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WHERE MONEY AND MEDICINE MEET: A CONVERSATION WITH HCFA ADMINISTRATOR CAROLYNE K. DAVIS

by John K. Iglehart

Prologue: For four grueling years, Carolyne K. Davis has presided over the Health Care Financing Administration (HCFA), the federal agency charged with managing Medicare and Medicaid. Davis is the first woman manager of HCFA and has served in the post for more than four years, a period that is longer than all of her predecessors combined. Davis came to the federal government with solid Republican credentials and a diverse background in academic medical administration. But her stewardship at HCFA has been particularly challenging for several reasons. The agency was directed by Congress to implement in short order a new Medicare payment mechanism, the policy object of which was to encourage hospitals and doctors through economic incentives to moderate the cost of medical care. HCFA assumed this task during a period of bureaucratic stress—while the Reagan administration has sought, in the context of the president’s general effort to reduce the size of government, to pare the agency’s workforce. Another reality that has complicated HCFA’s life has been its loss of influence to the Office of Management and Budget on policy issues of almost any consequence. Davis has been called on time and again to defend the policies of the Reagan administration on Capitol Hill, a task that comes with the territory of a political appointee, but in some instances those policies reflect more of the administration’s overall goal to reduce spending than they do sound management practices. Generally speaking though, Davis’s own thinking reflects well the administration’s steadfast belief in the marketplace as the chief allocator of resources in the medical sphere. This interview very much reflects that belief.
Q: You have been administrator of the Health Care Financing Administration (HCFA) longer than any other individual. You are a survivor. What do you regard as your major achievements?
A: Two activities spring to mind. The design and implementation of Medicare’s prospective payment system is clearly the major, long-lasting achievement of my stewardship. But I also regard as important my emphasis on engaging the agency in a broader and continuing dialogue with our publics—the beneficiaries, the doctors, the hospitals, and a range of other private and public interests. I regard my open door policy as one of great importance in an era of skepticism toward government.

Q: Prospective payment, as you well know, is being implemented. The movement toward a national payment rate based upon diagnosis-related groups (DRGs) is underway. Some hospital organizations—the American Hospital Association (AHA), some of its state affiliates, the National Association of Public Hospitals, the Council of Teaching Hospitals, and the Catholic Health Association, for example—are calling for a delay in implementation of the national rate, arguing that its financial impact on their member institutions would be too severe. Can you conceive of a situation that would prompt the administration to agree to a delay?
A: At the moment I cannot because I have seen no convincing data that suggests we ought to slow down the system. That doesn’t preclude the possibility, of course, that if someone came forward with positive data we could consider some delay in the future. In any event, I have concerns with the current AHA proposal which argues for delay. I do not think it places an appropriate incentive on hospitals to change their behavior. Indeed, I think it takes a step backward in terms of the incentives it offers hospitals to change behavior.

Q: Recently, several academic researchers (Alain C. Enthoven and Roger G. Noll, who wrote “Prospective Payment: Will It Solve Medicare’s Financial Problem?” in Issues in Science and Technology, Fall 1984; Drs. John E. Wennberg and Philip Caper, who wrote on DRGs in The New England Journal of Medicine, August 2, 1984; and Henry Aaron, who wrote “Prospective Payment: The Next Disappointment?” in Health Affairs, Fall 1984) have questioned the potential of the DRG-based payment mechanism to achieve substantial cost savings. Their arguments focus on the notion that the absence of controls on the volume of services will greatly limit the cost-savings potential of prospective payment. What is your view on this question?
A: We really thought we would see an increasing volume of services delivered because, obviously, if Medicare pays on a per case basis, one way for a hospital to maximize revenue is to increase its admissions. We all know that the number of admissions has been going down, not up, over the last year. HCFA has also imposed what we regard as a very strong volume control because we recognized that if the system was left unfettered, there might be hospitals that would push their volumes upward. These
controls come through the intermediaries’ monthly monitoring of admission patterns hospital-by-hospital, and if trouble spots are identified that need closer attention, peer review organizations assign physicians to examine medical charts in particular hospitals to determine whether questionable admissions were indeed appropriate. Having said this, though, we do recognize that the drop in admissions does not stem from prospective payment alone. Other forces—the movement to alternative ways of delivering medical care, increased competition through health maintenance organizations (HMOs), and other newer forms of provider delivery systems—are all interacting to draw down admissions.

Paying Physicians Under Medicare

Q: Medicare’s Part B (physicians’ services) is coming under closer scrutiny by the administration and Congress. What is your own view of the need to reform the way Medicare pays doctors?

A: Medicare’s Supplementary Medical Insurance (Part B) has been growing at a rate of 16 to 18 percent a year. In 1985, Part B will be the third largest federal domestic program ($25 billion), exceeded in size by only Social Security cash benefits and Medicare’s hospital insurance program. In FY 86 it is estimated to be the largest percent increase in the domestic side of the federal budget. Roughly 44 percent of the recent growth in Part B has derived from an increase in the utilization of services. HCFA has concluded that any policy approach that strives to get a handle on Part B rate of growth must include incentives to moderate the intensity of services delivered. Congress mandated in the Social Security Amendments of 1983 that HCFA study the advisability and feasibility of using a DRG measure to pay physicians for the inpatient services they render. We have found that 64 percent of the dollars Medicare pays physicians are for inpatient services. However! if we are to determine advisability as well as feasibility, how can we possibly know advisability unless we look at the entire spectrum (inpatient and outpatient services) of physician reimbursement because almost 40 percent of the dollars are paid out for ambulatory care? Therefore, we are examining many alternatives. One alternative is the establishment of a physician fee schedule, but, of course, that would control only price and not necessarily volume, unless we sought to impose a sentinel effect by monitoring volume in some fashion.

Q: Would the establishment of a fee schedule, as you envision it, lock in the payment differentials which now exist between, say, a family practitioner and a surgeon?

A: Yes it would, unless the fee schedule was modified through a relative value scale. (A relative value scale is a table of weights which defines the relative prices of procedures; a conversion factor changes the relative value into a dollar price and thus converts a relative value scale into a fee
schedule.) One could design a relative value scale and then either concurrently or later modify the fee schedule accordingly. This is a very complex set of issues. It would be my hope that through a body of very responsible physicians, HCFA could create a relative value scale using the collective judgments of the various medical specialties if they can agree somehow.

Q: The American Medical Association (AMA), as well as other physician organizations, would very much like to be granted the responsibility of developing a relative value scale that could be used to establish Medicare’s fees for doctors. To whom is HCFA likely to give that assignment?
A: A number of organizations, including the AMA, have expressed an interest in undertaking that task. HCFA’s central question is how can we involve physician organizations in this task when there are obviously antitrust considerations involved. We have been talking to the Federal Trade Commission (FTC) about trying to establish what role, if any, is appropriate for organized medicine in this regard. The FTC does not have a problem with a group of physicians offering advice in terms of development of a relative value scale. But when it comes to relating that scale to a payment mechanism, the FTC has a definite problem.

Q: Clearly, you must be sensitive to the fox in the chicken coop phenomenon?
A: Yes, absolutely. Part of our discussions right now are with a number of parties, including the FTC, to set the appropriate parameters for physician participation. However, it will be done with an arms length transaction utilizing some research institution to work with both HCFA and the physician community rather than with one physician group directly. I think development of a relative value scale needs to be done.

Q: The physician fee freeze which Congress imposed as a part of the Deficit Reduction Act expires in October 1985. Would you think it highly unlikely that the federal government will go back to conducting business with doctors as Medicare did before the freeze?
A: Yes, it is clear that both the administration and Congress have real concerns with the growth of Part B. If one recognizes that about 75 percent of the Part B dollar derives from general fund revenue, and further recognizes the overall problem with the federal deficit, it seems unlikely that Congress will leave Part B untouched. The recommendation for another year of physician fee freeze is simply a way to buy time and control escalating costs while we design an appropriate mechanism of reimbursement reform for the Part B services. We anticipate launching several demonstrations this year that will test such ideas as paying physicians based on hospital DRGs as well as structuring capitation systems by geography.

Q: The notion that the government would transform the way Medicare pays doctors through the imposition of DRGs has greatly disturbed the medical profession. Putting aside the obvious political problems involved, has HCFA deter-
mined that using DRGs to pay physicians is technically feasible?
A: Yes, on the surgical side, it seems quite feasible. We have been working with some of our outside contractors, and they have established a high degree of correlation between diagnostic groupings and appropriate payment levels. It should not surprise us, really, that the surgical DRGs correlate quite highly because many of the surgical fees tend to be global. Even on the medical side, our researchers advise us that the correlation between cost and DRGs is relatively good. The correlation is at least as high as the hospital DRG system. The more interesting question at the moment is, is paying physicians by DRGs advisable for the inpatient services they provide? If we implement such a system we will only have reformed a portion, about 64 percent, of the physician payment system. What should we do about payments for ambulatory services? These are some of the interesting questions we are now pondering.

Q: You meet regularly with a physician advisory group that you find very useful as a sounding board. What is their collective view on the need for reforming the way physicians are paid? Do they generally believe that change is necessary?
A: Yes, I think they have come to an agreement or a consensus on the need for reform. We have a group of about eighteen doctors from around the country that represent various disciplines and various points of view. They have spent many Saturdays with me talking through issues. Sometimes it gets quite lively! It would not be accurate to say, necessarily, that members of this group favor change, but it has become quite clear that they seem to be accepting the idea that the inevitable needs to happen. They have come to the realization that the payment system as we know it is inherently inflationary; it also has some inequities in it that government as a payer of physicians’ services has a responsibility to straighten out. As you would expect from such a diverse group there is not unanimity concerning what the best solution for structural reform should be.

Q: The department recently (January 10) published final regulations implementing a provision of the Tax Equity and Fiscal Responsibility Act (TEFRA) which encourages Medicare to contract with HMOs for the provision of medical care to eligible beneficiaries. What is your expectation in terms of the future growth of older people in HMOs?
A: We anticipate there will be substantial enrollment growth. Our projections estimate about 600,000 Medicare beneficiaries will enroll in HMOs over the next three years, and I regard that as a very conservative projection. As I have discussed this provision with people around the country, I have become aware of a much higher level of interest among providers than we had anticipated. Our beneficiaries find this new option attractive, too. HCFA’s demonstrations of this concept have proven that to us. There is little or no paperwork that beneficiaries must fuss with, they have a one-stop service delivery site in place of visiting physicians in
many different office locations. And generally, HMOs offer an enriched benefit package that goes beyond the minimum Medicare package. I anticipate that HMOs will become very popular with a significant portion of the elderly population as a consequence of this provision.

**Reimbursement For Heart Transplantations**

Q: Recently HCFA received a final report from the Battelle Memorial Institution on the question of whether or not Medicare should reimburse providers for heart transplantations performed on eligible beneficiaries. How will your agency approach this difficult policy question?

A: The final report stands about three feet high, and it is filled with excellent data. We have just finished analyzing it. Part of HCFA’s decision regarding coverage is an assessment by the Public Health Service on the efficacy of this procedure with the central question being, is heart transplantation still regarded as experimental by the medical profession? We also must evaluate issues that relate to the quality of life of people who undergo transplantation, and the Battelle study will be very useful in this part of our deliberations.

Q: I assume that in the context of the department’s assessment of these questions one issue the agency will face is whether or not every medical center that wants to do heart transplantation will be automatically reimbursed for such procedures, assuming that HCFA authorizes payment for it?

A: That’s a very tough question, but yes, you’re right; we will have to ponder that issue. If HCFA ended up declaring that only certain centers would be eligible for payment, that would raise many legal questions. I doubt whether we have the authority to make such judgments without new legislation.

Q: Yes, but Congress was more than willing to provide HCFA that kind of authority last year; however, the administration opposed enactment of such a provision.

A: That’s true, but even if we did have the authority I am not sure we have the expertise to make those kind of decisions. And yet, on the other hand, it’s really quite troubling because anyone who looks at the data sees that some centers clearly have better outcomes in performing heart transplantations than do others.

Q: So, it is not simply a cost question in your mind. The quality dimension is important, too?

A: Very definitely. I think it’s more importantly a quality question. I am always troubled by the expressed notion that HCFA does not know how to define who are the “so-called experts,” yet if government leaves this question unanswered I really worry about beneficiaries who might end up in medical centers where outcomes (of heart transplantations) are less than the best.
State Waivers And Competitive Bidding

Q: HCFA has granted many waivers that allow state agencies and other organizations to experiment with new approaches under Medicare and Medicaid. Will there be a continuation of this liberal policy toward waivers, or is the agency likely to tighten up in this regard?
A: We approve several different kinds of waivers. One kind, the programmatic waiver, relates primarily to Medicaid, and has allowed states, for example, to waive the freedom-of-choice provision so that they could experiment with enrolling eligible beneficiaries in closed-panel health plans, such as HMOs. These kinds of waivers will continue, although we will tighten our assessment of their cost effectiveness. On the research side, HCFA will continue to grant waivers in targeted areas of interest. We continue to have interest in such areas as competitive bidding. We need a lot of demonstrations in this particular area, not just with states as we've done with both Arizona and California, but even more with specific and discrete entities. For example, we could take a whole class of items such as clinical laboratory services, durable medical equipment, or even some kinds of hospital services and put them out for bid. I think the whole issue of competitive bidding is one that we're going to explore vigorously.

Q: Competitive bidding would fit, generically speaking, very well under your strategy of allocating resources through marketplace principles. What are the other pieces of the administration's grand strategy in health care finance?
A: Our grand strategy is encapsulated in the following concepts: competition, capitation, and coverage through the clustering of services that will improve our capacity to control utilization. Utilization control is a very critical factor in our strategy because without it and recognizing that we will have many more practicing physicians in the future the government will have a very difficult time moderating the cost of care.

Q: Is that what drives you so determinedly toward global payment of service, toward a reversal of the traditional economic incentives under which fee-for-service medicine operates?
A: That is certainly one of the driving pressures. DRGs for hospitals are a perfect example in this regard. Under DRGs, Medicare has clustered all of the former individual and discrete services into one global payment for particular diagnostic groupings. By determining a rate of payments prospectively and providing a risk/reward system for payments, there is an enhancement for behavior modification. Payment to providers for a cluster of services incorporates, by its very nature, a need for that provider to control utilization more effectively or be penalized financially for not doing so.

Q: Is not the TEFRA provision that seeks to marry the Medicare program more closely with HMOs the first step down this road of globalized payment
for services?
A: Yes it is because what we-and it is important to recognize that the administration and Congress were essentially of one mind in support of this approach-have done is captured all of the essence of both Parts A and B, globalized the payment for these services, and placed HMOs at financial risk for providing all covered services to enrolled Medicare beneficiaries. This provision will not only cluster the services around a globalized payment on a general basis, but it also will tend to encourage physicians to organize in groups or at least form contractual relationships that offer elderly beneficiaries a continuum of care. This trend should bode well for our population because many older people find it difficult to make their way through a delivery system that is composed of many diverse and individual providers.

Q: What is your opinion on the likelihood that HCFA will approve waivers for the four eastern states (Maryland, Massachusetts, New Jersey, and New York) which now administer all-payer health financing programs?
A: The major test is going to be the cost factor. That: is to say, will a state-administered, all-payer approach be more costly to Medicare than if Medicare itself was paying providers? Given the status of the Medicare trust funds, I think it is very appropriate that we scrutinize this question with great care. I do not know at this time whether HCFA will approve the requests, but then I’m not certain a couple of states will even apply again. However, the climate for these types of programs does appear to be changing. Recent conversations with people in the states of New York and Massachusetts seem to suggest there is not a significant demonstration of enthusiasm to support their all-payer programs.

Q: There is no question, though, looking at the issue philosophically rather than technically through data, that the administration does not favor the all-payer approach.
A: That’s right, there is no question about that. Philosophically, I and other ranking administration officials oppose the all-payer approach. It is too highly regulatory and could lead the United States health system to a public utility model, where care would be wrapped around and controlled by government. I think that would stifle creativity. On the other hand, I am bound to carry out congressional mandates, too. And Congress has clearly stipulated that if a state meets the twelve conditions which it set out, then HCFA is duty bound to grant a waiver. Our major test is to ascertain clearly that on granting a waiver we will spend no more than we currently spend under the DRG system of payments to hospitals.

### Financing Medical Education

Q: Sen. David Durenberger (R-MN) has introduced legislation that would create a block grant for the financing of Medicare’s share of medical education
expenses. Does this proposal strike you as a measure that would appeal to the Reagan administration?

A: I think in general it would, simply because the administration has been advocating this philosophical approach since early in 1982. Whether it’s appropriate for this specific area is a separate issue that we are mulling over. The department is engaged in a medical education study which is scheduled to be completed in the spring of 1985. The study’s purpose is to determine the real costs of medical education, both direct and indirect.

Q: You come from the world of academic medicine. Putting your public policy hat on, do you believe that academic medicine has resisted over the years informing the public on just what its tax dollars were being used for in medical education. Is this obfuscation, perhaps too strong a word in this case, coming back to haunt these institutions?

A: No, I think obfuscation is probably the right word. Yes, I do think it is coming back to haunt these schools. They admit their dilemma to me privately; they wish that over the years they had been collecting the data to substantiate more precisely how they allocated the massive federal investment in medical education. I think the Association of American Medical Colleges (AAMC) is working very vigorously to establish a better data base, but it is not that easy. I came out of an institution (University of Michigan) where we tried to dissect the costs of the teaching hospital and the medical school. The activities between these entities are blurred, thus it becomes very difficult to allocate accurately how monies are expended. But we must do so immediately. The federal policies regarding medical education are quite clear. The government believes that with the projected surplus of physicians we can no longer afford to utilize the inefficient incentives inherent in the cost-based system of reimbursement for direct medical education.

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**Research Priorities For HCFA**

Q: HCFA’s research budget was reduced by about one-third (from $35 million to $23 million) as a consequence of the administration’s 1986 spending plan. What will the agency’s research priorities be under this tighter budget?

A: We will continue to target on the development of extending prospective payment to other providers—physicians, skilled nursing facilities, and home health agencies. We will also be seeking to refine Medicare’s payment approach toward health maintenance organizations by developing a health status factor and by testing payment at 85 percent, rather than 95 percent, of what Medicare pays traditional providers. However, it is quite clear that a budget reduction of one-third of our total research will have a significant impact on the number of studies that we can fund, as well as the number of demonstrations we can afford to evaluate. While we will continue to target our scarce research dollars on high priority
agendas, there will be no dollars available for creative new ideas that are not a part of our research plans. Also, we will be reducing our grant solicitation to once a year or perhaps relying totally on RFP to respond to HCFA's own research agenda items.

Just as we are asking the provider community to tighten its belt, we in the federal sector are also attempting to manage our resources more prudently. For example, HCFA has reduced its employees by 20 percent since 1981 and yet increased productivity and surveillance activities. FY 1986 calls for a further reduction in staff of another 5 percent in addition to a pay decrease of 5 percent. I think it's important for health care providers to realize that we are asking no more of them than we are willing to do ourselves to reduce the federal deficit and health care inflation. Our primary goal is to insure access to quality care for our beneficiaries at an affordable price. Working together we can achieve this goal.

Q: Thank you.