

AMERICAN SOCIETY OF INTERNAL MEDICINE

Testimony to the Subcommittee on Labor, Health and Human Services and Education Appropriations
Senate Committee on Appropriations

on

Issues that Affect the Delivery of Quality Care to Medicare Beneficiaries

March 28, 1997

Introduction

The American Society of Internal Medicine (ASIM) represents physicians who specialize in internal medicine, the nation's largest medical specialty. Internists provide both primary and consultative care to more Medicare patients than any other physician specialty. Consequently, Medicare payment policies have a direct and disproportionate impact on the ability of internists to provide their elderly and disabled patients with the best care possible. ASIM's testimony today will address reforms that will improve the quality of care provided to Medicare beneficiaries.

Budget Savings Should Target Higher-Growth Areas

ASIM believes that structural reforms are preferable to attempting to squeeze more savings out payments to "providers." In repeated budget bills, Congress and the President have agreed to major reductions in the rate of growth in payments to physicians and other providers. Such approaches have done little or nothing to address the underlying problems with the Medicare program, however, and have taken a toll on the ability of physicians to provide their patients with the best care possible. We recognize, however, that some savings in the rate of growth in payments to providers is inevitable. In deciding where savings might be achievable without compromising access and quality, Congress should take into consideration which categories of spending are growing at a rate that may not be sustainable. By the same token, categories of spending that are growing so slowly that they are not contributing to Medicare's fiscal problems are not the place to look for further reductions.

The January "baseline" projections from the Congressional Budget Office show how much spending on physician services has already been curtailed. According to the CBO, *total* outlays for physician services *will grow by an average of only 2.4% per year* from 1996-2002. By comparison, payments to hospital, home health agencies, skilled nursing facilities, and most particularly HMOs will all exceed the rate of inflation. The CBO estimates that Medicare fee schedule payments--as expressed by the weighted separate conversion factor updates-- will actually *decline* by about one percent over the next decade--or by 21 percent after inflation is taken into account. Fee schedule payments to physicians therefore have the dubious distinction of being the *only* category of outlays that are projected to actually drop, in both real (after inflation) and nominal dollars. ASIM urges Congress to support the administration's approach of targeting savings toward higher growth areas of expenditures. It is not reasonable to expect that total outlays on physician services--which will now barely keep pace with inflation--can be reduced further without compromising access and quality.

Making Medicare Payments Resource-Based

Congress has an opportunity to make 1998 the year that Medicare payments *truly* become resource-based. Even though 1998 will represent nine years since Congress first said that it wanted Medicare payments to be resource-based, the fact is that some services continue to be reimbursed more for the resources involved than other services. ASIM believes that Congress should assure that the 1998 budget allows for correction of two distinct flaws in the Medicare fee schedule that have resulted in payments not being truly resource based:

1. Separate volume performance standards, conversion factors, and updates have resulted in surgical procedures being paid at a much higher rate than primary care and other nonsurgical services that require the same resources to perform.

2. Medicare payments for practice expenses continue to be based on historical charges, not resource costs. As a result, services that historically were overvalued prior to implementation of the resource based relative value scale (RBRVS) continue to be overpaid for their overhead expenses, while services that were undervalued continue to be underpaid for their practice expenses. Concern about the inequities created by the current charge-based formula led Congress to enact legislation in 1994 that mandates implementation of resource-based practice expenses on January 1, 1998.

Single Conversion Factor

ASIM strongly supports the administration's proposal to enact a single dollar conversion factor for the Medicare fee schedule, effective 1/1/98, and to establish the single conversion factor at a level that is no less than the current primary care conversion factor, updated for inflation.

Under current law, Medicare physician payments are determined based upon a formula that multiplies the relative values for work, practice expenses, and liability costs by a dollar multiplier, or conversion factor. Three separate multipliers--for surgical procedures, primary care services, and other nonsurgical services--are mandated. Surgical procedures are reimbursed under a conversion factor that is 14% higher than primary care services, and 21% higher than other nonsurgical services, that involve the same amount of physician work. In an effort to correct this inequity, Congress included a single CF in the Balanced Budget Act of 1995. The single CF would have been effective on January 1, 1996. As the subcommittee is well aware, however, President Clinton vetoed the BBA, with the result that the policy of separate conversion factors and updates remains in effect. There continues to be strong bipartisan support for enacting a single CF, however, as evidenced by the fact that it not only was included in the BBA and in the President's current budget, but it has also been included in other proposals such as the recently-unveiled "Blue Dog" budget proposal.

Current law requires that separate target rates of increase in expenditures--or volume performance standards (VPSs)--be established for surgical procedures, primary care services, and nonsurgical services. If actual spending is below the applicable VPS, the services in that category get a bonus increase (the Medicare economic index plus the percentage that actual spending came in under the VPS). If spending exceeded the applicable VPS, the Medicare economic index (MEI) is reduced by the percentage that spending exceeded the VPS unless Congress specifies otherwise. After adjustment for demographic changes and changes in law that may affect annual growth in expenditures on physician services, the VPSs represent a target rate of growth that is equal to the previous five year historical average expenditures for the category of services, minus a performance standard adjustment factor.

Payments for surgical procedures benefited from this formula because changes in practice patterns over the past five years resulted in surgical volume increasing at a slower rate than other physician services. The reduction in surgical volume is due principally to changes in practice patterns--specifically, the substitution of non-surgical treatments for surgical procedures. The Physician Payment Review Commission, citing the Agency for Health Care Policy and Research, reported in 1994 that "Reductions in the volume of prostate-related procedures mostly reflect changes in treatment through increased use of drugs, less invasive surgical procedures, and watchful waiting" (PPRC, Fee Update and Medicare Volume Performance Standards for 1995, May 15, 1994). The evidence also suggests that much of the reduction in surgical volume is due to an inevitable "bottoming out" of the number of patients who have a need for cataract surgery and several other surgical procedures that experienced explosive growth in the mid-1980s. In the same 1994 report from the PPRC that is cited above, the Commission noted that "The period of greatest growth in volume for a new medical procedure or technology is often the first few years following introduction, largely because it is during this period of diffusion that patients with existing indications are treated along with those newly identified. In the mid-1980s, the volume of new technologies such as cataract surgery was growing at double-digit rates, because there were tens of

millions of patients who needed--and could benefit--from those treatments. As time has passed, however, the demand for such procedures has naturally declined.”

ASIM opposes any additional transition or delay in mandating a single CF. Given that Congress intended for a single conversion factor to go into effect on January 1, 1996 (as would have been required under the BBA), physicians will already have had two years of a de facto transition to a single conversion factor under the administration’s proposals for implementation on January 1, 1998.

We also urge Congress to support the administration’s proposal to establish the single conversion factor at a level that is no lower than the current primary care conversion factor, updated for inflation. Payments for primary care services, which have been undervalued in the fee schedule updates for most of the past five years, should not be rolled back below current levels. Establishing the conversion factor at anything less than the primary care conversion factor, as updated for inflation, would also require deeper cuts in payments for surgical procedures, and provide less relief for the other nonsurgical services that have been most disadvantaged under the current update formula. A transition would also reduce the savings that the administration projects from a single CF by easing the reductions in payments for overvalued surgical procedures.

Implementation of Resource-Based Practice Expenses

ASIM continues to strongly support implementation of methodologically sound resource-based practice expenses. Because current practice expense payments are not truly resource-based, some services remain grossly overvalued while others remain substantially undervalued. An internist who provides 115 level 3 established patient office visits--typically requiring 29 hours of face-to-face time with patients--receives the amount of practice expense reimbursement that a surgeon gets for one bypass graft that takes only a few hours to perform. *Medicare also ends up paying surgeons for operating room overhead expenses that the hospital, not the physician, incurs and that are already paid under Part A.* In 1992, the Physician Payment Review Commission noted that “54% of the Medicare fee schedule payment for a coronary bypass graft in the final rule represents payments for practice expenses. However, this service is provided in hospital operating theaters that are equipped and staffed by the hospital, not the physician. In this case, the Medicare Part A payment includes the costs of virtually all of the expense payment for this service besides the physician work.”

Some have argued that because highly preliminary data released by HCFA in January indicate that major redistribution of income may occur under resource-based practice expenses, this means that the Health Care Financing Administration’s approach to this issue is fundamentally flawed. ASIM does not believe that the test of HCFA’s proposed methodology should be the degree that it does or does not redistribute payments. Rather, it should be whether or not the methodology that HCFA will propose is methodologically sound and more fair than the existing charge-based methodology. HCFA project staff have repeatedly stated that the data, methodological options, and specialty-impact estimates released in January for review and comments are “highly preliminary” and meant only to be “illustrative” of the impact of a range of approaches to determining RBPEs--and that *none* of the specific options presented will be adopted by HCFA to develop the proposed rule. Given the preliminary nature of the information that was released, we do not believe that it is appropriate to conclude now that implementation of RBPEs needs to be delayed. ASIM has provided HCFA with detailed recommendations for making improvements in the methodology and data that will be used to develop resource-based practice expenses.

We urge this subcommittee to withhold judgment on changing the timetable for implementation of resource-based practice expenses until a proposed rule is published, and until HCFA explains the process that will be used to refine the initial resource-based practice expenses. In its upcoming report to Congress, the Physician Payment Review Commission rejects any delay in implementation of RBPEs, on the basis that sufficient data are available and that no better data would be forthcoming should a delay be granted by Congress. We agree with the Commission’s view that the unfairness inherent in the current system demands that methodologically sound RBPEs be implemented as soon as possible, and that there is no reason to conclude now that this can’t be accomplished on January 1, 1998.

ASIM questions the assumption that access to surgical procedures will suffer if resource-based practice expenses are implemented next year. Under a valid resource-based practice expense methodology, all physician services would be paid based on data on how much it costs to provide each service. As long as those costs are appropriately recognized, there is no reason for access to suffer. The income estimates that are being cited by some to make the case that access could suffer are based on the most extreme numbers from only one of the options that HCFA presented in January. It is likely that the actual impact of the proposed rule will differ substantially from those preliminary numbers.

ASIM is *not* saying that we automatically will sign off on *anything* HCFA proposes as long as it is implemented on January 1, 1998. We've offered HCFA constructive criticism on the preliminary data and methodology. We will continue to work to influence the process so that the proposed rule is one that has credibility with physicians. We also believe that it is essential that there be a fair process for refining the initial practice expense RVUs. When the proposed rule is published, we will determine if it meets reasonable standards for methodological soundness. If it does not, then it would be appropriate to reexamine the timetable for implementation. But it doesn't make any sense for Congress to pull the plug on a process that may yet result in implementation on January 1, 1998 of a credible and defensible resource-based practice expense methodology that is more fair than the current charge-based formula.

Behavioral Offset

ASIM also strongly supports the Commission's view that unproven assumptions of a behavioral offset should not be incorporated into the RBPEs. A behavioral offset will magnify the reductions for overvalued services and reduce the gains for undervalued ones. The Commission correctly points out that the administration's contention that physicians offset 50 cents of every dollar that is lost when payments are reduced was not borne out when the RBRVS was implemented. HCFA should learn from its experience with the RBRVS, rather than repeating the same mistakes. If necessary, Congress should consider enacting legislation that would limit HCFA's ability to apply a behavioral offset.

RBPE Refinements

We also agree with the Commission's view that HCFA should propose a refinement process -- allowing for sufficient input from practicing physicians and other experts on practice expenses--to permit re-examination of the proposed practice expense RVUs prior to implementation of the final rule. Such refinement panels should be used to address major areas of disagreement with the proposed RBPEs for specific codes or families of codes, if a specialty has compelling evidence to suggest that the proposed RBPEs may be incorrect. We also believe that a process should be developed so that further refinements can occur in 1998 of the interim RVUs.

Because all of the interim RVUs will be subject to further refinement, ASIM has urged HCFA to exercise caution in implementing the interim practice expense RVUs to avoid the problems that would be created by "overshooting" or "undershooting" in the interim RVUs. "Overshooting" would occur if HCFA implements interim practice expense RVUs that call for major reductions in payments that are later found upon refinement to have been set too low. This can be avoided if HCFA errs on the side of being cautious in the magnitude of the reductions required for services that will undergo refinement.

Transition Issues

ASIM is not persuaded that a three-year transition to RBPEs is merited, as the Commission recommends. A transition not only would perpetuate current inequities for several more years, but it also makes the process of implementation far more complex, with the potential for creating the same kinds of unintended budget-neutrality problems that occurred with the transition to the RBRVS. When the proposed rule on implementation of the RBRVS was published in 1991, HCFA proposed a much larger budget neutrality adjustment than otherwise would have been necessary because the transition formula specified by Congress resulted in an asymmetrical transition (more services initially experienced gains in payments than received reduced payments, thereby creating a larger budget-neutrality offset). The result

was that the reductions for some services were much greater than was appropriate, while the gains for others were less than intended. Expressions of concern by Congress ultimately led HCFA to apply a lesser offset to deal with the asymmetrical transition. The complexity of developing a transition that would not have unintended consequences supports the wisdom of Congress' original plan to implement RBPEs on January 1, 1998 without further delay or transition.

Expanded Coverage for Preventive Services

ASIM supports proposals to expand Medicare coverage of preventive services and to increase payments for flu shots. Coverage of services that will *prevent* or allow for early detection of diseases not only will improve health care for the elderly, but may save Medicare money as well. Adequate payments for the costs incurred by physicians in providing influenza, pneumococcal, and hepatitis B vaccinations will encourage more physicians to provide those shots in the office, which could significantly increase the number of elderly persons who are inoculated against potentially life-threatening diseases. ASIM supports the administration's proposal for coverage of blood sugar self-management programs for diabetic patients, provided that it is modified to require that such programs be conducted under the direction and supervision of a physician.

Consumer Protection Standards for Medicare Managed Care

ASIM believes there is a need for Congress and the administration to make improvements in the standards used to evaluate Medicare managed care organizations (MCOs). The federal government must implement revised standards to assure that beneficiaries are given the information they need to make an informed choice of health plan, that beneficiaries receive reasonable assurances that they will have access to the physicians and services that they need, and that requests for reconsideration of denied claims are heard in a timely manner.

In recent years, the enrollment of Medicare beneficiaries in health maintenance organizations (HMOs) and competitive medical plans (CMPs) has grown rapidly. Currently, approximately 14 percent of beneficiaries belong to a Medicare managed care plan. The CBO projects that the share of total Medicare outlays that goes to HMOs and other Medicare managed arrangements will increase from 9.4% in FY 1996 to 32.9% in FY 2007--even without enactment of additional incentives for beneficiaries to enroll in managed care.

With increased enrollment, there is an increased need for the federal government to exercise appropriate oversight over the care provided to Medicare beneficiaries who are enrolled in MCOs. Recent reports from the Institute of Medicine, the General Accounting Office (GAO), and the PPRC all support the need for improved standards for health plans that contract with Medicare. In its 1996 report to Congress, the PPRC recommended that all health plans that contract to provide services to Medicare beneficiaries meet standards relating to quality, access, disclosure of information and due process. The GAO, in a recent report titled "HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance" supports ASIM's views that HCFA needs to do more to implement measures that will enable beneficiaries to make an informed choice of plan. The GAO concluded that HCFA can readily provide indicators of beneficiary satisfaction and other plan-specific information, including statistics on beneficiary disenrollments and complaints, medical loss ratios (the percentage of HMO revenues spent on medical care) and other financial data, and visit monitoring results. The percentage of claims that are appealed to HCFA, and then reversed or upheld upon appeal, is another indicator of HMO performance that can immediately be made available to beneficiaries. Although HCFA plans to require a standardized beneficiary satisfaction survey "beginning with the upcoming calendar year," the GAO expressed concern that HCFA has no plans to provide this information automatically to beneficiaries, and that the comparison chart that HCFA plans to develop will be available only through the Internet--a forum that may not be easily accessible to most Medicare beneficiaries. We agree with the GAO's conclusion that HCFA should provide comparative information on each plan directly to beneficiaries.

ASIM urges Congress to:

1. Direct the Secretary to mandate that Medicare MCOs disclose to current and prospective enrollees and providers information needed to make an informed choice of plans, including:

A. Requirements that limit access to services (i.e., extent to which enrollees may select the provider of their choice, restrictions that limit coverage to prescription drugs approved by the MCO, and rules that limit access to laboratory tests in physicians' offices);

B. Indicators of health plan quality, access, and patient satisfaction (including disenrollment rates; number and percentage of claims that were denied and then reversed upon appeal to the Secretary; the MCO's medical loss ratio--defined as the proportion of total revenue spent on medical care, as opposed to administrative expenses or funds retained or distributed to owners; and the results of standardized patient satisfaction surveys).

The GAO found that beneficiaries often are unaware of the restrictions on access to certain services that are typically required by MCOs. Disclosure of such restrictions will enable beneficiaries to make a more informed choice of plans, and will reduce subsequent misunderstandings and dissatisfaction. Information on disenrollment rates, claims denials, and medical loss ratios can be useful indicators of the quality of care rendered with a plan. HCFA has begun to provide beneficiaries with more information but its efforts to date fall short of providing the kinds of information discussed above.

2. Mandate that Medicare MCOs review preauthorization requests for urgent care services within one hour and all other preauthorization requests within 24 hours. Direct the Secretary to streamline the appeals process for denials by Medicare MCOs by reducing by half the days that MCOs are allowed to consider an appeal of an initial denial.

Although the administration has stated that it intends to make changes in the appeals process to provide more timely determinations on denials of care by Medicare MCOs, it is our understanding that the administration's proposal will not go far enough in assuring timely rulings on preauthorization requests, and in reducing the amount of time that MCOs have to rule on appeals of initial denials. According to the GAO and the PPRC, MCOs are currently given up to 60 days to make their initial determination. They have another 60 days to decide on an appeal of the initial determination--a total of four months when patients are effectively being denied access to care that they and their physician believe to be necessary. Cases that require HCFA review can take even longer--sometimes up to 270 days. Further, GAO found that MCOs and HCFA's own contractor often failed to meet the current deadlines for review and reconsideration of denied claims, but HCFA has been unwilling to take action against MCOs or the contractor for failing to process reviews and reconsideration in a timely manner. In the meantime, beneficiaries are the ones hurt by the failure to get a timely answer to their request that payment be authorized for medical services that they and their physicians believe to be appropriate.

3. Mandate that Medicare MCOs establish mechanisms to incorporate the recommendations, suggestions and views of enrollees and participating physicians into the medical policies, medical management, utilization review, and quality and credentialing policies and criteria developed by the MCO.

Physician involvement in establishing managed care policies that have a direct impact on clinical decision-making is essential if patients are to have confidence in their HMO. Rather than attempting to legislate the lengths-of-stay for given procedures, it would be far better to mandate a process that would assure that managed care plans do not adopt restrictions on coverage that lack the support of the physicians who are ultimately responsible for patient care.

Recommendations for Long-term Medicare Reforms

ASIM believes that the proposals included in the administration's budget fall short of the long-term restructuring of Medicare that is needed. ASIM has developed a detailed set of long-term proposals for keeping Medicare affordable and solvent. Our recommendations include:

1. Moving toward a defined federal contribution system. Beneficiaries would be given the option of remaining in the traditional Medicare program, or using their voucher to purchase coverage from HMOs, PSOs, indemnity plans, PPOs, and other competing health plans in their community that meet Medicare's standards for participation. The defined contribution must be set at a level that would enable beneficiaries to afford a wide choice of competing plans in their own locality, and it should be updated annually to reflect increases in the average premiums charged by the plan.
2. Requiring that all competing health plans meet minimum federal standards relating to access, quality improvement, physician and patient involvement in utilization review protocols, minimum benefits, and disclosure of information required for patients to make an informed choice of plans.
3. Increasing premium contributions for higher-income beneficiaries.
4. Phasing in a delay in eligibility age for Medicare.
5. Maintaining the Medicare fee-for-service program as a viable alternative to purchasing coverage from competing health plans.

Conclusion

The reforms advocated by the American Society of Internal Medicine would improve the quality of care provided to Medicare beneficiaries in several important ways. Medicare would be reformed, but without requiring that payments be reduced to the point where primary care physicians simply cannot afford to take care of beneficiaries. Payment policies that are skewed against access to primary care would be corrected. Medicare patients who are considering managed care would be protected by standards relating to choice, access, and quality. Finally, beneficiaries would have access to beneficial screening and preventive care benefits.

ASIM is committed to working with the Subcommittee to support Medicare policies that will improve quality and access to care for all Medicare beneficiaries.

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