Testimony to the House Ways & Means Committee
on
Impact of Resource-based Practice Expenses, Other Physician Payment Issues

March 20, 1997

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 created 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 arerequired 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 primary 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 conversion 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 *derived 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.