TALKING POINTS FOR MEETING WITH
THE AMERICAN ACADEMY OF FAMILY PHYSICIANS
THE ROOSEVELT ROOM
MARCH 6, 1996

- I want to thank all of you for the work you have done and continue to do, and I want to especially thank Bob Graham, Charlie Huntington, and Rosi Sweeney for the advise and assistance they give on a weekly basis to our healthcare team. Thanks to the tremendous effort of groups like yours we fought hard for health care reform. And together we have made progress toward a balanced budget that reflects this nation's values. I am still committed to reaching agreement on a balanced budget, but only if that budget protects Medicare and Medicaid and our other priorities.

- I also want to thank *your members* for their ongoing committment to providing essential primary care services to all Americans -- particularly to the most underserved in rural areas and inner cities.

- We have more work to do. In the past few years, we have reduced regulatory burdens for physicians, but we can do more. And we need to take steps toward giving families health security. That's why I support the Kassebaum-Kennedy bill, and that's why I am urging Congress to pass it immediately.

- We need your ideas and your dedication to work together on these issues.

Fax to: Marilyn Yager

From: Steve Gleason

Date: March 4, 1996

5 pages including cover sheet.

Briefing into for TMW 3/6
5:00pm

Jennifer

thought you might like to see some background info. Steve Gleason provided.

Marilyn

DRAFT

Briefing Information
Meeting with AAFP Board and Senior Staff
Roosevelt Room
5:00 p.m., March 6, 1996

Background

The American Academy of Family Physicians represents 75% (44,596) of the Nation's family practice doctors. Family physicians, like nurses, nurse practitioners, and general internists, have traditionally been at the end of the health care pecking order, with incomes and influence servile to high tech specialists and academics.

As the managed care movement strengthened, the real value of family physicians became more apparent. They became the primary patient advocates and health case managers within the changing health system. The political struggles of family physicians to become their own specialty and to fight oppressive control of their privilege by sub-specialists has created a political dynamic wherein family practitioners have become more friendly to Democratic initiatives.

The American Academy of Family Physicians, for instance, has tended to support universal coverage and employer mandates. Family doctors tend to be less fiscal conservative and more politically neutral than the American Medical Association.

The American Academy of Family Physicians is very concerned about the regulatory environment within which they must practice. Most family physicians oppose government efforts to micromanage doctors through regulations.

The American Academy of Family Physicians has consistently called for regulatory relief (e.g., CLIA), equity in Medicare reimbursement (RBRVS, immediate Medicare conversion update, etc.), and malpractice reform..

Family Physician Issues

- That family practice medical education funding has been cut.

  Response

  - *This Administration supports increased family practice education funding in the 1997 budget.*

- That wealthy specialists will continue to be overpaid at the expense of the family physicians. AAFP reported a rumor that the AMA and the Clinton Administration have collaborated to delay implementation of resource-based payment.

  Response

  - *This Administration supports immediate implementation of the single conversion factor using resource-base allocation of payments.*

- That the Congress has failed in its attempts to provide promised regulatory relief and that the Administration (more specifically, Democrats in general) are thought of as opposing regulatory relief. In addition, there is a sensitivity by AAFP members that the Medicare fraud and abuse dragnet will punish honest family physicians because complex billing requirements make errors and misinterpretations more likely.

  Response

  - *While the Congress has been debating the issue, the Clinton Administration has implemented regulatory relief, specifically, the elimination of the physician's attestation statement, establishment of revised criteria for CLIA, and the utilization of a common federal claim form. With respect to Medicare fraud and abuse, honest billing errors are not being targeted.*

    In addition to continued work in reducing the federal bureaucracy, this Administration is also concerned about the private bureaucracy of insurer-owned managed care organizations. The drive for profits should not compromise quality of care or the ability of physicians and their patients to make good health care decisions.

- There is significant concern that the Administration will not pursue universal coverage or stand its ground with Medicare and Medicaid.

  Response

  - *The Clinton Administration continues to advocate for universal coverage. At the present time the Administration fully supports the Kassebaum-Kennedy initiative because it is the one piece of legislation which is likely to pass this ultra-conservative Congress.*

The Administration is open to other ideas for moving to universal coverage in the future.

The Administration will stand its ground to preserve Medicare and Medicaid.

The Malpractice Mine Field

- There is no way to minimize the Administration's position against caps on damage awards nor would these physicians believe it if we did. However, the President has continuously advocated various measures to make the process fairer while trying to balance the interests of consumers and providers.

Special Notes

- It should be noted that, of the medical organizations, AAFP is the only one that has identified a board member who will work as part of the campaign team. That individual is Joe Scherger, M.D., a family physician from southern California who has had extensive media experience and has nation-wide credibility. He will be in the meeting.

- Doug Henley, M.D., President of the American Academy of Family Physicians from South Carolina, has been very Administration-friendly in the past, although he is likely a southern conservative that will not advocate for any candidate in this Presidential contest.

- Bob Graham, M.D., Executive Vice President and Rosie Sweeney from Government Relations have both been very helpful in working with the Administration, particularly during the health reform debate.

- Jim Weber, M.D., Immediate Past President. Is an Associate Professor at the University of Arkansas and considers himself a friend of the President and Mrs. Clinton. He may attend.

Unanswered Questions

The only issue that may surface specifically in discussions with the President might be questions about "Clinton Health Policy" in a second term. The President's response should include that the Administration will continue to search for creative ways to provide coverage for the uninsured while soliciting ideas about:

1. Ways to keep decisions about the individuals' health care as much a private matter between physicians and their patients as possible.

2. Ways for reducing the regulatory burden.

3. New ideas for strengthening the safety net for the underserved..

AMERICAN ACADEMY OF FAMILY PHYSICIANS

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FACSIMILE ROUTING PAGE

PLEASE DELIVER THE FOLLOWING FAX:

TO: Marilyn Yager

FROM:
- ☒ Rosemarie Sweeney
- ☐ Laura Edwards
- ☐ Charles Huntington
- ☐ Lorlita Alexander
- ☐ Susan Hildebrandt
- ☐ Wendy Gaitwood
- ☐ Leslie Tucker
- ☐

DATE: 3/1

NUMBER OF PAGES (Including Cover Page): 11

MESSAGE:

IF YOU DO NOT RECEIVE ALL PAGES OF THIS FAX OR HAVE ANY OTHER PROBLEMS WITH THIS TRANSMISSION, PLEASE CALL (202) 232-9033. THANK YOU.

Memorandum

To: Marilyn Yager
From: Rosi Sweeney
Subj: Topics for WH Meeting with AAFP
Date: March 1, 1996

For next week's meeting, I would envision we would discuss the more technical issues with Chris et.al. and the broader policy issues with the President.

The "technical" issues include:

Budget -- funding for family practice education training through Public Health Service grants (Attachment A)

Budget --funding for the Agency for Health Care Policy and Research, particularly for primary care research (Attachment B)

Medicare -- enacting a single conversion factor with no transition (Attachment C)

Medical liability reforms, CLIA relief, revisions to the AAPCC (all covered briefly in Attachments D and E)

The discussion with the President would focus on how he sees the issue of health care in his second term, particularly in regard to universal "enfranchisement" -- getting everyone health care -- and how to get more primary care in any health care system. How does he see this playing out over the next six months?

If you need anything else, feel free to call me over the weekend. My home number is (301) 229-8591. Thanks for all of your help, Marilyn.

Attachment A

Family Physician Training
FY 1996 Appropriations for Section 747 of the Public Health Service Act

Background

By whatever measure employed, the U.S. suffers from a severe shortage of family physicians and other primary care doctors. This shortage has existed for decades, and it is growing steadily worse. For example:

- Since 1986 the number of federally designated primary care health professions shortage areas has increased from 1849 to 2492, and the number of primary care physicians needed to eliminate these shortages has grown from 4314 to 4677. This has occurred despite a large increase in the overall number of physicians.

- Among community health centers, which rely heavily on primary care physicians, 52 percent report difficulty recruiting physicians.

- Managed care organizations, which are mostly urban based and aggressively recruit family physicians, 43 percent of salaried and 29 percent of capitated plans report that it takes almost one year to recruit a new primary care physician.

Of additional concern is that the U.S. population 65 years of age and older will rise about 2 percent per year between now and the year 2020. Delivering the preventive, primary, long-term, rehabilitative, and hospice care needed by these individuals will require a substantial increase in the number of family physicians.

The overspecialization of the American physician workforce is a large contributor to our nation's health care problems. Any attempt to control costs and maintain quality in the American health care system will be frustrated by the shortage of primary care physicians. The Physician Payment Review Commission, Council on Graduate Medical Education, American Medical Association and Association of American Medical Colleges all advocate increasing the supply of generalist physicians

The most compelling evidence for the shortage of family physicians is in the marketplace itself. The demand for family physicians in the market overwhelms our current training capacity. Primary care is the marketplace's answer to our nation's cost, quality, and access problems. However, the "marketplace" has little or no influence over the medical schools and teaching hospitals that train physicians, largely because federal support allows most of these training institutions to remain aloof to society's growing need for primary care. For example, Medicare's support of graduate medical education is heavily biased toward the production of subspecialty physicians and inpatient care. Over $6 billion in Medicare GME payments go exclusively to hospitals, where subspecialist physicians receive most of their training, rather than to ambulatory care sites, such as clinics and offices, where family physicians receive much of their training. This continues to occur despite the fact that more and more and more care is delivered outside the hospital. A May 1994 General Accounting Office (GAO) report noted that "barriers to primary care training persist in Medicare's payment method."

Title VII of the Public Health Service Act is the only federal program that provides targeted funding for family practice training. Title VII funds support grants for family practice residency programs, establishing and maintaining departments of family medicine, predoctoral programs, and faculty development. Section 747 is currently authorized at $54 million and received an appropriation of $47 million in FY 1995. Many family practice residency programs would not exist today if it were not for the availability of the Title VII funds. Until Medicare GME funding changes occur, family practice residency programs and

medical school departments of family medicine will remain highly dependent on grants from Title VII.

Title VII has improved the supply of primary care physicians in several important ways.

- Virtually all physicians who complete family practice residency training take up practice in direct primary patient care and are able to handle 85-90 percent of their patients' problems. Studies show that family physicians are more cost-effective due to their prudent use of hospital services, tests, and procedures. Furthermore, family physicians are distributed in urban and rural areas in the same proportion as the U.S. population as a whole.

- Title VII grants for establishing departments of family medicine in medical schools have resulted in seven new departments in the past three years. An October 1994 GAO report indicated that "students who attended schools with family practice departments were 57 percent more likely to pursue primary care." The same report indicated that "students attending medical schools with more highly funded family practice departments were 18 percent more likely to pursue primary care." However, 15 of the nation's 126 medical schools still do not have departments of family medicine. Title VII dollars are crucial to establishing departments of family medicine.

- Funding for predoctoral programs under Title VII encourages medical schools to create required third-year clerkships in family medicine. The October 1994 GAO report indicated that "students who attended schools requiring a third-year family practice clerkship were 18 percent more likely to pursue primary care." However, 51 of the nation's 126 medical schools still do not have required third-year clerkships in family medicine. Because so many medical schools still do not have required third-clerkships in family medicine, establishing required clerkships in all medical schools is the single, most effective action that can be taken to increase the number of graduates entering primary care careers.

- Faculty development funding under Title VII is essential to address a severe shortage of family practice faculty for residency programs and departments of family medicine. The success of family practice residencies in placing graduates in primary care practice settings has had the unintended consequence of creating a shortage of family practice faculty. There are nearly 600 vacancies at present. Seventy percent of residency programs have at least one faculty position unfilled. Currently 18 residency program director positions are vacant and another eight are anticipated in the next two years. In addition, approximately 20 to 30 department chair positions are vacant. Faculty development funding must be expanded to meet training needs as they currently exist.

Recommendation

The American Academy of Family Physicians strongly supports a FY 1996 appropriation of $54 million for Section 747 of the Public Health Service Act.

May 1995

Attachment B

AHCPR and Primary Care Research

Background

Health care payors are placing increasing emphasis on the clinical competencies of primary care physicians. Yet, our nation's health care cost and access problems can be traced directly to an over-emphasis on costly inpatient and subspecialty care and to the consequent geographic maldistribution of health care providers. Solving these problems will require a substantial investment in the primary care infrastructure. Part of the necessary investment will be workforce reform accomplished through a realignment of Medicare and Public Health Service physician training incentives. However, equal attention must also be paid to the highly relevant but to date largely ignored area of primary care research.

The National Institutes for Health (NIH) have not in the past and do not now include support for primary care research. Until recently, limited resources and competing priorities of the Agency for Health Care Policy and Research (AHCPR) have precluded adequate attention to such research. Accordingly, the focus of medical education and research has been on the catstrophic or end-stage medical problems in referred and hospitalized patients. As a result, the training of physicians and the research agenda have focused almost exclusively on inpatient evaluation and treatment -- despite the fact that over 95 percent of all medical conditions have been evaluated and treated outside of hospitals for the past 30 years. Although a defining feature of American medicine, this base of knowledge has frequently little or no relevance to the basic, entry-level concerns that afflict most people -- the very conditions treated on a daily basis by generalists in the primary care specialties of family medicine, general internal medicine and general pediatrics. If this trend continues unabated, the scarcity of primary care research will seriously undermine new strategies to train more generalist physicians and emphasize cost-saving preventive care in the evolving health care delivery system.

Accordingly, a primary care research agenda is crucial. The AHCPR recently committed itself to establishing a Center for Primary Care Research within the agency. Such a center, if adequately financed, would provide new tools to family physicians and other generalists as they serve hundreds of millions of patients each year. The agenda would include research to improve diagnostic accuracy and streamline the diagnostic process while at the same time reducing inappropriate use of expensive, unnecessary or potentially dangerous medical tests. Such research also would help primary care providers and subspecialists to better coordinate their efforts to provide a continuum of care to those patients with serious medical problems. Finally, much of primary care research focuses on the development and assessment of protocals of care that are intended to make the best use of this country's strained health care dollars.

Recommendations

The 1992 Senate Report 102-426 accompanying P.L. 102-410, which reauthorized AHCPR, states that the Agency should strengthen its committment to family practice and primary care research. The report asserts that,

> *The committee believes that inadequate attention has been given to conditions that affect the(se) vast majority of Americans -- that is, the undifferentiated problems individuals present to their generalist physicians. A focus on family practice/primary care research is essential if we are to redirect the U.S. health care system that is currently skewed toward high technology medicine for catastrophic diseases.*

Congress should support AHCPR and its new emphasis on primary care research, which is designed to better assist the generalist physician in diagnosis and treatment of the patient population most commonly seen in the ambulatory care setting. Priority areas include:

- Research on the diagnostic process in primary care settings, designed to assist the generalis physician to evaluate the myriad symptoms of the patient, differentiate self-limited diseases from those requiring ongoing or intensive treatment and initiate treatment. This line of research is intended to streamline the diagnostic process, increase accuracy, and reduce the use of expensive and potentially dangerous medical tests.

- Research to improve the effectiveness of medical care as the physician, in collaboration with the patient, designs and implements effective treatment plans that reconcile the idiosyncracies, preferences, and needs of the patients with the realities of the illness.

- Research related to the development of clinical guidelines, including evaluations of the practical usefulness of clinical guidelines.

- Research to improve access to health care and cost-effectiveness of care focusing on generalist training and experience and the role of frontline, generalist physicians.

To support this critical -- and timely -- line of research, the Academy requests that additional appropriations be provided to the Agency for Health Care Policy and Research, and that dollars be targeted specifically to the Center for Primary Care Research. We believe that supplementary funding, coupled with diretion from Congress, will enable AHCPR to support essential, productive research into primary care issues. We recommend $25 million for this effort.

Attachment C

Medicare – Budget Considerations

Background

As Congress develops proposals to achieve savings in the Medicare program, the American Academy of Family Physicians urges careful consideration of previous Congressional actions relative to physician payment and their impact on access to primary care services. In particular:

- **Changes enacted previously with OBRA 93 will reduce drastically Medicare payments for primary care services beginning in January 1996.**

Under Medicare's default formula for updating annually physician fees, primary care services will be **reduced** by 2.2 percent for CY 1996. In contrast, payments for surgical services will increase by 3.9 percent, payments for other non-surgical services will increase by 0.6 percent. The Physician Payment Review Commission estimates that these changes will result in Medicare fee schedule payments in 2003 that below 1995 payments, even before inflation and any additional budget savings are taken into account. Considering the inevitable impact of inflation on physician practice costs, the net effect of fee cuts that are **already in statute** will be even more drastic.

- **Medicare fees for primary care services are currently substantially below private sector fees and, for family physicians, below cost.**

The Physician Payment Review Commission estimates that Medicare fees are only two-thirds private sector fees. Under current-law provisions, Medicare fees will shrink even further relative to private sector fees. Of greater concern is the fact that Medicare fees for office visits are substantially below the cost to family physicians of providing those services. While the average cost of running a family practice is $135 per hour, Medicare office visit fees reimburse physicians at a rate of approximately $100 per hour. In the past, family physicians have been able to offset these loses by "cost shifting" to private sector patients. However, aggressive discounting by managed care plans leaves less room for family physicians to absorb Medicare losses.

- **Low Medicare fees may lead to problems in access to primary care services.**

Over one-quarter of family physicians have closed their practices to new Medicare patients. In some areas, this figure is as high as 37 percent. The main reason cited for no longer accepting new Medicare patients is that Medicare fees are too low.

- **Medicare expenditures for physician services are increasing more slowly than any other category of Medicare spending.**

The rate of increase in spending for physician services has decreased from the double-digit numbers in the mid-1980s to only 3 percent in 1994. Between 1989 and 1993, expenditures for physician services increased at an annual rate of 6 percent, compared to 60 percent for skilled nursing facilities, 58 percent for

hospital outpatient departments, 40 percent for home health, and over 12 percent for inpatient hospital services. Spending on physician serves dropped from 75 percent of total Part B expenditures in 1985 to only 63 percent in 1993.

- **A disproportionate share of previous Medicare savings have been derived from physician services.**

Previous Congressional efforts to reduce Medicare spending have taken disproportionate cuts from physician services. From 1981 through 1993, physician services absorbed 32 percent of Medicare spending reductions, even though they comprised only 23 percent of total Medicare spending.

Recommendations

In order to ensure access to primary care services, the Academy recommends the following changes to the Medicare physician fee schedule.

- **Implement a single fee schedule conversion factor and volume performance standard (VPS) rather than the three currently in use.**

Separate conversion factors and VPSs for surgical, primary care, and other non-surgical services has led to distortions in the worth of relative values so that they no longer reflect resource-based relative values. The relative value units in each category are no longer worth the same amount. Currently, the conversion factor for surgical services is 8.4 percent higher than the conversion factor for primary care and 14.0 percent higher than the conversion factor for other non-surgical services. Because the conversion factor updates are permanent, consecutive higher updates for surgical services are compounded. Implementing a single conversion factor and VPS would provide an incentive for physicians in all specialties to exercise collective responsibility for reducing inappropriate care.

- **Revise the Medicare Volume Performance Standard (MVPS) formula by replacing the current factor for the growth in the volume and intensity of services with one based on projected growth in gross domestic product plus two percentage points.**

By taking a fixed four percentage point reduction from the five-year trend in volume and intensity, the performance standard factor unlinks the volume and intensity factor from actual trends in health care delivery. Regardless of how much physicians reduce the volume and intensity of services, volume and intensity must be reduced by an additional four percentage points or the updates will be reduced. This formula sets-up unobtainable targets and will inevitably lead to negative updates. The Academy believes that replacing the current VPS formula with one based on projected growth in GDP plus two percentage points is preferable to the present formula.

Attachment D

November 3, 1995

<Name>
<address>
Washington, D.C. <zip>

Dear <Name>:

On behalf of the American Academy of Family Physicians, which represents 80,000 practicing physicians, residents, medical students, and others with an interest in family practice, I am writing to urge your careful attention to several critical provisions of the Medicare Preservation Act during House-Senate negotiations.

Specifically, we seek your commitment to support the following provisions contained in the *House* reconciliation measure:

- **Professional liability reforms, including a $250,000 cap on non-economic damages, joint and several liability reform, collateral source doctrine, periodic payment of non-economic damages, and a statute of limitations for filing claims.**

These provisions will spare physicians and patients from the costs and personal tribulations of an overly litigious tort system through lower professional liability insurance premiums and reduced exposure to those unnecessary services ordered for purely defensive reasons. The non-economic damages cap, in particular, will ensure that individuals who are injured as the result of medical negligence will receive full and fair compensation for their expenses while removing incentives to play the lawsuit "lottery."

- **Exemption of physician offices from the Clinical Laboratory Improvement Amendments of 1988 (CLIA).**

In a recent study of the impact of CLIA regulations on patient access to laboratory services, 63 percent of all practices, and 72 percent of rural practices, reported having reduced or eliminated on-site testing in response to CLIA '88. As a result, physicians noted that many of their patients either fail to obtain ordered tests or obtain them from the hospital emergency department if it is closer than the referred lab, at considerable extra expense to the health care system, including Medicare. Moreover, those patients who do obtain ordered tests from a referred lab now must routinely wait days, rather than hours or minutes, for definitive diagnoses. By exempting physician office labs from CLIA's cumbersome requirements, the House provisions will

Attachment E

The American Academy of Family Physicians supports the following provisions in the budget reconciliation conference:

Revisions to the formula by which Medicare's per beneficiary payment amounts are calculated, so that rural beneficiaries will have the same Medicare Plus options as urban beneficiaries. Unfortunately, according to PPRC, the AAPCC formula revisions proposed by both the House and Senate would permit the enormous but unjustified variation in Medicare payments among geographic areas to persist. We urge the conferees to adopt the most aggressive approach possible to eliminate this inequity.

Exemption of physician offices from the Clinical Laboratory Improvement Amendments of 1988 (CLIA), (sec. 15081 of the House bill) which will result in greater patient convenience, improved access to laboratory services, and more timely availability of the test results with which physicians diagnose and treat illness. CLIA had a disproportionate effect on rural areas; 72.1% of rural practices reduced or eliminated on-sited testing due to CLIA-88, compared to 63.4% of all practices. As a result, rural physicians report that many of their patients either fail to obtain ordered tests from a distant laboratory, or show up at the hospital emergency room instead of the referred laboratory.

Amendments to the self-referral statutes (Stark I and Stark II) that will restore a degree of reasonableness to the mechanisms by which the Medicare program protects beneficiaries against kickback schemes without obviating legitimate business practices or harming access to referral services. Of particular relevance to rural physicians and their patients are the clarfied rural exemption (sec. 15204(b)), the shared facilities exemption (sec. 15204(d)), and the "community need" exemption (sec. 15204(e)) of the House bill.

Federal oversight of provider sponsored networks through anti-trust reforms and limited pre-emption of state insurance regulations, which will foster marketplace competition and improve beneficiary access to cost-effective health plan options, particularly in rural/underserved areas that would not otherwise have meaningful access to the MedicarePlus option.

Graduate medical education reforms in the House measure that will ensure adequate funding for residency training and take important first steps toward a physician workforce appropriately configured for the nation's health care needs. The provision allowing training dollars to follow residents beyond the walls of academic health centers is particularly important to the creation and maintainance of rural ambulatory training programs.

A Senate provision that would allow the Secretary to apply the look-back mechanism selectively, penalizing only those areas which exceeded their spending target while allowing continued updates for other areas, is particularly important to rural areas. Rural counties should be allowed ample room under the look-back

"ceiling" to overcome historic inequities and "catch-up" to appropriate reimbursement and service levels.

A single Medicare physician fee schedule conversion factor and a revised formula by which the Medicare volume performance standard is calculated, which will help to ensure beneficiary access to essential primary care services. These changes will help prevent further erosion of primary care fees, which are currently set well below cost.

The Senate provision to redistribute Medicare Part B bonus payments and better target them to meet program objectives. As recommended by the HHS Inspector General and the PPRC, bonus payments for primary care services in rural HPSAs would be increased to 20% and bonus payments for subspecialty services in urban HPSAs would be eliminated.

The Senate provision to protect access to essential services for vulnerable populations by reserving 1% of Medicaid funds for Rural Health Clinics and Federally Qualified Health Centers. Under Medicaid reform, it is likely that these clinics will lose the cost-based reimbursement that has enabled them to deliver comprehensive primary care services to extremely disadvantaged populations. The Senate provision will enable states to sustain these essential services, as they deem necessary, through supplemental Medicaid payments.

A Senate provision requiring Medicare Choice plans to ensure that rural beneficiaries have access to primary care services within thirty minutes or thirty miles of their place of residence. Such a requirement will help avert the enrollee/provider mismatches that have characterized many state Medicaid managed care start-ups.

December 8, 1995

The Honorable William J. Clinton
The White House
Washington, D.C. 20500

Dear Mr. President:

On behalf of the American Academy of Family Physicians, I am writing to share with your our views on specific Medicare and Medicaid provisions in the seven-year budget reconciliation plans issued by both your Administration and the Congress. The Academy represents 82,000 practicing physicians, medical students and residents, and other individuals interested in family practice.

The Academy appreciates the opportunity to comment on the draft of your seven-year balanced budget package circulated yesterday. It would be extremely unfortunate if the budget talks failed to produce essential improvements in the Medicare and Medicaid programs. In this spirit, the Academy would like to go on record concerning those provisions in the budget plans offered by your Administration and the Congress that our members endorse.

Reforms Meriting Administration Support

Specifically, we seek your support for including the following reforms in a final budget package:

- **A single Medicare physician fee schedule conversion factor in 1996 and a revised formula by which the Medicare volume performance standard is calculated.**

The Academy is pleased by the Administration's recognition of the need for a single physician payment conversion factor in its Medicare plan. However, we are very dismayed to learn that the Administration is recommending a phased implementation of a single Medicare conversion factor and volume performance standard factor. There are several compelling reasons why the Administration should withdraw its support for a transition and instead support immediate implementation of a single conversion factor for all physician services.

Contrary to one of the express purposes of the Medicare fee schedule, under the current formula, reimbursement for primary and other non-surgical care services will continue falling behind payments for surgical services. Both the House and Senate agreed in the H.R. 2491 conference report to the establishment of a single conversion factor for Medicare payments beginning in 1996. The Coalition of moderate and conservative

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Democrats also supports this policy change in their budget proposal. Implementation of a single conversion factor without delay has bipartisan support.

This provision is absolutely necessary to prevent further erosion of primary care fees, which are currently set well below cost. We also note that even if a single conversion factor were implemented in 1996, surgical procedures will still have enjoyed annual average positive updates exceeding the rate of inflation from 1994-1996. Last year, surgical services received a 12.2 percent increase. The reduction necessary to achieve a single conversion factor in 1996 would be less than last year's update, and from 1994-1996, the cumulative increase in payments for surgical procedures would be 10.8 percent -- or a 3.6 percent annual update. It is not reasonable to expect that access to surgical procedures would suffer under a single 1996 conversion factor, as some surgeons have argued, given that updates for surgery will still have exceeded increases in the costs of providing services. For these reasons, the Academy urges you to support the full implementation of a single conversion factor in 1996.

- **Professional liability reforms, including a $250,000 cap on non-economic damages, joint and several liability reform, collateral source doctrine, periodic payment of non-economic damages, and a statute of limitations for filing claims.**

While a number of these provisions were included in the *Health Security Act*, the Administration's budget proposal is silent on liability issues. Comprehensive professional liability reform is also included in H.R. 2491 and in the budget plan introduced by the House moderate Democratic coalition, known as the "Blue Dog Coalition." There is good reason for the common agreement existing between such diverse parties on this issue. Taken together, these liability reforms will spare physicians and patients from the costs and personal hardship of an overly litigious tort system through lower professional liability insurance premiums and reduced exposure to those unnecessary services ordered for purely defensive reasons. The non-economic damages cap, in particular, will ensure that individuals who are injured as the result of medical negligence will receive full and fair compensation for their expenses while removing incentives to play the lawsuit "lottery."

- **Exemption of physician offices from the Clinical Laboratory Improvement Amendments of 1988 (CLIA).**

This policy change is included in H.R. 2491 and in the Coalition's package. In a recent study of the impact of CLIA regulations on patient access to laboratory services, 63 percent of all practices, and 72 percent of rural practices, reported having reduced or eliminated on-site testing in response to CLIA'88. As a result, physicians noted that many of their patients either fail to obtain ordered tests or obtain them from the hospital emergency department if it is closer than the

referred lab, at considerable extra expense to the entire health care system. Moreover, those patients who do obtain ordered tests from a referred lab now must routinely wait days, rather than hours or minutes, for definitive diagnoses. We were pleased with the Administration's recognition of the burden posed by CLIA's cumbersome requirements and by the limited reforms that your Administration proposed earlier this year. It is disappointing the more substantive CLIA relief is not included in the budget proposal. The House-approved physician office lab exemption would carry the spirit of these reforms to their logical conclusion and, in so doing, result in greater patient convenience, improved access to laboratory services, and more timely availability of the test results needed by physicians to diagnose and treat illness.

The efforts by some Members of Congress to derail an exemption for physician offices because of concern over the quality and accuracy of pap smears is misguided. The accepted exemption language included in both H.R. 2491 and the Coalition's package, explicitly maintains CLIA oversight of all laboratories that perform and interpret pap smears -- and this includes physician's offices.

- **Federal oversight of provider-sponsored organizations through adoption of an appropriate standard of review for joint venture activities and limited pre-emption of state insurance regulations.**

These provisions of H.R. 2491 and the Coalition plan are not dissimilar from anti-trust and provider network provisions in the *Health Security Act*, however the Administration's budget proposal is silent on this issue. Now as then, their objective is to foster marketplace competition and improve beneficiary access to cost-effective health plan options. By eliminating the administrative "middle man," PSOs will help reduce costs and increase efficiency in the medical marketplace while protecting physician-patient relationships. In areas that are not able to attract the interest of large managed care organizations, especially rural and frontier communities, locally-grown PSOs can still provide beneficiaries with a meaningful alternative to traditional Medicare.

Strict adherence to traditional antitrust doctrine will frustrate the development of provider-sponsored networks areas and prove counterproductive in efforts to realign the incentives of the health care system. Current FTC and DOJ antitrust enforcement policies restrict approval of non-exclusive provider networks to those which have fewer than 30 percent of the physicians in a market. Not only do these restrictions preclude provider networks from acquiring the size and geographic coverage to be attractive to employers and patients, they virtually assure that *any* collaborative activity in small rural and frontier areas will exceed the threshold (insurance company and HMO networks do not operate under this burden). A more flexible approach is needed to assure rural Medicare beneficiaries meaningful health plan options. The original

Conference agreement would allow the antitrust enforcement agencies to evaluate joint provider activities according to the "rule of reason," in which competitive benefits are weighed against competitive harms. Such an approach is capable of evolving with the changing demands of an evolving Medicare marketplace and merits strong support.

In addition, both the House and Senate proposals and the initial Conference agreement recognized, to varying degrees, that insurance company-sponsored HMOs and provider-sponsored organizations present different issues with respect to consumer protection and solvency requirements. In particular, they recognized that fiscal (capital) standards and criteria must reflect the operational differences between insurance companies, which contract for services, and PSOs, which provide services directly.

- **Amendments to the self-referral statutes (Stark I and II), especially the shared facilities exemption, the "community need" exemption, the revised definition of physician supervision, and clarification of the rural exemption.**

These changes will restore a degree of reasonableness to the mechanisms by which the Medicare program protects beneficiaries against kickback schemes without affecting legitimate business practices or harming access to referral services. Self-referral language in H.R. 2491 and the Coalition plan would greatly reduce the federal government's micro-management of physician groups and practice arrangements by tailoring the self-referral statutes more narrowly to their original purpose. Although no similar provision is included in the Administration's budget proposal, we believe these changes to be consistent with Vice President Gore's government reorganization initiative.

- **Graduate medical education reforms that will ensure adequate funding for residency training and take important first steps towards a physician workforce appropriately configured for the nation's health care needs.**

Government financing for the training of primary care physicians has been badly neglected for decades. Ironically, while the market for medical care demands more primary care services, the medical education system continues producing a surplus of physicians narrowly trained in subspecialty fields. There are several GME reforms in the congressional budget plans that we support, in particular, reducing in the total number of fully funded residency slots, removing the current incentive to create new residency positions, establishing a new trust fund mechanism to ensure a continued federal commitment to GME, and authorizing the Secretary to make GME payments to training consortia. We also support the GME reform proposals put forward by the Administration, which are complementary to those noted above. Two elements of the Administration GME proposal, in particular, meet with our strong approval: the removal of funds

for Medicare direct and indirect medical education and disproportionate share hospitals from Medicare HMO payments, and the establishment of a National Commission on Medical Education and Workforce Priorities. The national commission is doubly necessary given that the Council on Graduate Medical Education (COGME) charter is scheduled to expire in 1997 and that a similar commission was stricken from the H.R. 2491 conference report. The important task of aligning the government's financing of medical education with actual needs for primary and subspecialty care is an ongoing task that the Administration's commission would ensure is conducted without interruption.

- **An increase in bonus payments for primary care services in rural Health Profession Shortage Areas (HPSAs) to 20 percent, offset by eliminating costly and unnecessary bonus payments for subspecialty services in urban HPSAs.**

Such a redistribution of Medicare Part B bonus payments would better target scarce program dollars to support of program objectives. Although not included in the Administration's budget package, this provision has been recommended by the Health and Human Services Inspector General, the Physician Payment Review Commission (PPRC), the Congress as part of H.R. 2491, the Coalition as part of its Medicare budget plan, and was even included in the *Health Security Act*.

- **A requirement that any new selection of Medicare plans ensure that rural beneficiaries have access to primary care services within thirty minutes or thirty miles of their place of residence.**

The Academy is encouraged by the Administration's support for expanding the choice of health plan options offered by the Medicare program beyond traditional fee-for-service. Such expansion is long overdue and will help transform the Medicare program into one that resembles the insurance marketplace of the 1990's and beyond. A proximity requirement in this new environment will simply help avert the difficult and unintended enrollee/provider mismatches that have characterized, for example, many state Medicaid managed care start-ups (an analogous situation).

- **Revisions to the formula by which Medicare's per beneficiary payment amounts are calculated (AAPCC), so that rural beneficiaries will have the same new Medicare plan options as urban beneficiaries.**

The current variation in per beneficiary spending across geographic regions is far more than can be justified on the basis of differences in utilization and costs. As noted by the Physician Payment Review Commission (PPRC), the General Accounting Office (GAO), and numerous other

authorities, these variations are both inequitable and major impediments to the expansion of Medicare managed care in rural areas. Providing Medicare beneficiaries in wider geographic areas with a viable managed care option will require a substantial leveling of AAPCC payment rates. Unfortunately, according to the PPRC, the AAPCC formula revisions proposed by the Congress in H.R. 2491 would permit enormous geographic variations to persist. We are pleased the Administration recognizes the AAPCC problem in its own proposal and urge you to support adoption of the most aggressive approach possible to eliminate this inequity.

- **An improvement in Medicare coverage of preventive services by including better mammography coverage, colorectal screening, and a new respite benefit for the families of Alzheimer's patients.**

We compliment the Administration for increasing the number of preventive services the Medicare program would cover. These services will help greatly in the maintenance of beneficiaries' health as well as with the diagnosis and treatment of illness. As you know, lack of payment for most preventive health services has unfortunately hindered beneficiaries' efforts to obtain them.

Areas of Concern

A few provisions of the Administration's Medicare proposal addressing physician reimbursement and laboratory services do, however, raise concerns, which are outlined below. We urge you to withdraw these provisions from consideration at ongoing budget talks.

- **An extension to 1997 of the physician practice expense payment cut in the Omnibus Budget Reconciliation Act of 1993 (OBRA'93).**

Prolonging reductions in overhead expenses for physicians at this time is ill-advised and may have unintended consequences in regard to the current effort (stipulated in OBRA'93) to establish resource-based relative value units (RVUs) for use in determining future overhead expenses. The resource-based practice expense study is scheduled for implementation in 1998. Resource-based RVUs for the overhead costs of primary care physicians is especially critical given that historically-based overhead cost payments are literally "short-changing" generalists nearly 50-cents on the dollar. We urge you to withdraw this proposal for these reasons.

- **A proposal to limit payments to groups of physicians practicing in hospitals whose volume and intensity of services per admission exceeds 120 percent of the national median for urban hospitals and 140 percent for rural hospitals.**

This proposal is ill-advised on a number of grounds. First, it presumes that the case mix

adjustment used for Medicare hospital payments accurately reflects the physician services provided to inpatients. Second, restitution of inappropriately withheld amounts would be substantially delayed and, in many instances, would be incomplete. Most importantly, this provision constitutes a blunt instrument that would penalize physicians who have not contributed to the alleged excess average relative value and who have no control over those who did cause overruns. Efforts to control excess volume must be targeted on the sources of that excess volume. Of further concern is that the spirit of this provision is totally contrary to Medicare's new quality assurance program, which is intended to function by profiling physician practice patterns, providing physicians with useful information about relative performance, and encouraging physicians to use this information to bring excess volume in line with standards and norms. Providing hospital medical staff with information on per-admission relative values as well as more precise information about variation in relative value would be useful in helping physicians to identify and respond to possible inappropriate care. It is for these reasons that the Academy opposes the prospective withholding of Medicare payments based on projections of high volume and urges you to withdraw this proposal from budget negotiations.

- **A requirement that Medicare establish competitive bidding for clinical laboratory services.**

We are concerned about the implications of competitive bidding for certain Part B services on access to and the quality of these services. A competitive bidding process could open the door to under-bidding, which, in turn, might drive out competitors and lead to inappropriate decrements in access or service. These concerns are especially applicable to rural beneficiaries. Access and quality issues must be addressed before competitive bidding is imposed.

- **A proposal that several additional chemistry tests be added to the existing list of tests that are classified and paid by Medicare as automated tests.**

This recommendation addresses cases of abuses perpetrated chiefly by large commercial laboratories, whereby specific tests with elevated Medicare reimbursement were added to panels by the facility. The tests where subsequently unbundled when submitted for Medicare payment, resulting in a far higher return for the laboratory. These additional tests were never specifically ordered by the physician, but instead, were included in the lab requisition. This example of exploitation of the Medicare program originated in the commercial laboratory, not the physician office laboratory (POL). Consequently, POLs should not be penalized by revision of the panel reimbursement system that they never abused in the first place. Laboratory medicine is an important tool for the physicians' diagnosis and treatment in the total process of rendering medical care. As a result, adequate reimbursement for laboratory testing is equally important as adequate reimbursement for professional services. Family physicians cannot afford to provide laboratory

services below their cost. However, under the scenario of an expanded list of automated test panels, POLs will be expected to provide laboratory services for compensation below their cost. This is because reimbursement for tests performed manually will be made at a level equal to payment for the same tests performed with automated equipment -- a policy which favors larger, better equipped facilities. Most POLs do not have the most up-to-date automated equipment with which commercial facilities are able to take advantage of economies of scale. Indeed, POLs are already financially burdened by the cost of CLIA and OSHA compliance; it would be extremely difficult for most family physicians to withstand further reductions to adequate compensation through an expansion of the number of tests classified and paid for at the automated laboratory level. We urge you to withdraw this provision from consideration in budget talks.

Medicaid Reform

Not to be overlooked in the budget talks is the equally important need to reform the Medicaid program. Unlike the congressional plans in this area, the Administration does preserve the entitlement status of Medicaid. Also, the Administration plan imposes far less severe cuts in overall federal Medicaid spending. Congressional plans, in contrast, not only terminate the entitlement status of this "safety net," but also eliminate minimum national requirements for a defined benefit package while weakening enforcement of landmark 1987 nursing home quality and safety standards. This is unacceptable to the Academy. Our baseline requirements for supportable Medicaid reform are as follows:

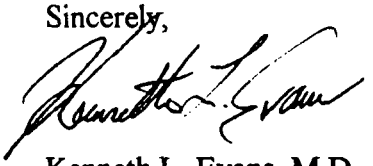
- **Medicaid restructuring cannot increase the number of uninsured individuals;**
- **State flexibility and experimentation with the design of Medicaid benefit plans and delivery systems are desirable, but with the important qualification that restructured Medicaid plans must include a defined benefit package that emphasizes primary and preventive care; and**
- **Nursing home quality and safety standards enacted in 1987 must not be weakened.**

Summary

In closing, we cannot emphasize strongly enough the fact that many of the Medicare and Medicaid policy changes discussed above are needed now, and must not be delayed until next year or, worse yet, until an unspecified point in time after the next election cycle. We believe a favorable opportunity for realizing many of these necessary program improvements is with the passage of a budget reconciliation package in the 104th Congress. We appreciate your attention

to the crucial elements of Medicare and Medicaid reform noted above, and look forward to final action on legislation that achieves the provisions we support.

Sincerely,



Kenneth L. Evans, M.D.
Chair, Board of Directors

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