, do nothing to further either of these goals. Rather, these proposals will cause dramatic shifts in Medicare payments even before the tasks of Medicare reform or deficit reduction are undertaken.

Again, the AGA thanks the subcommittee for the opportunity to provide our views and we urge you to act immediately to redirect HCFA's proposals on practice expense so they are based on reliable and fair data.

Statement of College of American Pathologists, Northfield, IL

The College of American Pathologists (CAP) appreciates this opportunity to present its views to the House Ways and Means Subcommittee on Health regarding recommendations for Medicare hospital and physician payment policies. The College represents more than 15,000 physicians who are board certified in clinical and/or anatomic pathology. College members practice in a wide variety of settings including community hospitals, independent clinical laboratories, academic medical centers, and federal and state health facilities.

Pathologists are responsible for the overall operation and medical administration of the laboratory and for ensuring that quality laboratory services are available. They provide or supervise the provision of the large majority of pathology services paid for under the Medicare program. In most pathology practices, Medicare patients comprise a significant percentage of the patients served. Therefore, Medicare payment policies have a significant impact on pathologists. When the precedent-setting effect of Medicare policies on other federal programs and private payers is considered, the effect of Medicare policy on pathology practices is significantly greater.

The College is grateful to the Subcommittee chair, Mr. Thomas, and the members of the Subcommittee for their leadership in conducting hearings to examine the policy options proposed by the Physician Payment Review Commission, as well as those in the Administration's fiscal 1998 budget proposal. The timing of this hearing is particularly important, as the Medicare program stands at a critical point in its development. Medicare should ideally be a model of efficient interaction between the public and private sectors, providing beneficiaries with a broad choice of providers, sites of care, and coverage options. But the program faces a severe financial crisis due to a flawed financial structure. Rather than addressing these underlying structural defects, Congress and the Administration have historically attempted to deal with Medicare's financial problems by cutting provider payments and making numerous operational changes that have added to the burden and confusion for everyone involved with the program. The results have been cost-shifting to the private insurance market, where premiums and prices increased dramatically. Now, as private payers intensify their bargaining with providers, the ability to cross-subsidize Medicare with private dollars is shrinking.

College members applaud the efforts of this Congress and the Administration to achieve a balanced federal budget. But the College is concerned that pressure to balance the budget will once again lead to short-sighted policy decisions to meet deficit reduction targets rather than moving toward a careful, comprehensive look at how the Medicare program could be financed more equitably.

While the College is pleased that the President's fiscal 1998 budget proposal imposes relatively small reductions in Medicare payments to physicians and laboratories, we are disappointed that it fails to address many of the long-term structural problems facing the program. We are also concerned that Congress may attempt to achieve greater deficit reduction, turning once again to Medicare providers for additional savings.

The College would like to take this opportunity to comment on several policies in the Physician Payment Review Commission's recommendations to Congress, as well as issues raised in the Administration's budget proposal. We hope these comments will be helpful to the Subcommittee as it crafts its own fiscal 1998 spending plan for the Medicare program.

RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUES

The College of American Pathologists supports the PPRC recommendation for a three-year phase-in of resource-based practice expense relative values. However, we believe a phase-in alone is inadequate to ensure equitable implementation of these changes in physician payment.

We share the concern expressed by the Commission in its 1996 Report to Congress, that ". . . it will be difficult for HCFA to develop reliable relative values in time for implementation in 1998 for a variety of reasons." These concerns were magnified in January, when the Health Care Financing Administration released preliminary information about the development of practice expense relative values. This information was released in a manner which has hampered efforts to analyze the data and allocation assumptions on which its calculations were based.

The data collection and analysis process used thus far to develop resource-based practice expense values is incomplete and badly flawed. A methodologically sound approach has not yet been identified, and it will take time to develop and implement such a process.

We therefore strongly urge Congress to adopt legislation this year that remove the statutory requirement to implement new practice expense relative values on January 1, 1998, and allow the time needed for productive analysis and refinement of data and methodologies for developing accurate relative values. Once begun, resource-based practice expenses should be phased in over three years.

SINGLE CONVERSION FACTOR

The College also supports the PPRC's recommendation, also included in the President's budget proposal, to establish a single conversion factor update and performance standard for all physicians' services covered by the Medicare fee schedule. However, we disagree with the PPRC recommendation for a phase-in. We believe that any further delay in moving to a single conversion factor and performance standard will serve only to delay the restoration of the resource-based relationship between physician services on which the current fee schedule is based.

The current system of three separate conversion factors for surgical, primary care, and all other physician services has distorted the relationship between these services for five years. Immediate use of a single conversion factor and performance standard for all physician services is needed to correct the five-year inequity in the Medicare fee schedule that primary care and other physician services have experienced. The large majority of physician services billed to the Medicare program are in the non-surgical categories, and all physicians would benefit to some extent from this correction—including surgeons who bill for office visits and other non-surgical procedures.

The College strongly urges Congress to support the President's proposal and enact legislation to implement a single conversion factor update and performance standard for all Medicare physician services beginning in January, 1998.

COMPETITIVE BIDDING FOR CLINICAL LABORATORY SERVICES

The ill-conceived idea of establishing a competitive bidding process for Medicare clinical diagnostic laboratory services is one which Congress has considered and repeatedly rejected. We are therefore disappointed to see the concept proposed once again in the President's budget, tied to an arbitrary 20-percent reduction in payments. This proposal seems particularly ill-timed, since the Administration is attempting to conduct a demonstration project to test the feasibility and effectiveness of using a competitive bidding procedure to set Medicare fees for clinical diagnostic laboratory services—despite the advice of a physician advisory committee to abandon this approach.

Competitive bidding or pricing arrangements will not, in fact, promote competition. True competition is based on comparing both service and price. The competitive bidding proposal for laboratory services deals only with price, ignoring the issues of service, choice and quality. In fact, such competitive pricing schemes can actually interfere with competition by creating a system that allows low bidders to provide inferior quality services at below-market prices without providing the services essential to basic patient care, driving many smaller laboratories out of business.

A nationwide competitive bidding program would be complicated and difficult to administer, potentially requiring a bureaucracy that would cost more to create and operate than the process would save in discounted prices. For that reason, the Administration proposes to arbitrarily reduce payments to laboratories if competitive bidding fails to achieve a 20-percent reduction in payments. Such an approach is clearly aimed solely at obtaining the lowest price for Medicare, with no concern for the quality of or access to clinical laboratory services. No evidence has been suggested to justify a 20-percent cut in payments. In fact, payments for clinical laboratory services have been reduced by roughly $6 billion over the past ten years.

The College strongly urges Congress to once again reject the Administration's proposal to competitively bid Medicare clinical laboratory services.

PAYMENT FOR AUTOMATED CLINICAL LABORATORY TESTS

The College is opposed to the Administration's proposal to expand the current list of 22 tests that Medicare now pays for as "automated" tests. Medicare rules for determining payment for tests added to the list of "automated" tests do not adequately compensate laboratories for the additional costs they incur in performing the additional tests. In addition, many laboratories do not have the equipment capable of performing the additional tests at the same time as other tests are being performed. For example, the tests that are proposed to be added to the automated list are often not capable of being performed by laboratories on multi-channel analyzers on a ran-

dom access basis. This means the laboratory cannot perform the additional tests on an incremental basis along with other tests during the same equipment run. As a result, these laboratories would be forced to accept lower payments when their costs have not decreased.

The College believes that current Medicare payment rules that limit the automated test payment policy to a specific list of 22 tests should remain unchanged.

PATIENT CHOICE AND ACCESS IN MEDICARE MANAGED CARE PLANS

The College supports the efforts of this Subcommittee to expand the choices of health plans available to Medicare beneficiaries. However, as the pressure of competition and efforts to reduce costs increase, we believe Congress has an obligation to enact appropriate safeguards to protect the Medicare population and assure that beneficiaries retain the ability to choose and have access to their own physicians. It is important that beneficiaries not be "locked in" to closed health maintenance organizations or similar plans that severely restrict access to physicians and other health care providers.

The College strongly believes that Medicare beneficiaries should have the right to choose their provider and that attending physicians should be able to refer patient specimens to the pathologist or laboratory of their choosing. This means that managed care plans should be required to provide access to out-of-network providers. Payment disincentives for the use of out-of-network providers, such as increased cost-sharing, should be limited to reasonable amounts and beneficiaries must have access to a meaningful, expedited grievance process to appeal denials of coverage for out-of-network services. Appeals procedures should include a requirement for timely notice of the denial and rapid response to beneficiary appeals.

Managed care plans often contract with laboratories to provide all clinical and/or anatomic pathology services for plan enrollees, regardless of where the patient lives or sees the attending physician. The perception seems to be that since the patient does not generally have to travel to the location of the laboratory, and that since all laboratories are federally licensed, access and quality are not an issue.

Our experience is that physicians choose pathologists and laboratories to which to refer patient specimens using a combination of variables that are not necessarily known by insurers and that can affect access and quality. These factors include familiarity with the pathologists involved in the laboratory and knowledge of their specialty expertise and other strengths, turn-around time for test results and tissue and cell examination and diagnosis, clarity of reports, availability of pathologists for discussion and consultation, and the inevitable balance between cost and quality. We believe physicians who are knowledgeable about the pathologists and laboratories to which they refer patient specimens are in a much better position to ensure quality services than are managed care plans that lack this knowledge and often contract primarily on the basis of price.

Accordingly, we strongly believe that Congress should enact legislation that requires health plans that limit access to health care providers within a chosen network should also be required to offer beneficiaries a plan that provides coverage for services by out-of-network providers at rates that do not unreasonably inhibit access. Specifically, the College endorses the "Medicare Patient Choice and Access Act of 1997," H.R. 66, introduced by Reps. Tom Coburn (R-Okla.) and Sherrod Brown (D-Ohio) and cosponsored by 68 Members of Congress.

GRADUATE MEDICAL EDUCATION

The College recognizes that U.S. medical schools, residency programs and teaching hospitals, faced with an abundance of physicians, must evaluate and possibly restructure the current manner in which programs and services are delivered. We believe that any restructuring of programs and services must enable medical schools, residency programs and teaching hospitals to continue to receive graduate medical education funding in the future.

Therefore, we are concerned that the President's budget proposal includes provisions to reduce graduate medical education payments by $7.6 billion over five years by capping the total number and the number of non-primary care residencies at the current level and reducing indirect medical education payments by 2.2 percent over five years. The College remains opposed to federal restrictions on the numbers and specialty mix of medical residencies. Any changes in funding for graduate medical education must ensure that an adequate supply of pathologists is trained to meet the nation's medical needs during the coming century.

The College supports the creation of a national physician workforce body, staffed independently of federal agencies. Such a body must have adequate representation and involvement of specialties for which increased funding for residency programs

is targeted, but also specialties which are likely to experience decreases in funding. A national physician workforce body should have broad authority to study and make recommendations on all aspects of the physician workforce issue, including the appropriate number of residency slots and specialty mix to be funded by the government and the effect of different funding approaches on graduate medical education. The College believes that it may become necessary to limit the number of entry-level positions receiving federal graduate medical education funds in the near future. However, we oppose the creation of arbitrary quotas. Until adequate studies are conducted, market forces should be allowed to determine the number and specialty mix of residency positions.

The College recognizes the continuing problem of inadequate numbers of physicians in underserved communities and, therefore, endorses the idea of encouraging and supporting opportunities for medical students to gain experience in rural and inner-city communities. Similarly, we support the concept of encouraging medical schools to increase the diversity of their student bodies to graduate a larger number of minority physicians. We recommend that incentives for training and practice be included as one of the issues addressed by a national physician workforce body.

There is no question that, in light of limited financial resources and the continuing pressure to reduce federal spending, the Medicare program cannot continue to be the primary funding source for graduate medical education. While approaches such as a voucher system and/or an all-payer system may be viable alternatives, these and other ideas need to be thoroughly studied before they are widely adopted and implemented. Again, we believe a national physician workforce body should have the authority to study and develop recommendations on alternative systems for funding graduate medical education.

FRAUD AND ABUSE

In adopting the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the 104th Congress wisely included important fraud and abuse provisions requiring the Departments of Justice and Health and Human Services to issue advisory opinions on the application of anti-kickback statutes, clarifying the standard of proof required to impose civil money penalties, and provide an exception to the anti-kickback law for risk-sharing arrangements to facilitate the development of cost-effective, innovative delivery systems.

We are disappointed that the Administration intends to press for legislation repealing these important protections. The College strongly believes that fraudulent and abusive activities have no place in the practice of medicine, but physicians who intend to comply with the law can be greatly assisted by the setting of standards for appropriate behavior. HIPAA provides important guidance by requiring the Department of Health and Human Services to issue advisory opinions and special fraud alerts. This guidance will allow physicians, hospitals and insurers to develop integrated delivery systems that will benefit patients.

The burden of proof for imposition of civil money penalties established in HIPAA is identical to that used in the Federal False Claims Act. The College sees no reason why two statutes aimed at preventing the same fraudulent behavior should not have the same standards of proof. These provisions of the law provide significant protection for physicians who may unwittingly engage in behavior that is found to be impermissible.

The College believes Congress acted appropriately in enacting these important fraud and abuse provisions and strongly urges you to reject any efforts to repeal them.

HIGH-VOLUME INPATIENT PHYSICIAN SERVICES

The College is also disappointed that the Administration chose to include in its budget proposal a new elaborate layer of physician volume performance standards. The Administration would limit payments to medical staffs in hospitals if the volume and intensity of services per admission exceed 125 percent of the national median for urban hospitals or 140 percent for rural hospitals. Each physician in a hospital that exceeds the limits would have 15 percent of each payment withheld during the year. The physician could receive the withheld payments plus interest at the end of the year if they "collaborate to efficiently manage the volume and intensity of the services."

Such a proposal would lead to creation of a new and onerous structure based, at best, on limited, purely socio-economic data. It would require medical staffs to establish expensive fiscal and administrative structures to monitor care and provide incentives to reward the provision of the least amount of care, regardless of the care's effectiveness. Hospital admissions and physician inpatient services have continued

to decline for more than a decade. For patients who need hospitalization, physicians and other care givers should not be penalized for advocating appropriate care for their patients. This proposal is unnecessary, and the College strongly urges Congress to reject it.

SUMMARY

Pathologists support the efforts of Congress and this Subcommittee to achieve a balanced federal budget and to restore financial solvency to the Medicare program. We urge you to confront Medicare's underlying structural problems and avoid relying on further reductions in payments to health care providers to achieve short-term savings goals.

The College of American Pathologists hopes you will take this opportunity to address long-standing physician payment policies, including halting the January, 1998, implementation of resource-based practice expense relative values and immediately implementing a single conversion factors and performance standard. We strongly urge you to enact meaningful protections for patient choice and access in Medicare managed care plans. The College urges the Subcommittee to reject the Administration's proposals for competitive bidding for clinical laboratory services, for repeal of HIPAA fraud and abuse provisions and for limiting payments for so-called "high-volume" inpatient physician services.

College members look forward to working with you to achieve these goals and to serving as a resource for the Subcommittee in considering future Medicare payment policies. Thank you again for the opportunity to share our views on these important issues.