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FULL COMMITTEE HEARING ON MEDICARE PHYSICIAN FEE CUTS: CAN SMALL PRACTICES SURVIVE?

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UNITED STATES HOUSE OF REPRESENTATIVES

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FULL COMMITTEE HEARING ON MEDICARE PHYSICIAN FEE CUTS: CAN SMALL PRACTICES SURVIVE?

Thursday, May 8, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 10:00 a.m., in Room 1539 Longworth House Office Building, Hon. Nydia Velázquez [chairwoman of the Committee] presiding.

Present: Representatives Velázquez, González, Grijalva, Ellsworth, Sestak, Chabot, Akin, Davis, Fallin, and Buchanan.

OPENING STATEMENT OF CHAIRWOMAN VELÁZQUEZ

Chairwoman VELÁZQUEZ. Good morning. I call this hearing to order on "Medical Physician Fee Cuts: Can Small Practices Survive?" Our health care system is facing many challenges today that are not only affecting patients but also medical providers. One of the greatest obstacles confronting small health care practices is the fiscal problem in the Medicare program.

With the baby boomer generation entering retirement, Medicare spending will increase exponentially over the next ten years. Efforts are underway to ensure access to health care remains while also meeting the long-term financial issues facing the program.

One of the top priorities in the upcoming months is addressing the scheduled cuts in physician fee payments. On July 1st, physician payments for Medicare services are scheduled to be reduced by 10.6 percent. Without option, these cuts will continue annually. And it is predicted that the total reduction will be about 41 percent by 2016.

Practitioners have warned that cutting doctor payments will undermine the physician foundation of Medicare for current and future generations of seniors, creating unnecessary barriers to care for older Americans. An AMA survey found that 60 percent of doctors believe this year's cut alone will force them to limit the number of new Medicare patients they can treat.

This hearing today will examine how any solution must account for small health care practices. In crafting a fix, the unique circumstances of small health care providers must not be ignored.

It is clear that they could be the most severely affected. Doctors surveyed by the American College of Physicians said cuts will force them to postpone purchases for their practice and to reconsider plans to upgrade health information technology.

Other providers went further, saying they will reduce their staff or get out of patient care altogether. Unfortunately, the administration has taken the position that the cuts are necessary, even if it could mean loss of access for our seniors.

In finding a solution to this problem, CMS must be an active participant, which is why the Committee has invited CMS here today. The Committee looks forward to CMS' testimony on what they are doing to work with the physician community. It is critical they hear the concerns of medical professionals here today and across the country on the potential implementation of the cuts as well as ways to mitigate their impact.

This includes reducing the paperwork burden and providing regulatory relief to help physicians reduce costs associated with operating a practice. With the cuts a little more than a month away, there are steps being taken to avoid this problem. The question simply becomes, how should it be done? And what does it mean for physicians?

The Senate has outlined a plan that will delay the Medicare physician payment cuts for 18 months. I support their effort to address this problem in the near term, but I also believe we should be working to finding a more permanent fix to Medicare's physician fee cuts, one that reflects the cost increases inherent in practicing medicine and preserves access to coverage for seniors.

Any fix needs to address the needs of small physician practices. A solution that doesn't meet this goal could mean that patients could face problems in accessing health care in the future.

I hope that during today's hearing, our witnesses will shed light on the steps they believe should be taken. It is also my hope that the panelists will provide insight on the short, long-term impact the cuts could have on the provider community.

In many ways, the physicians' community interests are aligned with those of the seniors that receive care. The Committee wishes to hear these concerns and how we can work together for a proper remedy.

I look forward to today's testimony. And I thank all of the witnesses for their participation and now yield to Mr. Chabot for his opening statement.

OPENING STATEMENT OF MR. CHABOT

Mr. CHABOT. Thank you, Madam Chair. And good morning to everyone. And thank you for holding this hearing on Medicare physician fee rates and cuts, et cetera.

This Committee and our nation recognize that small medical practices are critical to the country's overall physical and mental health and, like all other small businesses, essential to our economic well-being. I would like to extend a special thanks to each of our witnesses who have taken the time to come here and who will be providing testimony here this morning.

I especially want to welcome Dr. Charles Mabry, who is testifying on behalf of the American College of Surgeons. I am sure that we will find his testimony and all of the witnesses especially helpful. And I also want to especially thank Tom DiAngelis, who is from the greater Cincinnati area, who will also be testifying this morning.

Data on medical practice size show that physicians and patients continue to prefer small practice settings. The small setting allows the physician to have control of medical decision-making and is most conducive to the relationship of trust and confidence between physician and patient.

The practical preference of a small practice setting suggests that any Medicare physician fee system must be feasible and easily operable in a small practice setting. The managed care backlash is also driving the insurance industry toward traditional insurance principles that instruct insurers, like Medicare, to manage financial risk and allow providers to manage care.

The insurers forays into disease management emphasize this change in behavior with only cautious and limited outreach to physicians. The current Medicare physician fee schedule is clearly flawed.

Since its inception in 2002, the sustainable growth rate formula has required the government to reduce physician fees. Since 2003, Congress has passed and the President has signed laws that have prevented the reductions from actually taking place. The current system rewards the physician for seeing as many patients as possible and sometimes performing excessive services.

An example of this practice is the use of a CAT scan sometimes, rather than an X-ray, for example. Several studies have confirmed that expensive or excessive services do not necessarily lead to better quality outcomes.

As physicians, costs go up. And their Medicare reimbursements drop or are unrealistically low. They are engaged in a vicious cycle that forces them to see more and more patients to take in the same amount of money.

Medicare pays its providers based on quantity without rewarding those providers who improve quality. In fact, Medicare pays more when poor care results sometimes in preventable services. This needs to be changed.

Today access remains good for beneficiaries accessing current physicians and for those seeking new physicians. Continued efforts to monitor and protect Medicare beneficiary access are warranted. The Medicare physician fee schedule should be restructured to place a greater value on the quality of care and the efficient use of resources.

Attention should also be given to improved health IT efforts. Making electronic Medicare records available to patients' physicians will cut down on unnecessary tests, help doctors provide better care, and offer economic benefits to taxpayers and the federal budget.

We have an excellent panel of witnesses, as I mentioned before, here today. And I look forward to hearing their thoughts. I want to thank the Chair again for holding this important hearing. And I yield back the balance of my time.

Chairwoman VELÁZQUEZ. Thank you, Mr. Chabot.

And now I welcome the honorable Herb Kuhn. Mr. Kuhn is the Deputy Administrator of the Centers for Medicare and Medicaid Services. Most recently, he served as the Director of the Center for Medicare Management. As CMM Director, Mr. Kuhn was respon-

sible for the development of the regulations and reimbursement policies for Medicare, which covers 43 million elderly and disabled Americans.

Welcome, sir.

STATEMENT OF HONORABLE HERB B. KUHN, DEPUTY ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. KUHN. Thank you, Chairwoman Velázquez, Mr. Chabot, distinguished members of the Committee. Thank you for inviting me today to discuss Medicare physician payment.

Continued improvement in quality and access of health care for Medicare beneficiaries and all Americans requires the active participation of physicians. And in order to ensure that participation, Medicare needs to appropriately compensate physicians for the services they provide to people with Medicare. But how we pay also matters.

We need a payment system that will support high-quality care and avoid preventable costs to the program and to society. Simply adding expensive payment updates to the current system would be extremely expensive from a financing standpoint and would not promote better quality or more efficient care.

The current system has the effect of directing more resources to care that is not of the highest quality, such as duplicative tests and services or hospital readmissions. And it doesn't do as good a job as possible in treating those with chronic conditions. That is why payment reform is also so critical for Medicare beneficiaries, who are impacted in several ways. Not only are they impacted by access issues, but they also are threatened by rapid growth and expenditures that could make services unaffordable.

Growing physician costs directly impact Medicare beneficiaries through increased Part B premiums, coinsurance, and premiums for supplemental coverage. The current Medicare Part B premium stands at $96.40 per month.

As MedPAC recently noted, over the 1999 through 2002 time period, the Part B premium grew by an average of 5.8 percent per year while cost of living increases for Social Security benefits averaged just 2.5 percent per year.

Since 2002, the Part B premium has increased even faster, by 13.5 percent in 2004, 17.4 percent in 2005, 13.2 percent in 2006, and 5.6 percent in 2007. Right now 29 percent of an individual's Social Security check is applied to paying Medicare premiums, coinsurance, and deductibles.

The recent Medicare Trustees Report notes that the Medicare Part A trust fund will be insolvent by 2019. That is 11 years from now. That means if you are 54 years old today, the trust fund will be insolvent the day you are eligible for Medicare. For Medicare Part B, the Trustees Report noted an annual spending growth rate of 9.6 percent for the past 5 years per year.

This kind of course in uncertainty for Medicare beneficiaries and physicians is why CMS has been working with Congress and the physician community over the past several years to provide a better way to pay physicians. Our work centers around new concepts in the area of value-based purchasing with a goal of transforming

CMS from its current role of a passive payer of services into an active purchaser of high-quality, efficient care.

Nobody disputes the fact that there are problems with the current statutory formula for calculating annual physician payment updates. To date, we have seen short-term fixes instead of a comprehensive strategy for long-term reform. The problem with this approach is that it runs up the tab and makes the next scheduled cut even larger.

Case in point. As people have noted already, this July the law requires doctors' fees to be cut by 10.6 percent. Physicians face another five percent cut on January 1, 2009, and every year thereafter for the next decade.

We at CMS are very concerned by this tremendous uncertainty and what this Band-Aid approach causes in terms of physician-level participation in the program, particularly for the small practice, as the Chairwoman noted.

In order to move forward with physician payment reform, we have embarked on the following initiatives. First, we are addressing the inappropriate payment rates for certain individual services in the physician setting. In 2006, we completed the third 5-year review of physician payments. This resulted in a major rebalancing that provides for higher payments to primary care physicians.

Second, we are looking at creating larger bundles of payment for care across the entire episode of care. We and others believe this holds real promise for higher quality, particularly in the area of hospital readmissions and greater efficiencies.

Third, we have a shared savings demonstration that rewards physician practices for achieving higher-quality outcomes and savings. The demonstration is already showing impressive results. And we soon will be launching new electronic health record and medical home demonstrations.

Fourth, we are looking at better ways to measure physician resource use with actual reports being issued to physicians on how they compare with similar physicians in terms of their resource use.

And, then, finally, we have the physician quality reporting initiative up and running. Physicians are beginning to report on evidence-based quality measures. And the first payments under this system will be made to physicians this summer. The program is an important building block towards a value-based system for physicians.

To be sure, none of the steps that I and others will be presenting today represent the proverbial silver bullet everyone is looking for to address physician payment reform. If this were easy, it certainly would have been done long ago.

While many of these issues are technically complex, they represent the best thinking we and others have at this time. And, importantly, there was a growing consensus among all stakeholders that this was the right direction for the Medicare program.

So thank you again for the opportunity to testify on Medicare physician payments. CMS appreciates this Committee's review of this issue. And we look forward to continuing to work with you and Congress on this very important issue.

[The prepared statement of Deputy Administrator Kuhn may be found in the Appendix on page 46.]

Chairwoman VELÁZQUEZ. Thank you, Mr. Kuhn. And the Chair recognizes Mr. Ellsworth.

Mr. ELLSWORTH. Thank you, Madam Chair. Thank you, Mr. Kuhn.

You pretty much answered my question there when you said I don't have the silver bullets in my last five bullet points. Maybe you can address if those aren't the silver bullets that are going to fix this system because I agree with the Chairwoman and Mr. Chabot that this is something that we keep Band-Aiding and Band-Aiding and Band-Aiding 6 months, 18 months. It is not long enough. And it is not going to work. And our doctors and physician health care system needs it fixed. And we keep hearing that the next president.

And I continue to say we can't afford to keep waiting for the next president to do something. You know, this is going to be a tough debate and a lot of tough questions we have to ask ourselves. It is going to hurt. And it is going to take all of the stakeholders to talk about this.

Some of the things I heard from a medical professional last week. Sixty-two percent of all medical costs occurred in the last two weeks alike. If that is true, I would like to know that. And then that sparks a debate.

Nobody really wants to talk about this, but how do we deal with end-of-life issues? And are we going to change things in that arena? That is going to take I think generations of this country in how we deal with that.

We hear a lot about tort reform. I don't think you mentioned that in your statement. How much of it is really about liability and tort reform? Is that one of the silver bullets that needs to be added in there?

And then comparing apples to apples, I don't know if I have a question, but if you could address any of these things that—you know, who is giving what health care when I go in a standard of care? And I don't know what I am really asking, but we have got to start comparing apples to apples here.

I look at maybe it is a tier system. We have got to be able to talk out loud without getting your head chopped off for bringing these issues up. But, you know, the one person's insurance policy or health care policy is the same as the next person's and a standard across systems but maybe in those first ones about end-of-life issues, tort reform, maybe that helps.

Mr. KUHN. A lot of good thoughts there. And I think you are kind of swirling around the area where all of us have been kind of grappling with on these issues because if you really look at the current physician system, an economist would say you get what you pay for.

So nobody should be surprised that we have this great volume in this intensity of services for physician payment because when you really step back and look at it, it is a piecework system. You know, it is a fee schedule and we pay on 7,000 different codes in the system. And what are all the economic incentives in a piecework system? It is to do more.

And then you have this SGR cap on top of that, which basically penalizes all physicians equally. So if you are a physician that is practicing in an efficient way and someone else is practicing inefficiently, you get hit just as hard as the guy who is inefficient. So it is really kind of unfair in that regard as to how it looks forward.

So a lot of things that we are doing on our demonstrations and some of the programs that we have already started to build, infrastructures start to get at that. One is dealing with this issue in terms of cost variation around the country. Folks up at Dartmouth, Elliott Fisher and Dr. Winberg, have done some wonderful work about looking at great variations around the country and a lot of it about end-of-life care.

And we see sometimes a three- or four-fold difference in terms of spending in different parts of the country, as you indicated, with no material difference in terms of the outcome of care.

So one of the things we are really working with—pretty collaboratively with the physician community—is really to measure because if you really don't measure, you can't really improve. And so we are looking at new measurement outcomes, new quality measures, efficiency measures, where we can start to measure this and where physicians can compare themselves one to another to see how they are performing to see if we can get rid of some of this variation out there.

So there are a lot of different swirling activities out there, but I think you are asking the right questions. How do we fundamentally begin to look at what the gaps are in care, address those gaps, and improve? And part of that fundamental foundation of what we are doing is measurement so in the future we can start paying for outcomes, not just pay for services.

Mr. ELLSWORTH. That is all I had, Madam Chair. Thank you.

Chairwoman VELÁZQUEZ. Thank you.

Mr. Buchanan?

Mr. BUCHANAN. Thank you, Madam Chair.

I want to compliment my colleague from Indiana. I think he has got it right. This is a huge, serious problem. I am in a district, in a country, number one, as a member of Congress, with the most seniors, 65 and over, 176,000 according to groups. We have got the baby boomers this year first turning 62, talk to doctors, head of our medical society, Dr. Patel.

Since 1991, they have looked at continued cuts, but, yet, 90 to 95, 85 percent of their practice is Medicare. Their expenses continue to go up in terms of taxes, insurance, MedMEL, and all of these other things. And I know at the end of the year, a lot of them felt they were going to go out of business if they had that cut.

So when we are talking about these additional cuts that we are talking about—and I think there was some thought early on with Medicare that it would be 20 or 30 percent of your practice. But in areas like Florida and my area, I am sure different parts of the country, it has evolved, 85-90 percent of the government. They are basically working for the government.

So the bottom line, I just don't see. They can't attract a new doctor to our area. I think they have had one in a 300,000-population county, they were telling me, one medical society. They can't at-

tract new physicians to even come to the area because it doesn't make any sense.

So I guess I want to get back to the whole point of what are we going to do or what are the answers as you see it to these cuts. And I think, as my colleague from Indiana says, it is tough to deal with this, but we have really got to be truthful with the American people and put all of these things on the table across the board because, again, the first baby boomers are turning 62 and you have got 78 million to follow. We need to get real about that and right now.

Mr. KUHN. Those are very good points. And I think probably what you see in your district, as much or more than anybody else because of the numbers you laid out, is the fact that for the Medicare program to be successful, to really serve the seniors in this country, we need the active participation of physicians.

It is interesting. There was a GAO report that came out last year that said basically 80 percent of all health care spending is driven by physicians because they are the ones that order tests. They are the ones that admit patients. They are the ones that discharge. So we have to have active participation by physicians to be part of this program.

As you well-indicated, depending on the physicians' specialty, their part of the Medicare payer mix could be very low to very high, almost 100 percent of their business. But the way that we guarantee active participation by physicians is to have predictability and stability in the payment system. And we have neither right now. So I can understand that uncertainty that your physicians are feeling and others that are out there.

And, quite frankly, these are professionals that ought to be treated better by all of us as we go forward. And so what we can do with this program to try to manage that to get better as we go forward is going to be absolutely key.

One of the things that we are really trying to deal with with some of our other demonstrations here is really trying to look more thoughtfully in terms of the overall payment system in the Medicare program.

You know, right now when you look at Medicare Part B, it is pretty much siloed. You know, physicians spend more to try to care for a patient more effectively. They see their payments cut as a result of the SGR because spending exceeds the target.

But, yet, because they might be managing someone with diabetes much more effectively, they might spend a little bit more to manage it more effectively, but they save that trip to the emergency department. They save that hospitalization. The overall system costs come down as a result of that.

How do they be accounted for that? How do we reward them for that? And we are looking at new ways to do that. I think that is a good effort for the future in where we need to be going with this program. And I think we are getting some good support by the physician community to help us think those issues through.

Mr. BUCHANAN. I had one other quick question. I know we have got to go vote. But one of my doctors called me in reaching out to the community and said a lot of these young physicians are coming out with hundreds of thousands of dollars of debt out of medical

school. And then they are trying to pick up a practice and additional debt to set up an office. And, again, he said, how in the world do you expect anybody to go into this profession with the realities they are dealing with?

So it is a follow-on question but somewhat maybe just what you covered. But I do want to—

Mr. KUHN. I think that is a good point and a real concern as well because what we really need right now in health care is more primary care physicians. And if they are looking at that kind of debt, they are probably going to choose specialties that are not primary care. And that is going to be a problem in terms of access in the future.

So we have got to make sure our payment systems are fair, that they reward physicians across the board, and that we don't create incentives where people are abandoning primary care and moving into specialties, which I think could be one of the worst outcomes we could possibly see here.

Mr. BUCHANAN. Thank you, Mr. Kuhn.

Chairwoman VELÁZQUEZ. Well, we have five votes. So the Committee will stand in recess. And we will resume right after the votes.

[Recess.]

Chairwoman VELÁZQUEZ. The Committee is called to order. Mr. Kuhn, Congress is working on a physician fee fix that works for all health care providers. By what date does CMS need a Medicare bill signed into law to ensure physicians receive the proper payments on July 1st?

Mr. KUHN. In order for us to be able to work with our contractors to get all the programs put into place, probably mid-June would give us ample time and be ready to go on July 1 for a seamless transition so there would be no interruption in payments.

Chairwoman VELÁZQUEZ. And can you talk to us about the steps CMS has taken to prepare for either a reduction or the possibility of a congressional change to the formula?

Mr. KUHN. We will certainly be working very closely with Congress to make sure that if there is a reduction, it is hard-wired into the system now. And that would go forward. If there is a change by Congress, we would hopefully be able to anticipate that, again to make it as seamless a transition as possible. So, either way, we hope to be prepared and to implement the laws Congress determines for us to implement.

Chairwoman VELÁZQUEZ. The Medicare economic index is the government's measure of increases in physician practice costs. Most importantly, this index serves as CMS starting point for each year's physician payment update. Unfortunately, the way that MEI is calculated has not changed in nearly 35 years. Is there any reason why CMS hasn't attempted to reevaluate the MEI and bring it to the Twenty-First Century?

Mr. KUHN. That is a good question. And our Office of the Actuary and our head actuary, Rick Foster, has looked at the Medicare economic index, or the MEI, on a regular basis. And they believe that continues to be a good indicator for growth in this area at this time. If there is new information that they can be looking at and

new information the physician community and others can bring forward—

Chairwoman VELÁZQUEZ. Who is that person?

Mr. KUHN. Rick Foster, our actuary.

Chairwoman VELÁZQUEZ. So Mr. Foster really believes that the way health care practices operate today is not different from how health care practices were operated 35 years ago?

Mr. KUHN. No. I don't think I would characterize it that way, Madam Chair. I think it is rather in terms of it is a reasonable proxy for determining the inflation increase.

But I would absolutely agree with you that practices have changed over time. And, as a result of that, through the RBRVS system and through the American Medical Association's Relative Value Update Committee, also known as the RUC, in terms of trying to get the values between physician work, physician practice, expense, and ultimately malpractice, those are changed on a regular—

Chairwoman VELÁZQUEZ. Does the physician community agree with you on that assessment?

Mr. KUHN. On the MEI, perhaps maybe they do not.

Chairwoman VELÁZQUEZ. Why is that?

Mr. KUHN. They may think that there are other inputs that ought to be considered as part of the process.

Chairwoman VELÁZQUEZ. And CMS believed that there is no other input that should be considered.

Mr. KUHN. I don't believe that we have seen any evidence in terms of new survey information that would indicate that that would be changed at this time.

Chairwoman VELÁZQUEZ. So you are telling me that the way medicine is practiced today is not very different from how medicine was practiced 35 years ago and that the cost that a person, medical practitioner, incurs today in terms of new technology is not different and yet you want to link health care, quality health care, to new technology, IT, and so on, and so none of that is counted.

Mr. KUHN. Well, I think there are two parts to this puzzle. One is the MEI, which is the inflation update. The real work is done with the RBRVS system and the relative value updates that are valuated by the RUC, the Relative Value Update Committee of the American Medical Association. That is where the real activity is in terms of what payments are out there in terms of new technology, the work that physicians put in in terms of the services. Those are changed on a regular basis.

And what we did, actually, in 2006, we did a 5-year review. The statute requires, of course, every 5 years to review the codes, to work with the AMA and other physician specialties to do that. Then they made a number of substantial changes to that. And we accepted all of those.

So it is as accurate as we can possibly be for this time for the real activity for the payment schedule. In terms of the inflationary update, I think the factors that go into that continue to be consistent. But the rates that are paid are as accurate as they can possibly be.

Chairwoman VELÁZQUEZ. Well, I just can't buy that the Medicare economic index for the last 35 years has been unchanged. It doesn't make sense to me.

Mr. KUHN. If there is new information that our actuary ought to be looking at, we would be interested to see that.

Chairwoman VELÁZQUEZ. Mr. Kuhn, CMS has stated that Medicare spending on physician services is out of control, in part due to rapid utilization. However, the 2008 Medicare Trustees report indicates just the opposite. According to that report, the annual growth in the volume of Medicare physician services for 2005 and 2006 was just 3.6 percent, which is only about half the growth rate projected in their 2006 report.

Is the administration's position on physician fee payments reflective of MedPAC's finding?

Mr. KUHN. What we saw between about 2002 to about 2005-2006, is double digit increases in physician payment. And it has begun to level off—this last report—in terms of the volume of services that are out there. But it is still growing at rates that are much greater than other parts of the Medicare program and certainly growing at rates that are far higher than overall inflation. So it continues to be a cause of concern for us as well as MedPAC.

Chairwoman VELÁZQUEZ. Let me ask you again, sir. Is the administration's position on physician fee payments reflective of MedPAC's finding?

Mr. KUHN. Well, I guess I would need to know specifically what MedPAC's findings were on that. If you could restate that, then, please?

Chairwoman VELÁZQUEZ. I am sorry?

Mr. KUHN. What specifically were MedPAC's findings?

Chairwoman VELÁZQUEZ. Well, according to that report, the annual growth in the volume of Medicare physician services for 2005 and 2006 was just 3.6 percent, which is only about half the growth rate projected in their 2006 report. So you are talking about, you know, this out of control. Yet, the MedPAC's finding doesn't reflect it.

Mr. KUHN. I would need to check with our actuary to see if the recent information in the trustee's report, the Medicare Trustees report, matches up with MedPAC's findings.

Chairwoman VELÁZQUEZ. So let me ask you this question. Is CMS winning to refine its position on the physician fee issue, if utilization drops?

Mr. KUHN. I would think that where we are right now in terms of trying to change the way we pay physicians is not the debate that is before us. I think the real issue before us is how we go about making those changes.

I think everybody within organized medicine, certainly most in Congress, believe that it is time to have a change in the way we pay, to start paying for value, not volume of services. So even if we are seeing lower growth rates over the last couple of years, I don't think that should stop us or deter us from trying to find a better way to get better value and better quality in terms of our health care system.

Chairwoman VELÁZQUEZ. I don't think that anyone, no one here, is saying the opposite. The problem is when you say that we need

to attract more primary doctors to serve the senior community that is growing and, as Mr. Buchanan pointed out to you, the problem is that incentives are not there for these people to come and serve those communities.

And so you need to take into account the new economic reality of the new physicians and the type of incentives that you are providing to attract those physicians to enroll into the Medicare CMS services.

Mr. KUHN. I would agree with your statement there that we do need to make sure that this program, this particular physician fee schedule, continues to evolve. And I think it has over the last several years as we move forward.

And particularly on the issue of primary care physicians, again, in 2006, when we did the 5-year review, the RUC came forward with extraordinary recommendations in order to change values for what we call E/M codes, evaluation of management codes, which are primarily the codes used by primary care physicians. It is the time that physicians spend with patients, mostly in primary care.

Many of those codes went up 20-30 percent. We accepted all of those. And so we are working hand-in-glove with the physician community to try to make those changes and make them as accurately as we possibly can.

Chairwoman VELÁZQUEZ. Okay. I have another question, and I will come back on a second round.

Mr. KUHN. Thank you.

Chairwoman VELÁZQUEZ. Mr. Chabot?

Mr. CHABOT. Thank you, Madam Chair.

I guess on behalf of the Committee, we want to I guess express our sympathies for both the witnesses and the audience for having to wait so long in between when we started and taking this up again.

Obviously it was out of our control. We had votes on the floor. It is very common to get interrupted in Committee meetings with votes on the floor. Typically it is 45 minutes, maybe an hour, unfortunately. Two hours is what you all had to wait. The Chair and I obviously have no control over that, but I know how that can wreak havoc in your schedules for today and how long you think you might have to be here and that sort of thing. So our sympathies for you having to put up with that inconvenience.

Speaking of convenience, Mr. Kuhn, relative to Congress and the way we have dealt with a reimbursement issue and the cost for reimbursing physicians over the year with respect to Medicare, how inconvenient is it and how detrimental to doctors and others who depend upon this and the patients as well when year after year we have a tendency and the cuts are out there reflected in either the President's budget or perhaps our budget but by the end of the year, the fix comes very late? And so people don't know what it is going to be. And for planning purposes and everything else, I am sure that there is some negative impact.

Could you discuss that and what kind of problem that is?

Mr. KUHN. Sure. You are absolutely right, Congressman, that it probably is very disruptive for physicians because if they want to make plans in terms of their practice, whether it is to buy a new piece of equipment or invest in, say, an electronic health record or

something like that, the fact that they don't have predictability and stability in their payment system to know how they would amortize that out over the years in the future does create real disruption that is out there.

Also, I think it is disruptive in terms of Medicare beneficiaries to know whether a physician might take someone who now becomes age 65 and want to take on additional Medicare beneficiaries as patients or whether a physician may want to participate in the Medicare program that is out there.

So I think for any business person in this country, regardless whether it is health care or anything else, they need predictability and stability. And under the current physician fee schedule and the payment system we have now, they are not getting that.

Mr. CHABOT. Right. And we have, unfortunately, seen that that, the fact that this delay that is in the system, occurs year after year. Whether it was in Republican control or Democratic control now, it seems to be not really a political thing. It is just the way it works up here in Congress or doesn't work. And I think, really, Congress needs to get its act together. So people can depend upon things to come and be able to plan in advance.

What can we do about rewarding efficiency and, therefore, encouraging more of it?

Mr. KUHN. One of the best ways that we have really looked at is that we really need to measure in this area. And we really need to get this set of quality measures as well as resource use measures so that we can really kind of look at efficiency.

If you look at the Medicare payment system now, at least for physicians, we pay on volume. We don't pay for value. And we don't really know what kind of outcomes that we are getting as a result of that. And that is why we see this great variation in terms of care across the country and in a lot of cases great inefficiency in the system that is out there.

So I think one area is the development of measures. And the physician community, I think particularly led by the American Medical Association's consortium, is doing a very good job of developing new quality measures, thinking about efficiency measures as we go forward. But it is more than just measuring it. It is really, then, do you attach payment to it to really kind of drive the incentive as we go forward?

I think that is the next hill we all have to cross, but I think we are doing a very good job of building the infrastructure to get the measures in place. The next question is, then, how do we deploy those measures? And, ultimately, do we make those publicly available? Because that is part of the accountability as well as transparency is part of this, too.

Mr. CHABOT. Thank you.

What was the participation rate in the physician quality reporting initiative in 2007? And what percentage of participation was from office-based small practices; in other words, six physicians or less?

Mr. KUHN. That is a good question. Under PQRI, which began in July of '07, our current indication is about 16 to 17 percent of physicians participated in that first 6-month launch of the program. Some people have looked at that and said, "Boy, that is not

a very high number," but a couple of observations about that are worth noting.

One is, when it was authorized, it was only authorized for 6 months. So if you are a physician and you are trying to decide whether to train staff how to operate in this new program or to make the investment, if it is only for 6 months, you might want to think twice about that. So I think 16 percent with that level of uncertainty was pretty good.

The second thing is physicians, when it comes to these kinds of programs, sometimes are slow adopters to the program. We have the participating physician program. A physician would be either participating or nonparticipating in the Medicare program. And that has a differentiation in payment.

When that first started, physician participation was about 25 percent. And then over the next decade, it grew to about 95 percent. So I think the early start of this program looks good.

In terms of the breakdown of the smaller physician offices, I don't know if we have that number broken down that way. We have it more by specialties, whether it was ophthalmologist or others, but in terms of practice size, anecdotally the information I hear from our medical officers in CMS is that it looked like physicians across the spectrum, both small and large, participated.

And that seems to make sense because when you look at physician practices overall, about 50 percent are physicians in practices of 2 or 3 or less. So I think we would have had good representation by smaller offices as a result.

Mr. CHABOT. Thank you.

Madam Chair, I yield back.

Chairwoman VELÁZQUEZ. Mr. González?

Mr. GONZÁLEZ. Thank you very much, Madam Chair. And welcome, Mr. Kuhn.

First of all, thank you for your candid responses. Many times we will get witnesses, of course, and you are the messengers generally. And you know what we do to messengers. And so sometimes they are very careful in their responses.

And even with Secretary Leavitt in another committee hearing with Energy and Commerce, I just could not get him to answer whether he thought the SGR was the way to go. And I even had that transcribed so I could read it to all of my physician groups back home. He gave me a very Alan Greenspan answer. And Alan Greenspan is infamous for actually remarking to a senator, "If you understood me, I must have misspoken."

[Laughter.]

Mr. GONZÁLEZ. But that is really what we have been receiving. And I know it is the tail end of the administration and Secretary Leavitt's tenure and such.

Does anyone over in CMS or HHS believe that the SGR is an accurate means or manner in which to base reimbursement to physicians?

Mr. KUHN. I think that the consensus would be that it is a pretty blunt instrument and that it is time to move on to find a better way to pay physicians.

Mr. GONZÁLEZ. Okay. And as we speak, do you see that effort being undertaken, either by people over at HHS, CMS? I know we

are trying to do certain things in Congress. I know Dr. Bird just has his bill out there.

What do we have as we speak in a serious ongoing effort to find something in the way of a substitute?

Mr. KUHN. I think the real good news here is that over the last 2 or 3 years, there have been some great collaborations between CMS, the physician community, and I think Congress to a large extent, to really find a better way to pay physicians, to really think about paying for outcomes, to pay for quality, pay for better safety of care, instead of the volume of care that is out there right now.

So in that regard, we have got some wonderful demonstrations underway that are showing some great promise. It is a chance for us to prove a concept through a demonstration. I think there is a lot of good work in terms of collaboration between us and the AMA Physician Consortium for development of measures so we can actually measure what is going on out there. It is working very well.

And then, finally, some real good work with this PQRI program that Mr. Chabot mentioned in terms of really building the base to find a way for us to get that information from physicians so we can measure and know what the quality information is out there.

So some good start. Do I wish we were further along than we are now? Absolutely. But I think we have got a pretty good stake in the ground to get us going.

Mr. GONZÁLEZ. And as we come into a new administration, we are hoping that we are going to be much more aggressive. And I do believe it really is imperative that Congress leads the way. I really believe that, regardless of who wins the election, who is going to be there. And hopefully we will have people that are going to be sensitive to it and such.

I am going to read from the memorandum prepared by staff, "The law specifies a formula for the annual update to the physicians' fee schedule. Part of the update is based on whether spending in a prior year has exceeded or fallen below a spending target. It is calculated using the sustainable growth rate, SGR, a cumulative one for Medicare spending growth over time. If spending is in excess of the target, the update for a future year is reduced. The goal is to bring spending back in line."

I think that is the fundamental principle of the SGR. It is not reality-based. Whether it is Congress, whether it is the President, or whatever, we figure what we want to spend in a particular year. And then we make things fix.

If we say we are only going to have $10 to reimburse physicians, even though the cost of providing the service is $15, we are still going to do $10. And we may torture different numbers and formulas, but I think that is why we are all in agreement.

So then we come over to your testimony. And it says, "But in every year since 2002, Congress has overridden the statutory cost growth control, the sustainable growth rate. The problem with this recent approach is that it runs up a tab that makes the next schedule cut even larger. And, you know, we have been addicted to that kind of behavior. And it is really bad. It is stopgap.

But I guess the message really to CMS, to the physician community, and to Congress that, indeed, it is broken. It is not working. I have never had anyone really say that the SGR is the way to go.

Now, Secretary Leavitt may have danced around it, but I think in the final analysis, he was talking about pay for performance and how we do that. We have heard from the governors of the States of Minnesota and Pennsylvania regarding their universal health coverage and how they pay for performance. But then that opens up another can of worms.

So I hope before we go there, I am going to leave you with one last thought that I hope that you are very cognizant of and I think that you are. Everyone in the audience is. Whatever CMS says something is worth, that is adopted in the private sector. So everything that government does, then that basis is the predicate for what an insurance company is going to reimburse a physician.

So if we have got problems with Medicare, can you imagine the spillover? And so now that is cumulative, but it presents great challenges. We want to work with you, but we want absolutely straight answers.

If we are going to make this thing, it is going to be tortured logic to make it fit a budget, then we need to be saying that. And that is never going to work. I think that is going to be the biggest obstacle and challenge for all of us.

Again, I appreciate what you do and, again, your candid remarks today. And I yield back, Madam Chair.

Chairwoman VELÁZQUEZ. Do you want to respond?

Mr. KUHN. Thank you, Madam Chair. Absolutely. I would just say that all of your points—I don't think I would necessarily disagree with many of your observations you made, Congressman. And, you know, if you really think about the Medicare program and the evolution it goes through, when it started in 1965 and then we paid physicians on this thing called customary prevailing and reasonable charges that were out there, after about a decade and a half, everybody realized that was very inflationary and very problematic.

And so then came the RBRVS system, the current payment system that we have. That has been in place now 15, almost 20 years. And I think it is time to change to something else. And the change that we are all talking about here is value-based purchasing and how we move in that direction.

The good news continues to be that the collaboration between us and the physician community and the Congress and other stakeholders on this is there. And it is working, but it is slow work because you want to get it right as we go forward.

But you are right. It needs to be done. It is work worth doing. But I think, above all else, I'll just leave you with this point, that in terms of getting answers from us at CMS, as we move forward in this direction, I think we have to have some guiding principles that drive us forward.

One, I think we have to have investigative integrity in all that we do in driving forward on this change. I think second, and utmost, is that we have to have transparency in all that we do, not only with you all up here but with the physician communities and others, because this kind of change, I don't think you can order this kind of change on physicians and others. I think it has to be they have to believe in it, they have to help us develop it, and have to

be incentivized to drive it forward. That is where I think that we will get the success as we go forward.

Mr. GONZÁLEZ. Thank you very much.

Chairwoman VELÁZQUEZ. Mr. Grijalva?

Mr. GRIJALVA. Thank you very much, Madam Chair.

And I want to say that the comments that my colleagues have made to you, sir, are very important comments. And we are talking about change. I really appreciated the last statement you made that as we go through this very laborious and difficult process, that there have to be guiding principles and practices. And I couldn't agree more about the transparency and the buy-in factor from the physician community.

I represent a district in which I have under-served communities in the urban part, and I have big patches of rural communities that primarily rely on small practices for their health delivery system and for their Medicare services. And it is that access, particularly primary care for the elderly, that is getting more and more difficult in the rural areas of my district.

I wanted to ask you a question. One of the things that I hear from those physicians in those small practices is the issue of—I want to say duplicity, but I don't think it is—with Medicare Advantage, that there is no uniformity to the identification card. And what CMS has suggested to these physician practices is: why don't you call in to make that verification?

It is disruptive to the practice. It is disruptive to the quality time that you need to spend with your patient. And my question to you would be; would CMS oppose congressional intervention, for lack of a better word, to require one standard of MA card for patient ID cards?

Mr. KUHN. We have, my understanding through our marketing guidelines, some pretty good standardization right now in terms of ID cards that are supposed to be provided to Medicare beneficiaries. Furthermore, the terms and conditions and other aspects of the Medicare Advantage product need to be posted publicly on Web sites for easy access by everyone.

But I would like to go back and spend some more time with staff understanding the actual standardizations we have now and further needs that your constituents are talking about that. So I would kind of defer a final answer on that until I have some more information.

Mr. GRIJALVA. That is fine.

Mr. KUHN. But it is something that we would be happy to go back and then come back and talk to you and your staff about.

Mr. GRIJALVA. Thank you. Madam Chair, I yield back.

Chairwoman VELÁZQUEZ. Thank you.

Mr. Kuhn, I am concerned that there is inadequate oversight of Medicare Advantage by the states or by CMS. One issue, in particular, that challenges health care providers is the "all products" clauses. These contract provisions require providers to accept all of a health plan's sponsor contracts. Though a number of states have worked to outlaw such provisions, Medicare Advantage plans are exempted.

My question is, would CMS oppose congressional intervention to outlaw the use of all product clauses for Medicare Advantage products?

Mr. KUHN. I would think in terms of the—well, two aspects of that. One is, actually, this morning, we issued a new regulation to deal with marketing aspects of Medicare Advantage plans. And so many of the issues that have been raised in the past in terms of marketing, problems with brokers and agents, we think we are getting a pretty good handle on that. And we have got some new information out there.

I think on the second issue that you raise here in terms of the deeming requirements and the operation of the MA plans, particularly the private fee-for-service plans, I would like to hear more information in terms of the problems that it is creating for individual providers because right now I think with, again, our marketing standards that we have now, with the terms and conditions that are posted that providers are able to access, I would like to know what other things that perhaps we could do administratively first before we turn to legislation.

Chairwoman VELÁZQUEZ. Sir, you will have an opportunity this afternoon because some of the witnesses that will be testifying will be discussing that very same issue. So, for the record, I would like to know if you have any staff that will remain in here.

Mr. KUHN. Of course, we will make someone available to participate in the rest of the hearing. Thank you for asking.

Chairwoman VELÁZQUEZ. Mr. Chabot, do you have another question?

[No response.]

Chairwoman VELÁZQUEZ. Well, then the gentleman is excused. And I really thank you for being here this morning.

Mr. KUHN. Thank you all very much.

Chairwoman VELÁZQUEZ. And I will ask the second panel to please come forward and take your seats. Welcome, and I really appreciate your cooperation and understanding about the fact that we spent so much time this morning trying to have five to seven votes on the House floor. Sometimes we have members from both sides acting out.

[Laughter.]

Chairwoman VELÁZQUEZ. And the whole thing—

Mr. CHABOT. Yes, more one side than the other.

Chairwoman VELÁZQUEZ. Yes, to my left. To my left.

[Laughter.]

Chairwoman VELÁZQUEZ. Anyway, I know that some people are trying to take some flights later on this afternoon. So our first witness is Ms. Mona Reimers. Ms. Reimers is the Director of Revenue Services for Orthopaedics North East practice located in Fort Wayne, Indiana. She is President of the Indiana Medical Group Management Association and a member of the Medical Group Management Association. MGMA has more than 20,000 members, who manage more than 13,500 organizations, in which almost 270,000 physicians practice.

You are welcome. And you have five minutes to make your presentation.

STATEMENT OF MS. MONA REIMERS, DIRECTOR OF REVENUE SERVICES OF ORTHOPAEDICS NORTH EAST, PRESIDENT, MEDICAL GROUP MANAGEMENT ASSOCIATION INDIANA CHAPTER ON BEHALF OF THE MEDICAL GROUP MANAGEMENT ASSOCIATION

Ms. REIMERS. Madam Chair and members of the Committee, my name is Mona Reimers. And I am a practice administrator of a 26-physician orthopaedic practice in Fort Wayne, Indiana. Our practice has 12 locations, which serves patients in 30 counties from 3 states.

Medicare regulations significantly impact physician practices. And, as the President of the Indiana Medical Group Management Association, I wanted to express my concerns on behalf of my national association. Thank you for having me here today.

I echo the concerns of my fellow panel members regarding the flawed sustainable growth rate formula. Stopping the 10.6 percent physician payment cut scheduled to occur on July 1st should be a congressional priority. Our physicians are committed to our Medicare patients. We currently accept new Medicare patients; however, we are considering significantly trimming back our acceptance of Medicare Advantage patients.

If the 10.6 percent cut were to take effect, we would be forced to consider another operational change, such as reducing the number of traditional Medicare patients we accept. Some of the practices in Indiana are already managing the demand of Medicare patients in their offices by keeping only a few appointments per day available to Medicare patients. Therefore, these double digit cuts clearly threaten high-quality care to Medicare beneficiaries.

My local experience is reflected in recent MGMA national research for more than 1,100 group practices, representing nearly 29,000 physician respondents. As a result of the six-month financial uncertainty, nearly 24 percent of practices have begun limiting new Medicare patients. And nearly 50 percent indicated that an additional 10.6 percent cut will force them to stop accepting and/or limiting the number of Medicare beneficiaries their practices treat.

MGMA research also showed that more than half of responding practices are reducing administrative and clinical staff. Two-thirds described how information technology and clinical equipment investments are also sacrificed or postponed indefinitely. However, Medicare's challenges are not solely caused by the annual SGR struggle.

For the past two and a half years, we have encountered continued and growing frustration associated with the Medicare Advantage program. In 2005, Medicare Advantage was 3.6 percent of my practice's Medicare charges and has grown to 24 percent in 2007. Our Medicare Advantage patients share our practice's frustrations. They don't know the rules.

Practices like mine are bogged down trying to help patients understand their plans and navigate the many administrative complexities. My practice has been forced to hire two full-time staff just to deal with the avalanche of beneficiary questions and additional paperwork associated with Medicare Advantage, and even that is not enough.

MGMA has fielded countless practice inquiries and concerns regarding Medicare Advantage and has, therefore, developed four simple requests that if enacted would greatly improve the operational aspects associated with Medicare Advantage as well as improve provider and patient understanding about the program.

In recent MGMA research, over 56 percent of respondents said they could not accurately identify Medicare Advantage patients, with 90 percent of respondents indicating that patient insurance cards provided ineffective identification.

Because patients do not know what coverage they have, I have had to direct my staff to contact Medicare or the Medicare Advantage plan each time the Medicare patient walks through the door. This administrative burden could be avoided with the standardization of Medicare Advantage ID cards.

If standardized cards were issued, we could quickly identify the type of Medicare Advantage plan the patient is enrolled in and we could then know precisely where to bill the claim and what contact information to use for further follow-up information. These ID cards should be required to contain a toll-free number meant for providers to be able to get answers to questions and quickly check eligibility and/or claim status, just like traditional Medicare.

Our second request is the elimination of deeming in Medicare Advantage. Doing so would allow practices a fair opportunity to review, negotiate, and understand contracts with plans. Deeming allows a Medicare Advantage plan to consider a physician as accepting their contract if the patient presents a Medicare Advantage card prior to service.

Often we are essentially forced to sign the last page of a contract without knowing what the rest of the lengthy and non-negotiable contract says. For example, every day we treat arthritic patients who are driven to their appointments by family members that took time off work.

They present one of 100 nonstandardized identification cards upon arrival at the front desk. At that moment, we must decide whether we will treat this patient. It is cruel to delay or deny treatment because it is just impractical to review a contract while a patient is awaiting services. Yet, being denied the opportunity to review and negotiate the terms and conditions prior to rendering services is completely contrary to fair contracting principles.

Our third request is the elimination of "all products" clauses in plan contracts. Most states already outlaw these clauses, in order to protect physician practices from accepting all patients in all variations of insurance products offered by a given insurer. For any contract to be binding, there must be a quid pro quo, meaning both parties have received something from the other. But this does not exist for Medicare Advantage plans and the physician if contracting by default occurs.

Some states, like Indiana, have addressed this practice. The Medicare Advantage plans are exempt from these state laws. We urge Congress to prohibit the use of "all products" clauses in the Medicare Advantage program.

Our final recommendation is that Congress apply and enforce the same timely payment provisions to all Medicare Advantage products that exist for traditional Medicare. Traditional Medicare does

a great job paying promptly and accurately. But my office's accounts receivable for Medicare patients is 50 percent higher than it was in 2005. This is primarily due to Medicare Advantage.

We currently spend triple the workforce to collect what is due for Medicare Advantage payers than what we use to collect from traditional Medicare. In following up on unpaid claims with traditional insurance payers, we have avenues available to us such as the Department of Insurance and federal agencies for ERISA plans.

With Medicare Advantage, there is no comparable resource. Our Region V office from CMS has heard plenty from us and has offered some help, but it has been ineffective in causing any root change to the behavior of the payers. Applying the traditional Medicare prompt payment law to Medicare Advantage plans would be both logical and fair. Addressing our recommendations would greatly improve the medical community's perception of and willingness to participate with Medicare Advantage plans; therefore, strengthening the program overall for beneficiaries as well.

Thank you for this opportunity and I am happy to address your questions if you have any.

[The prepared statement of Ms. Reimers may be found in the Appendix on page 57.]

Chairwoman VELÁZQUEZ. Thank you, Ms. Reimers.

And now the Chair recognizes Mr. Chabot for the purpose of introducing our next witness.

Mr. CHABOT. Thank you very much, Madam Chair.

I would like to introduce Tom DiAngelis, who is a fellow Buckeye. And not only is he that, but he is a fellow Cincinnatian. Although he doesn't live in my congressional district, he lives in Loveland, Ohio, which is actually in Jean Schmidt's district, he is close.

Tom graduated with honors from Northeastern University in Boston, Massachusetts. He is President and co-owner of Comprehensive Physical Therapy Center, Inc., which is an outpatient physical therapy provider located in suburban Cincinnati.

Tom also is currently Vice President of the American Physical Therapy Association, Private Practice Section. Tom has served as the Reimbursement Chairperson for the Ohio Chapter of the American Physical Therapy Association. He is a member of the Physical Therapy Advisory Committee to United Healthcare. And he is a representative for the American Physical Therapy Association before payment policy organizations and committees. And we welcome them here this morning.

Thank you.

STATEMENT OF MR. TOM DiANGELIS, PT, PRESIDENT AND CO-OWNER, COMPREHENSIVE PHYSICAL THERAPY CENTER, INC. ON BEHALF OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION AND ITS PRIVATE PRACTICE SECTION

Mr. DIANGELIS.Chairwoman Velázquez, Ranking Member Chabot, and members of the House Committee on Small Business, thank you for the opportunity to address the House Committee on Small Business and provide a small business owner and clinician's

perspective on the pending cuts to payments under the Medicare physician fee schedule.

I am Tom DiAngelis, a practicing physical therapist and co-owner of a small physical therapist practice in the greater Cincinnati, Ohio area. We currently employ 24 individuals in 3 clinics and serve approximately 180 patients per week with musculoskeletal impairments. Our goal is to return these individuals to the highest level of function and productivity in their homes and in their communities.

Thriving in this payment environment is a challenge for small businesses in physical therapy. The physical therapist small business climate in Cincinnati has seen this firsthand. In the past 3 years, 14 clinics have closed their office doors due to the negative pressure on payment. My partner and I have personally reduced our salaries, eliminated our advertising budget, and seen significant increases in administrative and operating costs.

Today I represent the American Physical Therapy Association and their Private Practice Section, which advances small business ownership among physical therapists. If Congress does not act by July 1st, 2008, payments under the Medicare physician fee schedule will be cut by 10.6 percent. This would begin a series of payment reductions under the fee schedule, leading to an overall reduction in payment to health care providers of 40 percent by 2016.

APTA supports efforts to avoid the 10.6 percent cut in payments under the Medicare physician fee schedule and to replace the flawed sustainable growth rate formula with a more accurate indicator of health care inflation.

Payment cuts under the Medicare physician fee schedule will have significant ramifications on the ability of physical therapists to serve individuals who have suffered from stroke, had joint replacements, or chronic diseases that impair their ability to move, walk, and perform their daily tasks.

Physical therapy continues to be a critical need for Medicare beneficiaries. A recent Center for Medicare and Medicaid Services study indicated that 8.5 percent of Medicare beneficiaries utilize outpatient physical therapy services, resulting in 3.9 million patients in 2006.

The demand for high-quality rehabilitation services by physical therapists will only increase as baby boomers age and people seek the services of physical therapists to keep active and productive.

The impact of the pending cuts on physical therapists' small businesses can be summarized by three points. First, beginning July 1st, in addition to a 10.6 percent reduction in payment, physical therapists will also be subject to a $1,810 per beneficiary per year therapy cap on outpatient services. This would limit patient access to needed physical therapy by not considering the patient's condition, the diagnosis, or other contributing factors. This represents, in essence, a cut upon a cut and would make the viability of physical therapists' small business a significant challenge.

APTA recommends the passage of the Medicare Access to Rehabilitation Services Act, H.R. 748, legislation to repeal the therapy caps. Second, physical therapists in private practice have significant limitations on how patients may access their services and marketplace.

Currently Medicare requires that the patient be under the care of a physician as a prerequisite for payment of therapy services. If the payment cuts go into effect and physicians stop taking Medicare patients, then access to physical therapy services will be impacted as a ripple effect.

APTA advocates for the passage of the Medicare Patient Access to Physical Therapists Act, H.R. 1552, as a strategy to improve patient access to physical therapists.

As physician practices struggle with the payment cut, the incentive to develop additional sources of revenue increases. This puts physical therapist small businesses at a competitive disadvantage since patients cannot directly choose their physical therapy provider and are often directed to clinics in which referral sources have financial interests. APTA advocates for stronger self-referral provisions in federal law to ensure the integrity of the health care delivery services.

Third, physical therapists and small businesses are subject to burdensome administrative and regulatory requirements that add to the cost of providing health care. These administrative burdens complicate physical therapists' practice, direct the physical therapists away from patient care, and make it difficult to sustain physical therapists' small business over the long term.

The compounding effect of payment cuts under the Medicare physician fee schedule along with limitations on patient access, a competitive marketplace, and regulatory burdens makes it difficult to sustain physical therapy small businesses. Congress must move beyond the issue of temporary payment reprieves and look at the health of the Medicare physician fee schedule for the long term. The health care delivery system needs physical therapist small businesses to meet patients' rehabilitation needs.

In closing, I and the American Physical Therapy Association and their Private Practice Section want to thank the House Committee on Small Business and its leadership for holding this hearing. Thank you.

[The prepared statement of Mr. DiAngelis may be found in the Appendix on page 62.]

Chairwoman VELÁZQUEZ. Thank you, Mr. DiAngelis.

And it is my pleasure to introduce our next witness, Dr. Cecil B. Wilson. Dr. Wilson is the immediate past Chair of the Board of Trustees for the American Medical Association and has been on the Board of Delegates since 1992. The AMA is the largest medical association in the United States. Dr. Wilson has been in the private practice of internal medicine in central Florida for 30 years.

Welcome.

STATEMENT OF DR. CECIL B. WILSON, M.D., IMMEDIATE PAST CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. WILSON. Thank you, Madam Chairwoman.

My name is Cecil Wilson. I am the immediate past Chair of the Board of the American Medical Association Board of Trustees. I am also an internist in practice.

The AMA would like to thank the Chairwoman Velázquez and Ranking Member Chabot and the members of the Committee for your leadership efforts to address the fatally flawed Medicare physician payment formula called the sustainable growth rate, the SGR.

Due to fundamental defects of the SGR, a 10.6 percent cut in Medicare physician payment rates is scheduled for July 1. And on top of that, another cut of five percent is projected for January 1, 2009 and even more cuts through 2016, totaling 40 percent, during a time that physician practice costs would increase merely 20 percent. And that's according to the government's own conservative estimates.

Since 2002, the physician community has had to work with Congress each year to achieve eleventh hour interventions to ward off steep payment cuts and preserve patients' access to care.

Moreover, Congress has used a financing mechanism in the last two legislative interventions that has resulted in deeper projected cuts for each subsequent year, making each year's legislative fix more costly than the previous one.

We urge the Committee and Congress to take immediate action to advert the July 1 physician payment cut, replace it with 18 months of positive updates, updates that do not increase the size or duration of cuts that must be fixed in future years. If Congress allows the projected cuts to go into effect, this could adversely affect millions of patients, physicians, and individuals employed by physicians' offices, and related businesses across the country.

An 18-month fix would allow time to implement a new physician payment system that reflects increases in medical practice costs. This we think is especially important as the baby boomers begin enrolling in 2011.

A stable system consistent with the goals of the Medicare program is needed to ensure the promise of high-quality health care to beneficiaries. The SGR undermines the Medicare program.

First, patient access will be impaired if projected cuts go into effect. The vast majority of physician practices are small businesses. In fact, 50 percent of physician practices have less than five physicians. And they account for 80 percent of our patient visits. Physician practices as small businesses cannot absorb the steep losses projected under the SGR.

No small business could survive under a business model that dictates steep cuts year after year. In fact, in an AMA survey, 60 percent of responding physicians said they would have to limit the number of new Medicare patients they would treat if this year's pay cut is not stopped.

And the SGR will exacerbate physician shortages. We are predicting a shortage of 85,000 physicians by year 2020 without any of these cuts. And we know that physician pay cuts would force many practicing physicians over the age of 55 to weigh early retirement, exacerbating the shortage. This will impact all beneficiaries of Medicare.

In addition, the SGR is incompatible with physician adoption of health information technology and quality improvement initiatives. The reason is that quality initiatives, which rely on the use of health information technology, resulting in greater utilization of

physician services, including aggressive strategies to manage diseases, to increase physician visits, imaging/lab tests, and drug therapies.

This can reduce more expensive hospital admissions under Medicare Part A, but it increases spending under the SGR Medicare Part B, leading to additional payment cuts for physicians. And the payment cuts make it impossible for physicians to make the significant financial investment needed for health information technology. So the SGR has trapped physicians and policy-makers in a vicious cycle.

So the AMA asks Congress to ensure that physicians also are treated like hospitals and other providers, whose payment updates keep pace with inflation. And we again urge Congress to take immediate action to avert the July 1 cut, replace it with 18 months of positive physician payment updates, updates that reflect increases in medical practice costs. This will allow time to repeal the SGR.

Thank you again for the opportunity to be here today.

[The prepared statement of Dr. Wilson may be found in the Appendix on page 69.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Wilson.

Our next witness is Dr. David C. Dale. Dr. Dale is President of the American College of Physicians. He became a fellow at ACP in 1976 and was elected to the Board of Regents in 2001.

ACP is the largest medical specialty organization and the second largest physician group in the United States. Members include 124,000 internal medicine physicians, related subspecialists, and students.

Welcome.

STATEMENT OF DR. DAVID DALE, M.D., FACP, PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS

Dr. DALE. Thank you. Thank you, Chairwoman Velázquez and Ranking Member Chabot, for allowing me to share my thoughts on this subject with you today.

I am David Dale, President of the American College of Physicians, the ACP. And I am an internist, professor of medicine, and former dean of the School of Medicine in Seattle. Our school focuses on training primary care physicians for the Northwest, for Alaska, Montana, Idaho, Washington, and Wyoming.

ACP is the largest medical specialty society, as mentioned. And about 20 percent of our ACP members are in solo practice. And, as mentioned with the AMA statistics, nearly half of our members are in practices of five physicians or fewer.

During my year as President of ACP, I have met with many of our members as I have traveled the country. Many of them are in businesses which are at a breaking point, due in large part to the problems with the Medicare payment system, just not keeping pace with practice expenses.

In fact, I have become extremely concerned about doctors across the country, particularly in smaller communities, where the departure of a single physician because the doctor moves to town, retires, or dies and has no replacement creates a major community prob-

lem. There is simply no elasticity in the system other than for small town folk to drive further. And, of course, the whole community suffers when this occurs.

These practices are small businesses, where much of their revenue is tied directly to Medicare's flawed reimbursement rates and formulas under the sustainable growth rate formula. Application of this flawed system and its scheduled payment reductions over the last six years has created a genuine problem for physicians.

Earlier this year the ACP surveyed its members to measure the impact of pending Medicare payment cuts on their practices and on their patients. Although not designed as a scientific sample, almost 2,000 internists responded and provided a firsthand account of the effects of these cuts.

Thirty percent of our survey respondents noted that they have already taken steps in their practice to anticipate the scheduled Medicare payment cuts in July 1, 2008 and January 1st, 2009, such as limiting the number of new Medicare patients that they will accept.

Eighty-six percent of ACP respondents reported that they would be forced to make changes if Congress does not avert the ten percent cut scheduled for July. The most commonly mentioned matter is to reduce the number of Medicare patients they see.

ACP members have expressed heartfelt concern for the impact of these changes on their patients. A Texas internist told us "The practice of medicine is a calling. And, as such, my colleagues and I have endured far more unfair revenue cuts than most businesses would endure.

"Yet, a medical practice is also a small business. We are now at the point where further cuts are not survivable. Just like any small business, our revenue has to exceed costs in order to survive. Despite everything that I have done to cut costs, the margin of profit is now thin and the proposed greater than ten percent cuts will put us out of business.

"The only option will be to downsize the practice and stop seeing Medicare patients. I would hate to do this, but it will be the only option I have if Congress does not reverse the proposed cuts."

As an educator, I have also encountered hundreds of young people, our students, who are excited about the challenges and opportunities of becoming a patient's personal physician. However, when it comes to choosing a career path, very few see a future in primary care and being this kind of a doctor.

The numbers are startling. In 2006, only 26 percent of third year internal medicine residents planned to practice general internal medicine, down from 54 percent only 8 years earlier. Only 13 percent of first year internal medicine residents plan to go into primary care. The percentage of medicine school seniors choosing general internal medicine has dropped from 12 percent in 1999 to 4 percent in 2004.

ACP's survey asks if Medicare payments are an important factor in medical students' selection of a specialty. Sixty-three percent responded that this issue is extremely or very important.

A resident at Case Western Reserve in Cleveland commented, "When I entered medical school, I had always planned to become a general internist in primary care. Seeing the current deterio-

rating funding environment has cemented in my mind not to go into primary care."

The ACP has conducted its survey in a number of other ways. And a key feature is the accelerated retirement of older physicians with a high percentage expressing an interest in retiring very soon, in fact, if the payment system isn't changed.

The college is very interested in the patient-centered medical home concept, which holds great promise for choosing better outcomes for patients, potentially lowering costs and reducing complications and avoiding hospitalization. We also believe it will attract new physicians to general medicine and family medicine, the key specialties in deficit.

We see an urgent need to address this problem for many reasons. And I am pleased that this Committee is interested in this problem and is addressing it today.

Thank you.

[The prepared statement of Dr. Dale may be found in the Appendix on page 77.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Dale.

Our next witness is Dr. Mabry. Dr. Charles Mabry is a general surgeon in private practice in Pine Bluff, Arkansas. In addition to being a general surgeon, Dr. Mabry serves on the Board of Regents of the American College of Surgeons. The American College of Surgeons currently has over 70,000 members, making it the largest organization of surgeons in the world.

Welcome.

STATEMENT OF DR. CHARLES MABRY, M.D., FACS, BOARD OF REGENTS, AMERICAN COLLEGE OF SURGEONS

Dr. MABRY. Thank you, Madam Chairman and Ranking Member Chabot. I appreciate the opportunity to be here today. And I will simply echo the statements of the other presenters today that there is no question that the SGR is broken and we are in dire straits.

We are really grateful to have this opportunity to present before you because I am an example of a small business person. I am a general surgeon. I live in a town of around 60,000. There are seven of us in town that take the general surgery call.

It is important for the members to understand that we all are in our own businesses. We have to hire employees. We have to buy from other small businesses in our community. And so what happens to us affects all small businesses. And, vice versa, what affects small businesses in our community affects us.

Now, it is interesting that the American College of Surgeons is composed of many different surgical specialties, but I am going to refine and constrain my comments to general surgery, which is about 40 percent of our membership.

It turns out that of the general surgeons around, 70 percent are in private practice. So it's a high percentage that are small business people. And of those, around 40 percent or so derive their income from Medicare. So Medicare is one of our larger payers. And, therefore, what happens to Medicare is very, very important.

The average general surgeon has in a practice of around 4 to 5 people around 15 employees. And they have a payroll of around

$130,000. So it is like a regular business. And part of our concern is that we don't know when to depend upon the next pay cut. We can't make our budget. We can't project our expenses, not knowing what is going to happen with the SGR.

Now, the other thing that sets surgeons apart from other physicians to some extent is the fact that we are paid on a global payment scale. We are paid a 90-day global payment for most of our major surgical procedures. Major surgical procedures really have not risen much in the last five to ten years. We are at about a three percent growth rate. But our payment is a lump sum payment for everything we deliver in 90 days.

Now, for many different reasons, payment being one of them, we are running out of general surgeons. And the general surgeon, as you very well may know, is the surgeon that is in charge in your hospital, your local hospital, for emergent surgery and trauma surgery.

There are only 1,000 general surgeons that come out of residency every year. And of those general surgeons, only around 300 elect to go into true general surgery. Others subspecialize, go into laparoscopic surgery and other things. So the number of general surgeons available to be emergent surgeons and trauma surgeons is dropping dramatically.

When you look at the big numbers, HRSA release a study in October of '06. There are only 21,000 active practicing general surgeons in America. Now, that is a small number. And when you put on top of that the drop in the number of surgeons we project, it is really going to become critical to the local hospitals for trauma care and emergent care.

As small business people, though, however, the general surgeon has also an effect on the local hospital. As we heard, if a surgeon retires and a physician retires, often times we can't find replacements to fill the slot. For a general surgeon, if he or she retires, the hospital has roughly 18 months—if that is the only general surgeon—to replace that surgeon or the hospital will have to dramatically reduce its services or have to close. So the loss of a general surgeon has an impact not just on the local physician practice but also on the small business practices that rely upon that hospital.

We have seen a drop in our physicians that go into private office-based practice of about 18 percent in the last 5 years. So this is not just a hypothetical thing. We are actually seeing this drop in general surgery today.

Well, I have gone on a long time about this. What evidence do we have that this is really occurring? There are two studies I have included in my written comments, and I will just highlight those. In North Carolina, from 1995 to 2005, 47 North Carolina counties experienced a decline in the number of general surgeons. And four completely lost all general surgery coverage.

I was intrigued by that. So I looked at the data from Arkansas. Between 1997 and 2004, 12 Arkansas counties experienced this same decline. We have 21 counties that have no general surgeon. And of the seven counties that lost general surgeons, two hospitals closed. And five hospitals had to decrease their services dramatically. So this has an impact not just on the surgeons but on the community itself.

Our proposal and one of the things that we are trying to discuss with others, the American Osteopathic Association and we have an alternative proposal for the SGR, which is broken. Our proposal is the service category growth rate. It is a proposal to divide physician services into six unique service categories, not by surgical or medical specialties but by the type of practice or service: preventative and primary care; other evaluation management services; major procedures, which involves what we as surgeons do; minor procedures; imaging services; and then diagnostic tests.

We feel that this will allow Congress and the administration to better control the management of individual services—much like operating with a scalpel, instead of a broad ax. Right now, with the SGR, we just have a large ax to perform surgery with because one cut takes care of everyone. We propose having a much more refined solution.

In conclusion, we propose that the current SGR itself needs to be fixed immediately. We agree with everyone here, and we would ask for also attention to some alternatives, such as a separate category growth rate.

On behalf of the American College of Surgeons, I really appreciate your time and effort today. Thank you.

[The prepared statement of Dr. Mabry may be found in the Appendix on page 88.]

Chairwoman VELÁZQUEZ. Thank you, Dr. Mabry.

Dr. Wilson, if I may, I would like to direct my first question to you. I was deeply dissatisfied with Mr. Kuhn's response concerning the Medicare economic index. Clearly the MEI does not reflect the current practice of medicine. What do you believe are the problems if there is any problem with MEI? And what alternative assumptions do you believe the MEI should include?

Dr. WILSON. Well, thank you, Madam Chair.

We do believe that the medical economic index does provide an inflation measurement of the inputs that are sort of the market best that is there.

Our intention is the market best components, the inputs, are not the same as they were back in the 1970s, that staffing requirements, positions are much higher. So we believe that other inputs need to be added to that medical economic index, which would more accurately reflect practice as it is.

In essence, the amount of contention for us is the productivity adjustment that is put in the medical economic index, which suggests that if you have an inflation-adjusted increase, then physicians and others will compensate for that by doing more procedures. And so you account for that by an adjustment.

We believe that that is not the case. And we also believe that if that is going to be a part of it, it ought to be applied to everyone else. At this time, that inflation adjustment or that adjustment is only applied to physician practices and physician payments.

So we believe that a comprehensive look at the MEI to see if there are some other things that need to be measured, in essence, makes a lot of sense.

Chairwoman VELÁZQUEZ. Thank you.

Are those contained in the MedPAC findings?

Dr. WILSON. I will confess, Madam Chair, I do not know that.

Chairwoman VELÁZQUEZ. Okay. Dr. Mabry, you spoke about that the American College of Surgeons has been working on an alternative mechanism for calculating Medicare updates. Can you talk to us a little bit more about how it differs from some of the approaches currently being considered?

Dr. MABRY. Yes, ma'am. I will do my best. You know, it is a very technical issue. And I really would defer to more people expert than me. Basically, the concept would be that we would divide the large spectrum of services provided into discrete categories of services.

In each one of those categories, Congress and the administration, would have the capacity to adjust the amount of money that is put in that bucket to spend in that given year. And if the need arises, for instance, for the patient-centered medical home or for more primary care payments, Congress would have that ability to do that.

On the other hand, if there is an over-utilization of services and it was the wisdom that those payments should be reduced, then that would allow you a much finer tool to reduce those payments for over-utilization. And, therefore, it would be more successful, we think.

Chairwoman VELÁZQUEZ. Do any of the other witnesses have any opinion on the proposal made by the American College of Surgeons? Dr. Wilson?

Dr. WILSON. Yes. Madam Chair, actually, MedPAC did at least look at some options related to what they would call many SGRs that might be based on specialty or service, as you just heard, from the surgeons or maybe even based on geography.

I guess our concern at the AMA is that having had a global SGR, which clearly has not worked, has not been able to distinguish between good growth and bad growth, as you have heard, really is a meat ax, where a surgical scalpel is needed, we would have some concerns and think that to look at, in essence, having many SGRs, which one might characterize this as, would need careful study to be sure it didn't just compound the problem.

We believe that the critical thing is to move away from this system, which says we are going to decide ahead of the year how many people are going to get sick. And if more people get sick that year, then we are going to dock the physician's pay. And we believe that in terms of the payment, we ought to be looking at the increased cost of providing care.

And we also need to be looking at accountability and quality and performance and the kinds of things that you did hear Mr. Kuhn talk about and that the AMA has been working with CMS on.

Chairwoman VELÁZQUEZ. Thank you.

Dr. Dale?

Dr. DALE. Yes. It is an important issue. And I think we would be strongly in favor of careful study of proposals like this. We can see some pluses and minuses to it. Really, the bigger problem is since the beginning of Medicare, there have been lots of changes.

And, in particular, the relationship between hospitals, doctors, and pharmaceuticals has changed enormously. And it would really be much more important to study the global costs of health and then the partitioning of the funds to pay for it.

Chairwoman VELÁZQUEZ. Thank you.

Ms. Reimers, the pending Medicare physician cuts could affect the ability of practices to make needed capital purchases. This is officially true in the current economic environment, when it is even more difficult and costly to get a loan.

In your opinion, will these cuts affect ability of practices to purchase needed health information technology and medical equipment?

Ms. REIMERS. Absolutely. And I believe that it already has. I mean, we really haven't had a raise in the last seven years. So imagine working for seven years without ever a pay increase but only your expenses going up. And so there is absolutely no reason to believe that they haven't already had an effect.

There are many people who are still struggling to try to find creative ways to make purchases of this kind of equipment. So it is happening but just not at the rate that the nation would like to move to have integrated health information systems.

Chairwoman VELÁZQUEZ. Any other member of the panel would like to—

Dr. WILSON. Well—

Mr. DIANGELIS. No, go ahead.

Dr. WILSON. Okay. Well, thank you, Madam Chairwoman.

I would just emphasize that I am in solo practice of general internal medicine. And 75 percent of my practice is Medicare. So it is actually a challenge for me to replace existing equipment in the office and with this uncertainty, much less to consider other newer things, which have benefits and are very positive and I would like to have, but it is just out of the realm of possibilities.

Chairwoman VELÁZQUEZ. Let me ask you. Some members of Congress has suggested paying higher reimbursement rates for practicing investing in health information technology. Do you think that the fee structure should be used as an incentive to encourage information technology adoption?

Dr. WILSON. We believe that there need to be incentives. You know, one of the realities is at this point only 11 percent of the benefits of going to health information technology actually accrue to the provider. The other 79 percent go to payers and insurance companies and managed care companies.

So we believe that assistance will be needed. And we are supporting things that Congress can do in terms of tax deductions and credits and loans and incentives. We are also asking Congress to consider looking at the anti-kickback laws and antitrust laws that might be able to be tweaked so that physicians can enter into relationships with hospitals and insurers to help finance this change.

Chairwoman VELÁZQUEZ. Thank you. Dr.—Mr. Chabot? Dr. Chabot.

Mr. CHABOT. Dr. Chabot. Yes. Thank you.

[Laughter.]

Mr. CHABOT. Great. Ms. Reimers, if I could begin with you? I think you mentioned that 24 percent of your patients are Advantage. Is that correct?

Ms. REIMERS. Twenty-four percent of our Medicare patients are now Medicare Advantage.

Mr. CHABOT. Okay. And is the treatment that they receive any different from a person that's under regular Medicare versus a person that might have some sort of private health care versus is there anybody that still pays for it out of their own pocket in your practice or do they all have one of those coverages?

Ms. REIMERS. We do have an Amish community around us who pays cash. And so yes, we do have self-pay patients and a few uninsured.

Mr. CHABOT. So the question would be, how is the care?

Ms. REIMERS. In our mind, when they get back to see the doctor, there is no change. There is no directive to not see a patient in a certain manner or care for them in any way differently.

Mr. CHABOT. And as a business person, do you have any preference amongst the four different categories that we talked about?

Ms. REIMERS. Well, I certainly would like to see an insured patient who I know the rules, rather than an insured patient who I don't know the rules, because this patient may have to be directed to a particular hospital. This patient may have to have certain services done before they will be approved for surgery. So there could be a variety of reasons why I need to have information prior to.

Currently the way our practice operates, the physician would probably know what kind of insurance the person has. So that he might, for instance, say, "Well, I see that you have to be done at this particular hospital. So I go there on Wednesdays," that kind of thing. But other than that, we do not do anything differently.

We have a few instances, too, where we have to get prior permission from a patient to do services on Medicare or Medicare Advantage patients. They have to sign a release, very rare but occasional. And so we have to be cognizant of that.

Mr. CHABOT. Thank you.

Dr. Wilson, I think you had mentioned the eleventh hour intervention. And going back to the question that I had asked in the previous panel about how disruptive is it, how inconvenient is it that Congress doesn't act so we don't tell you ahead of time what the rules are going to be, when you are going to get the money, how much is it going to be? How disruptive is that when you are practicing medicine?

Dr. WILSON. Well, first let me thank you for the question you asked because it was good to hear that CMS does think there is a time certain that they could make those changes. It was chilling, though, to realize that the cuts are already locked in the computer. So we hope something will happen in time for that to be changed.

Clearly small businesses cannot plan for the future unless they have some way of estimating what their income is going to be. So your estimate of what the income is going to be, what is certain is that there could be a ten percent cut, you can't plan for that future. You are really planning for survival.

So to think that one can add new technology in the way of health information technology or other medical technology which comes across the way, those uncertainties for any small business are exaggerated in physician practices.

Mr. CHABOT. Okay. Thank you.

Dr. Mabry, you had mentioned that you are a small business and so you face the small challenges that other small businesses do, even outside the medical profession. Is it accurate that also in the other challenges that you face, they would include things like energy costs and how they have been going through the roof? And so you are paying those same costs as well.

In fact, even in the products that you have to purchase, with diesel being as high as it is right now, the inflationary factors in all the things, if you buy a chair for your office, for example, so, in other words, even, say, the federal inheritance death tax, when one has to plan for the future, so you face all of those same problems that other businesses would face as well. Is that correct?

Dr. MABRY. Yes, sir. I think all the practices have to bear the burden and the brunt of any inflationary increases from their suppliers. And this goes without saying.

Another thing that we have not talked about today but that is certainly a very true phenomenon is the increase in health insurance premiums that small businesses have to shoulder. We are health care providers, but we have no control over the cost of health insurance, which is going up, and it is harder to get. So that is another inflationary cost.

And, as Dr. Wilson pointed out, it's not just small things, such as tongue blades. In our practice, our endoscopes that we use to do screening colonoscopy for colon cancer, they are getting old. My partner and I were trying to decide when and if we can buy those or not. Well, we don't know. We don't know what the next six months are going to hold.

So those sorts of things are real-life examples of how it is becoming more and more difficult to practice medicine. It is hard enough to practice medicine in surgery, but now we have to worry about the business aspects of it. And that just adds more to the problem.

Mr. CHABOT. Thank you.

And then for all of the doctors, does it continue to be a problem or something that you have in your mind, the potential of having a lawsuit filed against you and the challenges that one faces, sometimes frivolous suits but, nonetheless, you still have to defend them? Is that still an issue that resonates that you think should be dealt with, either at the state level or at the federal level? I invite any of the doctors.

Dr. WILSON. Well, it is a part of the real world, and it is never far from the surface. It is a fair observation to say that a lot of those premiums that have arisen have tapered in the last year. They have stopped rising as fast, but they are at unconscionable levels. So that if you are an ob/gyn in Miami, Florida and paying $247,000 a year, that is a constant financial reminder of those challenges.

And then I think the thing that you alluded to—and that is, the apprehension about taking that trip, even if you are acquitted, if you are sued, taking that trip, and the hassles of that are what drives a lot of what we call euphemistically defensive medicine, which we know. And, actually, I guess the CBO offices indicated add to another $120 billion to the cost of health care in this country. So we are still very concerned.

Chairwoman VELÁZQUEZ. Would the gentleman yield?

Mr. CHABOT. I would be happy to yield.

Chairwoman VELÁZQUEZ. Doctor, is insurers' consolidation an issue that is in your mind?

Dr. WILSON. Absolutely and not just in terms of liability but particularly in terms of health insurance.

Chairwoman VELÁZQUEZ. But it is not only tort reform and liability issues one of the biggest issues that you have to confront but also the insurer consolidation? So it has to be coupled with insurance reform?

Dr. WILSON. Our plate is full.

Chairwoman VELÁZQUEZ. Yielding back.

Mr. CHABOT. Okay. Thank you.

And reclaiming my time, just one last question. Also, the marginal tax rates, income taxes, on everyone was reduced somewhat over the last few years. And capital gains taxes were reduced and those types of things. Those tax cuts were not permanent, unfortunately, because we didn't have the votes in the Senate to make them permanent. So they are going to go back up in a couple of years unless Congress does something to make those tax cuts permanent.

Is that a concern to the members of the panel or do you want to have your taxes go up?

[Laughter.]

Chairwoman VELÁZQUEZ. An easy one.

Mr. CHABOT. Anybody want to take? Mr. DiAngelis, since I hadn't talked to you?

Mr. DIANGELIS. The idea of taxes increasing I don't think excites anybody at the table. So it is a concern. You know, anything that is going to increase our expenses for the small physical therapist practice has the potential to be extremely detrimental because we are literally right now working in a survival mode.

An example, Dr. Mabry just brought up that his health insurance goes up every year. I just got my renewal notice for our small company. And this year it goes up in June. And they are proposing a 49.5 percent increase in my premiums. I don't know how that is justified, but I know that it is something that we cannot afford.

And so we are in a situation where we really live paycheck to paycheck in the small business. And so anything that is going to increase expenses anywhere we are not going to be able to make it, quite frankly.

Chairwoman VELÁZQUEZ. Okay. Thank you.

Dr. Dale?

Dr. DALE. I will comment because I think doctors are interested both in the cost and in the revenue side of government. I would say that doctors are good citizens. They pay their taxes. And they pay them as happily as anyone else. And I think that in terms of paying for Medicare, that we have been happy participants on both sides. And in talking to physicians, they appreciate the value of Medicare to the public but also to themselves.

Mr. CHABOT. Thank you very much. I thank the entire panel and yield back my time.

Chairwoman VELÁZQUEZ. Mr. González?

Mr. GONZÁLEZ. Thank you very much, Madam Chair.

And, again, thank you for your testimony today. And I also join my colleagues in expressing regrets that it has been such a delay. But it has just been a tough week.

First and foremost, I think everyone agrees that the SGR is, in fact, broken, for whatever reason. Maybe it is not such a bad vehicle or manner in which to arrive, but obviously the elements, the factors, and everything else, maybe we're not getting the right information, one.

Two, we are also working within fiscal constraints. We are going to make it work, whether we have the right information or not. And that is the scary thought.

My question goes to your efforts of having your voices heard as we work through this problem. I do want to touch on—and I am sure the Chairwoman and Ranking Member may have something to say—we don't know what is going to happen other than we are not going to let the ten percent cut go into effect. But is it going to be a six-month fix?

This is an election year. You know, dump it on the new administration and see what happens. And every year we have been doing this since 2002. And, to be honest with you, in the final analysis, I think health care providers are just happy that the cuts weren't effectuated. But we still don't fix the underlying problem, which is never good. And we have gone over the consequences of that.

You heard Mr. Kuhn say something to the effect that there is a collaboration with the medical community, ongoing. And that was his testimony. So my question all the way down the line because each of you represent an organization or an association, is your voice being heard? What form does it take? I am really starting to wonder.

Whether it is the Texas Medical Association, my local medical society, the different specialist associations, I don't get the message that there is a huge collaborative going on.

So, you know, I will start with the first witness. Is it Ms. Reimers?

Ms. REIMERS. I guess I will, first of all, say from an administrative standpoint, getting the job done, paying us when we send in the claim—you know, we submit a bill. They pay us. Traditional Medicare is doing a very good job, as opposed to a number of years ago where there were all kinds of administrative struggles and timeliness of payment was a severe issue.

I do not feel that CMS has done enough to oversee Advantage payers' behavior after the claim is submitted. They are working pretty hard to try to straighten out beneficiary issues, but I do not feel that they have done much to support physicians.

And, to that end, there is not, to my knowledge—and I have tried to ask a lot of people. There is no apparent method to review an unpaid claim or a claim that is not paid correctly. If the Advantage payer sends you a $10 check for something that should be $100, there is no mandated way that a deemed provider can make the Advantage payer review that claim and resubmit and possibly pay correctly. They sometimes will and sometimes won't.

Mr. GONZÁLEZ. Thank you.

Ms. REIMERS. So I would say CMS is doing a great job on traditional Medicare, maybe hasn't worked out the kinks on the Medicare Advantage.

Mr. GONZÁLEZ. Mr. DiAngelis?

Mr. DIANGELIS. On your specific question, if I understand you correctly, you know, is our voice being heard by CMS in this, I will defer some to our national organization, ask them to follow up with you since I am not on the inside day to day with the association.

However, from the discussions that I have had, my understanding is there is dialogue there and fairly consistent dialogue. So I see that as a positive. However, I cannot state specifically how well the voice is being heard. But I will be happy to have somebody follow up with you on that.

Mr. GONZÁLEZ. Dr. Wilson?

Dr. WILSON. Thank you, Congressman. It is a yes and no answer. And the first thing to do is to agree with Mr. Kuhn that in those areas related to quality and performance improvement, the whole area that the AMA has been involved with along with all of the specialty societies since 2000, the Physician Consortium for Performance Improvement, which has developed now in excess of 213 performance measures; that is, physicians deciding how physicians out to measure their work product, we are pleased that CMS is using, I think it is, like 85 percent of the measures they are using and the physician quality reporting initiative are AMA Consortium performance measures.

So we believe that is a positive. We are using real science the physicians have adopted. So we have been very pleased. We do believe that our voice is being heard.

The other side of the coin does have to do with the issue we are talking about here today. And that is the SGR. We have felt for a long time that the administration had some options. And we suggested some along the way. They might have been more helpful in addressing the problem of the cuts. There may have been some wiggle room there.

Now, their attorneys have suggested to them otherwise, but we believe that they have said—and I think you heard that, that it is at the Congress to do that. And so we don't think that that part of the concern has been heard well.

Well, the other concern we have, of course, is the continued emphasis on volume, not always appreciating that that doesn't distinguish between good volume and bad volume.

Mr. GONZÁLEZ. Thank you.

Dr. Dale?

Dr. DALE. I guess I will make three brief points. One is the ACP has really been interested in the initiative, the patient-centered medical home, as a new framework for thinking about the organization of medical services, which, as I mentioned, may save costs, provide more patient satisfaction, and also make the field of being a generalist more attractive.

We would like to urge Congress to enact legislation that would initiate a pilot testing of this idea. There is a limited demonstration project that has been funded but hasn't gotten started. I guess our basic feeling is it has been awfully slow in getting started.

The other two things I would briefly mention are we have testified before before Congress about relative effectiveness of treatments and tests. And we think the government, CMS, should be investing more in looking at the relative value of things that we pay for. And, second, we have an initiative also to look at the cost-benefit of things we pay for. And we need to be both more imaginative and more critical and put more effort into really analyzing what we are doing.

Mr. GONZÁLEZ. Thank you.

Dr. Mabry?

Dr. MABRY. Thank you.

I would echo what was said. The three things that I would like to talk about that the American College of Surgeons has been very engaged with and with the both the administration as well as the other societies has been in the search for quality. If you are going to give us a dollar to deliver care, then we owe it to you to show that we are delivering good care. And that is what all of us have said.

The College has the National Surgical Quality Improvement Project, which actually measures surgical outcomes in hospitals. And that is a very important we think risk-justified program. And we are trying to spread that throughout the hospitals.

The other is the Surgical Quality Alliance that comes up with new measures to measure the actual quality of surgery that is being delivered. Are you getting a good operation? Are your complication rates low? What are you doing to prevent problems? Those things are very important.

I think the third thing in this, probably the most important as far as the dollar impact, is we would like to see the agency ask what I would call the tough questions. An 80-year-old man who has pancreatic cancer, do they really need an aggressive chemotherapy when their life expectancy is short anyway? If they do need that, what sort of aggressive therapy do they need?

The outcome effect of this is very critical. That is where we are going to tell the difference between money that is wasted and money that is well-invested in a patient.

And those tough issues, those tough questions, that is what we need to be asking: How we are going to spend our money and can we spend it well?

Mr. GONZÁLEZ. And, real quick, just kind of a final thought. The Chairwoman will have these early breakfasts, like 8:00 in the morning. And we have these roundtable discussions. And we have had them with, of course, health care providers. And it has been very interesting.

And I think one of the most interesting aspects is that we have had individuals that are representative of either your associations, organizations at the table. And they have been able to identify specific individuals within the CMS who are very responsive.

And I would say that you all need to start looking at that and saying, "Okay. Who does listen to us?" because this next administration is probably going to be looking for some guidance and from the different professional organizations as to who gets the promotion, who remains, and so on.

We are going to have to have someone that is incredibly sensitive and is going to be listening to you. You have to be very organized, though, in your approach because bureaucracy has a way of just either waiting you out or wearing you out. And we have to fight that.

I can assure you that we are very, very vested on the small business aspect. And most of the practitioners are small businessmen and women.

Thank you very much.

Chairwoman VELÁZQUEZ. Mr. DiAngelis, I want to ask my last question to you. And maybe, Ms. Reimers, you might want to comment. Many health policy leaders are discussing ways to further integrate and promote efforts in information technology, quality improvement, and outcomes measurement in Medicare.

What do you believe the challenges will be for small practices attempting to integrate this initiative into their practice?

Mr. DIANGELIS. I think the first challenge is any technological requirements that would require an investment up front. We would like to right now be moving towards electronic medical records and be able to capture some data that way, but, quite honestly, we just can't do that.

The expense is too high. And with the uncertainty of where we are going, we are hesitant to take on any more debt load and move forward in that area. So I see that probably the biggest limitation for a practice like ours would be the up-front expense of what we would have to do there.

I think that there might be some ways to capture certain data through billing mechanisms and things of things of that nature that we already do. And that is why I think getting everybody to the table and trying to figure out how we do that would be critical in sorting through that.

Chairwoman VELÁZQUEZ. Thank you.

Ms. REIMERS. I would initially say, first of all, the up-front cost. But once you get past that, you do have with so many businesses involved, whether it be hospitals, doctors, physical therapists, audiologists—you know, the list goes on and on—you are going to have a great need to figure out which pieces of discrete data you are benchmarking and what makes good quality, especially with an elderly population who, by definition, are going to decline.

So I would say that the process to measure is going to be a lengthy one. And maybe just picking certain measures, as in PQRI, is a good start, but I see that the definition of each discrete data field may have a lengthy two-page definition to it. So I think that defining each element you are trying to measure would be an issue.

Chairwoman VELÁZQUEZ. Thank you.

Anyone else would like to comment?

[No response.]

Chairwoman VELÁZQUEZ. Okay, Mr. Chabot. Well, again I want to thank all of you. You know, I participate every week with the Democratic leadership, regarding legislation that will be brought up to the floor. We will continue to monitor this issue as it moves from the Senate into the House. I will voice the concerns of the small business community when it comes to physician cuts for-

mula. And we hopefully get a resolution soon, before the summer gets here.

With that, I thank all of you for participating. And I ask unanimous consent that members will have five days to submit a statement and supporting materials for the record. Without objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 2:05 p.m., the foregoing matter was concluded.]

NYDIA M. VELÁZQUEZ, New York
Chairwoman

STEVE CHABOT, Ohio
Ranking Member

Congress of the United States
U.S. House of Representatives
Committee on Small Business
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STATEMENT
of the
Honorable Nydia Velásquez, Chair
House Committee on Small Business
Hearing on the
"Medicare Physician Fee Cuts: Can Small Practices Survive"
Thursday, May 8, 2008

Our health care system is facing many challenges today that are not only affecting patients, but also medical providers. One of the greatest obstacles confronting small health care practices - is the fiscal problem in the Medicare program.

With the baby boomer generation entering retirement, Medicare spending will increase exponentially over the next ten years. Efforts are underway to ensure access to health care remains - while also meeting the long term financial issues facing the program.

One of the top priorities in the upcoming months is addressing the scheduled cuts in physician fee payments. On July 1st, physician payments for Medicare services are scheduled to be reduced by 10.6 percent. Without action, these cuts will continue annually. And it is predicted that the total reduction will be about 41 percent by 2016.

Practitioners have warned that cutting doctor payments will undermine the physician foundation of Medicare for current and future generations of seniors – creating unnecessary barriers to care for older Americans. An AMA survey found that 60 percent of doctors believe this year's cut alone would force them to limit the number of new Medicare patients they can treat.

This hearing today will examine how any solution must account for small healthcare practices. In crafting a fix, the unique circumstances of small health care providers must not be ignored. It is clear that they could be the most severely affected. Doctors surveyed by the American College of Physicians said cuts would force them to postpone purchases for their practice and to reconsider plans to upgrade health information technology. Other providers went further - saying they would reduce their staffs or "get out of patient care altogether."

Unfortunately, the Administration has taken the position that the cuts are necessary even if it could mean loss of access for our seniors. In finding a solution to this problem, CMS must be an active participant - which is why the Committee has invited CMS here today.

The Committee looks forward to CMS' testimony on what they are doing to work with the physician community. It is critically they hear the concerns of medical professionals here today - and across the country - on the potential implementation of these cuts, as well as ways to mitigate their impact. This includes reducing the paperwork burden and providing regulatory relief to help physicians reduce costs associated with operating a practice.

With the cuts little more than a month away, there are steps being taken to avoid this problem. The question simply becomes how should it be done and what does it means for physicians.

The Senate has outlined a plan that would delay the Medicare physician payment cuts for 18 months. I support the effort to address this problem in the near term, but I also believe we should be working to finding a more "permanent fix" to Medicare's physician fee cuts -- one that reflects the cost increases inherent in practicing medicine and preserves access to coverage for seniors.

Any fix needs to address the needs of small physician practices. A solution that doesn't meet these goals could mean that patients could face problems in accessing health care in the future.

I hope that during today's hearing our witnesses will shed light on the steps they believe should be taken. It is also my hope that the panelists will provide insight on the short and long-term impact the cuts could have on the provider community.

In many ways, the physician community's interests are aligned with those of the seniors that receive care. The Committee wishes to hear these concerns and how we can work together for a proper remedy.

U.S. House of Representatives
SMALL BUSINESS COMMITTEE
Representative Steve Chabot, Republican Leader

Thursday,
May 8, 2008

Opening Statement of Ranking Member Steve Chabot

Medicare Physician Fee Cuts: Can Small Practices Survive?

Good morning. Thank you, Madam Chair, for holding this hearing on Medicare physician fee cuts. This committee and our nation recognize that small medical practices are critical to the country's overall physical and mental health and, like all other small businesses, essential to our economic well-being.

I'd like to extend a special thanks to each of our witnesses who have taken the time to provide this committee with their testimony. I would also especially like to welcome Dr. Charles Mabry, who is testifying on behalf of the American College of Surgeons. I am sure we will find your testimony extremely helpful.

Data on medical practice size show that physicians and patients continue to prefer small practice settings. The small setting allows the physician to have control of medical decision making and is most conducive to the relationship of trust and confidence between physician and patient. The practical preference of the small practice setting suggests that any Medicare physician fee system must be feasible and easily operable in a small practice setting.

The managed care backlash is also driving the insurance industry toward traditional insurance principles that instruct insurers like Medicare to manage financial risk and allow providers to manage care. The insurers' forays into disease management emphasize this change in behavior with only cautious and limited outreach to physicians.

The current Medicare physician fee schedule is flawed. Since its inception in 2002, the Sustainable Growth Rate formula has required the government to reduce physician fees. Since 2003, Congress has passed and the President has signed laws that have prevented the reductions from taking place. The current system rewards the physician for seeing as many patients as possible and performing excessive services. An example of this practice is the use of a CAT-scan rather than and an x-ray. Several studies have confirmed that expensive or excessive services do not lead to better quality outcomes.

As physicians' costs go up and their Medicare reimbursements drop or are unrealistically low, they're engaged in a vicious cycle that forces them to see more and more patients to take in the same amount of money. Medicare pays its providers based on quantity without rewarding those providers who improve quality. In fact, Medicare pays more when poor care results in preventable services. This needs to change.

Today, access remains good for beneficiaries accessing current physicians and for those seeking new physicians. Continued efforts to monitor and protect Medicare beneficiary access are warranted.

The Medicare physician fee schedule should be restructured to place a greater value on the quality of care and the efficient use of resources. Attention should also be given to improving health IT efforts. Making electronic Medicare records available to patients' physicians will cut down on unnecessary tests, help doctors provide better care, and offer economic benefits to the taxpayers and the federal budget.

We have excellent witnesses here today and I look forward to hearing their thoughts. Thank you Madam Chair and I yield back the balance of my time.

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Statement of Rep. Jason Altmire
Committee on Small Business Hearing
"Medicare Physician Fee Cuts: Can Small Practices Survive?"
May 8, 2008

Thank you, Madam Chair, for holding today's hearing to examine how small practices will cope with upcoming Medicare physician fee cuts. The fiscal problem within the Medicare program is one of the biggest challenges facing small health care practices today. At the same time our baby boomer generation enters their retirement, Medicare is expected to dramatically increase over the next decade.

One of the immediate issues that our small medical practices will face is the 10.6 percent physicians' payment cut scheduled to go into effect on July 1. Unless action is taken, these scheduled cuts will continue annually, and it is predicted that by 2016 the total reduction will be about 41 percent. Many practitioners have warned that these planned cuts in doctor payments will force doctors to limit the number of Medicare patients they are able to treat.

Today's hearing will provide us with the opportunity to hear not only from small health care practices, but also from the Centers for Medicare and Medicaid about how they plan to help small practices during this period of change. With the scheduled cut just over a month away, we need to take steps to address this issue in the short and long term.

Madam Chair, thank you again for holding this important hearing today. I yield back the balance of my time.

# # #

May 8, 2008

Congressman Bruce Braley Statement
Submitted for the Record

House Small Business Committee Hearing on
"Medicare Physician Fee Cuts: Can Small Practices Survive?"

Thank you Chairwoman Velázquez, and thank you for holding this hearing. It is essential we examine the consequences of Medicare physician fee cuts on access to health care in places like Iowa.

Here we are once again trying to resolve a problem we ended up just slapping a band-aid on last year. The *Medicare, Medicaid, and SCHIP Extension Act of 2007* temporarily delayed a drastic cut to Medicare payments to physicians and provided for a 0.5 percent increase for six months. However, unless Congress acts soon, Medicare payments to physicians will be cut by 10.6 percent on June 30th and by another 5 percent at the beginning of next year.

I continue my commitment to fighting the proposed 10 percent cut to physician reimbursements and replacing the Sustainable Growth Rate (SGR) formula. The SGR formula is seriously flawed and unless something is done about this, it could create a situation where physicians will no longer be able to afford admitting Medicare patients.

While the costs of practicing medicine have increased significantly in recent years, the amount of current Medicare physician payments is essentially the same as it was in 2001. Over the next eight years, these payments are slated to be cut about 40 percent while practice costs will increase nearly 20 percent. Many small practices are already losing money every time they see a Medicare patient. If physicians cannot afford to admit new Medicare patients, primary care for groups like the elderly could be severely limited. With an aging population this is especially problematic. Some seniors today are already having a difficult time finding a physician who accepts Medicare.

I have asked House Leadership to address the proposed 10 percent cut, and I have been glad to see a certain amount of progress. In August of 2007, I supported H.R. 3162, the *Children's Health and Medicare Protection (CHAMP) Act,* which passed the House by a vote of 225 to 204. In addition to expanding health care for low-income children, this bill would have eliminated the proposed 10 percent cut to Medicare reimbursements in 2008. And most importantly, this bill would have replaced the SGR as the mechanism for setting Medicare's physician payment rates with a new system that creates six different categories of physician services.

As physicians cheered for the House efforts to prevent the 10 percent cut, the White House promptly issued a veto threat of that bill. Unfortunately, the permanent fix to the 10 percent cut was lost along the way, as the Senate was obliged to make compromises with the White House.

In addition to this 10 percent cut, Iowa doctors have an additional obstacle to overcome. Iowa is already short-changed in the reimbursement formula, due to another flawed piece of the formula: the Geographic Practice Cost Indexes, or GPCIs. These outdated figures ensure that some parts of the country receive much lower Medicare reimbursement rates than other places. In order to ensure that places like Iowa are able to retain high-quality doctors, it is essential that Iowa physicians receive the reimbursement rates they deserve.

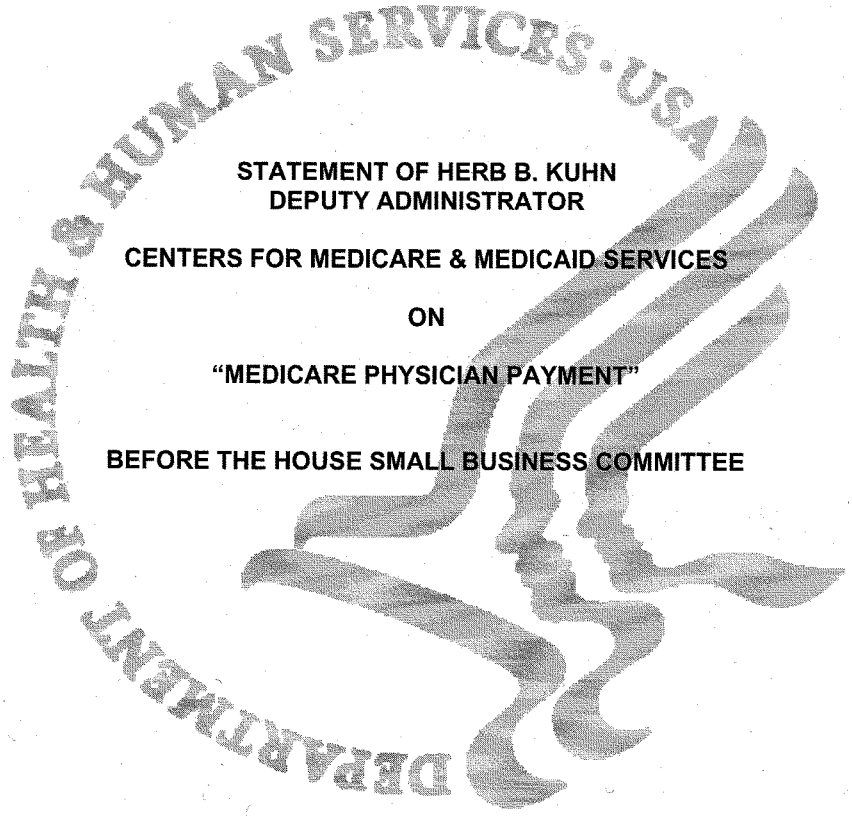
To work towards leveling the geographic inequity of physician reimbursement, the *Medicare Modernization Act of 2003* (MMA) established a temporary floor of 1.0 to the Work GPCI, which helps level the playing field for physicians in Iowa and other rural states.

But the GPCI floor expired December 31, 2006 and has been subject to temporary extensions ever since. Now we're faced with the Work GPCI floor fix set to expire again on June 30th. This upcoming expiration looms heavily for Iowa doctors, especially when compounded with the 10 percent cut. Despite the well-documented quality of Iowa's health care system, Iowa's health care providers stand to lose millions of dollars because they choose to care for Medicare patients. There is already a physician shortage in Iowa, and now we stand poised to further disincentivize the treatment of those who often need it most – Medicare patients.

In order to create a permanent fix to the geographic inequities in the Medicare formula, I authored and introduced the *Medicare Equity and Accessibility Act of 2007*. This legislation would increase Medicare Part B reimbursement rates for physicians in Iowa and other rural states. These increased rates will help retain our doctors, recruit new doctors, and improve patient access to quality healthcare.

The *Medicare Equity and Accessibility Act* would institute a permanent floor on both the Work and Practice Expense Geographic Practice Cost Indexes under Medicare Part B. My bill has gathered significant bipartisan support and has resulted in a companion bill in the Senate. This legislation is supported by the state medical associations in 25 states, including the Iowa Medical Society. It is clear that we need to correct inequities in reimbursement rates, address the shortage of doctors in rural areas, and ensure that the Medicare formula does not penalize physicians for seeing Medicare patients.

Thank you, Chairwoman Velázquez, for considering this important issue, and thank you to the witnesses for coming in today.



STATEMENT OF HERB B. KUHN
DEPUTY ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"MEDICARE PHYSICIAN PAYMENT"

BEFORE THE HOUSE SMALL BUSINESS COMMITTEE

May 8, 2008

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of
Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services
Before the
House Small Business Committee

Hearing on
Medicare Physician Payment

May 8, 2008

Chairwoman Velázquez, Mr. Chabot, distinguished members of the Committee, thank you for inviting me here today to discuss Medicare physician payment. The Centers for Medicare & Medicaid Services (CMS) is actively engaged with the Congress and the provider community on this important topic. As indicated in the President's Fiscal Year (FY) 2008 and 2009 Budgets, the Administration supports payment reforms for providers that do not increase Medicare spending, and that encourage providers to deliver high-quality, efficient care. Given the size and impact of the Medicare program, now and in the future, it is critical that we move from passive payer to active purchaser of high-quality, efficient care.

Medicare currently pays for health care mainly based on resource consumption and service volume. Payments for treatment of healthcare associated infections and other preventable complications contribute to growing Medicare costs The disconnect between current payment policy and fostering high-quality, efficient care is one reason why the health care share of our nation's gross domestic product (GDP) continues to increase. Our nation's total health care bill (already $2.1 trillion in 2006) is expected to more than double by 2017 to an estimated $4.3 trillion. By 2017, our nation would be spending almost one of every five dollars on health care.[1] As Secretary Leavitt recently stated, "There is no place on the world economic leader board for countries that spend 25 to 30 percent of their total output on health, and unless we change, that is where we're headed."

[1] Keehan, et al., "Health Spending Projections Through 2017: The Baby Boom Generation is Coming to Medicare," *Health Affairs*, March/April 2008; 27(2): w145-w155.

For the second year in a row, this year's Medicare Trustees Report predicts that Medicare's Hospital Insurance (HI) Trust Fund will be insolvent as soon as 2019, just eleven years from now. This is the fund that pays for Medicare Part A services – hospital inpatient care, limited care in a skilled nursing facility, home health, and hospice care. Medicare's other Trust Fund, the Supplementary Medical Insurance (SMI) Fund that pays for Medicare Part B services including physicians, similarly is expected to face rapid growth in spending according to the Trustees. Unlike the HI fund, SMI is supported by general revenues as well as beneficiary premiums.

In light of Medicare's financing challenges, our single most important goal is to encourage continued improvement in the efficiency and quality of health care delivered to Medicare beneficiaries, while preserving access to services in a way that is fiscally responsible. Our ability to fulfill the goal of access depends, of course, on continued active participation of physicians in Medicare. Currently, nearly 95 percent of eligible physicians and other practitioners are Medicare participating providers, up from approximately 90 percent in 2004.

We have an interest in appropriately compensating physicians for the care they furnish to Medicare beneficiaries. This does not mean we should continue "business as usual" in the area of physician payment, however. Since its inception, the fee-for-service Medicare program has been largely a passive payer of health care services. Our goal throughout Medicare, including with respect to physicians' services, is to pay based on the value of services provided, not simply based on quantity of services or resources consumed.

With respect to physicians, some of the fundamental pillars of appropriate payment include: encouraging physicians to provide the right care at the right time; ensuring greater transparency so physicians and their patients have the information they need to choose and ensure high quality care; and avoiding

unnecessary services, such as duplicate tests. In other words, quality and transparency are critical to appropriate payment.

This concept is neither new nor unpopular. The Institute of Medicine (IOM), MedPAC, congressional legislation, and many in the provider community now agree that well-designed and comprehensive quality and efficiency measurement should play a key role in reforming Medicare physician payments. The *2008 Dartmouth Atlas of Health Care* released in February underscores the importance of such an approach, finding "glaring variations" in the nationwide distribution of health care services and "remarkably uneven" quality of care. Prominent among potential explanations for these disparities is Medicare's current physician payment policy, which "rewards providers for staying busy." Additional health care spending does not necessarily mean greater quality of care or better patient outcomes

CMS is playing a leadership role in a multi-pronged approach to addressing such issues, with the overarching goal of linking provider payment for Medicare services to outcomes and best practices. We recognize the problems in the current statutory formula for calculating annual physician payment updates. Service volume and Medicare costs for physician care have increased steadily, but in every year since 2002 Congress has overridden the statutory cost growth control, the Sustainable Growth Rate (SGR). The problem with this recent approach is that it runs up a tab that makes the next scheduled cut even larger. This July, the law requires Medicare to cut doctors' fees by 10.6 percent.

CMS is concerned by the tremendous amount of uncertainty the recent approach to physician payment issues causes at the physician level, which can be particularly difficult for small physician practices. We are going to continue working collaboratively with medical professionals, the Congress and MedPAC to develop and implement necessary changes to physician payment policy, with the goal of applying the most effective clinical and financial approaches to achieve

better health outcomes and long-term program sustainability for Medicare beneficiaries and taxpayers.

Medicare's Success Depends on Active Participation by Physicians

Currently, updates to Medicare physician payments are made each year based on a statutory formula set forth in section 1848(d) of the Social Security Act. The annual update calculation compares target spending to actual spending for Medicare physicians' services using a combination of annual and cumulative (since 1996) spending targets. By statute, if actual spending exceeds the targets, updates in subsequent years are reduced. If actual spending falls short of the targets, subsequent year updates are increased.

Actual spending on physicians' services has been growing at a faster rate than target spending. Since 2001, the statutory update formula has called for payment cuts. However, in every year since 2002 Congress has intervened to temporarily override formula requirements in favor of a specific, statutorily defined update. In passing these measures, Congress did not include a long-term modification to the underlying update formula, causing the gap between actual and target spending to grow even larger.

We have worked collaboratively with the physician community since the early 1990s to develop Medicare payment rates for individual services. We receive recommendations on the development of these payment rates through a multispecialty physician process administered by the American Medical Association's Relative Value Update Committee (RUC). The statute requires a comprehensive examination of the payment rates every five years and in 2007 we substantially raised the rates for primary care services based on the third five-year review. We are continuing to look at ways to further improve the fee schedule based on concerns raised by MedPAC, primary care representatives, and some others. For example, MedPAC is concerned that the current

distribution of Medicare physician payments may still undervalue primary care services and introduce other distorted incentives that may encourage overuse of some services and underuse of others. We expect to discuss our plans further during future rulemaking.

A system that aligns payment with quality and efficiency can better encourage physicians to provide the type of care that is best suited for our beneficiaries by focusing on prevention and treating complications and the most effective, proven treatments available. A system that also enables beneficiaries to identify providers of high quality care, better understand the cost of care, and achieve the transparency of information that exists in other sectors of the economy--features that have been sorely lacking in the healthcare arena—could also enhance a beneficiary's ability to make informed decisions about their healthcare.

As part of the President's commitment to making health care more affordable and accessible, CMS launched a broad Transparency Initiative in 2006. We are working to improve transparency on price and quality of services provided to Medicare beneficiaries. The Medicare web site now displays quality data that allows consumers to make informed choices by comparing the performance of hospitals, nursing homes, home health agencies, dialysis facilities, Medicare Advantage plans and prescription drug plans. We will continue to consider ways for increasing transparency and expanding our web-based quality compare resources.

Just over a month ago, we announced the posting of new patient survey information to our Hospital Compare website, which now contains twenty-six quality measures plus ten new measures of patient experience of care. We also are adding information about the number of Medicare patients treated for certain conditions and provided certain hospital procedures, and the average Medicare payment. For the first time, consumers have access to the three critical elements they need to make effective decisions about the quality and value of health care

available to them through local hospitals: quality information, patient satisfaction survey information, and pricing information for specific procedures.

CMS has posted this hospital service volume and payment information so the public can see the cost to Medicare of treating beneficiaries with certain illnesses in their community. A better understanding of the cost of care can lead to more informed decision-making – one more way beneficiaries can help improve their health and support the longer term financial health of Medicare.

We are pleased that public interest in our Transparency Initiative is strong and growing, as evidenced by a substantial volume of web page views and ongoing collaboration from the provider and consumer communities.

Ongoing CMS Initiatives Explore and Support Potential Solutions

We believe that a quality health care system is one that:

1. Measures effectiveness by objective standards;
2. Makes it easy for anyone who is interested to review provider track records and what they charge for services;
3. Keeps records and communicates electronically; and
4. Uses financial incentives to enhance efficiency and value.

CMS is engaged in a number of initiatives to implement these four principles within the Medicare program. For example, the Physician Quality Reporting Initiative (PQRI) makes physicians and other eligible professionals potentially eligible for additional payments if they satisfactorily report on quality measures applicable to their practice.

CMS has implemented a broad array of evidence-based quality measures developed through a consensus-based process for the PQRI that promote improved clinical quality, better outcomes and higher efficiency for Medicare beneficiaries. In 2007, there were 74 measures. For 2008 we now have 119

measures that include structural measures on the use of e-prescribing and electronic health records (EHR).

Physician specialty societies, organizations of other professionals, the American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI), and the National Committee for Quality Assurance (NCQA) have all helped us in developing PQRI measures. The measures are endorsed or adopted by the National Quality Forum (NQF) or the AQA Alliance consensus organizations.

We were encouraged by the physician participation rate in PQRI for 2007, its first year, and we expect participation to increase over time. To facilitate this, effective for the 2008 PQRI, we have established several new reporting alternatives to make reporting easier and more meaningful. These include registry-based reporting for 2008, which offers physicians an alternative to reporting quality measures on claims, taking advantage of data reporting to registries that they may be already doing. We are also exploring and testing the capacity to receive information on quality measures directly from EHRs.

We intend to continue to expand and refine PQRI quality measures and the reporting mechanisms available. We will work closely with the AMA-PCPI, the NQF, the AQA and others to make sure our tools promote high quality and efficient care for Medicare beneficiaries.

In addition to PQRI, through several demonstrations CMS is testing new physician payment methodologies that link payment to quality and efficiency. For example, the Medicare Physician Group Practice (PGP) Demonstration, the Medicare Health Care Quality Demonstration, the Medicare Medical Home Demonstration, the Medicare Care Management Performance (MCMP) demonstration, and the new EHR Demonstration are focused on physicians

succeeding in improving patient outcomes and increasing health care efficiencies. We are considering additional demonstrations in this area.

The PGP demonstration is a value-based purchasing initiative that rewards certain large physician groups for improving the quality and efficiency of health care delivered to Medicare fee-for-service beneficiaries. We are seeing evidence that value-based purchasing works. For example, the Everett Clinic in Washington State, one of ten group practice demonstration sites across the country, is raising quality of care with a change as simple as having a doctor follow-up ten days after hospital discharge to address any unsolved or new health problems.

Section 646 of the Medicare Modernization Act (MMA) authorized the Medicare Health Care Quality Demonstration. This demonstration will enable CMS to identify, develop, test, and disseminate major and multi-faceted improvements to the health care system. Projects approved under this demonstration are expected to achieve significant improvements in safety, effectiveness, efficiency, patient-centeredness, timeliness and equity: the six aims for improvement in quality identified by the IOM in *Crossing the Quality Chasm*. Physician groups, integrated health care delivery systems, and regional health care consortia were eligible to apply for the demonstration. The program will identify best practices in terms of system designs that encourage greater quality, efficiency and effectiveness, and focus on ways to make payment more consistent with these practices.

In late 2006, Congress authorized a 3-year Medicare demonstration project of the Medical Home. The demonstration targets high-need Medicare beneficiaries who have been diagnosed with multiple chronic illnesses and require regular medical monitoring, advising or treatment. It establishes a framework to begin building the IOM's vision of patient-centered care: a partnership among practitioners, patients, [and] their families to ensure that patients have the

education and support they require to make decisions and participate in their own care.

Under the Medical Home demonstration, which will be implemented in up to 8 States, a board-certified physician will provide comprehensive and coordinated care as the "personal physician" to Medicare beneficiaries with multiple chronic illnesses. This care would include using evidence-based medicine and decision support tools, health assessments and the use of health information technology (HIT), such as patient registries or electronic health records. Physicians will receive a care management fee, in addition to payment for whatever Medicare covered services they may provide.

The Medicare Care Management Performance demonstration is a pay for performance demonstration with approximately 2300 physicians representing almost 700 practices. It started in July 2007 and provides financial rewards for practices' performance on 26 clinical quality measures covering care for diabetes, congestive heart failure, coronary artery disease and the provision of preventive health services to beneficiaries with chronic conditions. It also will reward physicians who are able to report measures to us electronically through Certification Commission for Health Information Technology certified EHRs certified by the Certification Commission for Health Information Technology and are able to report the measures to us electronically.

Finally, earlier this year Secretary Leavitt announced a new CMS demonstration program to provide as many as 1200 small to medium-sized primary care practices across 12 sites nationwide with incentive payments for increasing EHR functionality and improving care through the use of EHRs. Individual physicians could earn up to $58,000 over the course of the five-year demonstration or up to $290,000 per practice. By design, the demonstration will be budget neutral, requiring that associated costs be offset by savings resulting from more efficient health care delivery.

We are hopeful and encouraged that these opportunities will yield information helpful to CMS and the Congress as we consider options for revising the Medicare physician payment system. However, it is important to note that all of these approaches are in their infancy and need further refinement and analysis before they could be appropriate for widespread adoption in the physician payment system. They also pose significant technical and operational challenges that need to be considered. We will continue to work with physicians in an open and transparent way to further develop these innovative ideas that support the best approaches to provide high quality health care services without creating additional costs for taxpayers and Medicare beneficiaries.

Conclusion

Thank you again for this opportunity to testify on Medicare physician payments. CMS looks forward to working with Congress and the medical community to develop a system that ensures appropriate payments for providers while also promoting the highest quality of care, without increasing overall Medicare costs. As a growing number of stakeholders now agree, we must increase our emphasis on payment based on improving quality and avoiding unnecessary costs. I would be happy to answer any of your questions.

Statement by the

Medical Group Management Association

to the

Small Business Committee
United States House of Representatives

RE: Medicare Physician Fee Cuts: Can Small Practices Survive

Presented by: Mona Reimers, CMPE, CPC

May 8, 2008

Statement by the
Medical Group Management Association
to the
Small Business Committee
United States House of Representatives

RE: Medicare Physician Fee Cuts: Can Small Practices Survive

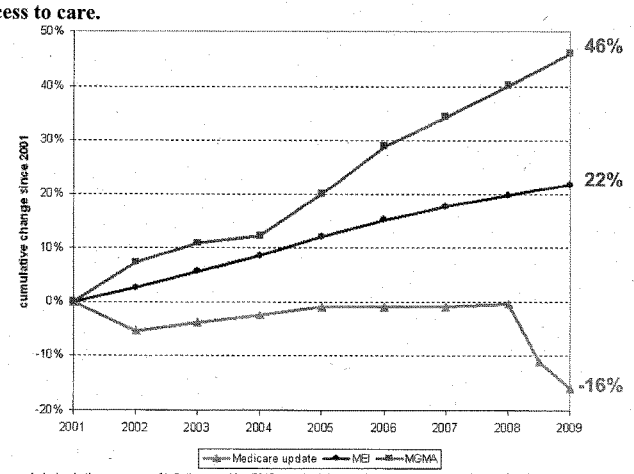
Presented by: Mona Reimers, CMPE, CPC

May 8, 2008

The Medical Group Management Association (MGMA) applauds the Small Business Committee for examining the operational impact of Medicare programs on medical group practices. MGMA, founded in 1926, is the nation's principal voice for medical group practice. MGMA's more than 21,500 members manage and lead 13,500 organizations, in which more than 270,000 physicians practice. MGMA's core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them.

Flawed sustainable growth rate formula

Medicare payments have continually failed to keep pace with both the Medicare Economic Index (MEI) and MGMA's annual survey of practice expense costs. **MGMA urges Congress to provide physicians with an 18-month positive payment update that reflects ever-increasing practice costs and stabilize an extremely uncertain financial environment that threatens Medicare beneficiaries' access to care.**



•Medicare Economic Index is the measure of inflation used by CMS to calculate practice costs and general wage levels.
•MGMA's survey data of total operating costs per FTE physician.

Congress averted the 10.1 percent reduction in Medicare payments that physicians were scheduled to receive on Jan. 1. This stop-gap measure allowed medical groups to continue providing quality

treatment to Medicare beneficiaries. However, by only approving a short-term, six-month delay, Congress has heightened the uncertainty that physicians and Medicare patients now face.

MGMA surveyed over 1,100 medical groups nationwide in which 28,679 physicians practice. The research indicates that group practices have already taken significant steps in reaction to the tenuous reimbursement environment and the continued failure of Medicare physician payments to accurately cover the costs of delivering care. Nearly 24 percent of respondents indicated they had already begun limiting or not accepting new Medicare patients. Also, in light of the anticipated 10.6 percent cut scheduled to go into effect in July 2008, nearly half - 46 percent - of respondents said that failure to halt this cut would cause them to stop accepting and/or limit the number of Medicare beneficiaries their practices treat.

MGMA members reported they are considering changes to their practice operations as a result of the physician payment instability. More than half of responding practices are considering reducing administrative and clinical staff, with the majority reporting they would limit hiring decisions for those positions. More than two-thirds of the respondents described how they are sacrificing or postponing indefinitely their information technology and clinical equipment investments resulting from the six-month payment adjustment.

Operational burdens caused by the Medicare Advantage program

While averting the scheduled Medicare payment cut remains our primary interest, an equally important and rapidly growing concern is the administrative burdens associated with Medicare Advantage plans. As beneficiary enrollment in Medicare Advantage plans steadily increases, statutory loopholes, coupled with a lack of oversight by the Centers for Medicare & Medicaid Services (CMS), are creating serious problems for Medicare Advantage patients and the medical practices that care for them.

Recent efforts by CMS suggesting voluntary guidance have been insufficient, and as a result, MGMA believes Congress should take a strong leadership role in fixing the program. Congressional action on the following recommendations is imperative to allow medical group practices to continue to provide efficient, high-quality care to Medicare Advantage patients.

Standardization of Medicare Advantage patient identification cards

Variations in the Medicare Advantage program subject medical practices to an excessive administrative burden in identifying Medicare Advantage plan patients. This impairs efficient care and adds to the cost of treating Medicare beneficiaries. In recent research:

- More than 50 percent MGMA members expressed concern regarding their inability to identify Medicare Advantage patients;
- 90 percent of respondents indicated that patient insurance cards did not provide clear identification of insurance coverage;
- MGMA members overwhelmingly believe that a majority of Medicare Advantage patients do not understand their coverage; and
- 89 percent of respondents believe that Medicare Advantage enrollees do not understand that they are no longer traditional Medicare patients.

The last two factors contribute to widespread patient confusion.

Standardized patient identification cards for Medicare Advantage enrollees would allow physicians to more easily identify the specific type of beneficiary health coverage (such as traditional Medicare, Medicare Advantage health maintenance organizations, Medicare Advantage private fee-for-service plans). Identification card standardization already exists for traditional Medicare patients and should be extended to Medicare Advantage. By standardizing Medicare Advantage patient identification cards, physicians can correctly deliver the appropriate medical services to which patients are entitled, and patients can better understand their Medicare Advantage plan and its benefits.

Therefore, MGMA recommends that all Medicare Advantage products be mandated to adhere to a national standard for patient identification cards. The card should bear a CMS-approved Medicare Advantage logo, the Medicare Rx logo (if Part D coverage applies) and clearly state the Medicare Advantage plan sponsor, type of Medicare Advantage product, co-insurance amounts (if any) and claim submission address and phone number. Additionally, the card should prominently state "Providers: Do not bill Medicare. Submit claims directly to [name of plan]." **MGMA encourages Congress to use the Workgroup for Electronic Data Interchange (WEDI) endorsed American National Standard (INCITS 284:1997) for all Medicare patient identification cards.**

Elimination of the Medicare Advantage "deeming provision"

MGMA members also report widespread concerns associated with Medicare Advantage private fee-for-service plans. Physicians seeing Medicare Advantage private fee-for-service patients are treated as if they have a contract with the sponsoring plan. However, physicians lack the ability to review and negotiate the terms of such a contract. These plans are not required to have a provider network, but may "deem" physicians to accept the plans' terms and conditions and be part of a network by virtue of treating the plans' patients.

While the Medicare regulations stipulate that physicians are only deemed if they knew or were "given a reasonable opportunity to obtain information" that they are treating Medicare Advantage private fee-for service patients, plans do not pro-actively ask physicians whether they knew that certain patients were indeed enrolled in a private fee-for-service plan. The regulations state that a physician is deemed if the provider knew or should have known that an individual was enrolled in the plan and understood the terms and conditions of payment. The regulations state that this information must be provided in a manner that is designed to "effect informed agreement," such as a patient identification card. Sixty-five percent of respondents to our research noted that they have been classified as "deemed" physicians by one or more Medicare Advantage plans. This requirement underscores the importance of the standardized Medicare Advantage patient identification card.

No other insurance product enables plans to create networks without contracts with physicians. Medicare Advantage plans should be held to the same contracting standards as the rest of the industry. The deeming provision section of the Medicare regulation is found at 42 CFR 422.216(f). **MGMA recommends that the deeming provision be eliminated in its entirety.**

Fair contracting for Medicare Advantage providers

Several private insurance companies include provisions in their provider contracts that require providers to accept all of the plan-sponsored products. Thus, a medical practice may be forced to participate in a Medicare Advantage plan by virtue of an unrelated contract signed previously by the practice. "All-products" clauses in provider-private payer contracts result in a practice being

classified as a network participant with a Medicare Advantage sponsor - without the practice's affirmative acceptance of a Medicare Advantage plan. The elimination of the all-products clauses in Medicare Advantage plans would increase transparency of the Medicare Advantage program and improve patient and physician relations.

Many fair-contracting practices have already been agreed to by several Medicare Advantage plan sponsors in relation to their commercial products in the Multi-District Litigation settlements and mandated by several states. All-products clauses typically require a provider to submit to the same terms that would have applied had he or she originally signed a separate contract to provide services for a specific insurance plan. According to MGMA members who participated in our Medicare Advantage research, 41 percent were considered part of Medicare Advantage networks through all-products clauses. Thus, all-products clauses are a significant component of Medicare Advantage provider network creation.

Several named payers in the Multi-District Litigation settlements are restricted from requiring physicians to participate in products without affirmative agreement for each product. Notably, Aetna, CIGNA, Anthem/Wellpoint and HealthNet are required to exclude all-products clauses from their contracts. Several states have passed similar prohibitions, including Alaska, District of Columbia, Colorado, Kentucky, Maryland, Minnesota, Nevada and Virginia.

MGMA recommends that Congress prohibit the establishment of Medicare Advantage networks through private-contract, all-products clauses and require affirmative acceptance of plan sponsor and products for Medicare Advantage networks.

Medicare Advantage prompt payment of providers

The Medicare statute requires Part B contractors to issue payment for 95 percent of all clean claims within 30 days after the date on which claims are received. Plans participating in Medicare Advantage should at a minimum be required to comply with CMS' payment policies regarding timely payments made to physicians. Medicare regulations, found at 42 USC 1395u(c), already require prompt payment for non-network physicians seeing Medicare Advantage private fee-for-service patients, but these logical provisions are not extended to network providers.

For example, under current law, a Medicare Advantage health maintenance organization only has to specify a prompt-pay clause, but without any minimum requirement.

MGMA therefore recommends that Congress apply the Medicare Part B timely processing requirement for all claims submitted by providers to Medicare Advantage plans as part of the plans' contracting requirements to the Medicare program.

Thank you for providing MGMA the opportunity to inform the Small Business Committee of these issues. We appreciate your attention to fixing the Medicare physician payment formula and reforming operational aspects associated with the Medicare Advantage program. Our goal is to ensure patient access to high quality medical care. If you should have any questions, please contact Robert Bennett in the Government Affairs Department at rbennett@mgma.com or 202.293.3450 ext. 1378.

CONGRESSIONAL TESTIMONY

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Statement

of

Tom DiAngelis, PT
on behalf of

American Physical Therapy Association
and its
Private Practice Section

United States House of Representatives
Committee on Small Business

Hearing on "Medicare Physician Fee Cuts: Can Small Practices Survive."

May 8, 2008
10:00 am

Chairwoman Velázquez, Ranking Member Chabot, and Members of the House Committee on Small Business:

Thank you for the opportunity to address the House Committee on Small Business and provide a perspective on the pending cut to provider payments under the Medicare physician fee schedule. If Congress does not act by July 1st, payments under the Medicare physician fee schedule will be cut by 10.6%. This would begin a series of payments reductions under the Medicare physician fee schedule with an additional 5% cut pending on January 1, 2009 and an overall reduction in payment to health care providers of 40% by 2016. Surviving this degree of payment reductions is unsustainable for small business in the health care sector, including those in physical therapy.

Today, I represent the 72,000 members of the American Physical Therapy Association (APTA) and the 4,200 members of its Private Practice Section. APTA's goal is to foster advancements in physical therapy practice, education, and research. Payment policy is critical to the success of this mission. The goal of APTA's Private Practice Section is to advance small business ownership among physical therapists. Physical therapists are leaders in the rehabilitation of individuals who have impairments, functional limitations, and disabilities that limit their mobility and ability to fully function and participate in their activities of daily living, jobs, and communities.

The impact of payment cuts under the Medicare physician fee schedule is unique for physical therapist small businesses, and has significant ramifications on the ability to serve the rehabilitation needs of our seniors and persons with disabilities. These Medicare beneficiaries are individuals who have suffered from stroke, had joint replacements, or chronic diseases that impair their ability to move, walk, and perform their daily tasks. Physical therapist small businesses address these beneficiaries' health care needs throughout the United States, and contribute to the health status of our country, including its economic health.

Today, I'd like to provide background on physical therapist small business, present three points to show the impact of Medicare payment cuts, and conclude by answering the question at hand, "Can small business survive in this environment?" Without doubt, the pending cuts to the Medicare physician fee schedule will have a detrimental impact on physical therapists as small business owners, the patients we serve, and the overall quality of the health care for our patients.

Physical Therapist Small Business: A growing portion of service delivery in outpatient physical therapy.

Beginning in 1971, physical therapists have been able to independently bill the Medicare program for their services. This was a major catalyst to small business ownership in physical therapy. Over the past thirty-seven years, physical therapist practice has transformed from an ancillary service to an independent health care profession, due in part from the ability of physical therapists in independent practices serving patients in their communities in a cost effective outpatient environment. In 1992, payment for

services provided under the Medicare outpatient Part B benefit by physical therapists in private practice (PTPP's), as well as physicians and other non-physician qualified providers in office settings, transitioned from being paid under a reasonable charge payment mechanism of actual, customary and prevailing charges to one based on the Resource Based Relative Value Scale (RBRVS). Private practice physical therapists who became providers under the Part B benefit and organized their private practice as a rehabilitation agency (and therefore were able to bill for other rehabilitation services, including speech language pathology services) transitioned from cost-based payments to payment under the Medicare physician fee schedule in 1999, as part of the Balanced Budget Act.

Today there are over 172,000 licensed physical therapists practicing in the United States. Private practices, the small businesses in physical therapy, are estimated to be the practice setting of over 25% of the total workforce or 43,000 licensed physical therapists. A recent study by Medicare showed a marked increase in physical therapists in private practice (PTPPs) from 11,620 PTPP providers in 2000 to 41,980 PTPP providers in 2006. The membership profile of the APTA shows that 41.5% of its members identify their practice setting as private practice or outpatient group practice. A vast majority of these practices are small businesses.

A recent Center for Medicare and Medicaid Services (CMS) study indicated that 8.5% of Medicare beneficiaries utilize outpatient physical therapy services, resulting in 3.9 million patients per year in 2006. Medicare expenditures for outpatient physical therapy services were just over 3 billion dollars in 2006. Of these expenditures, 35% of these expenditures were for physical therapists in private practice, representing the largest single setting designation under Medicare. Of interest, the number of beneficiaries utilizing physical therapy services under Medicare has grown by 3.5% while the total expenditures has decreased 4.7% from 2004 to 2006. Physical therapy continues to be a critical need for beneficiaries and an efficient and effective service to address the health care needs of the growing Medicare population.

The physical therapist small business that I own with my partner in the Greater Cincinnati, Ohio area currently employs 24 individuals in 3 clinics. We serve approximately 180 patients per week with orthopedic and musculoskeletal impairments. Our goal is to return these individuals to the highest level of function and productivity in their homes and communities. Physical therapy following injury, impairment, and disability is a major contributor to keeping our citizens healthy.

Our clinic has significantly reduced costs in order to be able to address the static and more often decreasing reimbursement environment. My partner and I have personally reduced our salaries 50% and eliminated our advertising budget. In addition, we've seen significant increases in administrative costs, such as energy costs, postage, and fuel surcharges from our suppliers. As members of this committee well know, the margins in small business are tight. With rising costs in the operations of business along with a decrease in the revenues due to payment and policy challenges, small businesses in physical therapy are struggling to survive. As Congress has grappled with the pending

Medicare physician fee schedule cuts, it is important to point out that these cuts have a detrimental impact beyond the physician practice, and ripple throughout the entire health care delivery system, including all providers that are paid under the fee schedule. Without significant reform to the Medicare payment system for all health care providers, the ability for these providers to survive is limited, at best.

The Impact of Medicare Fee Schedule Cuts on Physical Therapist Small Business

The impact of pending cuts to the Medicare physician fee schedule is significant to physical therapist small business. APTA supports efforts to avoid the 10.6% cut in payments under the Medicare physician fee schedule and to replace the flawed Sustainable Growth Rate (SGR) formula with a more accurate indicator of health care inflation, such as the Medicare Economic Index. The pending cuts are unsustainable and would have significant ramifications on patient access, the delivery of health care services, and the viability of the small businesses that are so critical to meeting patient needs and making the health care system work on a daily basis.

As one of the non-physician providers that bill the Medicare physician fee schedule, APTA believes it is important for policymakers to understand the full impact of the cuts on the health care system and how these cuts are detrimental to innovative and independent small businesses in health care. We believe physical therapist small businesses are a unique segment of the health care delivery system under Medicare. The impact of the pending cuts and their impact on physical therapist small businesses can be summarized by three points.

First, the pending payment cuts under the Medicare physician fee schedule have a compounding effect in physical therapy. On July 1, 2008, if Congress does not act, not only will physical therapist small businesses be subject to a 10.6% reduction in payment, they will also be subject to an $1,810 per beneficiary per year therapy cap on outpatient services. This arbitrary therapy cap would limit patient access to needed physical therapy by not considering the patients' condition, diagnosis, or other contributing factors.

This cap will not save the Medicare program money. It would only shift the cost of care away from outpatient facilities and small business to more costly settings. Small businesses in physical therapy will be impacted as the therapy cap policy includes an exemption for hospital outpatient departments. This exemption will do nothing more than encourage patients to seek services in the hospital setting to avoid having to change providers over the course of their physical therapy treatment when they reach the cap or stop treatment all together.

APTA recommends the passage of the ***Medicare Access to Rehabilitation Services Act (HR 748)***, legislation to repeal of the therapy caps, currently supported by a bipartisan majority of the US House of Representatives, or an extension of the current exceptions process that maintains access to clinically appropriate physical therapy services under Medicare. Payment cuts along with an arbitrary cap on therapy services are a cut upon a

cut and would make the viability of physical therapist small businesses a significant challenge.

Cuts to the Medicare physician fee schedule have a significant impact throughout the reimbursement environment. The Medicaid program, state workers' compensation programs and many third party payers utilize the Medicare fee schedule to base their reimbursement rates. The implementation of a 10.6% cut on July 1, 2008 would only lead to cuts throughout the multiple payers that reimburse health care providers for the services they provide patients.

Second, physical therapists in private practice have significant limitations on how patients may access their services and the marketplace. Currently, Medicare requires that the patient be under the care of a physician as a prerequisite for payment of therapy services, along with a physician certification of the therapy plan of care. If the payment cuts go into effect and physicians stop taking Medicare patients or limit the accessibility or availability of physician services, then access to physical therapy services will be impacted as a ripple effect. The Centers for Medicare and Medicaid Services has continued to reduce the patient burden on access to physical therapists, but legislation is needed to remove this requirement to ensure access to physical therapist small businesses as pending payment cuts begin to limit access to health care providers.

APTA advocates for passage of the ***Medicare Patient Access to Physical Therapist Act (HR 1552)*** as one strategy to provide relief to physical therapist small businesses. This legislation would allow patient access to physical therapists that bill the Medicare physician fee schedule as authorized under state law and has more than 130 bipartisan cosponsors.

In addition, physical therapist small businesses are struggling due to the proliferation of situations where referral sources are directing patients to clinics in which they have a financial relationship. This puts physical therapist small businesses at a competitive disadvantage in the marketplace as patients can not choose their physical therapy provider due to the referral requirement. This is particularly true since, under the current Medicare requirements, the patient must be under the care of a physician. As physician practices struggle with the payment cut, the incentive to develop additional sources of revenue is increased.

The push to develop additional revenue sources squeezes independent physical therapist small business' ability to compete in the marketplace and provide care to the patients that need physical therapy services. APTA advocates for stronger enforcement of self-referral provisions in federal law, and in addition the need to look at the abuse in this area and provide recommendations for additional policy changes to ensure the integrity of health care service delivery to the beneficiary.

Third, physical therapists in small businesses have significant administrative burdens that add to the cost of providing health care. These administrative burdens complicate physical therapist practice and direct the provider away from patient care.

Physical therapists in private practice under the Medicare program have some of the most restrictive policies, including supervision requirements for physical therapist assistants that are stricter than inpatient practice settings where the patients are arguably more critical and medically unstable. These policy inconsistencies just do not make sense, and add to the limited ability to sustain physical therapist small business over the long term.

APTA also supports the elimination of setting-specific regulations that encumber physical therapists with inconsistent requirements and administrative burdens, and advocates for the adoption of a consistent set of standards to the extent possible for physical therapy regardless of its site of delivery. Regulations should be adopted for the benefit and protection of the patient and should not adversely impact the small business by virtue of the setting in which care is delivered. In addition, physical therapists in private practice are saddled with requirements that limit their flexibility. Physical therapists do not have the ability to opt out of the Medicare program, privately contract, nor do they have locum tenens authority like other Medicare providers, such as physicians, dentists, or podiatrists.

The compounding effect of payment cuts under the Medicare physician fee schedule along with limitations on patient access, a competitive marketplace, and regulatory burden makes the 10.6% cut just the tip of the iceberg for physical therapy small businesses. Congress, CMS, and health care providers that serve Medicare beneficiaries must move beyond this issue of temporary extensions of payment reprieves and look at the health of the Medicare physician fee schedule for the long-term.

APTA is investigating alternative models of reimbursement for physical therapist services that would be based on the reporting of severity of the patients' condition, their rehabilitation needs, and the complexity of physical therapist's evaluation and intervention to meet the appropriate functional outcome for the individual. This assessment-based model that would be designed to drive the payment system is consistent with the direction CMS is headed in its transformation of payment from volume of services to a quality-based, patient-centered payment system. This potential payment system could involve elements of a fee-for-service payment methodology, or could address payment by bundling services by visit or episodes of care. What is essential is that any payment system be based on the individual health care professional's ability to bill appropriately for their services and then be held accountable for the services they deliver.

APTA also supports the transition to quality reporting under the Medicare physician fee schedule and compliments the Centers for Medicare and Medicaid Services for their efforts to work with health care providers to ensure this program represents the diverse services and professions that provide care to seniors and persons with disabilities. APTA believes the biggest barrier in making the transition to quality is the looming payment cuts and the lack of incentives for investing in the quality reporting infrastructure.

We also hope that the transition to new or alternative payment systems will increase the opportunity for small business ownership in health care and with that, APTA strongly

advocates for independent billing authority in all outpatient settings. A payment system that enhances accountability and best represents the quality of health care services provided is a long-term solution to the flawed SGR formula and we encourage Congress to continue to take incremental steps in this direction.

Can Physical Therapists in Small Businesses Survive?

Despite the challenging environment, physical therapist small businesses must find strategies to survive. The demands for high quality rehabilitation services by physical therapists will only increase as baby boomers age and people seek the services of qualified physical therapists to keep active and productive. Payments under the Medicare physician fee schedule, at a minimum, must keep pace with inflation. Yet simply keeping pace with inflation at this point in time would only keep the situation from becoming more dire.

We also need to investigate new opportunities to enhance the payment system to improve quality of care and provider accountability. In addition, reforming the regulations under the Medicare physician fee schedule would assist in alleviating some of the payment pressures by reducing administrative burdens, seeking legislative changes to improve access, and reducing incentives to utilize physical therapy as a revenue source by non-physical therapists. These are all essential elements to assist physical therapist small businesses in surviving one of the most challenging marketplaces, the health care delivery system.

Thriving in this payment environment is a challenge for small businesses in health care, including those in physical therapy. The physical therapist small business climate in the Greater Cincinnati, Ohio area has seen this first hand. In the past three years, 14 clinics have closed their office doors due to the negative pressure on payment in physical therapy along with obstacles which do not allow them to be competitive in a closed health care market. This has created an unstable environment. In addition, our reimbursement on average has remained static due to the annual freeze or minor update in the Medicare physician fee schedule, despite our annual increases in expenses, including salaries, overhead costs, and the cost of health insurance. The health care delivery system needs physical therapist small businesses to meet patients' rehabilitation needs. If those needs are unmet, then health care costs will be transferred to more intensive, costly environments, compounding the existing crisis in health care spending. Physical therapist small businesses are a cost-effective, efficient delivery model for physical therapy services, and efforts to maintain and enhance this setting are essential.

In closing, I, on behalf of the 72,000 members of the American Physical Therapy Association and its Private Practice Section, compliment the House Committee on Small Business and its leadership for holding this hearing. I hope the opportunity to explain the impact of the Medicare physician fee schedule cuts on one sector of the health care market was beneficial to the Committee and its role in ensuring the viability and success of small businesses. Thank you for your time and dedication to these issues.

STATEMENT

of the

American Medical Association

Committee on Small Business
United States House of Representatives

RE: Medicare Physician Fee Cuts: Can Small Practices Survive

May 8, 2008

Division of Legislative Counsel
202 789-7426

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding today's hearing on "Medicare Physician Fee Cuts: Can Small Practices Survive."

We commend you, Chairman Valazquez, Ranking Member Chabot, and Members of the Committee for your strong efforts and leadership in recognizing the serious access crisis that looms as physicians face drastic payment cuts under the current fatally flawed Medicare physician payment update formula, called the sustainable growth rate (SGR). In addition, on top of these cuts, is the tremendous government-imposed regulatory burden incurred by physicians and their office staff on a daily basis, which ultimately takes physician time away from treating their patients.

The vast majority of physician practices are small businesses. In fact, 50% of physician practices have less than five physicians, and yet account for 80% of outpatient visits. Steep payment cuts under the SGR, along with numerous other challenges in the current health care environment, threaten the continued viability of these practices. Physicians are the foundation of our health care system, and thus it is critical that Congress address these challenges to ensure the continued delivery of quality health care in our country.

THE MEDICARE PHYSICIAN PAYMENT FORMULA IS FATALLY FLAWED

Medicare payment rates for physicians' services are updated annually on the basis of the SGR, a fatally flawed formula that has resulted in steep Medicare physician payment cuts. The SGR formula sets a target and if Medicare spending on physicians' services exceeds this target, physician payment rates are cut. This target is linked primarily to growth in the gross domestic product (GDP), in addition to several other factors. The SGR is flawed because these factors do not take into account significant contributors to the growth in physicians' services, such as patient health care needs, technological advances, shifts in the provision of care from the hospital to the physician office setting, and government policies that, although beneficial to patients, increase Medicare spending on physicians' services. Though these factors are beyond physicians' control, when Medicare utilization of physicians' services exceeds the SGR target, physicians are unfairly penalized with cuts in their payment update. **Because of these fundamental defects of the SGR, Congress has had to scramble at the 11th hour in each of the last six years to forestall steep Medicare physician payment cuts.** Moreover, Congress has used a financing mechanism in the last two legislative interventions that results in deeper and deeper projected cuts for each subsequent year, thus making each year's legislative fix more costly than the previous one.

Some policymakers have advocated that a spending target is necessary to prevent "rapid" utilization growth in physicians' services, which they believe is a major cause of Medicare long-term financing problems. In fact, however, utilization of physicians' services has declined significantly in recent years. The 2008 Medicare Trustees report indicates that annual growth in the volume of Medicare physician services for 2005 and 2006 was just 3.6%, which is only about half the growth rate that the Trustees had projected in their 2006 report. In fact, the rate of growth in volume has been declining for several years in a row. Physicians are managing patients in their offices, which has resulted in fewer hospital and emergency room visits, and the growth rate for imaging services has also slowed as medical specialty societies have released guidance to physicians concerning the appropriateness of certain tests.

The physician community recognizes that efforts to improve the value of health care provided to Medicare beneficiaries are part and parcel of a long-term solution to the SGR problem. The AMA supports physician efforts to develop and implement clinical practice guidelines that promote appropriate utilization of services. We urge Congress to support funding for quality comparative effectiveness research that will improve health care value by enhancing physicians' clinical judgment and fostering the delivery of patient-centered care.

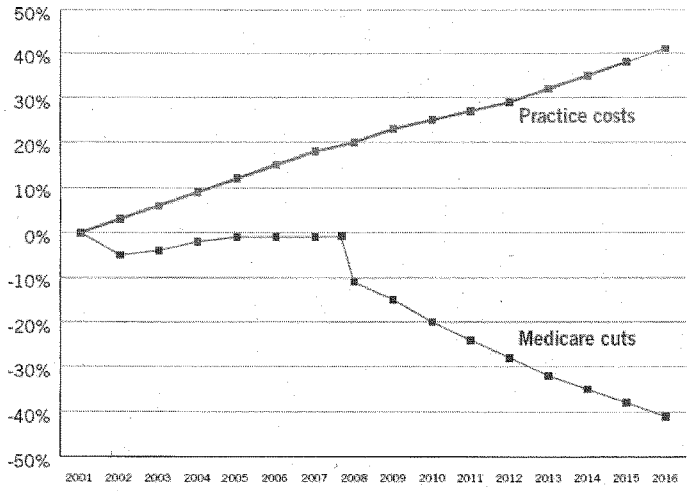
CONGRESS MUST TAKE IMMEDIATE ACTION TO AVERT THE JULY 2008 MEDICARE PHYSICIAN PAYMENT RATE CUT

Despite well-intentioned Congressional efforts to avert Medicare physician cuts due to the flawed SGR, Medicare payment rates for physicians in 2008 are about the same today as they were in 2001. Further, Medicare physician payment rates are scheduled to be cut 10.6% on July 1, 2008, and an additional cut of 5% or more is projected for January 1, 2009. These will be part of a series of cuts totaling about 40% in the coming decade. Yet, even by the government's own conservative estimate, physician practice costs will increase nearly 20% during this time period. Physicians cannot absorb these steep losses.

As of May 8, there are only 53 calendar days (and substantially less legislative days) remaining for Congress to address this problem before the 10.6% Medicare physician payment cut goes into effect. Congress must act now to enact 18 months of positive Medicare physician payment updates that reflect medical practice cost increases. Rapidly eroding margins are threatening the viability of medical practices, putting health information technology and other high-capital intensive purchases out of reach, and forcing the large cohort of practicing physicians over 55 years of age to weigh retirement.

The steep cuts that are yielded by what is ironically called the "sustainable growth rate," would be unsustainable for any business, especially small businesses such as physician practices. Further, once Medicare implements a payment rate cut, it has a ripple effect and other payers that tie their rates to Medicare (including Medicaid, TRICARE, and various private payers) follow suit. In fact, the Military Officers Association of America (MOAA), which represents 5.5 million members of TRICARE (the government's health insurance for military families), recently sent a letter to Congress calling for positive Medicare physician payment updates. MOAA stated that "since TRICARE payment rates are tied to Medicare's rates, any such reductions will significantly deter more doctors from seeing any uniformed service beneficiaries – not just those over age 65." MOAA further added that when "our service members are sent in harm's way, the last thing they should have to worry about is whether their families will be able to find a TRICARE doctor."

The chart below shows the gap in Medicare payment to physicians from 2001 through 2016, as compared to increases in medical practice costs, as measured by the government's own Medicare Economic Index (MEI).



cost data is from the MEI, a conservative index of practice cost growth maintained by the Centers for Medicare & Medicaid Services. Medicare physician ve from the 2007 Medicare Trustees report with 2008 adjustments to reflect Sec. 101 of P.L. 110-173.

The Medicare Physician Payment Cuts Will Impact Patient Access

Numerous surveys project a crisis in patient access if Medicare payments fall further behind practice cost increases:

- In an AMA survey of almost 9,000 physicians, 60% said they would have to limit the number of new Medicare patients they treat if this year's pay cut is not stopped. Further, more than half of the surveyed physicians said they could not meet their current payroll with a 10% Medicare pay cut and would be forced to reduce their staff.

- The Medicare Payment Advisory Commission reports that 30% of Medicare patients looking for a new primary care physician already have trouble finding one.

- The Medical Group Management Association found that 24% of group practices already limit their acceptance of new Medicare patients.

- The Council on Graduate Medical Education is predicting the country will face a shortage of 85,000 physicians by 2020.

- An Association of American Medical Colleges workforce study found that 51% of physicians over 50 cite "insufficient reimbursement" as a "very important" factor in retirement decisions.

Although physicians want to continue providing care to all their patients, continued Medicare payment cuts make it difficult to do so, and thus the Medicare physician payment rate cuts

threaten the foundation of our health care delivery system. The Medicare physician payment formula must be addressed now to preserve care for our seniors and disabled patients. **We urge Committee Members and Congress to take action immediately to avert the pending Medicare physician payment rate cuts scheduled for July 1 and replace it with 18 months of Medicare physician payment updates that better reflect medical practice cost increases, and do not increase the size or duration of Medicare physician pay cuts in future years.**

Immediate legislative action is also needed to avoid extensive administrative costs and related problems that 11th-hour Congressional interventions cause for both the Medicare carriers and physicians. In order for the Centers for Medicare and Medicaid Services (CMS) to implement physician payment rate changes by July 1, 2008, the agency would need substantial lead time to meet a July 1 implementation date. Otherwise, CMS, Medicare carriers and physician practices must implement such changes on a retroactive basis, which becomes administratively confusing and costly.

If Congress fails to act to prevent the 10.6% cut scheduled for July 1, CMS should give physicians a period of time during which they are permitted time to change their Medicare participation or non-participation status. If physicians' rates are cut, as small businesses, they may no longer be able to meet cover the cost of delivering care and thus need ample opportunity to determine the terms on which they can accept Medicare patients.

Medicare Physician Payment Cuts Impact Millions
Of Patients, Employees And Physicians Across The Country

If Congress allows the projected Medicare physician pay cuts to go into effect, this could adversely impact millions of patients, physicians and the nearly three million individuals employed by physicians' offices and related businesses across the country. In New York, for example, physicians will lose about $1 billion for the care of elderly and disabled patients over the 18 months from July 2008 through December 2009 due to the 10.6% cut in Medicare payments in July 2008 and an additional 5% cut in 2009, and that loss increases to $19.3 billion by 2016 due to nearly a decade of projected cuts. Further, 177,520 employees, over 2.5 million Medicare patients and 180,226 TRICARE patients in New York will be affected by these cuts. Ohio physicians will lose $490 million over the 18 months from July 2008 through December 2009 due to the projected SGR cuts, and $9.4 billion by 2016. Further, 115,272 employees, over 1.6 million Medicare patients, and 160,415 TRICARE patients in Ohio will be affected by the SGR cuts. A solution to the SGR is needed now to protect these patients, employees and physicians across the country.

Medicare Physician Payment Updates Must Have Parity
With Updates Of Other Medicare Providers

Only physicians and other health professionals (whose payment rates are tied to the physician fee schedule) face steep payment cuts. As physicians have been receiving below-inflation updates or a payment freeze, other Medicare providers' payment updates have kept pace with their costs increases. For example, CMS recently announced that the 2009 capitation rates for Medicare Advantage Plans will increase by 4.24% and 2009 hospital inpatient payment rates will increase 2.3%. There is no rational basis for the significant disparity in updates for other

providers and the steep payment rates cuts slated for physicians. Physicians and other health care professionals should have payment updates that keep pace with their cost increases, similar to the updates for other providers.

The Medicare Physician Payment Formula Undermines The Use Of Health Information Technology And Quality Initiatives

Widespread health information technology (HIT) adoption will transform the practice of medicine and provide physicians with a powerful tool by putting real-time, clinically relevant patient information and up-to-date clinical decision support tools in practitioners' hands at the point of care and will ultimately raise the overall quality and safety of patient care.

The Medicare physician payment formula, the SGR, however, undermines policymakers' vision of a Medicare health care system that uses HIT, as well as quality initiatives, to deliver the highest quality of care to Medicare patients. The SGR directly conflicts with this vision because quality initiatives, which rely on the use of HIT, often encourage greater utilization of physicians' services through the use of more preventive and chronic disease management services that policy experts predict will produce overall savings in the health care system through reduced use of other more intensive services such as hospitalizations. Yet, the SGR (or other similar spending target) penalizes physician service volume increases that exceed the target through additional payment cuts. These payment cuts, in turn, make it nearly impossible for physician practices, as small businesses, to make the substantial financial investment required for HIT and participation in quality improvement programs.

Indeed, a study by Robert H. Miller and others found that initial electronic health record costs were approximately $44,000 per full-time equivalent (FTE) provider, and ongoing costs were about $8,500 per FTE provider per year. (Health Affairs, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from $37,056 to $63,600 per FTE provider.

The AMA survey discussed above showed that with a 10% physician cut in 2008, two-thirds of physicians will defer investments in their practice, including the purchase of new medical equipment and information technology. If rates are cut by 40% by 2016, about 8 in 10 physicians will forgo these investments.

To fulfill policymakers' vision of an HIT-based health care system, Congress must ensure that Medicare payments to physicians are premised on a stable physician payment system that provides positive physician payment updates and accurately reflects increases in medical practice costs. It is not practical or feasible to transition to a system that uses important initiatives, such as HIT and electronic prescribing, when physicians, especially those in small practices, must first ensure that they can keep their doors open in the face of steep Medicare physician cuts. Further, such initiatives require significant financial investment by the federal government to: (i) establish national HIT standards that ensure interoperability, privacy and security; and (ii) encourage widespread adoption of e-prescribing. The current weakened economy highlights the importance of federal financial assistance in these respects since it is becoming more difficult for borrowers, including physicians as small businesses, to obtain loans to make high-cost capital purchases.

PHYSICIANS FACE SIGNIFICANT OBSTACLES AND BUDGETARY PRESSURES FROM OTHER FACTORS

As discussed above, physicians have been hit with continual below-inflation payment updates, along with steep payment cuts scheduled for the near- and long-term. In addition, other factors also affect physician practices' bottom line:

- *Rural extender provisions should be extended:* Congress has temporarily provided an increase in certain counties' Medicare physician payments based on geographic location. This provision positively affects 58 of the 89 Medicare payment localities, including many in rural areas. Yet, this provision will expire on July 1 of this year. Another provision that would provide a 5% bonus for physicians practicing in physician shortage areas will also expire on July 1. **These provisions should be extended from July 1, 2008, through December 31, 2009.**

- *CMS should evaluate and make needed revisions to the Medicare Economic Index.* The current MEI has been around since 1973, and it measures increases in the prices of particular inputs used in physician practices. The actual composition of the inputs themselves, however, has not changed to keep pace with the way medicine is practiced today. For example, the number of staff needed per physician has risen dramatically since the 1970s, but the MEI looks only at increases in wages and benefits, not the number or type of staff employed. CMS should evaluate the MEI and make needed revisions to reflect the way medicine is practiced in the 21st century.

- *CMS should reduce or eliminate the productivity adjustment to the Medicare Economic Index:* Medicare physician payment updates also are based in part on changes in the MEI, which measures physician practice cost increases. In establishing the MEI each year, CMS adjusts it downward to account for assumed physician productivity increases. In 2008, the MEI is 1.8%, and CMS included a 1.4% productivity offset. Yet, there is no productivity adjustment applied to the hospitals or nursing home market basket, nor any other Medicare provider.

  It is not reasonable to apply such an adjustment for physicians services. It would be nearly impossible for physicians to increase their productivity in treating patients in light of various Medicare initiatives that impose numerous time and paperwork burdens, thereby slowing productivity, not increasing it. Further, economists generally agree that productivity in the health care industry is much lower than in other industries. **We, therefore, have urged CMS to reevaluate and reduce this 1.4% productivity adjustment to the MEI, but CMS has declined to do so. We urge the Committee to press CMS to evaluate the productivity adjustment to the MEI and reduce or eliminate it accordingly.**

- Physicians must comply with a wide-array of government regulations and other initiatives, including those relating to the national provider identifier, recovery audit contractors, the Health Insurance Portability and Accounting Act, Part D drugs, quality improvement, and a host of regularly issued Medicare regulations that take extensive amounts of time to digest. All of these regulatory initiatives impose huge

costs on physicians and their office staff as they struggle to review, interpret and implement these initiatives, along with the added costs that often must be paid to attorneys, coding experts, consultants, accountants and other related professionals to assist in these endeavors and ensure proper compliance.

All of these pressures exacerbate the Medicare crisis that is looming due to the steep Medicare physician cuts scheduled for July 1 and projected to continue through 2016. Thus, it is imperative that Congress act now to stabilize the Medicare program. This is especially important considering that the first wave of baby boomers will begin entering the Medicare program in 2011, with enrollment growing from 44 million in 2011 to 50 million by 2016. A recent AMA poll found that eight out of 10 Americans are concerned that the Medicare cuts will harm access to care for seniors and baby boomers, and nearly three-quarters of Americans want Congress to act.

Accordingly, we urge Committee Members and Congress to take immediate action to preserve the Medicare program for our nation's seniors by enacting Medicare physician payment updates from July 1, 2008, through December 31, 2009, that better reflect medical practice cost increases, and do not increase the size or duration of Medicare physician payment rate cuts in future years.

The AMA appreciates the opportunity to provide our views to the Committee on these critical matters that adversely impact all physicians, especially those in small practices. We look forward to working with the Committee and Congress to address each of these matters in order to preserve patient access to high quality, cost-effective care.

U.S. House Committee on Small Business
Statement for the Record
Medicare Physician Fee Cuts: Can Small Practices Survive

Testimony of the American College of Physicians

May 8, 2008

Thank you, Chairwoman Velazquez and Ranking Member Chabot for allowing me to share my thoughts on this important issue.

I am Dr. David Dale, MD, FACP, the President of the American College of Physicians, a Seattle internist and Professor of Medicine at the University of Washington. I joined the faculty at the University of Washington in 1974 and served as the Dean of the School of Medicine from 1982 to 1986. I have taught students and doctors in training, conducted medical research, and practiced internal medicine for more than 40 years.

The College is the largest medical specialty society in the United States, representing 125,000 internal medicine physicians and medical students. Approximately 20 percent of the Members, Fellows and Masters of ACP are in solo practices and approximately 50 percent are in practices of 5 or fewer physicians. During my year as President of ACP, I have had the opportunity to meet with many ACP members who lead these small practices across the country. I have learned that many of them are at a breaking point, due in large part to Medicare's inability to provide payments that keep pace with practice expenses.

These practices are medicine's small businesses, where much of their revenue is tied directly to Medicare's flawed reimbursement rates and formulas. The formula that controls the pool of available funding for the Medicare physician fee schedule, called the Sustainable Growth Rate (SGR), has led to scheduled annual cuts for six consecutive years. On July 1st of this year, physicians face a 10.6 percent decrease in reimbursement unless Congress intervenes. Many private insurance plans tie their fee schedule payments to those set under Medicare, putting the practices in "double jeopardy" of financial failure.

Instead of encouraging high quality and efficient care centered on patients' needs, existing Medicare payment policies have contributed to a fragmented, high volume, and inefficient model of health care delivery that fails to produce consistently good quality outcomes for patients. We greatly appreciate Chairwoman Velazquez and Ranking Member Chabot for focusing attention on the impact of Medicare's flawed physician reimbursement formula on solo and small group practitioners. These are the practices that are least able to absorb the uncertainty of annual payment decreases and projected cuts in Medicare reimbursement.

The Effects of Medicare Payment on Small Practices

Earlier this year, ACP mailed a questionnaire to its members to measure the impact of pending Medicare payment cuts on their practices and on their patients. This questionnaire asked internists to report on the changes they would be forced to make if Congress does not act to avert the 10.6 percent Medicare payment cut on July 1, 2008. The questionnaire also asked them what changes their practices have already made due to declining Medicare reimbursement and uncertainty in the Medicare physician fee schedule. Although not designed as a scientific sample, almost 2000 internists responded, providing ACP with a first-hand account of how the SGR cuts are affecting millions of Medicare beneficiaries.

Thirty percent of our survey respondents noted that they have already taken steps in their practice in anticipation of the scheduled Medicare payment cuts on July 1, 2008 and January 1, 2009:.

What patient-related changes in your practice have you already made?

Answer	Percent	# of Respondents
I do not accept any new Medicare patients.	29.2%	156
I only accept new Medicare patients who are referred to us by a family member who is already a patient in our practice, or from a physician colleague.	36.1%	193
I no longer see any Medicare patients nor accept Medicare as a payer.	3.4%	18
I charge my patients an administrative fee for services not covered by Medicare.	15.0%	80
I increased charges to my non-Medicare patients.	15.9%	85
I have changed my Medicare participation status from participating to non-participating, allowing me to "balance bill" my Medicare patients for up to 109% of Medicare's approved charges.	5.6%	30
I have not made any patient-related changes in my practice.	24.3%	130

Eighty-six percent of ACP survey respondents reported that they would be forced to make changes in their practices if Congress does not avert the 10.6% Medicare cut:

What patient-related changes in your practice do you think you are likely to make in your practice?

Answer	Percent	# of Respondents
I will discontinue seeing new Medicare patients.	35.7%	531
I will only see new Medicare patients who are referred by another family member who is already a patient in our practice, or from a physician colleague.	32.2%	480
I will discontinue seeing all of our current Medicare patients.	6.3%	94
I will charge my Medicare patients an administrative fee for services not covered by Medicare.	29.7%	443
I will increase charges to my non-Medicare patients.	16.7%	249
If given the opportunity to change my Medicare participation status, I will switch from participating to non-participating, allowing me to "balance bill" my Medicare patients for up to 109% of Medicare's approved charges.	32.5%	484
I will make no patient-related changes to my practice.	10.3%	153

What practice operations-related changes do you think you are likely to make in your practice?

Answer	Percent	# of Respondents
I will lay off some of my office staff.	23.8%	351
My staff will not be getting	40.5%	598

a salary increase this year.		
My staff will get a smaller salary increase this year.	25.3%	374
I will reduce benefits to my staff.	33.7%	498
I will postpone making capital purchases.	57.9%	854
I will postpone or reconsider plans to purchase an electronic health record, electronic prescribing, and/or other health information system.	49.9%	736
I will leave traditional practice and join a "boutique" or "concierge" practice that accepts only those patients who can pay a required retainer fee.	13.2%	195
I will leave ambulatory practice and join a hospital-only practice (hospitalist).	9.7%	143
I will add new laboratory or ancillary services to generate more practice revenue.	13.5%	199
I will make no practice operations-related changes.	7.0%	104

Although many ACP members who stated that they have made, or are likely to make, changes in their practices because Medicare cuts, they also expressed heartfelt concern about the impact on their patients. To cite just one example, Dr. Michael Wilkinson, a practicing internist in Palestine, Texas told us:

> *"The practice of medicine is a calling and as such, I and my colleagues have endured more unfair revenue cuts than most businesses would have endured without quitting. Yet, a medical practice is also a small business, and there are limits to how much we can endure. We are now at the point where further cuts are not survivable. Just like any small business, our revenue has to exceed costs in order to survive. Despite everything that I have been able to do to cut costs, the margin of profit is now thin, and the proposed greater than 10 percent cut will put us out of business. The only option will be to downsize the practice and stop seeing all Medicare patients. I would hate this, but it will be the only option I have if Congress does not reverse the proposed cuts."*

Medicare Payment Policies are Contributing to an Imminent Collapse of Primary Care

As an educator at the University of Washington, School of Medicine, I encountered hundreds of young people who are excited by the unique challenges and opportunities that come from being a patient's personal physician. However, when it comes to choosing a career path, very few see a future in primary care and being this kind of a doctor.

Our medical students are acutely aware that Medicare and other payers undervalue primary care and overvalue specialty medicine. With a national average student debt of $140,000 at graduation and rising, by the time they finish from medical school, medical students feel they have no choice but to go into more specialized fields of practice that are better remunerated.

The numbers are startling:

- In 2006, only 26 percent of third year internal medicine residents planned to practice general internal medicine, down from 54 percent in 1998, and only 13 percent of first year internal medicine residents planned to go into primary care;

- The percentage of medical school seniors choosing general internal medicine has dropped from 12.2 percent in 1999 to 4.4 percent in 2004.

ACP's recent survey of members included a question to medical students on how important Medicare payments are in medical students' selection of a specialty. **Sixty-three percent of students responded that this issue was extremely or very important in determining the type of medicine that they practice.**

Christopher Baliga, MD, an internal medicine resident at Case Western Reserve, responded:

> *"when I entered medical school, I always planned on becoming a general internist in primary care. Seeing the current (and deteriorating) funding environment, has cemented in my mind not to go into primary care. I have chosen to pursue subspecialty training instead. In fact, here at Case* Western *Reserve University Hospitals of Cleveland, out of 30 graduating senior residents, none of us plan on pursing primary care."*

As fewer medical students are choosing primary care, increasing numbers of practicing physicians are leaving general internal medicine, while others near retirement, are choosing to retire earlier than planned. Approximately 21 percent of physicians who were board certified in the early 1990's have already left general internal medicine, compared to a 5 percent departure rate for internal medicine subspecialists.

ACP's survey on the SGR cuts found that **62 percent of respondents—about 1000 responding internists across the country-- stated that they will "accelerate plans to retire from practicing medicine" if the 10.6% cut goes into effect.** This finding likely reflects the fact that many internists, particularly those in primary care, are at an age when they are within five to ten years of retiring from practice under the best of circumstances.

Any acceleration of internists' retirement plans will compound the growing shortage of primary care physicians in communities that even now are just one or two physician retirements away from an access crisis. Who will take care of Medicare patients if 86% of established primary care internists choose to leave practice early because of Medicare's SGR cuts?

This precipitous decline is occurring at the same time that an aging population with growing incidences of chronic diseases will need more primary care physicians to take care of them. A recent article in *Health Affairs* predicts "that population growth and aging will increase family physicians' and general internists' workloads by 29 percent between 2005 and 2025" and that shortages of "35,000-44,000 generalists are likely by 2025." (Colwill, et al. Will Generalist Physician Supply Meet Demands Of An Increasing And Aging Population? Web release in advance of publication, Health Affairs, April 28, 2008]. The authors note that:

> *"Generalist physicians are the foundation for health care in this country. Yet generalist specialties-general internal medicine, family medicine and pediatrics-are the only major specialties that show a decade of declining numbers of graduates. Declines continue as population growth and aging drive use of primary care upward. Using 2005 levels as a benchmark, we anticipate a sex- and age-adjusted shortfall of 20-27 percent for care for adults.*
>
> *The major decline is in general internal medicine, as more internal medicine graduates subspecialize. The decline in primary care delivery is even greater when one recognizes that almost a third of general internal medicine graduates plan to be hospitalists. Although hospitalists relieve primary care physicians from inpatient duties, they also care for inpatients of surgical and medical specialists, thus reducing the effective primary care supply."*

Ending the Cycle of SGR Pay Cuts

Congress should enact legislation to provide positive and predictable updates to physicians as a first step toward ending the cycle of SGR payment cuts that is threatening the economic viability of so many practices. The College recognizes and appreciates that with the support of this Committee, last year the House passed legislation – under the CHAMP Act- to reverse the 10.1 percent SGR cut in Medicare payments scheduled to take place on January 1 of this year and replace it with an annual .5 percent increase for 2008 and 2009. Unfortunately, the Medicare provisions were stripped out of the SCHIP reauthorization legislation as part of a compromise with the Senate.

Once payments are stabilized in the near-term, Congress should then enact legislation to permanently eliminate the cycle of SGR payment cuts. The SGR has been wholly ineffective in restraining inappropriate volume growth, has led to unfair and sustained payment cuts, and has been particularly harmful to solo and small practices of primary care. The SGR:

- Does not control volume or create incentives for physicians to manage care more effectively;

- Cuts payments to the most efficient and highest quality physicians by the same amount as those who provide the least efficient and lowest quality care;

- Penalizes physicians for volume increases that result from following evidence based guidelines;

- Triggers across-the-board payment cuts that have resulted in Medicare payments falling far behind inflation;

- Forces many physicians to limit the number of new Medicare patients that they can accept in their practices;

- Unfairly holds individual physicians responsible for factors- growth in per capita gross domestic product and overall trends in volume and intensity- that are outside their control;

A permanent solution to the SGR payment cuts should assure that future payment updates keep pace with the costs to practices of providing care to Medicare patients.

Comprehensive Medicare Reform

ACP believes that more needs to be done to fix a dysfunctional Medicare payment system than just eliminating the SGR. There are many other elements of Medicare payment policies that do not serve the interests of patients:

- Medicare pays little or nothing for the work associated with coordination of care outside of a face-to-face office visit. Such work includes ongoing communications between physicians and patients, family caregivers, and other health professionals on following recommended treatment plans;

- Low fees for office visits and other evaluation and management (E/M) services provided principally by primary care physicians discourage physicians from spending time with patients;

- Except for the one-time new patient Medicare physical examination and selected screening procedures, prevention is not covered at all;

- Low practice margins make it impossible for many physicians, especially in solo and small practices, to invest in health information technology and other practice innovations needed to coordinate care and engage in continuous quality improvement;

- Medicare's Part A and Part B payment "silos" make it impossible for physicians to share in system-wide cost savings from organizing their practices to reduce preventable complications and avoidable hospitalizations.

Research shows that health care that is managed and coordinated by a patient's personal physician, using systems of care centered on patients needs—**the Patient-Centered Medical Home**-- can achieve better outcomes for patients and potentially lower costs by reducing complications and avoidable hospitalizations. Such care usually will be managed and coordinated by a primary care physician, which for the Medicare population typically will be a physician who is trained in and practices in internal medicine, a geriatrician, or a family physician.

The Medicare Payment Advisory Commission (MedPAC) recently voted to recommend two major changes in Medicare payment policies to improve care coordination through a Patient-Centered Medical Home and to create incentives for primary care.

One recommendation would create a national pilot of a Medicare medical home. This pilot would expand upon the existing Medicare Medical Home demonstration project authorized by Congress, which will soon be launched by CMS in up to eight states. The national pilot, as MedPAC envisions it, would allow qualified practices throughout the country to qualify for care coordination payments if they can demonstrate that they have the capabilities, using stringent criteria, to manage and coordinate care effectively. As a national pilot, the Secretary of HHS would be authorized to apply the findings from the pilot to making overall changes in Medicare payment policies without seeking new authorization from Congress.

ACP urges Congress to enact legislation, consistent with the MedPAC proposal, to initiate a national Medicare medical home pilot. We recommend that Congress also allow the existing, more limited, demonstration project already authorized by Congress to continue uninterrupted but with increased and sufficient funding to support the ability of qualified practices to manage care effectively.

MedPAC also recommends that Congress direct HHS to create a methodology to allow for targeted adjustments in payments for evaluation and management services provided principally by primary care physicians. Although much more work needs to be done on developing a workable criteria for determining which physicians should qualify for such adjustments, ACP supports MedPAC's goal of identifying a simple, effective mechanism for HHS to provide for higher payments for services by primary care physicians. Such an adjustment is needed to help reverse the decline in the numbers of physicians going into primary care and the early exodus of those already in practice.

Finally, ACP feels strongly that new ways are needed to fund primary care that take into account the impact of primary care in reducing utilization and costs in other parts of Medicare. Currently, any increase in payments for primary care services must be "budget neutral" within the Medicare physician fee schedule, meaning that costs of such increases must be offset by across-the-board cuts in payments for all physician services.

A better way to fund primary care would be to re-define budget-neutrality rules to consider the impact of paying more for primary care on total aggregate Medicare spending, Parts A, B, C and D combined. A portion of anticipated savings in other parts of Medicare (such as from fewer preventable hospital or emergency room admissions associated with care coordination by primary care physicians) could then be applied to fund increased payments for primary care.

To illustrate how much can be saved by creating payment incentives for primary care, a recent study in The American Journal of Medicine found that "higher proportions of primary care physicians [in each metropolitan statistical area] were associated with significantly decreased utilization, with each 1 percent increase in the proportion of primary care physicians associated with decreased yearly utilization for an average size metropolitan statistical areas of 503 admissions, 2968 emergency department visits, and 512 surgeries." (Kravet, et al, Health Care Utilization and the Proportion of Primary Care Physicians, The American Journal of Medicine, February 5, 2008).

It stands to reason, then, that Congress should allow for some of the aggregate savings from reduced utilization associated with primary care to be used to fund payment increases targeted to primary care.

Conclusion

The College commends Small Business Committee Chairwoman Velazquez and Ranking Member Chabot for holding this important hearing to shine a spotlight on how the SGR is impacting solo and small physician practices.

We believe that it is critical that both the House and the Senate report legislation that will not only avert the pending 10.6 percent cut in Medicare physician reimbursement on July 1, and the anticipated 5% cut on January 1, 2009, but also move toward enacting new Medicare payment policies that will improve quality and lower costs by aligning incentives with the needs of patients. Such legislation should stabilize Medicare payments with positive updates for at least the next 18 months, followed by repeal of the SGR by a specified date.

Assuring the viability of small primary care physician practices, however, will involve more than replacing the SGR cuts with positive updates. ACP also calls upon Congress to:

- Direct HHS to implement the Patient-Centered Medical Home on a national pilot basis, with sufficient funding to qualified practices to support monthly, risk-

adjusted care coordination payments to such practices in addition to fee-for-service payments for office visits and performance-based payments for meeting evidence-based performance metrics. In the meantime, the existing Medicare Medical Home demo should be continued but with increased funding equal to the $500 million for a medical home demo authorized by the CHAMP Act.

- Direct HHS to create a methodology to allow for targeted increases in Medicare payments for evaluation and management services provided principally by primary care physicians.

- Direct HHS to pay for specific services, such as remote monitoring, care plan oversight, and telephone and email consultations, associated with care coordination by primary and principal care physicians.

- Create new ways to finance primary care and care coordination services that take into account the impact of primary care and care coordination on reducing aggregate Medicare costs, such as reductions in Part A expenses associated with reducing preventable hospital admissions for patients with chronic diseases. Specifically, budget neutrality rules should be redefined to allow for a portion of the anticipated savings associated with primary care, the Patient-Centered Medical Home, and Care Coordination services to be applied prospectively to improve payments for primary care, fund the Patient-Centered Medical Home, and to pay for coverage of specific care coordination services such as secure email consultations.

- Provide an add-on to Medicare office visit fees when supported by certified health information systems, as called for in H.R. 1952, the National Health Information Incentives Act of 2007, sponsored by Reps. Charles Gonzalez (D-TX) and Phil Gingrey (R-GA).

Conclusion

Congress has the choice of maintaining a deeply flawed reimbursement system that results in fragmented, high volume, over-specialized and inefficient care that fails to produce consistently good quality outcomes for patients and that is forcing many solo and small physician practices to curtail services or close their doors. Or it could embrace the opportunity to put Medicare on a pathway to a payment system that encourages and rewards high quality and efficient care, centered on patients' needs, that recognizes the critical role played by primary care physicians in delivering better care at lower cost.

The policies proposed by the College in today's testimony will benefit patients by assuring that they have access to a primary or principal care physician who will accept responsibility for working with them to manage their medical conditions. Patients will benefit from care in a medical home by improved health and fewer

complications that often result in avoidable admissions to the hospital. Patients will benefit from receiving care from physicians who are using health information technology to improve care, who are fully committed to ongoing quality improvement, and who have organized their practices to achieve the best possible outcomes.

Medicare patients deserve the best possible care. The College looks forward to working with the members of this Committee and those on the authorizing Committees on legislation to reform physician payments that will help us achieve a vision of reform that is centered on patient's needs.

Statement
of the
American College of Surgeons

Presented by

Charles D. Mabry, MD, FACS

before the
Committee on Small Business
United States House of Representatives

RE: *Medicare Physician Fee Cuts:*

Can Small Practices Survive?

May 8, 2008

Madam Chairwoman, Ranking Member Chabot, and Members of the Committee, my name is Charles D. Mabry, MD, FACS, and I am a general surgeon from Pine Bluff, Arkansas. I am the Chairman of the American College of Surgeons Health Policy Steering Committee and am here representing the American College of Surgeons and its more than 74,000 members, the large majority of who work in and own small businesses. We are grateful to you for holding this hearing on the Medicare physician payment system and, specifically, how that system impacts the ability of the small business surgeon to provide high-quality and efficient care to Medicare beneficiaries and to their communities as a whole. Contrary to public perception, most surgeons are not employees of the hospitals in which they operate but rather are small business owners. I am a small business owner and one of seven general surgeons in my town of 60,000. I practice at Jefferson Regional Medical Center, a 300-bed hospital that serves as the regional referral center for southeast Arkansas.

Surgeons as Small Business Owners

Seventy-eight percent of the Fellows of the American College of Surgeons practice in an office-based private practice, and on average, they derive 38 percent of their revenue from Medicare.[1] Forty percent of our Fellows are general surgeons. The typical general surgery practice is composed of five surgeons and 15 employees. Each individual general surgeon employs three health care workers with a payroll of roughly $130,000. These practices and

[1] Characteristics of Office- Based Physicians and Their Practices: United States, 2005–2006 Data From the National Health Care Survey, April 2008

their employees typically purchase services and supplies within their own communities, often from other small businesses. Thus, in addition to providing critical surgical care to their communities, surgical small businesses help support local economies and numerous local small businesses.

As small businesses, surgical practices, including my own, have seen costs rise year after year due to single- and double-digit increases in the costs of medical supplies, professional liability insurance, health insurance for our employees, and numerous other business expenses. Like any other business, surgical practices must budget and plan for the future. Medicare payments compose a major source of revenue for surgeons (25-40%)[2], and we have seen continued, inflation-adjusted decreases in Medicare payments for major surgical procedures—in some cases, as high as 70 percent—since 1989. Sound business planning for surgical practices has been further complicated by the annual possibility of cuts of 5 percent or more in Medicare payments, which are required under Medicare's current method for calculating physician reimbursement known as the sustainable growth rate (SGR).

The Crisis in Surgical Workforce in America

Cuts in Medicare reimbursement coupled with rising practice costs are a major reason that many surgeons are retiring early, moving their practices to a hospital-based location, or opting to sub-specialize. The decrease in the numbers of surgeons is being seen across the surgical specialties, including my specialty

[2] Data from Medical Group Management Association, Cost Survey 2006

of general surgery. Between 2000 and 2005, the number of general surgeons in full-time practice decreased by 4.4 percent; over the same period, the number of thoracic surgeons declined by 4.7 percent.[3] Between 2005 and 2020, the number of practicing surgeons is expected to grow only 3%. If obstetrics and gynecology, which is often classified by policymakers as a primary care specialty, is not included in this calculation, the actual number of practicing surgeons in all surgical specialties is projected to decrease by 1.7 percent over this time period—with several specialties, including general surgery, thoracic surgery, and urology facing much larger projected declines in their total workforce.[4]

The decrease in the numbers of general surgeons most directly impacts the 54 million Americans who are cared for in small and rural hospitals. Unlike other medical specialties, there are no good substitutes or physician extenders for a well-trained general surgeon or surgical specialist when it comes to trauma care or surgical emergencies. [5] A recent study by the Lewin Group has noted that trauma surgical specialties are in short supply for emergency department (ED) on-call panels, while the American College of Emergency Physicians notes that 75% of ED medical directors have inadequate on-call surgical coverage, an increase from two-thirds in 2004. [6], [7]

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[3] Bureau of Health Professions. Health Resources and Services Administration. Physician Supply and Demand: Projections to 2020. October 2006

[4] Bureau of Health Professions. October 2006

[5] Zuckerman R. General surgery programs in small rural New York state hospitals: a pilot survey of hospital administrators. J Rural Health. 2006;22(4):339-342

[6] Lewin Group Analysis of AHA ED Hospital Capacity, 2002
http://www.aha.org/ahapolicyforum/resources/EDdiversionsurvey0404.html

The compounding challenges facing surgeons are leading increasing numbers to choose a hospital-based practice over private practice. In fact, since 2001, there has been an 18 percent decrease in office-based surgical practices.[8] If a surgeon is forced to move from private practice to a hospital-based practice, the effects on other individuals and businesses can be significant. In fact, it is often the small businesses that furnished services and supplies to that office-based surgical practice that suffer because hospital-based practices often purchase services through large, national suppliers as opposed to local small businesses. In addition, a shift from office-based to hospital-based practice may result in the laying off of some of the office employees, further impacting a community and its economy.

However, the worst case scenario is when a surgeon retires or moves thereby leaving the local hospital without the capability of providing surgical care to patients. This is a scenario that is becoming increasingly common in hospitals in rural communities. In such a situation, the hospital must replace the departed surgical specialty within 18 months or significantly curtail services. Often, those hospitals are subsequently forced to close.[9] Such closures have a devastating impact on the health care of the community, the economy, and especially on the small businesses that support these communities.

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[7] ACEP On-call specialist coverage in US EDs, April 2006 http://www.acep.org

[8] Characteristics of Office- Based Physicians and Their Practices: United States, 2005–2006 Data From the National Health Care Survey

[9] Fischer, JE. The Impending Disappearance of the General Surgeon. JAMA 298(18) 2191-3, Nov 2007

For example, researchers at the Sheps Center at the University of North Carolina found that between 1995 and 2005, 47 counties in North Carolina suffered a decline in the numbers of general surgeons, and four counties lost all of their general surgeons.[10] In my state of Arkansas, we have seen a similar, disturbing pattern. Between 1997 and 2004, 12 Arkansas counties saw a decline in the number of practicing general surgeons; seven counties lost all of their general surgeons. In those seven counties, five hospitals have significantly reduced their services and two have closed their doors. It is in situations such as these that we observe the far-reaching impact of the surgical workforce shortage. If current trends are not reversed, such situations are likely to become increasingly common in our rural communities.

Medicare: A Broken Payment System

The sustainable growth rate (SGR) was created to control the growth in Medicare spending for physician services by setting targets for allowable Medicare spending on physician services from one year to the next. Whenever the spending target is exceeded in a given year, the spending above the target must be recouped in future years, resulting in a reduction in the Medicare conversion factor, the key component in determining Medicare payments for physician services. As a result, this spending above the SGR results in payment cuts for all physician services, regardless of whether utilization of a particular service actually grew beyond the limits of the SGR. This means that services

[10] NC Health Professions Data System, and the Southeast Regional Center For Health Workforce Studies, Cecil G. Sheps Center for Health Services Research, UNC, Chapel Hill 2007

with relatively inelastic demand and lower rates of growth, such as surgery, are subject to the same payment cuts as rapidly growing services that exceed the limits of the SGR.

In 2002, the SGR resulted in a 5.4 percent reduction in the Medicare conversion factor, and congressional action has been needed to prevent further cuts every year since. Late last year, by replacing a scheduled 10.1 percent with a 0.5 percent increase, Congress approved the first increase to the conversion factor since 2005. Unfortunately, these provisions will expire on June 30, and without congressional action, payments are scheduled be cut 10.6 percent on July 1, 2008. Without further congressional intervention or full-scale reform, payments are scheduled to be cut over 40 percent by 2016.

In the past five years, spending on Medicare physician services has increased between 7 and 14 percent per year. These increases are fueled by growth in the volume and intensity of evaluation and management (E/M) services, imaging, lab tests, physician-administered drugs, and minor procedures. However, volume for major surgical procedures has remained relatively low—growing by less than 3 percent a year. While other specialties can increase Medicare billings by increasing the volume of the services they provide, surgeons cannot. For example, while patient may see a physician many times for a particular condition, a surgeon can only remove a patient's gall bladder once. As a result, it is much more difficult, if not impossible, for surgeons to compensate for payment reductions by providing additional services or by seeing an individual patient more often.

Further, surgical care is reimbursed differently than other physician services in Medicare, making the ability to bill for additional services much more difficult for surgeons than other specialties. This is because the bulk of care provided by surgeons, unlike other physician services, is not reimbursed as discrete units but rather is reimbursed in global payments over 10- or 90-day periods. Instead of being paid separately for the surgery and for each post-operative visit associated with the surgery, the surgeon is paid in one payment for all of the necessary care associated with a patient's surgery over that period. As a result, this reimbursement structure adds an implicit incentive for the surgeon to ensure that the surgical care he or she is providing is being delivered in the most efficient way possible.

The challenge facing surgical reimbursement in Medicare also extends beyond the SGR. This is because the SGR and the conversion factor, though significant, are not the only factors in determining reimbursement for a particular service. Every five years, the Relative Value Update Committee (RUC), which is convened by the American Medical Association and comprised of physicians from across the spectrum of physician specialties, meets to make recommendations regarding the value of the work included in physician services provided under Medicare. The RUC assigns a value for the work in each service relative to the value of the work in other physician services. The values assigned to the work in each service are measured in relative value units (RVUs). After the completion of the five-year review process, the RUC's recommendations are submitted to the Centers for Medicare and Medicaid Services (CMS), who

reviews the RUC's work and implements the final recommendations, sometimes with modification, in the Medicare physician fee schedule. The most recent five-year review was completed in 2006 and implemented on January 1, 2007.

Under the RUC's most recent five-year review, which CMS approved, more than $4 billion in the fee schedule was shifted to E/M codes from codes for other services, including surgical care. For instance, the work values associated with an intermediate office visit, the most frequently billed physician service in Medicare, increased 37 percent. Because all changes to the fee schedule must be budget-neutral, these increases were offset by a 10.1 percent across-the-board reduction in work values for all physician services, known as the "work adjuster." As a result, in 2007, most surgical codes were cut between 3 and 7 percent, depending on how many E/M visits were factored into the service. In 2008, even with a 0.5 percent increase in the conversion factor, the calculation of new work values for other services, in particular anesthesia services, along with the phase-in of other changes relative to practice expenses, meant that Medicare payments for many surgical services were cut again. As a result, the minimal growth in overall Medicare physician payments has meant significant cuts for surgical reimbursement.

Solutions: Preserving Access Today and Tomorrow

While there are many facets to the broken Medicare payment system, it is critical that Congress act to protect patient access to surgical care and all physician services before July 1. It is hard to project what will happen if the 10.6

percent cut does go into effect, but it is scenario that none of us should want to explore. Therefore, the most important thing this Congress can do in the short-term is pass legislation to stop the scheduled 10.6 percent cut on July 1, 2008, and to replace a scheduled 5.4 percent cut in 2009 with a reasonable increase in Medicare physician payments. By stopping scheduled cuts through 2009, small business surgical practices will be better able to budget and plan for the next 18 months, and policymakers will be able to consider long-term reforms that will preserve patients' access to high-quality surgical care.

When the conversion factor was first cut in 2002, the physician community called on Congress to replace the SGR with payment updates based on a measure of practice cost inflation such as the Medicare Economic Index (MEI). From early on, budget policy complicated the prospects for this proposal, and the cost of this proposal has continued to escalate. According to the latest estimate from the Congressional Budget Office, this proposal would now cost as much as $364.1 billion over the next ten years. As a result, the American College of Surgeons has developed an alternative for long-term reform.

The Service Category Growth Rate (SCGR)

As an alternative, positive solution, the College has proposed a reform of the Medicare physician payment system that recognizes the differences among the various types of services physicians provide to their patients. The College's reform proposal would establish a system of **six separate physician service categories** to use in calculating Medicare payment updates. The service

categories would include: 1) primary and preventive care; 2) other evaluation and management services; 3) major procedures; 4) anesthesia services; 5) imaging and diagnostic services; and 6) minor procedures and all other physician services.

In addition to the replacing the current SGR with separate service categories, the College's proposal would do the following:

- SCGR targets would be based on the current SGR factors (trends in physician spending, beneficiary enrollment, law and regulations), except that GDP would be eliminated from the formula and be replaced with a statutorily set percentage point growth allowance for each service category.
- To accommodate already anticipated growth in chronic and preventive services, we estimate that primary and preventive care services would require a growth allowance about twice as large as the other service categories (between 4 and 5 percent as opposed to somewhere between 2 and 3 percent for other services).
- Like the SGR, spending calculations under the SCGR system would be cumulative. However, the Secretary would be allowed to make adjustments to any of the targets as needed to reflect the impact of major technological changes.
- As under the SGR, the annual update for a service category would be the Medicare Economic Index (MEI) plus the adjustment factor. But, in no case could the final update vary from the MEI by more or

less than 3 percentage points; nor could the update in any year be less than zero.

The benefit of separate physician service categories is that reimbursement for particular services would be based on the growth rates of similar services, allowing better analysis and understanding of the factors driving the rising costs of medical care and particular physician services. This stands in contrast to the current system of combining the utilization of dissimilar services to determine reimbursement rates. In addition:

- Low-volume growth services, such as major surgical care, would no longer be subject to the blunt payment cuts produced by the SGR.
- Different utilization trends would be easier to identify, providing the opportunity to study those differences so future payment policies can be developed to either allow higher growth rates or constrain spending, as appropriate, to meet beneficiary needs.
- Current and future efforts to identify and promote the use of specific services would be simplified.
- The SCGR would provide a framework for the development of quality improvement initiatives and value-based purchasing systems that are tailored to differences in the way various physician services are provided.

I am pleased to say that the College's proposal has already garnered significant bipartisan interest on Capitol Hill. The original version of the College's proposal was introduced as the "Medicare Physician Payment Reform Act of 2007," H.R. 3038, by Rep. Pete Sessions in July 2007. A modified version of the College's proposal was included in the "Children's Health and Medicare Protection Act of 2007," H.R. 3162, which was introduced by Rep. John Dingell and passed by the House on August 1, 2007. In addition, in a letter dated December 8, 2007, a bipartisan coalition of 140 members of the House of Representatives (90 Democrats and 50 Republicans), led by Rep. Lincoln Davis and Rep. Pete Sessions, sent a letter to Speaker of the House Nancy Pelosi and Republican Leader John Boehner expressing support for measures included in the House-passed CHAMP Act that would replace Medicare payment cuts in 2008 and 2009 with payment increases and would replace the Medicare payment system with a system that establishes six separate service category targets starting in 2010. By either voting for the CHAMP Act or signing the Davis-Sessions letter, 279 Members of the House have expressed support for separate service category targets.

Madam Chairwoman, thank you and your colleagues for providing this opportunity to share with you the challenges facing surgeons under the Medicare program today, and to provide positive recommendations to help the small business medical practice survive. The College looks forward to continuing to work with you to reform the Medicare physician payment system to ensure that Medicare patients will have access to the high-quality surgical care they need.

I appreciate this opportunity to testify before the committee and I would be happy to take any questions.

The American College of Surgeons is a voluntary, educational and scientific organization of 74,000 Fellows devoted to the ethical and competent practice of surgery and to enhancing the quality of care provided to surgical patients. Founded in 1913, the College was established to improve the care of surgical patients and the safety of the operating room environment. For over 90 years, the College has provided educational programs for its Fellows and for other surgeons in this country and throughout the world. In addition, the College establishes standards for the practice of surgical, trauma, and cancer care, as well as guidelines for office-based surgery facilities. It also provides information on surgical issues to the general public.

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STATEMENT FOR THE RECORD

American Optometric Association
to the
Committee on Small Business
United States House of Representatives

"Medicare Physician Fee Cuts: Can Small Practices Survive?"
May 8, 2008

The AOA commends Chairwoman Velazquez, Ranking Member Chabot, and members of the House Small Business Committee, for the leadership and vision you have shown in recognizing the fundamental need to address the hopelessly flawed Medicare Sustainable Growth Rate (SGR) formula — and the disastrous impact the fee cuts cause to small business health care professionals.

The American Optometric Association (AOA), representing over 34,000 doctors of optometry in more than 6,500 communities across America, urges Congress to adopt an equitable and long-lasting replacement for the Medicare SGR formula to ensure the current health of the Medicare program as well as its sustainability for years to come. The SGR payment formula has produced disastrous results for Medicare providers — especially small and rural health care providers/businesses — and their patients. Rising practice costs have outpaced payment levels, placing access to quality care for America's seniors increasingly at risk and threatening to undermine America's promise to future generations. As the Medicare program prepares to usher in an unprecedented number of enrollees from the baby-boomer generation, the system is on the verge of a full-blown meltdown.

But, we are confident that, working together, Congress, the Centers for Medicare and Medicaid Services (CMS), the AOA, and other health care provider organizations can achieve our common objective and deliver on Medicare's long-held promise to America's Medicare beneficiaries and to the American people—access to needed health care services, including eye and vision care services, that are high quality, furnished by the beneficiary's provider of choice, and cost-effective for the Federal Government and the American taxpayer.

In October, Dr. John Whitlow, a small business owner of an independent private optometric practice in LaGrange, GA, testified before the House Small Business Subcommittee on Regulations, Healthcare and Trade regarding the chilling affect that minimal Medicare reimbursement is having on efficient and high quality health care, including the delivery of eye and vision care. As the frontline providers of eye and vision care, optometrists face many obstacles as they strive to provide care to an ever-increasing number of Medicare patients.

"Access to quality care, particularly that provided by small health care providers, is increasingly at risk because of the strains on the current system that threaten the ability of providers to deliver needed care," Dr. Whitlow stated. "Low payments from federal health care programs and administrative burdens put on providers by the ongoing transformation of the current health care system are creating an undue burden on America's health care provider network."

Optometrists are often the only eye care providers available in rural communities and underserved areas and, like other providers, are struggling to serve America's children, seniors, and the underserved while keeping pace with health care demands and rising costs. When reimbursement rates are pegged at artificially low levels that do not reflect genuine practice costs, patient access suffers because clinicians will be financially unable to serve many patients.

In the last five years, Congress has shown tremendous leadership and vision by taking action in each of those years to prevent unreasonable Medicare payment cuts due to the flawed SGR payment formula. The AOA applauds these temporary "fixes." However, a permanent solution is needed to ensure that optometrists and other small business health care providers can continue to open their doors and provide quality health care services.

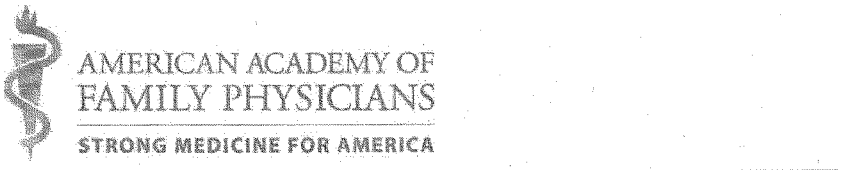
The AOA believes that successful efforts to encourage judicious use of care are best fostered through positive incentives that inspire doctors of optometry and other health care providers to work toward this end, not by top-down spending targets that cannot distinguish between appropriate and inappropriate care. The AOA urges the Committee and Congress to work with CMS to avert future cuts by repealing the SGR and enacting a system that produces rational health care provider payments that accurately reflect increases in practice costs.

After years of "band-aid" approaches, we are well acquainted with the cost concerns associated with any substantive reform of the Medicare payment formula. We understand that the path to reform may not be as direct or rapid as we would like; however, last year's six month temporary relief expires on June 30, 2008, and action is necessary to keep small business health care practices in business.

RECOMMENDATIONS:

- Replace the looming Medicare physician payment cut with an 18 month plan including positive updates that accurately reflect practice cost increases.
- Develop a path for permanent replacement of the flawed SGR payment formula to ensure beneficiaries' access to needed care.

The AOA looks forward to working with the Small Business Committee and Congress to pass immediate legislation that preserves patient access, averts the next two years of payment cuts, and provides a positive update that reflects optometric practice cost increases. The AOA firmly believes that if America is to fulfill her promise to current Medicare beneficiaries, we must act swiftly—by the June 30 deadline—to avert payment cuts and ensure continued access to care. But, if we are to deliver on that same promise to future beneficiaries, decisive action is needed to replace the flawed Medicare-SGR payment formula and ensure the future health of the program.



Statement of the American Academy of Family Physicians

Submitted

To The

Regulations, Healthcare and Trade Subcommittee
of the House Small Business Committee

Concerning

Medicare Physician Fee Cuts: Can Small Practices Survive?

May 8, 2008

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Introduction
On behalf of the 93,800 members of the American Academy of Family Physicians and, more importantly, for the 50 million of your constituents who give us the privilege of taking care of their health every day, thank you for convening this hearing. The Academy commends the subcommittee for your persistent efforts to address the serious problems that the Medicare payment formula creates for family physicians whose practices are small businesses.

A large percentage of family physicians works in practices of four physicians or fewer. These practices are typical of small businesses that operate with very tight financial margins. Nearly half of the patients of family physicians are Medicare beneficiaries, Medicaid beneficiaries, or have no insurance at all.

The average gross revenue for family medicine practices in 2003 was $360,000. From this total, family physicians pay staff salaries, rent, utilities, medical equipment costs and medical liability insurance premiums. Most of these costs have risen rather steadily and predictably with the single, significant exception of medical liability premiums. When these premiums increase at the rate of which we have seen for the last several years, family medicine practices have no way to absorb them.

The AAFP appreciates the work this Committee has undertaken to examine how Medicare pays for the services that physicians deliver to Medicare beneficiaries and how Medicare reimbursement affects the operation of these small businesses. Family physicians also share the Committee's concerns that the current system is inefficient, inaccurate and outdated. For this reason, the AAFP supports the restructuring of Medicare payments to pay for quality improvement and care coordination. This should be done with the needs of Medicare patients foremost in mind. Since most of these patients have two or more chronic conditions that call for continuous management and that depend on differing pharmaceutical treatments, Medicare should focus on how patients' personal physicians can coordinate beneficiary care and prevent expensive and duplicative tests and procedures.

Most people in this country receive the majority of their health care in ambulatory care settings from physicians in small or medium size practices. Specifically, about a quarter of all office visits in the U.S are to family physicians, and Medicare beneficiaries comprise about a quarter of the typical family physician's practice. Finding a more efficient and effective method of paying for physicians' services delivered in diverse settings to Medicare beneficiaries with a large variety of health conditions is a difficult but necessary endeavor, and one that has tremendous implications for millions of patients. Likewise, the implications are enormous for the specialty of family medicine. The AAFP, therefore, is committed to working with Congress in the design of a new payment system that meets the needs of patients and physicians.

AAFP appreciates Congress's action that avoided a 10.1-percent payment reduction in the Medicare Physician Fee Schedule for the first half of this year. Nevertheless, the current Medicare reimbursement rates for physician services is less than it was in 2001 and this underscores the urgency of correcting this problem for this all-important health program for our nation's seniors. Continuing to waive the statutory formula at the last minute on virtually an annual basis, and more recently funding the Medicare program for physicians services for only six months, is no way to run a health care program for more than 43 million senior citizens. Such maneuvering renders the Medicare program extremely unstable and unpredictable for beneficiaries and their physicians.

Current Payment Environment

The environment in which U.S. physicians practice and are paid is challenging at best. Medicare, in particular, has a history of making disproportionately low payments to family physicians and other primary care physicians, largely because its payment formula rewards procedural volume and fails to foster the comprehensive, coordinated management of patients that is the hallmark of primary care. More broadly, the prospect of steep annual cuts in payment resulting from the flawed payment formula is discouraging. In the current environment, physicians know that, without Congressional action before the end of next month, they face Medicare payment cuts of 10.6-percent followed by another cut of 5-percent scarcely six months later. Moreover, if Congress does not waive or eliminate the current formula, yearly reimbursement cuts in the range of 5-8 percent will result. No small business can be expected to survive when such a sizeable and important portion of its revenues does not keep pace with inflation and even decreases precipitously and profoundly (cuts of nearly 40 percent over the next nine years are projected). Meanwhile, of course, business expenses relentlessly increase. Clearly, this Sustainable Growth Rate (SGR) formula belies its name and simply is not sustainable.

Primary Care Physicians in the U.S.

The United States spends roughly 16 percent of its gross domestic product on health care while other industrialized nations spend approximately half that. Moreover, those other nations report better quality and better health outcomes than does the U.S. While there are many elements of distinction between the U.S. healthcare system and that of other nations, one notable difference is the other industrialized countries place on primary care.

While other developed countries have a better balance of primary care doctors and subspecialists, primary care physicians make up less than one-third of the U.S. physician workforce. Compared to other developed countries, the U. S. spends the highest amount per capita on healthcare but has some of the worst healthcare outcomes. More than 20 years of evidence shows that having a primary care-based health system has both health and economic benefits. Four years ago, a study comparing the health and economic outcomes of the physician workforce in the U.S. reached the same conclusion (*Health Affairs*, April 2004). By not having health care

predicated on the coordination of patients' care by primary care physicians, the U.S. health care system wastes resources and foregoes significant quality improvement.

The Patient-Centered Medical Home
From the outset, the Medicare program has based physician payment on a fee-for-service system. This system of non-aligned incentives rewards individual physicians for ordering more tests and performing more procedures. The system lacks incentives for physicians to coordinate the tests, procedures, or patient health care generally, including preventive services and care to maintain health. This payment method has resulted in an expensive, fragmented Medicare program.

The outdated payment scheme does not adequately compensate physicians who do manage and organize their patients' health care, much of which is accomplished with the use of non face-to-face interactions. Currently, there is no compensation to physicians in recognition of the considerable time and effort associated with coordinating health care in a way that is understandable to patients and cost-effective for the Medicare program.

Proposed Solution
To correct these inverted incentives, the American Academy of Family Physicians recommends that Medicare compensate physicians for care coordination services. Such payment should go to the personal physician or practice chosen by the patient to perform this role. Any physician practice prepared to provide care coordination could be eligible to serve as a patient's "medical home."

The AAFP, the American College of Physicians (ACP), the American Osteopathic Association (AOA) and the American Academy of Pediatrics (AAP), who combined represent all of U.S. primary care physicians, over 325,000 in number, have worked with the National Committee on Quality Assurance (NCQA) to develop a program for those physician practices that want to be recognized as a "patient-centered medical home." We would recommend that Congress require each physician practice that wants to be designated a patient centered medical home be recognized by an appropriate third party examiner, like NCQA. By requiring this independent recognition, the federal government can be assured that the physician practice will have met rigorous standards of organization and service.

The Institute of Medicine (IOM) has repeatedly praised the value of, and cited the need for, care coordination. And while there are a number of possible methods to build this into the Medicare program, AAFP recommends a blended model that combines fee-for-service with a per-beneficiary, per-month stipend for care coordination in a beneficiary's medical home. Patients should be given incentives to select a personal medical home by reduced out-of-pocket expenses such as co-pays and deductibles.

The more efficient payment system should place greater value on cognitive and clinical decision-making skills that result in more efficient use of resources and that result in better health outcomes. For example, the work of Barbara Starfield, Ed Wagner and others has shown that patients, particularly the elderly, who have a usual source of care, are healthier and the cost of their care is lower because they use fewer medical resources than those who do not. The evidence shows that even the uninsured benefit from having a usual source of care (or medical home). These individuals receive more appropriate preventive care and more appropriate prescription drugs than those without a usual source of care, and do not get their basic primary health care in a costly emergency room, for example. In contrast, those without this usual source have more problems getting health care and neglect to seek appropriate medical help when they need it. A more efficient payment system would encourage physicians to provide patients with a medical home in which a patient's care is coordinated and expensive duplication of services is eliminated.

One model that the Committee could well consider is the Medicaid program in North Carolina, designed by a family physician, Dr. Allen Dobson. Gov. Mike Easley announced recently that Community Care of North Carolina, based on this primary care "medical home" model saved North Carolina taxpayers more than $231 million dollars in state fiscal years 2005 and 2006.

Community Care is a good example of a good business model that enables physicians to work smarter, raise the quality of health care for the patient while at the same time making it more efficient for the purchaser.

The model has been the subject of discussions between the primary care physician organizations and IBM in the Hudson Valley area of New York, to create a demonstration project for their employees that will examine the characteristics of a successful patient-centered medical home. And AAFP, ACP, AOA and the National Association of Community Health Centers have joined with the ERISA Industry Committee, the National Business Group on Health and several major employers to form the Patient Centered Primary Care Collaborative to advance the medical home as a way to improve the health care system generally.

The patient-centered, physician-guided medical home being advanced jointly by the American Academy of Family Physicians, the American College of Physicians, the American Osteopathic Association, and the American Academy of Pediatrics would include the following elements:

- ***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*** across all domains of the health care system (hospitals, home health agencies, nursing homes, consultants and other components of the complex health care system), 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.

- ***Quality and safety*** are hallmarks of the patient-centered medical home: 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.

  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.

- ***Enhanced access*** to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

The care management fee for the medical home would reflect the value of physician and non-physician staff work performed outside of the face-to-face visit with the patient, and it would pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. In order to capitalize on the effectiveness of primary care and the capabilities of family physicians who function in small business environments, it is this type of innovation to the Medicare program that must be implemented and emphasized and when accomplished it will pay dividends to the beneficiary and the Medicare program alike.

Aligning Incentives

Beyond replacing the outdated and dysfunctional SGR formula, a workable, predictable method of determining physician reimbursement - one that is sensitive to the costs of providing care - should align the incentives to encourage evidence-based practice and foster the delivery of services that are known to be more effective and result in better health outcomes for patients. Moreover, the reformed system must facilitate efficient

use of Medicare resources by paying for appropriate utilization of effective services and not paying for services that are unnecessary, redundant or known to be ineffective. Such an approach is endorsed by the Institute of Medicine (IOM) in its 2001 publication *Crossing the Quality Chasm.* Moreover, any Medicare reimbursement system must recognize that medical practices are small businesses which, as such, cannot survive in an unhealthy and unpredictable payment environment.

Another IOM report released in 2006, entitled *Rewarding Provider Performance: Aligning Incentives in Medicare*, states that aligning payment incentives with quality improvement goals represents a promising opportunity to encourage higher levels of quality and provide better value for all Americans. The objective of aligning incentives through pay for performance is to create payment incentives that will: (1) encourage the most rapidly feasible performance improvement by all providers; (2) support innovation and constructive change throughout the health care system; and (3) promote better outcomes of care, especially through coordination of care across provider settings and time. The AAFP concurs with the IOM recommendations:

- Measures should allow for shared accountability and more coordinated care across provider settings.
- P4P programs should promote care that is patient-centered and efficient and reward providers who improve performance as well as those who achieve high performance.
- Payment systems should offer providers adequate incentives to report performance measures.
- The federal government should assist providers in implementing electronic data collection and reporting to strengthen the use of consistent performance measures, because electronic health information technology will increase the probability of a successful pay-for-performance program.

Aligning the incentives requires collecting and reporting data through the use of meaningful quality measures. AAFP has demonstrated leadership in the physician community in the development of such measures. It is the AAFP's belief that measures of quality and efficiency should include a mix of outcome, process and structural measures. Clinical care measures must be evidence-based and physicians should be directly involved in determining the measures used for assessing their performance.

A Chronic Care Model in Medicare

If the Medicare payment system is not changed, the aging population and the rising incidence of chronic disease will overwhelm Medicare's ability to provide health care. Currently, 82 percent of the Medicare population has at least one chronic condition and two-thirds have more than one illness. However, the 20 percent of beneficiaries with five or more chronic conditions account for two-thirds of all Medicare spending.

There is strong evidence that the *Chronic Care Model* (Ed Wagner, Robert Wood Johnson Foundation) would improve health care quality and cost-effectiveness, integrate patient care, and increase patient satisfaction. This well known model is based on the fact that most health care for the chronically ill takes place in primary care settings, such as the offices of family physicians. The model focuses on six components:

- self-management by patients of their disease
- an organized and sophisticated delivery system
- strong support by the sponsoring organization
- evidence-based support for clinical decisions
- information systems; and
- links to community organizations.

This model, with its emphasis on care-coordination, has been tested in some 39 studies and has repeatedly shown its value. While we believe payment should be provided to any physician who agrees to coordinate a patient's care (and serve as a medical home), generally this will be provided by a primary care doctor, such as a family physician.

Information Technology in the Family Medicine Office Setting

An effective health care system emphasizing coordinated care is predicated on the presence of health information technology, i.e., the electronic health record (EHR) in the physician's office. Using advances in health information technology (HIT) also aids in reducing errors and allows for ongoing care assessment and quality improvement in the practice setting – two additional goals of recent IOM reports. We have learned from the experience of the Integrated Healthcare Association in California that when physicians and practices invested in EHRs and other electronic tools to automate data reporting, they were both more efficient and more effective, achieving improved quality results at a more rapid pace than those that lacked advanced HIT capacity.

Family physicians are leading the transition to EHR systems in large part due to the efforts of AAFP's Center for Health Information Technology (CHiT). The AAFP created the CHiT in 2003 to increase the availability and use of low-cost, standards-based information technology among family physicians with the goal of improving the quality and safety of medical care and increasing the efficiency of medical practice. Since 2003, the rate of EHR adoption among AAFP members has more than doubled, with over 30 percent of our family physician members now utilizing these systems in their practices.

However, there are a number of barriers that discourage broad EHR implementation and cost is a top concern for family physicians. The AAFP has worked aggressively with the vendor community through our Partners for Patients Program in an attempt to lower the prices of appropriate information technology. Yet, conversion to a functional efficient EHR remains a staggering investment which most estimate at a cost of $20,000 to $30,000 per physician per year. At a time when Medicare reimbursement system is unstable and unpredictable, such an investment is extremely difficult for a small business to make.

Nevertheless, AAFP recognizes the importance of converting the physician practices to an electronic health record in the near future. We, therefore, initiated the Physician EHR Coalition, now jointly chaired by ACP and AAFP, to engage a broad base of medical specialties to advance EHR adoption in small and medium size ambulatory care practices. Moreover, to foster greater adoption of EHR systems, every family medicine residency will implement EHRs by the end of 2008.

To accelerate care coordination, the AAFP joins the IOM in encouraging federal funding for health care providers to purchase HIT systems. According to the US Department of Health and Human Services, billions of dollars will be saved each year with the wide-spread adoption of HIT systems. Despite a modest financial commitment to this technology made by the federal government, more funding needs to be directed to the systems that will truly have the most impact and where ultimately all health care is practiced, i.e., at the individual physician practice.

Conclusion

It is time to modernize Medicare by appropriately valuing primary care and by embracing the Patient Centered Medical Home model as an integral part of the Medicare program.

Specifically, the AAFP encourages Congressional action to reform the Medicare physician payment system in the following manner:

- Repeal the Sustainable Growth Rate formula at a date certain and replace it with a stable and predictable annual update based on changes in the costs of providing care as calculated by the Medicare Economic Index.

- Adopt the patient-centered medical home by giving patients incentives to use this model and compensate physicians who provide this function. The physician designated by the beneficiary as the patient-centered medical home shall receive a per patient, per-month stipend in addition to payment under the fee schedule for services delivered.

- Phase in value-based purchasing based on the Physician Quality Reporting Initiative. Analyze compensation for reporting and ensure that it is sufficient to cover costs associated with the program and provide a sufficient incentive to report the required data.

- Ultimately, payment should be linked to health care quality and efficiency and should reward the most effective patient and physician behavior.

In the short term, AAFP advocates for revisions to the Medicare physician payment system that:

- Extend the current payment level to the end of 2008;
- Provide a positive update for all of 2009;
- Extend the special provisions for physician shortage areas and rural practices;
- Use the 18 months of payment stability to work with physician groups and patient advocates to shape a payment formula consistent with recommendations of the Medicare Payment Advisory Commission, i.e.,
    - increase payments for primary care providers by using an adjustment to the fee schedule, and
    - initiate a three-year medical home pilot project to improve health care quality, enhance care coordination and save costs.

The AAFP commends the Committee for its commitment to identify a more accurate and contemporary Medicare payment methodology for physician services. Moreover, the AAFP is eager to work with Congress toward the needed system changes that will improve not only the efficiency of the program but also the effectiveness of the services delivered to our nation's elderly.