HEALTH CARE FINANCING ADMINISTRATION

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REMARKS:

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAY 31 1995

James Todd, M.D.
Executive Vice President
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Dr. Todd:

I am writing to follow up on the Secretary's recommendations for the 1996 Medicare physician fee schedule update and the 1996 Medicare volume performance standards (MVPS) for physician spending. As you may know, the Secretary recommended that Congress establish a single physician fee schedule update of 1.1 percent for all physician services for CY 1996. This would require a statutory change. For the MVPS, the Secretary recommended FY 1996 rates of an increase of 2.0 percent for all physician services, - 1.8 percent for surgical services; 6.5 percent for primary care and 2.0 percent for other non-surgical services.

As you know, the Administration supports improvements to the MVPS and update frameworks, and I would like to work with you as we develop legislative and regulatory proposals for change. In particular, it is our intention to move toward the development of a single MVPS and update. Because of past differential updates, the surgical conversion factor currently is 8 percent and 14 percent higher than the conversion factors for primary care and non-surgical services, respectively. This state of affairs clearly undermines the original intent of the Medicare fee schedule.

Of course, we will need to consult other interested parties to consider how a transition would be made from the three separate conversion factors that currently exist to a single conversion factor covering all physicians' services. In addition, as you know, the Republicans' budget resolutions call for extraordinary reductions in Medicare spending of a magnitude that would imply significant reductions in payments to all providers. Rapid implementation of a single update might, in that context, have untoward consequences we can not fully anticipate. Preventing cuts of that magnitude should be a priority for all of us.

I have asked Tom Ault, Director of the Bureau of Policy Development, to meet with physicians' groups and other interested parties to discuss possible changes in the MVPS and update framework. We look forward to meeting with you to obtain more detailed suggestions on how best to develop an alternative and improved physician reimbursement methodology.

Sincerely,

Bruce C. Vladeck
Administrator

Primary Care/Family Doc AG

March 21, 1995

Honorable Donna Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Shalala:

The undersigned organizations, representing approximately 250,000 primary care physicians and medical specialists, are writing to urge you to recommend and implement changes in the Medicare fee schedule volume performance standards (VPSs) and update formulae to correct payment inequities that are undermining--even destroying--the intent of the resource based relative value scale (RBRVS).

In 1990, Congress mandated that HHS determine the volume performance standards for each category of services based upon five year volume trends for each category, respectively. HHS has continued, however, to use a common "all services" baseline in calculating the VPSs for each category of services. Although we understand that HHS initially did not implement this change because it did not have the data to track expenditures separately for each category, it is our understanding that such data were available and could have been used for the FY 1995 VPS calculations, and possibly for the FY 1994 VPSs. The Physician Payment Review Commission recommended last year that HHS use separate volume data for each category of services, and proposed VPSs based on the separate trends for each category. HHS declined, however, to accept this recommendation. Further, the PPRC recommended that Congress enact an update for 1995 that reflected what would have occurred had the FY 1992 and 1993 VPS been based on separate volume trends for each category. The administration did not support this recommendation.

According to the PPRC, use of a common volume baseline has resulted in significantly higher updates in the conversion factors for surgical procedures, and lower updates for primary care services and other nonsurgical services, than would have been the case had category-specific volume trends been used as required by OBRA 90. This has also magnified the distortions and inequities created by having separate updates and conversion factors for each category. The PPRC projects that continued use of a common volume baseline will result in the 1997 conversion factor for surgical procedures being 26.5 percent higher than primary care services and 29 percent higher than "other nonsurgical" services.

In the past, HHS has expressed its belief that OBRA 90 gave the Department the option of using either a common volume baseline or separate baselines for each category of service. We do not believe that is a correct reading of the statute. The PPRC agrees with us that OBRA 90 required use of separate volume baselines for each respective category of service. The common volume baseline can only be used to determine the "all services" VPS, which has no practical bearing on the updates for each category of service.

We believe that the agency must take steps now to bring the conversion factors back to where they should have been had the requirements of the law been followed. We specifically recommend that HHS:

1. Publish a notice in the Federal Register that corrects the FY 1995 VPSs by recalculating them based on separate volume trends for each category of services, as required by OBRA 90. Since the FY 1995 VPSs were announced only three months ago, there is still time to make this correction before too much of the fiscal year has passed.

We do not believe that HHS needs congressional approval to make this change, since OBRA 90 not only gives HHS the authority to base the VPSs on volume trends for each respective category, but requires that you do so.

2. Calculate the FY 1996 default VPSs based on separate volume trends for each category. Since this would follow the requirements of OBRA 90, we do not believe that this change requires congressional action or publication of a proposed rule.

3. In the department's upcoming report to Congress, due on April 15, provide calculations on what the conversion factors for CY 1996 would have been had the VPSs for FY 1993 and 1994 been based on separate volume trends for each category of service. HHS should propose an update for calendar year 1996 that results in the conversion factors being equal to what would have occurred had the OBRA 90 requirements been followed. Now that historical data on volume trends within each category are available, it is incumbent on the administration to propose changes that bring the conversion factors to the level that were intended when Congress enacted the OBRA 90 requirements. It must be noted that these changes will not recoup the losses incurred by physicians who were underpaid for their primary care and other nonsurgical services for the past two calendar years.

We cannot stress more how important it is that HHS take steps to correct the inequities created by its practice of calculating the VPSs in a way that is in conflict with OBRA 90. The errors made in calculating the VPSs are destroying most of the shift toward primary care services intended under the RBRVS, and have unfairly reduced payments for other nonsurgical services as well. There is no justification for not taking steps now to correct those mistakes.

Finally, we welcome the opportunity to meet with you and/or HCFA administrator Bruce Vladek to discuss our concerns and recommendations in more depth.

Sincerely,

American Academy of Allergy, Asthma, and Immunology
American Academy of Family Physicians
American Academy of Neurology
American Academy of Pediatrics
American Association of Clinical Endocrinologists
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Physicians
American College of Preventive Medicine
American College of Rheumatology
American Gastroenterological Association
American Geriatrics Society
American Medical Directors Association
American Osteopathic Association
American Society for Gastrointestinal Endoscopy
American Society of Clinical Oncology
American Society of Hematology
American Society of Internal Medicine
Infectious Disease Society of America
Joint Council of Allergy and Immunology
Renal Physicians Association
Society of General Internal Medicine

A healthy place

In a turbulent practice environment, Louisville, Ky., physicians turn to community health outreach to restore medicine's rewards.

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the damage cap is far from over, they added.

All of the reforms were introduced earlier this month as amendments to a product liability measure sponsored by Sens. Jay Rockefeller (D, W.Va.) and Slade Gorton (R, Wash.). Tort reform advocates had hoped to replicate their victory in the House in March, when a Joseph Lieberman (D, Conn.), the measure passed by a six-vote margin, 53-47.

But at press time, the ultimate fate of this amendment, and several others, was unclear. Their enactment hinged on passage of the product liability bill to which they were attached, an outcome that was far from certain.

the attorney who tries for the big jackpot."

But Kyl was up against several staunch tort reform opponents, including the sponsors of the product liability bill and Sen. Edward Kennedy (D, Mass.).

"In urging ill-considered malpractice

See ***TORT REFORM****, page 26*

Supreme Court lowers barrier to health reform

Ruling in N.Y. ERISA case gives more power to states

By Julie Johnsson
AMNEWS STAFF

In a surprise move, the U.S. Supreme Court last month unanimously broadened states' power to regulate employee benefit plans.

The landmark decision could give new life to stymied state efforts to reform health delivery, oversee managed care and devise creative funding mechanisms to cover charity care costs, analysts say.

It also gives state lawmakers new recourse against an old nemesis: the Employee Retirement Income Security Act. The federal law insulates more than two-thirds of all benefit plans from direct state oversight.

The justices upheld a New York surcharge on hospital rates paid by commercial insurers and HMOs, ruling that plans couldn't claim an ERISA preemption for provider taxes and other state rules that carry only an "indirect economic effect."

This "should give state and local governments greater power to regulate the economics of health care delivery," says D. Bruce La Pierre, a St. Louis attorney who filed an amicus brief in the case for the National Governors' Assn. and state and local governments.

See ***ERISA****, page 28*

Primary care may face Medicare pay cuts

By Sharon McIlrath
AMNEWS STAFF

WASHINGTON — Unless Congress steps in, payments for the four visit categories Medicare calls primary care are likely to fall by about 2% next January.

Numbers may change slightly between now and then. At this point, however, it appears that unless Congress overrides the formulas that usually dictate Medicare updates, payments for home, office, nursing home and emergency department visits will drop by 2.2%. At the same time, calculations for the Physician Payment Review Commission suggest, surgical payments will rise by 3.9% and other nonsurgical services by 0.6%.

Seniors likely to pay more. Page 3
GOP still looking for savings. Page 25

A decline in Medicare's physician payment rates has been expected and over the next few years is projected to encompass all services. But due to an as-yet-unexplained spending jump by the end of 1994, the drop now facing primary care is sooner and sharper than anticipated, and ironically will hurt some of the very services payment reforms were supposed to benefit.

As a result, the commission is urging lawmakers to drop the three separate service categories and boost all 1996 payments by 1.1%. But Congress has consistently ignored past PPRC and AMA efforts to move to a single update, and whether the latest news will inspire action in a Congress embroiled in a debate over Medicare's future remains to be seen.

PPRC and the AMA also have warned lawmakers that laws passed in 1993 are about to set off a period of annual reductions in Medicare payment levels, so that within 10 years all doctors will be paid less per service than they were in 1992 (*AMNews*, April 17). Thus far, however, lawmakers have paid little heed to an impending nosebleed in physician payments.

To stem the bleeding entirely would increase Medicare expenditures at a

See ***PAY****, page 25*

Projected default fee updates

Medicare's default formulas would lead to separate updates for each of the three categories of service shown below. PPRC is recommending they all get the 1.1% weighted average instead.

	Surgery	Primary care	Other nonsurgical	Average
1994 performance standard	9.1%	10.5%	9.2%	9.3%
1994 expenditure growth	7.4%	14.9%	10.8%	10.7%
1996 default update *	3.9%	-2.2%	0.6%	1.1%

* Assumes increase of 2.2% in Medicare economic index.

GOP still looking for Medicare savings

WASHINGTON — After a delay to build political support, congressional budget committees are proceeding with budget-balancing plans that call for unprecedented Medicare savings.

Budget panels in both houses had targeted the program for $250 billion to $300 billion in savings over seven years. But they had hoped to first convince voters the drastic action is needed to stave off bankruptcy.

Democrats have argued this could be done at far lower cost if the GOP wasn't also intent on tax breaks that benefit the wealthy at the expense of seniors, who typically have income under $25,000 a year. Moreover, they add, Republicans showed no similar sense of doom when a similar report was issued on President Bush's watch in 1990.

Recent polls for the American Hospital Assn. and by *Wall Street Journal*/NBC News showed these arguments were gaining ground. Republicans began a full-court press, scheduling a series of briefings and hearings in response.

The Senate Budget Committee postponed deliberations to give other committees time to highlight Medicare's fragile financial health with hearings on a new Medicare Trustees report that predicts hospital trust fund insolvency by 2002. But before the hearings could be held, House Majority Leader Newt Gingrich (R, Ga.) and his Senate counterpart Bob Dole (R, Kan.) had second thoughts. By April's end, both concluded that Medicare restructuring should be handed over to a commission and kept out of the budget debate.

At press time May 3, however, the two reportedly still disagreed on the commission makeup and mandate. They walked out of a press conference staged to call for White House cooperation in rescuing the trust fund when asked how the GOP goal of a balanced budget could be met without big Medicare savings.

In the meantime, the Senate budget panel was making plans to resume budget work, and its House counterpart reportedly had nearly finished with a plan calling for about $300 billion in Medicare savings over seven years. The panel is expected to recommend increasing beneficiaries' out-of-pocket liability and moving more seniors into managed care.

A May 2 Ways and Means Committee hearing on the trust fund report turned into a partisan battleground. Republicans challenged HHS Secretary Donna Shalala, PhD, to unveil an administration formula for rescuing Medicare from insolvency; she replied that restructuring should be done as part of systemwide reforms and that it's not up to the administration to tell Republicans what to put in their budget proposal.

A reinvigorated Rep. Pete Stark (D, Calif.), who's found life as a minority member particularly hard to swallow, advised the secretary and other Clinton officials to continue letting Republicans "stew in their own juice."

—Sharon McIlrath

Pay

Continued from page 1

time when Republican leaders want to clamp down on federal spending. Protecting fee-for-service medicine is somewhat at odds with a prevalent GOP desire to move more beneficiaries into managed care.

On the other hand, about 90% of the elderly and disabled still are treated by doctors paid a fee for service. Medicare's payments to those doctors already are a third lower than those of most private plans. Further fee assaults thus could jeopardize access to care, particularly among primary care doctors who already are disappointed with the results of payment reform.

In addition, HMO payment rates currently are tied to fee-for-service averages. That could change eventually. But for the short run, any drop in fee-for-service rates will drive down HMO rates and thus could hinder, rather than help, efforts to move more Medicare beneficiaries into managed care.

The case for overhaul

Weighing all those countervailing factors, PPRC at its April meeting resolved to renew its call for a major overhaul in the physician payment rules Congress enacted in 1989.

The problem, in the commission's eyes, is not with the resource-based relative value scale but with the spending limits or volume performance standards that accompanied the RBRVS.

Much of the difficulty stems from the fact that lawmakers rewarded the American College of Surgeons for supporting the VPS by creating a separate standard for surgery. In each of the last four years, surgery has won higher increases than other services, and it has been clear for several years that surgeons are regaining through the VPS what they lost in the RBRVS.

To deny surgeons the higher increases might undermine the VPS and doctor confidence in lawmakers' promises. But to continue that will undo the RBRVS, since it leads to a situation where Medicare pays more per unit of value in surgery than other services.

Congress hasn't wanted to tackle the dilemma head-on, however, and up to now lawmakers have preferred to tinker with the system rather than overhaul it. PPRC, in its annual recommendations on next year's performance standards and fee updates, will advise the lawmakers in the strongest terms yet that tinkering hasn't worked.

The recommendations, due May 15 each year, are supposed to follow and react to a similar report due April 15 from Health and Human Services. That report is hung up at the Office of Management and Budget, so as always, the HHS contribution is late.

That complicated PPRC's deliberations. But Medicare has become the latest game of political chicken, and until either side blinks, decisions over either the direction or details of the program aren't likely anyway.

What default formulas would mean

Such delays already have put lawmakers seriously behind schedule in the development of a 1996 budget. The passage of time isn't likely to enhance their taste for digging into the minutiae of Medicare's physician payment scheme. And if they do nothing, the so-called default formulas will kick in.

It's too early to say for certain what the results will be. At this point, however, it appears that surgical spending rose by 7.4% in 1994, primary care by 14.9% and other services by 10.8%. That puts surgery 1.7 percentage points under its 9.1% VPS, primary care 4.4 points over its 10.5% standard and other services 1.6% above their 9.2%.

Under the default formula, each category is to receive an update equal to that difference between actual spending and the standard plus an adjustment for inflation in physicians' practice costs. The Medicare Economic Index, which serves as an inflation proxy, is expected to rise by 2.2%.

Hence, surgical payment levels would rise by 3.9% in January, primary care payments would fall by 2.2% and other services would rise by a slight 0.6%. When adjusted to reflect each category's proportion of total physician expenditures, that averages out to a 1.1% increase overall.

Exactly what will happen with the volume standards is not clear. There's room for interpretation, and HHS may modify the way it calculates the VPS defaults. The best guess at the moment, PPRC senior analyst Sally Trude told members, is that the standards will be -0.1% for surgery, 3.4% for primary care and 1.4% for other services.

That produces a weighted average of 2% across all services and is well below the 7.5% average for 1995. Standards also are projected to become tighter each year until there is virtually no way doctors can remain within them, and annual payment reductions are guaranteed. The explanation lies in the budget law, which increased a so-called performance factor in the VPS.

That formula factors in five-year volume growth, projected growth in the Medicare population and the impact of pay and legislative changes. The performance factor, which the 1993 law increased to four percentage points, is subtracted to encourage doctors to cut Medicare expenditure growth.

This means that any time growth is stable, five-year trends eventually will equal actual volume growth, and after the performance factor is subtracted, actual increases always will exceed the standard by 4%. The fee update formula combines that negative 4% with a positive inflation adjustment of around 2%, setting up a situation where payment rates are likely to fall by 2% every year.

Are formulas necessary?

It could be argued that the automatic formulas are a coward's way out. As outgoing PPRC head John Eisenberg, MD, said, "An ideal world wouldn't have a default formula so [Congress] can chicken out."

But the default formulas have dictated the updates and spending limits in most of the years since reforms were enacted. So, as Harvard economist and Commissioner Joe Newhouse, PhD, put it, "The problem with not having a default is that the government's past record makes it too risky."

That means the formulas are here to stay. Most of the commissioners agree with Kaiser Vice President and Commissioner Richard Anderson's conclusion that the resulting payment rates are "just not viable."

But savings from current formulas already have been "scored," and anything that stops the downward pay drift will be viewed as adding to spending.

That's almost certainly a nonstarter. So the commission will enter any fight to modify the formula with one hand tied behind its back. There are ways to redistribute payment gains and losses, however, and small increases in physician fees could come again after the current five-year budget cycle ends.

Proposal: Back to single standard

Moreover, as PPRC has argued repeatedly, the current formulas are nearly unintelligible. They have bounced around from year to year. And they are rapidly undoing the RBRVS. It's therefore desirable, the commissioners believe, to rewrite them even if that doesn't stop the payment freefall.

They would start by returning to a single performance standard and a single update for all. In other words, all payments would be increased by 1.1% in 1996, and all would have a 2% VPS.

The end result is that primary care would get a higher fee update and a lower standard than if the default formulas prevail. Surgery's fee update would be lower and its standard higher. The other services would get slightly higher updates and standards.

PPRC also wants to tie the VPS to a more predictable measure — the increase in the gross domestic product. But that would produce higher updates than the current formula. So to stay within the current budget, the formula in the early years would have to be set at GDP minus a percent or two. But as Trude noted, it also could be set to rise gradually over time until it reached the commission's ultimate goal of GDP plus one or two percent in the years outside the five-year budget window.