

March 18, 1996

William Jefferson Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Mr. President:

The American Medical Association and undersigned national medical specialty societies advocate comprehensive reform that will assure the solvency and quality of the Medicare program. As the Administration refines its FY 1997 budget proposal, we urge careful consideration of the following issues which we believe are important in protecting quality medical care and preserving patient access to health care services.

Reductions in Part B Payment

We hope that allocations of any future cuts to Part B take into account the considerable contribution physicians have already made toward reducing Medicare expenditures. Despite working under a flawed OBRA93 payment update -- as described in the next section -- physicians have successfully controlled the rate of growth in Medicare Part B over the last several years.

Medicare Volume Performance Standard (MVPS)

Like you, our goal is to maintain patient access in the Medicare program. With this in mind, it is essential that the flawed MVPS update system be corrected. Specifically, the volume component of the MVPS, which asks physicians to cut volume by four percentage points each year no matter how low volume falls, should be revised. We commend the Administration for addressing this issue in its last Medicare proposal. However, **it is imperative that the volume factor be set at least at the level of real per capita gross domestic product (GDP) plus two percentage points.** We are concerned that anything lower than GDP+2 would result in an annual decrease in the conversion factor. Over time, quality, access, and confidence in the system would deteriorate for Medicare beneficiaries as medical service payments moved even further below private market rates.

Competitive Bidding

We oppose the use of competitive bidding for clinical lab and certain imaging services. While competitive bidding may be appropriate as a purchasing mechanism for goods and services where quality is readily discerned or generally does not vary, it is wholly inappropriate for the purchase of professional services that are tailored to dynamic and highly individual needs. While initial savings may be generated by competitive bidding, the savings may be counterbalanced by a loss in the quality of health care service and diminished access to care where the "winning bidder" is remote from the patient, or where "non-winners" cut back on their provision of the particular service. Such savings are short-sighted and carry

the high potential for negative health care outcomes. Eliminating freedom of choice eliminates a major quality check that oftentimes is a patient's or referring physician's only significant option in directing care; the ability to seek care from the complete range of physicians and other health care providers.

Centers of Excellence

This proposal would direct the Secretary to expand the Medicare demonstration projects for coronary artery bypass and cataract surgery in urban areas, with payment made on the basis of a competitive bid, negotiated, or all inclusive rate. There are simply too many questions and too many potential problems mostly with patient access to justify implementing this proposal. Furthermore, contracts would be awarded to the lowest bidder, quality considerations being otherwise equal. Hence, the name "center of excellence" erroneously implies that certain providers of health care are sanctioned by the government and provide higher quality care than others in the same geographic area. We question expanding these demonstration projects without fully considering the results of the demonstration study.

"High Cost Hospitals"

This convoluted and untested proposal establishes an elaborate scheme of hospital medical staff volume performance standards. In general, it requires the Secretary of Health and Human Services (HHS) to project a hospital-specific per admission relative value for the next year for each hospital and to estimate whether or not this hospital-specific projected relative value will exceed the allowable average per admission relative value applicable to the hospital for the following year. Where payments for medical services exceeded the established threshold, the Secretary of HHS would have the authority to reduce physician payments for inpatient care.

This proposal creates a new and onerous regulatory structure based, at best, on limited data. It also requires medical staffs to establish expensive fiscal and administrative structures to monitor care using measures that may not be appropriate for such a purpose. Finally, this proposal shifts both hospital and physician payment incentives to reward the provision of the least amount of care, irrespective of effectiveness or quality or the patient's needs. Physicians as well as other care givers should not be penalized for advocating appropriate care for their patients. For relatively few budget savings, this proposal could wreak havoc with hospital medical staffs and with the Administration's credibility with physicians on physician payment issues.

Practice Expense

We would oppose further reductions in physician practice expenses. The Health Care Financing Administration (HCFA) is in the process of gathering data for potential adjustments in practice expenses. The data would be integrated into the resource-base relative value scale and implemented in 1998 as mandated by Congress. Arbitrary reductions at this time would interfere with this process.

American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology - Head and Neck Surgery, Inc.
American Academy of Physical Medicine and Rehabilitation
American Association of Clinical Endocrinologists
American College of Cardiology
American College of Obstetricians and Gynecologists
American College of Nuclear Physicians
American College of Rheumatology
American Gastroenterological Association
American Medical Association
American Osteopathic Association
American Pediatric Surgical Association
American Society for Dermatologic Surgery
American Society for Gastrointestinal Endoscopy
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of General Surgeons
American Society of Hematology
American Society of Internal Medicine
American Society of Plastic and Reconstructive Surgeons, Inc.
American Society for Reproductive Medicine
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College of American Pathologists
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Society of Cardiovascular and Interventional Radiology
Society of Critical Care Medicine
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