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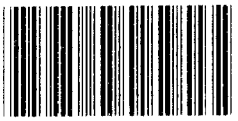

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STATEMENT OF

THOMAS G. DOWDAL, GROUP DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ON

PHYSICIAN PAYMENT RATES UNDER MEDICARE'S END STAGE RENAL DISEASE PROGRAM

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss GAO's report on physician payments under Medicare's End Stage Renal Disease (ESRD) program.[1] As you requested, I will be addressing only that portion of the report that deals with establishing the level of the Monthly Capitation Payment (MCP), the Medicare payment a physician receives each month for each ESRD patient he or she treats. Our findings were the basis for the Department of Health and Human Service's (HHS's) July 2, 1986, revision of the MCP. Basically, we found that HHS's original computation of the MCP resulted in a rate that was too high because the computation overstated physician involvement with patients' dialyzing at home.

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[1] Changes Needed in Medicare Payments to Physicians Under the End Stage Renal Disease Program, GAO/HRD-85-14 and GAO/HRD-85-14A, February 1, 1985.

In 1983 the MCP was computed by HHS based on the average estimated physician involvement with ESRD patients, weighted by the national percentage of patients who dialyze at home and at facilities. Generally, physicians have less involvement with home patients than with facility patients. To recognize this difference, HHS estimated that a physician could care for about 10 home patients for every 7 facility patients, a ratio of 1.4 to 1. This ratio was based on medical advice received by HHS in 1974.

We sent a questionnaire to a national, statistically valid sample of physicians who provided renal services to ESRD beneficiaries to evaluate, among other things, the accuracy of the 1.4 to 1 ratio. We selected the sample size so the overall sampling error would be no more than $\pm$ 0.8 percent at the 95 percent confidence level. We asked the physicians the number of monthly contacts they had, in person and on the telephone, with renal patients and the length of time spent with each patient.

The results of our questionnaire showed that physicians had much less involvement with home patients than the 1.4 to 1 ratio that HHS used to compute the MCP. The physician-supplied data showed that physicians could treat 3.9 home patients for every facility patient, a ratio of 3.9 to 1.

We recomputed the MCP, using our ratio and HHS's methodology and found that on the average the MCP was overstated by about $14 and that using our ratio would reduce annual MCP

payments by about $11.8 million. We recommended in our February 1985 report that HHS modify the MCP rate by taking into consideration our data on relative physician involvement with home and facility patients. HHS's July 2, 1986, MCP rate revision did so.

That concludes my prepared remarks and I would be happy to answer any questions you may have.