Mr. McDermott. Thank you, very much.
Dr. Moorefield.

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

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

I am Dr. James Moorefield, and I am a radiologist from Sacramento, Calif., and chairman of the board of chancellors of the American College of Radiology. I appreciate the opportunity to share our feelings on the Bush administration's proposed Medicare fee schedule for 1992.

The ACR believes that the fee schedule, as proposed 3 weeks ago by the Health Care Financing Administration, is virtually a complete violation of the intent and spirit of physician payment reform. There are many issues in the fee schedule to which we object. I will concentrate on four and ask that we have the opportunity to submit further comments to the subcommittee in the coming days.

The proposed fee schedule ignores the fact that physician payment reform began 4 years ago. Radiology procedures, among others, have been subjected to reductions over the last 4 years. These reductions have been made under legislation aimed at reform of Medicare payments to physicians. None of these prior reductions have been taken into account in the proposed fee schedule. For radiologists this amounts to an additional 18 percent.

OBRA of 1990 determined remaining reductions in radiology payments through 1996 to be of the order of 13 percent, and 9 percent of this has already occurred in 1991. It is unconscionable that the administration has chosen to ignore the significant reductions that we have already contributed to physician payment reform. If this fee schedule were to be implemented, radiology procedures in 1996 would be reduced by 50 percent from the 1988 base year used in physician payment reform studies. No study, public or private has ever categorized radiology procedures as overvalued by 50 percent.

The second issue of concern to us is the transition offset. A reduction of greater than 6 percent has been made to the conversion factor because of HCFA's interpretation of the transition rules contained in the law, and the legal requirement for budget neutrality. Again, HCFA has ignored the fact that some specialties and some procedures began the transition in physician payment 4 years ago.

We, too, believe it was the intent of Congress that the whole of physician payment reform be budget-neutral and that it be phased in, in a reasonable way, not that some specialties should experience additional cuts in implementing the reform.

The next issue we must address is the behavioral offset. To our knowledge, HCFA has never published data or analysis subject to public review and scrutiny which justifies their contention of a 50-percent volume response to payment reductions. In fact, Medicare's data, BMAD data for radiology, if we might give that as an example, since the radiology fee schedule was implemented has shown an abatement of growth of volume of radiology procedures since that time.

I also would like to note that the PPRC has recommended a 1-percent behavioral offset instead of HCFA's 3 percent. Therefore, it is clear that before such an adjustment is made to conversion factors there should be a thorough study of behavioral response that offers data and analysis that can support it. This study should be subjected to public scrutiny before a behavioral offset is used.

The final issue we must address is that of geographic practice cost adjustments. While we are aware that HCFA has utilized indices to adjust for differences in practice costs across the country, these adjustments become meaningless in light of the reductions described above. For those physicians practicing in areas where payments have been historically suppressed, there is no relief from the historical bias. Rural physicians have little to cheer about when told by HCFA that their payments will be adjusted to more equitably reflect the differences in practice costs, when their conversion factor has been slashed more than 16 percent. And if they are radiologists the value of their procedures has been subjected to a double reduction for overvaluedness.

Mr. Chairman, in 1987, my colleague and former president of the American College, Dr. Joseph Marasco, appeared before this subcommittee and discussed with you the possibility of the American College of Radiology working with the Congress and HCFA to devise a fee schedule for radiology services.

The Congress agreed and we have spent the last 3 years working with HCFA and American radiologists to make a fee schedule for Medicare work. It has required a great deal of effort and sacrifice. We agreed to work with you because we sincerely believed we could develop a payment scheme that was fair and equitable. Until June 5, 1991, we believed we were doing just that. The Bush administration's proposed fee schedule is an outrageous violation of our mutual goals. We ask for your support and your assistance in putting physician payment reform back on the right track.

Thank you.

[The prepared statement follows:]

Statement of the
American College of Radiology
to the
U.S. House Ways and Means
Subcommittee on Health

Presented by James M. Moorefield, M.D.
Chairman, ACR Board of Chancellors

June 25, 1991

The following comments are submitted on behalf of the over 20,000 physician members of the American College of Radiology. The comments are submitted concerning the Bush Administration's proposed rule in implementing a Medicare fee schedule for physician services as published in the *Federal Register*, June 5, 1991.

Thank you Mr. Chairman. I am James Moorefield. I am a radiologist from Sacramento and chairman of the Board of Chancellors of the American College of Radiology. I appreciate the opportunity to share our feelings on the Bush Administration's proposed Medicare fee schedule for 1992.

The ACR believes that the fee schedule, as proposed three weeks ago by HCFA, is a total violation of the intent and spirit of physician payment reform. The Bush Administration's action on the physician fee schedule is nothing short of draconian.

There are many issues in the fee schedule to which we object. I will concentrate on four and ask that we have the opportunity to submit further comments to the subcommittee in the coming days.

The proposed fee schedule completely ignores the fact that physician payment reform began four years ago. Radiology procedures, among others, have been subjected to reductions over the last four years. These reductions have been made under legislation aimed at reform of Medicare payments to physicians. None of these prior reductions have been taken into account in the proposed fee schedule. For radiologists, this amounts to an additional 20 percent cut.

It is unconscionable that the administration has chosen to ignore the significant reductions that we have already contributed to physician payment reform. If this fee schedule were to be implemented, radiology procedures in 1996 would be reduced by 50 percent from the 1988 base year used in physician payment reform studies. No study, public or private, has ever categorized radiology procedures as overvalued by 50 percent.

The second issue of concern to us is the transition offset. A reduction of greater than ten percent has been made to the conversion factor because of HCFA's interpretation of the transition rules contained in the law and the legal requirement for budget neutrality. Again, HCFA has ignored the fact that some specialties and some procedures began the transition in physician payment four years ago. We believe it was the intent of Congress

that the whole of physician payment reform be budget neutral and that it be phased-in in a reasonable way, not that some specialties should experience additional cuts in implementing the reform.

The next issue we must address is the behavioral offset. To our knowledge, HCFA has never published data or analysis for public review and comment which justifies their contention of a 50 percent volume response to payment reductions. In fact, Medicare actuary's data show that volume growth has been slightly slower from 1984 to the present, than for the period before 1984. Obviously, from 1984 to 1991, Medicare fees have been significantly constrained. This data contradicts the volume response contention.

I also note that the Physician Payment Review Commission recommended a one percent behavioral offset instead of HCFA's 3 percent. It is clear that before such an adjustment is made to conversion factors, there should be a thorough study of behavioral response that offers data and analysis to support it. This study should be subjected to public scrutiny before a behavioral offset is used.

The final issue we must address is that of geographic practice cost adjustments. While we are aware that HCFA has utilized indices to adjust for differences in practice costs across the country, these adjustments become meaningless in light of the reductions described above. For those physicians practicing in areas where payments have been historically suppressed, there is no relief from the historical bias. Rural physicians have little to cheer about when told by HCFA that their payments will be adjusted to more equitably reflect the differences in practice costs, when their conversion factor has been slashed more than 16 percent. And if they are radiologists, the value of their procedures has been subjected to a double reduction for overvaluedness.

Mr. Chairman, in 1987, the American College of Radiology (ACR) appeared before this subcommittee and discussed with you the possibility of the ACR working with the Congress and HCFA to devise a fee schedule for radiology services. You agreed. The Congress agreed and we have spent the last three years working with HCFA and American radiologists to make a fee schedule for Medicare work. It has required a great deal of effort and sacrifice.

We agreed to work with you because we sincerely believed we could develop a payment scheme that was fair and equitable. Until June 5, 1991, we believed we were doing that. The Bush Administration's proposed fee schedule is an outrageous violation of our mutual goals. We ask for your support and assistance in putting physician payment reform back on the right track.

Thank you Mr. Chairman.