

Statement to the

House Committee on Small Business
Subcommittee on Regulations, Health Care and Trade
United States House of Representatives

“MEDICARE REIMBURSEMENT CUTS: The Potential Impact on Solo and Small Group
Medical Practices”

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Mr. Chairman, my name is Melinda Allen. I am in a solo private internal medicine practice in Ponca City, Oklahoma. I am honored to be here today on behalf of the American Osteopathic Association (AOA) and the nation's 61,000 osteopathic physicians practicing in all specialties and subspecialties of medicine. I also wish to acknowledge my colleagues in the American College of Osteopathic Internists for their assistance with my appearance here today.

The AOA and our members appreciate the continued efforts of you and the Committee to raise awareness regarding the devastating impact current Medicare reimbursement policies are having upon Medicare beneficiary access to physician services and on physician practices—especially those like mine.

In my testimony, I will lay out the impact current payment policies are having upon my business and my ability to provide care to my patients, to support the financial needs of my practice, and to meet the growing demands placed upon physicians. The AOA shares the Committee's goal of reforming the Medicare physician payment formula and improve the quality of care provided by physicians.

Nowhere do Medicare beneficiaries experience access to care issues more severely than in the rural communities. Rural communities, like those in which I live and serve, are home to seniors who have had little or no preventive care. Additionally, due to the difficulty of attracting and retaining physicians in these communities, they are much less likely to have had a consistent relationship with a physician. As a result, they are more likely to have multiple chronic conditions. Sadly, many new Medicare beneficiaries in these areas find that the physicians serving these communities have no room in their practices for new Medicare patients. These realities have shaped the person, and ultimately the physician, I desire to be.

I was born to a farming family in rural Oklahoma. Hardworking people, my parents and grandparents instilled in me the desire to serve and persevere. I am a first generation physician, inspired at the age of thirty to apply for medical school. I began my studies at the Oklahoma State University College of Osteopathic Medicine in 1995. Then thirty-two years old, I was a full time medical student as well as a young mother raising a four year old and a 6 month old. Upon graduation, there were several opportunities presented to me that would have allowed me to keep my family in Tulsa. Although taking a position with a hospital or in a private practice in a large city like Tulsa would have allowed much more financial stability, I was determined to return to my roots in rural Oklahoma.

In 2002, I decided to open a private practice in Ponca City, Oklahoma. A small rural community of about 28,000 residents, Ponca City was once the home of Conoco Petroleum. International and domestic crude oils are still processed in the region. An aging community, Ponca City and neighboring areas are feeling the strain from a lack of physicians practicing in the area.

I opened Internal Medicine Associates of Ponca City with a partner in June of 2002. I was able to purchase a small building in Ponca City and renovate it for use as a medical practice. Despite our best efforts, my partner could not support his family, manage his medical school debt, and sustain his portion of the practice. Just a short year after opening the practice, he filed for bankruptcy and left Ponca City. Suddenly, I discovered that I was a young physician and a small business owner

with a mortgage on a practice and a staff to support. I struggled financially. However, I continued to accept Medicare beneficiaries, despite payment rates that did not meet rising practice costs.

My small practice has six employees, including a full-time nursing staff, an office manager, and a front office staffer. I own my building, and serve as my own landlord. As with any small business, I struggled early on. Often, it seemed the growth in practice expenses were unsustainable given the stagnant rates of reimbursement from both Medicare and private payers, who set their annual rates based on those of Medicare.

In my first year of practice, Medicare physician payments were cut 5.4 percent. Since that time, Congress provided physicians with increases of 1.6 percent in 2003, 1.5 percent in 2004 and 2005, and freezes for 2006 and 2007. While Congressional actions over the past five years to avert additional cuts are appreciated, costs associated with running my medical practice over the last five years are approximately two times the amount of the payment increases provided by Congress. This is an impossible way to sustain any business.

In 2006, I reluctantly stopped admitting new Medicare patients into my practice. Since that time, I estimate that I turn away six to eight beneficiaries daily that are seeking admittance as a new Medicare patient. My patient base consists of approximately 5,000 patients, 25 percent of whom are enrolled in Medicare. However, in the months of February and June of 2007 I saw 526 and 560 patients respectively. In each of those months, Medicare beneficiary visits totaled over 40 percent of all evaluation and management appointments in my practice. While tallying only 25 percent of the patient base, these elderly patients with multiple chronic conditions and little preventive care account for close to half of the patient visits to my office each year.

In 2005, I took on the responsibilities as Chief of Medicine at Ponca City Medical Center. In 2007, I was named Chief of Staff. This facility is the main healthcare provider for Ponca City and the surrounding areas. In the last year, our community lost four physicians and is unable to attract new physicians. Of the 50 physicians working in the Medical Center, only 6 primary care physicians are actively admitting patients. The loss of physicians means that those working in the hospital have seen increases in the amount and length of time they are required to serve away from their practices. Hospital compensation is minimal and many of the patients entering the Ponca City Medical Center are uninsured.

In addition, I serve as Medical Director of the Ponca Center Nursing Home where I manage the care of approximately 70 residents. Most of these patients are enrolled in Medicaid. These residents typically have multiple chronic and complex medical conditions. Managing their care consists not only of the individual visit for which I am compensated, but many hours of follow-up as well, including coordination with other health professionals tasked with caring for these residents. This time, for which physicians are not compensated, is the pivotal distinction between managing health and providing acute health care.

The discord between managing health and providing acute care is prevalent among populations in northern Oklahoma, where many communities qualify as a Medically Underserved Area under the U.S. Department of Health and Human Services. Health disparities manifest themselves in

uninsured or underinsured populations where patients often avoid seeking care, receive inadequate care, or suffer from undetected and untreated health conditions.

Many communities in northern Oklahoma are designated as Health Professions Shortage Areas, (HPSAs) due to the rural nature of the area and the large population of Native American members of the Ponca Indian Tribe. The nearby community of Newkirk houses the Newkirk Rural Health Clinic as well as an Indian Health Service Clinic. In these areas, a physician often serves as an “extender,” overseeing care provided to patients by a physician’s assistant or nurse practitioner.

I spent several years staffing the Newkirk Rural Health Clinic as a supervising physician because I felt it was important to support this underserved community. In 2006, an uninsured patient received incorrect treatment from a physician’s assistant on staff with the clinic. Though I was not personally connected to this patient or his treatment, as the supervising physician, I found myself in a dispute over medical liability. As much as I was pained to leave the clinic, I ceased my responsibilities shortly thereafter, refocusing on my practice. My decision to no longer serve the Rural Health Clinic created additional access to care problems for many patients, but I felt the economic volatility of my involvement was not conducive to continued service.

I also serve northern Oklahoma as a Qualified Veterans Physician contracting with the Veterans Administration. Through this program, I see approximately 700 veterans in my practice. In the VA Health Care System, patient records are maintained electronically within the Computerized Patient Record System (CPRS). This system is often discussed as a “model” for the implementation of an interoperable health information technology system. While far more advanced than a traditional paper chart system, the CPRS system is not without its flaws. The system is complicated and does not interface with other electronic medical record (EMR) systems in clinics across the county. To interface the CPRS data with my own electronic billing system, I employ one full time assistant tasked with the sole responsibility of transitioning this data between systems. Though the reimbursement rates under the Veterans Administration program are somewhat more stable than Medicare reimbursements, the ancillary costs counterbalance the slight appreciation in payment.

In 2004, after spending a significant amount of time and resources, I implemented an electronic billing system. While it has helped to manage patient data, process electronic claims, and schedule appointments, it has not increased the number of patients I am able to see in a day. It also has not helped to track patients for involvement in the Physician’s Quality Reporting Initiative (PQRI), in which I participate. Without the aid of an electronic medical records system, I weighed the options of participation in the PQRI. Devising a color coding system to identify which measures to report on and which patients qualified to be treated for those measures, my staff and I continue to record and report these measures by hand. In total, I anticipate a bonus payment in January of just over \$5,000, less than the cost of supplies, staff and time it takes to participate. I continue to contribute to this effort, however, because I want my government to know that I am a quality practicing physician.

To aid in my continued participation, and to enhance my patient services, I am examining all options for purchasing and implementing an electronic health record system. Many of the systems that are available to me are not capable of communicating with other systems in my office or in the community. This suggests that any system I invest in will need to be upgraded or replaced as new

standards are developed. Due to limited resources, these upgrades will be particularly difficult for all rural physicians.

I believe that a national, interoperable health information system is vital to the care management of my patients. However, I do not believe that such a system should be an unfunded mandate placed on physicians who are small business owners. Assisting physicians like myself in the selection, implementation and utilization of these systems for care management, electronic consultation and prescribing, and the expansion of patient registries is an approach that is preferable. I appreciate the work that the Chairman of this committee has done to ensure that tax incentives and Medicare payment incentives encourage physicians who are dedicated to these communities most in need, like myself, are able to provide patients with the same technology as my more urban counterparts.

As stated earlier, I employ a staff of six, including a full-time nursing staff, a front office staffer, and an office manager. I provide my employees with annual cost of living increases, though there is not an annual update in my payments from Medicare. My office is open for an estimated 235 days per year. This allows for 1 week of vacation, one week of continuing education, and 10 holidays.

Generally I average 22 to 25 patients per day during a 60 hour work week, totaling 5,170 to 5,750 patient visits per year. My estimated practice costs in 2007 will be \$264,370.00 This number includes only those items necessary to operate my practice daily, such as mortgage payments, utilities, property taxes, payroll, medical liability insurance, and medical and office supplies, as well as annual maintenance on my electronic billing software.

As evidenced by the chart below, assuming that I continued to see only Medicare patients over the next five years, I will not be able to sustain my business through 2015 with the impending cuts to reimbursement rates.

	Type of Visit	Current level of Reimbursement	Number of visits (assuming 25 patients per day)	2007	2008 (-10.1%)	2009 (-5%)	2015 (-40%)
Medicare Insurance	level 3	\$48.16	2875	\$138,460.00	124475.54	\$118,251.77	\$83,076.00
Medicare Insurance	level 4	\$75.75	2875	\$214,781.25	193089.35	\$183,433.94	\$128,868.75
Total Reimbursement				\$356,241.25	317563.89	\$301,685.71	\$211,944.75
Less Cost to Operate* (Assuming 3% Cost of living adjustments)				\$264,370.00	\$272,301.10	\$280,470.13	\$334,895.97
Net Income for Practice				\$91,871.25	\$45,262.79	\$21,215.58	(\$122,951.22)

With these same conditions, sustaining a practice split as it is currently with 25% Medicare patients and 75% private insurance is difficult given that private payers set their rates based on Medicare payments in a given year. Splitting my practice between private insurance and Medicare still is detrimental to my business. As referenced by the chart below, if the scheduled payment cuts are realized, by 2015 I will be operating at a \$65,000 annual loss.

	Type of Visit	Current level of Reimbursement	Number of visits (assuming 25 patients per day)	2007	2008 (-10.%)	2009 (-5%)	2015 (-40%)
Private Insurance	level 3	\$65.02	2156	\$140,183.12	\$126,024.63	\$119,723.40	\$84,109.88
Private Insurance	level 4	\$102.26	2156	\$220,472.56	\$198,204.84	\$188,294.60	\$132,283.54
Medicare Insurance	level 3	\$48.16	719	\$34,627.04	\$31,129.71	\$29,573.23	\$20,776.22
Medicare Insurance	level 4	\$75.75	719	\$54,464.25	\$48,963.36	\$46,575.19	\$32,678.55
Total Reimbursement				\$449,746.97	\$404,322.54	\$384,106.42	\$269,848.19
Less Cost to Operate* (Assuming 3% Cost of living adjustments)				\$264,370.00	\$272,301.10	\$280,470.13	\$334,895.97
Net Income for Practice				\$185,376.97	\$132,021.44	\$103,636.29	(\$65,047.78)

These numbers indicate the real impact that the Medicare physician payment cuts have on a small business owner. Modest increases in annual operational costs do not include major maintenance or repairs, hiring of new staff, investing in health information technology, or any other challenges facing a solo practitioner. Without any real adjustment to the system, many physicians like myself, that are called to serve in these rural communities, will be unable to do so, compounding the existing health disparities and leading to a true access crisis for the millions of beneficiaries expected to be added to the Medicare system in the years to come.

MEDICARE PHYSICIAN PAYMENTS: 2008 AND BEYOND

Since its inception in 1965, a central tenet of the Medicare program has been the physician-patient relationship. Beneficiaries rely upon their physician for access to all aspects of the Medicare program. Over the past decade, this relationship has been compromised by dramatic reductions in reimbursements, increased regulatory burdens, and escalating practice costs. Given that the number of Medicare beneficiaries is expected to double to 72 million by 2030, now is the time to establish a stable, predictable, and accurate physician payment formula. Such a formula must:

- Reflect the cost of providing care;
- Implement appropriate quality improvement programs that improve the overall health of beneficiaries; and
- Reflect that a larger percentage of health care is being delivered in ambulatory settings versus hospital settings.

The AOA strongly supports the establishment of a new payment methodology that ensures every physician participating in the Medicare program receives an annual positive update that reflects increases in the costs of providing care to their patients. Moreover, the AOA is committed to ensuring that any new physician payment methodology reflects the quality of care provided and efforts made to improve the health outcomes of patients. As a result of this commitment, we continue to support the establishment of standards that, once operational, will allow for the reporting and analysis of reliable quality data. Additionally, we support the establishment of a fair and equitable evaluation process that aims to improve the quality of care provided to beneficiaries.

It remains our opinion that the current Medicare physician payment formula, especially the sustainable growth rate (SGR) methodology, is broken and should be replaced with a new formula that reimburses physicians in a more predictable and equitable manner. We recognize that comprehensive reform of the Medicare physician payment formula is both expensive and complicated. However, we believe that the long-term stability of Medicare, the future participation of physicians, and continued access to physician services for beneficiaries are dependent upon such actions.

The AOA believes that a future Medicare physician payment formula should provide annual positive updates that reflect increases in practice costs for all physicians participating in the program. Additionally, while we support the establishment and implementation of “pay-for-reporting” programs, we believe that these programs should be phased-in over a period of two to three years and that physicians choosing to participate in such programs receive bonus payments above the annual payment updates for their participation. Additionally, we do not believe that the current Medicare payment methodology can support the implementation of a quality-reporting or pay-for-performance program.

Finally, we believe that a future Medicare physician payment formula should provide the framework for a more equitable evaluation and distribution of Medicare dollars. Under the current program, various components are isolated from each other, thus preventing a fair and thorough evaluation of overall spending. As Congress and the Centers for Medicare and Medicaid Services (CMS) establish new quality improvement programs, it is imperative that Medicare reflect fairly the increased role of physicians and outpatient services as cost savers, especially to the Part A Trust Fund. Quality improvement programs may increase spending in Part B, but very well could result in savings in Part A or even Part D. These savings should be credited to physicians. We encourage Congress to pursue this as a means of stabilizing Medicare financially.

The AOA continues to encourage Congress to take appropriate steps to ensure that all physicians participating in the Medicare program receive positive payment updates for 2008 and 2009 and that Congress put in place mechanisms that begin a transition away from the continued use of the current sustainable growth rate (SGR) formula. The House-approved “Children’s Health and Medicare Protection Act of 2007” (H.R. 3162) included provisions that met these goals and the AOA encourages the House to continue pursuing their enactment into law.

ANALYSIS OF CURRENT MEDICARE PHYSICIAN PAYMENT POLICIES

In 2002, physician payments were cut by 5.4 percent. Congress averted payment cuts in 2003, 2004, 2005, 2006, and 2007 replacing projected cuts of approximately 5 percent per year with increases of 1.6 percent in 2003, 1.5 percent in 2004 and 2005, and freezes for 2006 and 2007.

The AOA and our members appreciate the actions taken by Congress over the past five years to avert additional cuts. However, even with these increases, physician payments have fallen further behind medical practice costs. Practice cost increases from 2002 through 2007 were approximately two times the amount of payment increases.

According to CMS, physicians are projected to experience a reimbursement cut of 10.1 percent in 2008 with additional cuts predicted in years 2009 through 2015. Without Congressional intervention, physicians face cuts of greater than 40 percent in their Medicare reimbursements over the next eight years. During this same period, physician practice costs will continue to increase. If the 2008 cut is realized, Medicare physician payment rates will fall greater than 20 percent below the government's conservative measure of inflation in medical practice costs over the past six years. In plain terms, physicians are paid less today than they were in 2001. Since many health care programs, such as TRICARE, Medicaid, and private insurers link their payments to Medicare rates, cuts in other systems will compound the impact of the projected Medicare cuts.

While there are some steps that can be taken by physicians to streamline their business operations, they simply cannot afford to have the gap between costs and reimbursements continue to grow at the current dramatic rate. Many osteopathic physicians practice in solo or small group settings. These small businesses have a difficult time absorbing losses. Eventually, the deficit between costs and reimbursements will be too great and physicians will be forced to limit, if not eliminate, services to Medicare beneficiaries. Additionally, continued cuts limit the ability of physicians to adopt new technologies, such as electronic health records, into their practices.

Physicians should be reimbursed in a more predictable and equitable manner, similar to other Medicare providers. Physicians are the only Medicare providers subjected to the flawed SGR formula. Since the SGR is tied to flawed methodologies, it routinely produces negative updates based upon economic factors, not the health care needs of beneficiaries. Additionally, the formula has never demonstrated the ability to reflect increases in physicians' costs of providing care. Every Medicare provider, except physicians, receives annual positive updates based upon increases in practice costs. Hospitals and other Medicare providers do not face the possibility of "real dollar" cuts—only adjustments in their rates of increase.

Problems with the Sustainable Growth Rate (SGR) Formula

Concerned that the 1992 fee schedule failed to control Medicare spending, five years later Congress again examined physician payments. The "Balanced Budget Act of 1997" (BBA 97) (P.L. 105-33) established a new mechanism, the sustainable growth rate, to cap payments when utilization increases relative to the growth of gross domestic product (Congressional Budget Office, "Impact of the BBA," June 10, 1999).

This explanation of the SGR not only highlights the objectives of the formula, but also demonstrates the serious flaws that resulted. The AOA would like to focus on three central problems associated with the current formula: physician administered drugs, the addition of new benefits and coverage decisions, and the economic volatility of the formula.

The SGR penalizes physicians with lower payments when utilization exceeds the SGR spending target. However, utilization is often beyond the control of the individual physician or physicians as a whole.

Over the past twenty years, public and private payers successfully moved the delivery of health care away from the hospital into physicians' offices. They did so through a shift in payment policies, coverage decisions, and a trend away from acute based care to a more ambulatory based

delivery system. This movement continues today. As a result, fewer patients receive care in an inpatient hospital setting. Instead, they rely upon their physicians for more health care services, leading to greater utilization of physician services.

For the past several years, CMS has failed to account for the many policy changes and coverage decisions in the SGR spending targets. With numerous new beneficiary services included in the “Medicare Modernization Act” (MMA) (P.L. 108-173) and an expected growth in the number of national coverage decisions, utilization is certain to increase over the next decade. The Congressional Budget Office (CBO) cites legislative and administrative program expansions as major contributors to the recent increases in Medicare utilization. The other major contributors were increased enrollment and advances in medical technology.

An additional major contributor to increased utilization of physician services is the inclusion of the costs of physician-administered drugs in the SGR. Because of the rapidly increasing costs of these drugs, their inclusion greatly affects the amount of actual expenditures and reduces payments for physician services.

Over the past few years, Congress has encouraged the Administration to remove the cost of physician-administered drugs from the formula. The AOA encourages Congress to continue pressing the Administration on this issue. We do not believe the definition of physician services included in Section 1848 of Title XVIII includes prescription drugs or biological products. Removal of these costs would ease the economic constraints that face Congress and make reform of the physician payment formula more feasible.

The use of the GDP as a factor in the physician payment formula subjects physicians to the fluctuating national economy. We recognize the important provisions included in the MMA that altered the use of the GDP to a 10-year rolling average versus an annual factor.

We continue to be concerned that a downturn in the economy will have an adverse impact on the formula. We argue that the health care needs of beneficiaries do not change based upon the economic environment. Physician reimbursements should be based upon the costs of providing health care services to seniors and the disabled, not the ups and downs of the economy.

IMPACT OF CURRENT MEDICARE POLICIES ON BENEFICIARY ACCESS TO CARE

The continued use of the flawed and unstable sustainable growth rate methodology may result in a loss of physician services for millions of Medicare beneficiaries. Osteopathic physicians from across the country have told the AOA that future cuts will hamper their ability to continue providing services to Medicare beneficiaries.

The AOA surveyed its members on July 14-16, 2006 to analyze their reactions to previous and future payment policies. The AOA asked what actions they or their practice would take if the projected cuts in Medicare physician payments were implemented. The results are troubling. Twenty-one percent said they would stop providing services to Medicare beneficiaries. Twenty-six percent said they would stop accepting new Medicare beneficiaries in their practice and thirty-eight percent said they would limit the number of Medicare beneficiaries accepted in their practice.

Many experts concur with these findings. Annual surveys conducted by the Medicare Payment Advisory Commission (MedPAC) show that Medicare beneficiaries are having problems finding a primary care physician. MedPAC, in 2006, concluded that Medicare beneficiaries “may be experiencing more difficulty accessing primary care physicians in recent years and to a greater degree than privately insured individuals.”

HEALTH INFORMATION TECHNOLOGY

A viable interoperable health information system is key to the implementation and success of quality-improvement and performance-based payment methodologies. Our main focus is ensuring that software and hardware used throughout the healthcare system are interoperable. There is no benefit to be found in the utilization of systems unable to communicate with others. Additionally, the AOA believes strongly that systems developed and implemented must not compromise the essential patient-physician relationship. Medical decisions must remain in the hands of physicians and their patients, independent of third-party intrusion.

The AOA remains concerned about the costs of health information systems for individual physicians, especially those in rural communities. According to a 2005 study published in *Health Affairs*, the average costs of implementing electronic health records was \$44,000 per full-time equivalent provider, with ongoing costs of \$8,500 per-provider per-year for maintenance of the system. This is not an insignificant investment. With physicians already facing deep reductions in reimbursements, without financial assistance, many physicians will be prohibited from adopting and implementing new technologies.

A July 2006 survey conducted by the AOA demonstrates this concern. According to the survey, 90 percent of osteopathic physicians responding agreed that “decreased reimbursements will hinder their ability to purchase and implement new health information technologies in their practice.”

PATIENT CENTERED MEDICAL HOME

For the past year the AOA has worked with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Academy of Pediatrics (AAP) to develop a new payment model—the Patient Centered Medical Home—that promotes an enhanced physician-patient relationship. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, developed the following joint principles to describe the characteristics of the PCMH:

Personal physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.

Physician directed medical practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated - All elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services) are interwoven. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home - Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making - Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. Physicians, patients and their families participate in quality improvement activities at the practice level.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provisions of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

We urge Congress to include the PCMH as a central tenant of future Medicare physician payment policy. We are convinced that by enhancing the primary care system, beneficiaries will have access to higher quality and more efficient care. Additionally, we believe the PCMH is capable of improving the overall financial stability of the program by decreasing the costs of providing care to beneficiaries with multiple chronic conditions.

QUALITY IMPROVEMENT AND PAY FOR PERFORMANCE

Today's health care consumers—including Medicare beneficiaries—demand that physicians and other providers provide the highest quality of care per health care dollar spent. The AOA recognizes that quality improvement in the Medicare program is an important and worthy objective. For over 130 years osteopathic physicians have strived to provide the highest quality care to the millions of patients they have cared for. Through those 130 years, standards of care and medical practice evolved and changed. Physicians changed their practice patterns to reflect new information, new data, and new technologies.

As a physician organization, we are committed to ensuring that all patients receive the appropriate health care based upon their medical condition and the latest research information and technology. The AOA recognized the need for quality improvement and the national trend toward quality improvement programs. In response, we took several steps to ensure that our members were educated, aware, and prepared for these new programs.

In 2000, building on the hypothesis that some barriers to transforming evidence into practice may begin during physician post-graduate training and that measurement is key to identifying opportunities for incorporation of evidence based measures into practice, the AOA launched the Clinical Assessment Program (CAP). The CAP measures quality improvements in current clinical practices in osteopathic residency programs. The goal is to improve patient outcomes by providing valid and reliable assessments of current clinical practices. The program has been widely praised and is starting to produce data on the quality of care provided. The CAP is able to collect data from multiple clinical programs and provide information regarding performance back to participating programs. This allows for evaluation of care provided at a single practice site in comparison to other similar practice settings around the region, state, or nation.

In September of 2006, the CAP was made available for physician offices. The “CAP for Physicians” measures current clinical practices in the physician office and compares the physician's outcomes measures to their peers and national measures. The AOA looks forward to working with

Congress and CMS to explore ways that the CAP may be incorporated into broader quality reporting and quality measurement systems.

As Congress began to debate the issues of quality reporting and pay-for-performance, the AOA established a set of principles that guide our efforts on these issues. These principles provide a set of “achievable goals” that assist in the development of quality improvement systems while recognizing the skill and costs benefits of physician services. We support the establishment of standards that, once operational, will allow for the reporting and analysis of reliable quality data. Additionally, we support the establishment of a fair and equitable evaluation process, or pay-for-performance goal that aims to improve the quality of care provided to beneficiaries. To support this goal, in July 2005, the AOA developed the following principles on quality reporting and pay-for-performance.

- The American Osteopathic Association (AOA) supports the establishment of quality reporting and/or pay-for-performance systems whose primary goal is to improve the health care and health outcomes of the Medicare population. The AOA believes that such programs should **not** be budget neutral. Appropriate additional resources should support implementation and reward physicians who participate in the programs and demonstrate improvements. The AOA recommends that additional funding be made available through the establishment of bonus-payments.
- The AOA believes that to the extent possible, participation in quality reporting and pay-for-performance programs should be voluntary and phased-in. The AOA acknowledges that failure to participate may decrease eligibility for bonus or incentive-based reimbursements, but feels strongly that physicians must be afforded the opportunity to not participate.
- The AOA recommends that physicians be central to the establishment and development of quality standards. A single set of standards applicable to all physicians is not advisable. Instead, standards should be developed on a specialty-by-specialty basis, applying the appropriate risk adjustments and taking into account patient compliance. Additionally, quality standards should not be established or unnecessarily influenced by public agencies or private special interest groups who could gain by the adoption of certain standards. However, the AOA does support the ability of appropriate outside groups with acknowledged expertise to endorse developed standards that may be used.
- The Federal government must adopt standards prior to the implementation of any new health information system. Such standards must ensure interoperability between public and private systems and protect against exclusion of certain systems. Interoperability must apply to all providers in the health care delivery system, including physicians, hospitals, nursing homes, pharmacies, public health systems, and any other entities providing health care or health care related services. These standards should be established and in place prior to any compliance requirements.
- The AOA encourages the Federal government to reform existing Stark laws, allowing physicians to collaborate with hospitals and other physicians in the pursuit of electronic health records systems. This will promote widespread adoption, ease the financial burden on

physicians, and enhance the exchange of information between physicians and hospitals located in the same community or geographic region.

- The AOA supports the establishment of programs to assist all physicians in purchasing health information technology (HIT). These programs may include grants, tax-based incentives, and bonus payments through the Medicare physician payment formula as a way to promote adoption of HIT in physician practices. While small groups and solo practice physicians should be assisted, programs should not expressly exclude large groups from participation.
- The AOA supports the establishment of programs that allow physicians to be compensated for providing chronic care management services. Furthermore, the AOA does not support the ability of outside vendors to provide such services.
- The AOA does not support the exclusive use of claims-based data in quality evaluation. Instead, we support the direct aggregation of clinical data by physicians, such as the data collected through the CAP. Physicians or their designated entity would report this data to the Centers for Medicare and Medicaid Services (CMS) or other payers. Claims data are used to look at a provider's total cost for delivering care to a group of individuals or costs associated with various episodes of care. Based on that information, private insurers commonly place doctors into tiers. Patients are then "steered" to those doctors identified with lower resource use. We believe these practices are misleading to patients and do nothing to enhance consumer awareness of health care services. In fact, using claims data may put patients at risk by steering them to physicians and institutions that do not merit a high ranking.

Ongoing efforts to address the issues of transparency and public reporting are occurring in Congress, in the courts, and by private payers, and are being masked as "quality improvement" initiatives. While the AOA is committed to the collection of data and the utilization of that information to better educate patients, we continue to oppose the public release of Medicare claims data in a physician-identified format because claims data alone are insufficient for quality improvement. Giving payers access to claims data will hinder the development of reporting systems that include OR accept clinical data. The implementation of this decision would most certainly interfere with the implementation of the Medicare Physician Quality Reporting Initiative (PQRI), a program that the AOA and many physician organizations support.

Attempting to join measures of cost to "quality" in order to identify providers delivering the highest quality care in the most efficient manner is a noble goal. However, the focus of such measurement cannot be derived from an individually billed service, such as an exam or surgical procedure, but rather should be assessed by episodes of care looking at all aspects of inpatient, outpatient, and other care a patient may receive during illness. Without reliable information regarding episodes of care, the use of claims data can lead to payers inaccurately "tiering" or "profiling" physicians. The result is physicians who are forced to select patients based on the probability of favorable outcomes. Such risk aversion by physicians will obstruct access to care for those in the greatest need, exacerbating health care disparities.

It is widely accepted that data must be reported back to physicians and other health care providers on a routine and frequent basis in order to affect and measure change in practice patterns. Reports based on this information are beneficial and meaningful to physicians when they are comprised of clinical data measures. Amassing numeric information on the number of procedures performed by a physician and releasing this massive amount of raw data to the public will not provide crucial information on service quality, patient health status and outcomes – all of which are necessary to assess performance. The public release of such irrelevant data can only lead to confusion on the part of the patient, and ultimately a fractured, incomplete and inaccurate portrait of the quality of health care they believe they are receiving.

Patient care is the composite product of many interwoven processes and activities within and across practice care settings. Attributing an outcome or measure to a single physician oversimplifies performance measurement, diminishes the preferred model of team-based care and undermines the ideal collaborative design necessary to delivering patient-centered care. Publicly releasing large amounts of data attributing a single event to a physician based on billing patterns creates a view of health care that is skewed and dangerous. Misinterpretation of data and fear of exposure will lead patients to shield vital information from their physician, putting their health at risk.

SUMMARY

Reform of the Medicare physician payment formula, specifically, the repeal of the sustainable growth rate (SGR) formula, is a top legislative priority for the AOA. The SGR formula is unpredictable, inequitable, and fails to account accurately for physician practice costs. We continue to advocate for the establishment of a more equitable and predictable payment formula that reflects the annual increases in physicians practice costs.

The AOA believes that a multi-faceted approach is needed to address this issue. We believe that Congress must ensure that all physicians receive positive payment updates for 2008 and 2009, and that a mechanism that allows for the transition away from the current sustainable growth rate (SGR) methodology be put in place. Additionally, we urge Congress to implement the patient centered medical home in the Medicare program as a means of improving access to primary care physicians, reducing costs, and enhancing the quality and efficiency of care. Finally, Congress should evaluate Medicare financing as a whole, versus the individual parts. Congress should study the overall financing structure of the Medicare program to determine if increases in Part B as a result of improved access and quality of care delivered results in savings in other parts of the program. We view the elimination of “Medicare funding silos” as a reasonable and obtainable means of partial financing, for a future physician payment formula.

I would like to express my gratitude to the committee for focusing its attention on this vital segment of our nation’s small business community which is often overlooked in these conversations. No other segment of the American economy faces a more complex and expansive set of federal and state regulations than medicine. Navigating and complying with these regulations only adds to the costs of operating our practices. As a small business owner, I comply with regulations that fail to provide compensation comparable to increases in operating costs while limiting my ability to recover losses by passing on costs through fees. As a physician and small

business owner, I operate today at approximately the same level of compensation I received when I opened the doors to my practice over five years ago.

I appreciate this Committee's willingness to ensure that these small businesses are able, economically, to participate in the Medicare program. The members of the American Osteopathic Association urge Congress to approve reforms that provide every physician annual payment updates that accurately reflect increases in practice costs.