ANALYSIS/RECOMMENDATIONS ON DRAFT “BLUE DOG” MEDICARE PROPOSAL

American Society of Internal Medicine

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The following analysis is based on the draft summary proposal distributed by Rep. L.F. Payne in Fall, 1996.

Overall assessment: The proposal is quite consistent with ASIM policy on expanding health plan choices while achieving short and long-term savings. Some of the proposed reforms in Medicare physician payment, such as a single conversion factor for the Medicare fee schedule, are strongly supported by ASIM. As noted below, the proposed formula for updating the conversion factor could cause unwarranted reductions in payments for physician services, however.

Medicare Payments to Providers: ASIM has no specific policy on a one-year freeze in PPS updates or the other proposed changes in Part A, although it is unclear if the proposed freeze would apply to payments for physician services under Part B. We do believe strongly, however, that since spending on physician services under Part B is already below the rate of growth in every other major category of Medicare spending--and is projected by the CBO to continue to grow at a very modest pace--there is no room to extract further savings from physician services without endangering access and quality. From 1991-1995, Part B spending on physician services increased by only 6.5% per year, compared to 7.3% for inpatient hospital, 10.5% for total Medicare, 11.5% for total Part A, 13.7% for Part B nonphysician services, and 35.2% for home health (source: HCFA Office of the Actuary).

The latest CBO projections are that physician fee schedule payments will grow by only 2.59% per annum from FY 1996-2007. The CBO also projects that the Medicare physician fee schedule conversion factor (weighted average of current three CFs) will be lower in the year 2007 ($35.83) than it is today ($35.95). This means that in constant dollars--after inflation is taken into account--the conversion factor will decline to approximately $29.39 assuming an annual inflation rate of only 2 percent. Reductions of this magnitude--which will occur without Congress mandating additional savings--will severely limit beneficiaries' access to physician services. Rather than mandating further savings, Congress should enact legislation that will provide a reasonable opportunity for physicians to receive updates that will keep pace with inflation.

ASIM's specific recommendations are as follows:

1. If a limit of no more than five percentage points above the MEI is mandated, then a comparable floor (5 percent) should be maintained on reductions from the Medicare economic index.

2. The proposal to re-establish resource based payments through a single target and update for all services should specify an implementation date of January 1, 1998 (with no further transition). The initial single conversion factor should be "budget neutral"--at the very least, it should not be set at a level that would cause rollbacks in payments for primary care and other nonsurgical services. ASIM strongly supports the requirement for a single CF, which has been included in previous versions of the "Blue Dog" proposal, in the administration's FY 1997 budget, and in the BBA. Since Congress originally intended to mandate a single CF effective 1/1/96, as proposed in the BBA, no further delay is needed. ASIM is also pleased that the draft summary does not call for any delay in implementation of resource-based practice expenses, which under current law will go into effect on 1/1/98.

3. The proposal to replace the volume performance standards with an sustainable growth rate (SGR) based on GDP should be revised to specific that the SGR will be based on per capita GDP and a minimum volume/intensity add-on of 2 percent. Limiting growth to GDP without any additional add-on for volume and intensity and basing the updates on the cumulative disparity between actual growth and the standards would continue to cause unwarranted absolute reductions in the conversion factor for the fee schedule. As a result, the unwarranted reductions in the conversion factor(s) from the OBRA 93 changes
in the VPS formula would not be corrected by the proposal—it would replace one flawed update formula with another. A volume/intensity add-on of 2 percent would allow at least give physicians the opportunity to obtain an inflation update if they held volume/intensity growth to an extremely modest level.

**Medicare choice program:** ASIM supports expanding health plan options to include PSNs, PPOs, HMOs and other arrangements; transitioning the program to an annual open enrollment period, with the option for beneficiaries to disenroll within 60 days; requiring the plans to provide current Medicare benefits with the option of providing additional benefits; changing the AAPCC formula to de-couple payments from fee-for-service and to address geographic inequities; providing comparative information to beneficiaries; and requiring that plans explain the benefits available for out-of-network services, the requirements and procedures for referral and authorization and the beneficiary’s potential liability for out-of-network services. ASIM recommends that the “Choice” proposal be modified as follows:

1. **The requirement that Medicare choice plans contract with PROs for review of quality should NOT be eliminated, at least until an alternative mechanism for external quality oversight of health plans is identified.** It is essential that beneficiaries have assurance that the quality of, and access to, medical care in Medicare choice plans will be held accountable to an independent review entity that is solely concerned with quality improvement. The current PRO program has shown that it can work collaboratively with Medicare plans to improve quality; therefore, PRO review should not be eliminated unless it can be shown that there is a better way to hold Medicare Choice plans accountable.

2. **The provision to “eliminate restrictions on provider contracting” should not be included in the bill, at least without clarification on its intent and scope.** ASIM would be strongly concerned if the intent of this provision is to allow plans to contract with non-physician providers for “physician” services, unless such providers are currently defined as physicians under Medicare law. ASIM would also be concerned if the intent is to pre-empt state laws that require that health plans provide due process to physicians who are de-selected by the plan.

3. **The proposal to pre-empt state “anti-managed care laws” should not be included, unless it is clearly stated what laws would—and would not—be pre-empted.** ASIM does not support any willing provider laws, but we would oppose federal pre-emption of state laws relating to due process for physicians who are de-selected by a plan, choice of physician, requirements relating to disclosure of utilization review protocols, etc.—unless it was clear that the federal consumer protection standards proposed in the bill provided adequate patient protections in these areas, as discussed in recommendation # 4 (below).

4. **The beneficiary protections specified in the summary should be expanded, as proposed in ASIM’s recommendations on reinventing Medicare managed care.** In particular, the disclosure requirements should be expanded to include restrictions on coverage of services provided outside the Medicare Choice plan; restrictions that limit coverage to drug formularies; restrictions on access to in-office testing; grievance and appeals and disenrollment rights, disenrollment rates; percentage of physician contracts that were not renewed; utilization review protocols, criteria and algorithms, and medical expense ratio. Standards relating to choice and accessibility of providers and methods for developing utilization review protocols and for assessing physician performance, including due process procedures, should also be specified. ASIM would be pleased to provide its detailed recommendations in these areas and our supporting rationale. The General Accounting Office and the Institute of Medicine have made similar recommendations to expand consumer protections for beneficiaries enrolling in managed care and other “choice” plans.

5. **The solvency standards should be made more specific to assure that PSOs would not be held to excessive and unnecessary requirements that will act as a barrier to their competing in the market.** ASIM supports the language that was included in the Balanced Budget Act of 1995. Although the solvency standards relating to PSNs would “recognize multiple means to demonstrate solvency,” it is not clear if the proposal would sufficiently address concerns about being required to meet solvency standards for insurers that effectively keep PSNs out of the market. The BBA would have established specific requirements for federal solvency standards and pre-emption of state requirements that were unnecessary and excessive.
**Provisions Relating to Regulatory Relief:** ASIM recommends that the regulatory relief section be modified as follows:

1. **Expand the proposed change in the self-referral requirements include an exemption for shared facilities, as proposed in previous version of the “Blue Dog” proposal.** This change is necessary to maintain access to in-office laboratories that are shared by physicians who practice in the same building but who are not members of the same group practice.

2. **Provide relief from the Clinical Laboratories Improvement Act, as proposed in previous versions of the “Blue Dog” proposal.** The bill should provide for an expanded waiver category so that routine in-office tests do not have to meet the requirements mandated for more complex tests. The Secretary should be directed to reduce the number of inspections required for moderate complexity laboratories in good standing. Excessive CLIA regulations are hurting access to in-office tests without improving quality.

**Provisions relating to beneficiaries:** ASIM supports keeping the Part B premium at 25 percent of program costs, relating the premium to income for certain high income individuals, and expanding coverage of preventive services.

**Access proposals:** ASIM supports the proposed increase in the bonus payments for undeserved areas and a re-examination of whether or not the current HPSA definition adequately identified undeserved areas.