HEARING ON MEDICARE'S REIMBURSEMENT CUTS: THE POTENTIAL IMPACT ON SOLO AND SMALL GROUP PRACTITIONERS AND THE BUSINESSES THEY RUN

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CONTENTS

OPENING STATEMENTS

	Page
González, Hon. Charles	1
Westmoreland, Hon. Lynn	2

WITNESSES

PANEL I:

Burgess, Hon. Michael, Member of Congress	4

PANEL II:

Fedderly, Dr. Brad, American Academy of Family Physicians	12
Harris, Dr. Jeffrey P., MD, FACP, American College of Physicians	14
Rother Allen, D.O., Dr. Melinda, American Osteopathic Association	16
Noller, MD, MS, Dr. Kenneth L., American College of Obstetricians and Gynecologists	18
Whitlow O.D., Dr. John, American Optometric Association	20

APPENDIX

Prepared Statements:

González, Hon. Charles	30
Westmoreland, Hon. Lynn	32
Altmire, Hon. Jason	33
Braley, Hon. Bruce	34
Burgess, Hon. Michael, Member of Congress	36
Fedderly, Dr. Brad, American Academy of Family Physicians	40
Harris, Dr. Jeffrey P., MD, FACP, American College of Physicians	49
Rother Allen, D.O., Dr. Melinda, American Osteopathic Association	58
Noller, MD, MS, Dr. Kenneth L., American College of Obstetricians and Gynecologists	74
Whitlow O.D., Dr. John, American Optometric Association	79

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Thursday, November 8, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
SUBCOMMITTEE ON REGULATIONS, HEALTH CARE & TRADE
Washington, DC.

The Subcommittee met, pursuant to call, at 11:26, a.m., in Room 2360, Rayburn House Office Building, Hon. Charlie González[Chairman of the Subcommittee] Presiding.

Present: Representatives González, Westmoreland, Fallin, and Jordan.

OPENING STATEMENT OF CHAIRMAN GONZÁLEZ

ChairmanGONZÁLEZ. I now call this hearing to order on Medicare's Reimbursement Cuts: The Potential Impact on Solo Practitioners and the Businesses they Run. I have some preliminary remarks. It looks like we are going to have a vote in about 15 minutes. My apologies to the witnesses that we started late and we are going to continue being a little late. So we appreciate your patience, but your testimony is quite vital to the work that we are trying to do here. The practice of medicine is changing. With the rise in managed care, increased insurance consolidation, and growing paperwork, small health providers face many challenges. Complicating matters is that the physician graduate of today faces a much different business environment than in the past.

Today's hearing will address one of the next great challenges that could affect the small medical practice. In 2008, Medicare is scheduled to cut physician payment rates by 10 percent. These reductions will continue annually, and it is predicted that the total cuts will be about 40 percent by 2016. That could have a devastating impact on the operation of small medical practices. The potential impact of these cuts must be considered in light of the fact that these medical practices function like any other small business, and face low profit margins.

Physicians are responsible for expenses like rent, payroll, employee health insurance, and malpractice insurance. Beyond the Medicare cuts, these general business costs are expected to increase 20 percent in the next 9 years. Some may find the link between medicine and money objectionable, but the truth is that the current business model for the practice of medicine is not sustain-

able. At a time when more and more baby boomers are approaching the age of 65, some physicians have simply stopped accepting Medicare patients. Already, some practices lose money every time a Medicare patient is seen. The problem of access to care will only grow if the Medicare cuts are not stopped. Some seniors are already faced with calling 20 to 30 providers in the desperate hope that someone will accept Medicare.

According to a recent survey by the American Medical Association, 60 percent reported that they would have to limit the number of new Medicare patients they treat due to next year's cuts. Half would reduce their staff. Fourteen percent would completely get out of patient care. That means these cuts in physician payments will affect everyone, not just Medicare patients. It is unlikely that the primary care shortage will improve in the near future, as Medicare reimbursement rates continue to be a primary driver of physician salaries. Medical students, already burdened with an average debt in excess of $100,000, are clearly gravitating towards specialties.

According to the Center For Study and Health System Change, incomes of primary care physicians fared among the worst in keeping pace with inflation between the years of 1995 and 2003, while medical specialists fared the best. The report concludes that with, ″the diverging income trends between these specialties and primary care,″ the result is likely to be an imbalance in the physician workforce, and perhaps a future shortage of primary care physicians.

The facts are clear. Medicare reimbursement cuts are a barrier to the successful operation of solo and small group practices. For many small practices, Medicare is the single most important source of revenue, and is often used to extend or supplement charitable care to the uninsured and underinsured. Cutting Medicare's low reimbursement rates would result in many practitioners denying or limiting access to charitable care. Medicare is an important component in American's health care system. It provides source revenue for decisions to invest in capital projects like Health IT, computers, and to expand and offer necessary tests like mammography services and other preventative screenings. It also enables small practices, particularly in rural and underserved communities, to extend the scope of their charitable services.

Without it, many of our Nation's most vulnerable populations would receive no care. The question is how can we reform the system to keep the small medical practice viable. There must be a careful consideration to how those rates are developed and their impact on small practices. The panel before us today knows firsthand these challenges. Unfortunately, they may be put in a situation where they must deny access to care in order to keep their businesses open and running. I would now yield to the ranking member, Congressman Westmoreland, for his opening statement.

OPENING STATEMENT OF MR. WESTMORELAND

Mr.WESTMORELAND. Thank you, Mr. Chairman, for that statement and for holding this hearing today. I would also like to thank all the witnesses for their participation. And I am sure today's testimony will prove to be very helpful in any decisions that we would make in trying to fix a problem. Medicare's Physician Payment

Program is an issue of great concern, not only in my district, but all over the country.

Mr. Chairman, I know that you and I agree that the Sustainable Growth Rate, the SGR, specifically is a system that needs to be examined carefully. And I hope the testimony today will give us some direction in how to do that. With an issue as complex as this, I think it is important to lay out all the facts. We know that the SGR system was designed to respond to concerns that the fee schedule would not adequately control overall increase in physicians' services. Also, we know that the SGR is a formula targeted for cumulative spending. Unfortunately, we also know that in the past few years, expenditures have been significantly above the formula's target, causing cuts to physician payments. Congress has attempted to treat the symptoms by placing legislative Band-Aids on the problem and overriding the reductions.

However, we have yet to fully treat the illness, and I believe that our work here today is a step towards that goal. It is important that we have an honest and frank discussion about the situation that we now face. There is a growing, and, in my opinion, real concern that physicians may be unable to absorb continued payment cuts. I know that the fallout of such a scenario is something that we all want to avoid. My wife had surgery, Mr. Chairman, Monday. And as I was talking to the surgeon, he said that his daughter had come to him and talked to him about going into the medical field. And he had to give her advice that she may want to reconsider what she was doing. I think that is a real shame to that profession. But I welcome these distinguished panels today and thank you for your willingness to have this hearing and their willingness to testify.

ChairmanGONZÁLEZ. And I thank the ranking member. The first witness—and first of all, of course, the first witness knows the rules, but for the benefit of the witnesses that will be following Dr. Burgess, you will be given 5 minutes within which to present your testimony. You have submitted a written statement that will become part of the record. We will refer to it, as well as staff, as resource. And then, of course, you may be able to follow up on that which you didn't think you could cover in your 5 minutes in the question and answer period. And I think we are going to have plenty of time. And again, I seek your indulgence and your patience, because I think we will have a vote in a few minutes.

Panel one consists of one witness. But I am proud to introduce our first witness, the Honorable Michael Burgess from Texas. Congressman Burgess was elected to Congress in 2002 to represent the 26th Congressional District from the great State of Texas. Before heading to Congress, Congressman Burgess practiced as an OB-GYN for more than 21 years, delivering 3,000 babies. 1,501 of those babies turned out to be Democrats. I added that. That is not true. He is the founder—

Mr.BURGESS. They are still young.

ChairmanGONZÁLEZ. —of Obstetrics and Gynecological Associates of Lewisville. Our colleague—and I want to tell our audience, because I was sharing this with Lynn, I saw Michael on the floor as we were voting, and I said get ready for a real grilling, Mr. Wit-

ness. He said get ready for my answers. So my pleasure to introduce Congressman Michael Burgess.

STATEMENT OF THE HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr.BURGESS. Thank you, Chairman, and Ranking Member Westmoreland, for giving me the opportunity, extending me the courtesy of allowing me to talk about this on this morning. As you know, from knowing me for the past 5 years, I will talk about this issue literally at the drop of a hat anywhere at any time. So I am happy to be here talking to your Subcommittee and taking some time to highlight this so that the decision-makers can get a greater understanding of a very serious issue that faces medicine. Most of us, unless we are in our first term, we have been through a couple of these in the past. And when I say these, I mean, what happens between Thanksgiving and New Year's Eve, when we deal with the proposed physician payment cuts that have now been set by the Centers for Medicaid and Medicare Services on November 1st.

And I believe they were assessed this time at a 10.1 percent cut this year unless Congress acts. Every year that I have been in Congress, Congress has acted before that final date except for 2005, when doctors were delivered an at that time I think it was a 5 to 6 percent reduction, and my fax went wild over New Year's weekend, with doctors all over the country saying, okay, you have done it now, let me show you the letter that I am sending out to my patients. They were leaving the practice of Medicare in droves.

I can promise you if it was that bad at 5 percent, it is going to be even worse at 6 percent. It is not that my fax machine can't handle it, but I worry if the practice of medicine can. We usually act in Congress, but when we act, we not only are not fixing the underlying problem, but we are making the ultimate fix of the underlying problem that much worse. And it is for that reason I am really ambivalent about what happens this year, whether it is a 1-year or 2-year fix. And we hear both being talked about over at Senate Finance. I haven't heard much talked about on this side of the Capitol. But whatever we do, whether it is a 1-year or 2-year fix, we are just delaying the pain and we are making the ultimate solution that much harder.

When I first thought about running for Congress in December of 2001, the first Medicare cut came to the house of medicine in this country at a time the budget was in surplus. And quite frankly, many of us at the AMA House of Delegates that year just frankly could not understand why it was necessary to do that. And we were told don't worry, Congress will fix the problem.

Indeed, they did not in 2001, so the year 2002, my last year of active practice, Medicare reimbursement declined 5.4 percent. As a consequence, most of the doctors who practice my specialty in my part of the county discontinued taking Medicare from their practices. I continued because my mother told me I had to. But as a consequence, when I left to Congress it was quite a vacuum that was left behind for that patient population.

Now, in the last Congress, in the 109th Congress, I introduced a bill, 5866, and perhaps relatively naively said let us just repeal

the SGR formula, find a way to pay for it, we are people of good will, we can figure this out at the Committee level, and no one has to actually have the individual target on their back, but I was wrong. Even failing to delineate payfors, I did attract a lot of negative energy with the introduction of that bill. But the reality was we need to do something. Now no sooner was the ink dry on the fix that we did at the end of last year, on the tax extender bill, than I knew we had to work on this. Mr. Chairman, we have really got to approach this from a short-term, a mid-term, and a long-term strategy.

And that is really what has been lacking, and in all candor, when my party was in charge the first two terms that I was here, but it still seems to be lacking today. We need that short-term, mid-term, and long-term strategy to deal with this. So in 2006, December of 2006, we tried to reframe the problem that would dispose of the Sustainable Growth Rate formula and replace it with the Medicare Economic Index, but I also proposed that we do that over a transition period that would take some time to do that. We had a lot of discussions, and I am grateful to the input from the American Medical Association, the American College of Surgeons, American Osteopathic Association, my colleagues, the American College of OB-GYN, that laid out some principles that would lay the foundation for legislation that eventually came to be known as 2585. It was introduced earlier this year.

I believe that these principles are transformational in nature, and will help this House avoid solutions that are merely transactional or cosmetic and make the problem worse. Number one, the SGR formula, Sustainable Growth Rate, it is insufficient to meet the cost of physicians or even a methodology that allows the physician to plan for the future. So it must be repealed. Medicare reimbursement must fairly compensate physicians to provide the services.

Any new Medicare payment system must be able to adjust for growth in service, but agile enough to determine what constitutes appropriate growth in service volume. Any future cost containment device must be delinked to trends in the economy, unlike the SGR. Quality reporting should encompass a variety of options, and should be voluntary. Implementation of health information technology should be rewarded, but also should remain voluntary. The solution is actually extremely simple. It is so simple we forget about it sometimes. The solution is stop the cuts, repeal the formula. And that is the concept on which I based the legislation that I introduced, 2585, in this Congress. It eliminates the SGR formula in 2 years' time. What happens to the doctors in 2008 and 2009? Is the SGR formula in fact going to result in these 10 percent cuts? You can actually readjust the baseline, reset the baseline. And that was done in the legislation that I introduced. And it scored from the CBO as about just bit little less than an MEI update for 2008, and a little under that for 2009, but still positive updates, and nowhere near the 10 percent cut that has been proposed for this year. And then in 2010, the formula is repealed outright. I would love to go into Part A to take the money to just pay for the repeal of the SGR, but I am not allowed to do that.

So all of the savings that we are achieving in Medicare currently, and we are achieving some savings in Medicare. Remember the Trustees report that came out in June of this year said the bad news is Medicare is going broke, but the good news is it is going to go broke a year later than we told you last year.

So that year of savings, if you will, although it is savings that accrues to Part A, because now Part A trust fund is not going to be into bankruptcy until a year later than we told you last year, but really that savings occurred in Part B. But Part B still got charged for that money. Why not give that money or sequester that money or hold that money for Part B and then let us pay for the repeal of the SGR with that money that we have held, the lock box from 2000 that no one is using anymore.

Let us bring that lock box out and put those savings in the lock box—I don't think Al Gore needs it anymore—and we will hold this money to repeal the SGR formula. Now we really do have to be careful with some of the things we do because we all know we have a problem with disparities in this country. And we don't want to make the issue of disparities worse by creating new problems with the SGR formula.

Let me just wrap up with this: During his last days on Capitol Hill, Alan Greenspan was doing a couple victory laps around the Capitol, came to talk to a group of us one morning. And the question inevitably came up after his talk, well, Mr. Greenspan, what are we going to do about Medicare? What are we going to do this unfunded liability? And he thought for a minute and he said it is going to be very hard, but I think when the time comes Congress will make the correct decisions about what to do to keep Medicare solvent. And then he stopped for a minute, he thought, and he said what concerns me more is are you going to have anyone there to deliver the services when you require them? And that hit me like a ton of bricks.

So that is why I have focused on this issue for the last 2 years, and why it is my overarching consideration for if I get nothing else done in Congress, if I can get this system changed, it is incumbent upon me to do that. Finding a solution is going to be the key to the problem that we face with physician workforce issues in this country. And we are coming up on some serious ones.

I had two companion pieces of legislation that I won't go into today, but they dealt with the student contemplating a career in health care and they dealt with the individual who is in residency programs today. Everything for me comes down to this when I think about health care policy in this Congress. What is the fundamental unit of production of the American medical machine? If the American medical machine was cranking out a widget, what would that widget look like? It would look like the doctor-patient interaction in the treatment room.

Anything that we do that delivers value to that doctor-patient interaction in the treatment room is something I will look at and something that bears giving a careful assessment to. Anything that detracts from value is really not something that I am interested in pursuing. Well, you cannot, I will submit you cannot deliver value to the doctor-patient interaction in the treatment room if you have no doctor there in the first place. So this becomes central to again,

to everything that I do as I spend my time here in Congress. The fact is no doctor can continue to practice with what we are asking them to do. I ran a medical practice. Yes, it is a small business. What is the biggest cost when you are in a small business? It is the cost of capital. Usually that is for hiring a new doctor or buying a piece of equipment. We can't plan because we don't know what Congress is going to do to us in the future.

If we come up with a formula for getting rid of the 10 percent cut this year the price tag of the $268 billion to repeal SGR over 10 years time next year becomes over $300 billion. Every year we delay we make it worse. If we had taken this approach, short-term, mid-term, long-term when I first arrived here and we did the first omnibus in 2003.

The fact is we would be pretty much past this problem now and we could all argue about something else. And wouldn't we be happy doing that? I know I have gone a little bit long, and I thank you for your indulgence, and I will yield back my time.

[The prepared statement of Mr. Burgess may be found in the Appendix on page 36.]

ChairmanGONZÁLEZ. Thank you very much, Congressman Burgess. I am going to suggest—it is one vote. That is my understanding. It is one vote. Why don't we get over there, vote real quick, make sure we all get back at the same time. And then we will open it up and have some questions for you.

Mr.BURGESS. Very good.

ChairmanGONZÁLEZ. And we will stand in recess until we get this vote out of the way. Again, to the other witnesses, thank you for your patience. We will be right back.

[Recess.]

ChairmanGONZÁLEZ. The Committee will reconvene. We were going to wait for Mr. Westmoreland, and he is on his way. However, I am going to go ahead and pose a question to Dr. Burgess, our first witness. And I will explain to the other members if they get here, of course, that we are going to limit ourselves to the five-minute rule.

Dr. Burgess, I guess the question, and it is a mystifying formula for doctors, but even more so for Members of Congress. And I am just going to read from the memo that has been provided and prepared by our staff. And this is how confusing it can be to us.

And I guess I want you to sort of explain it, but also the difference of what you are proposing and what you think might be the answer. What does the Sustainable Growth Rate mechanism do? The SGR system sets spending targets for physician services and adjusts payment rates as needed to bring spending back in line with those targets. Which kind of puts you on notice that we are probably going to have problems, right?

The SGR target for total spending is based on spending in an initial or base year and the estimated growth in real per capita GDP each year and three other factors that affect overall spending on physician services: The changes and cost of inputs used to produce physician services such as measured by the Medicare Economic Index, the MEI, the number of Medicare beneficiaries in the traditional fee-for-service program, and expenditures that result from

changes in laws or regulations. The spending target for physician payments is applied by incorporating it into the adjustment to the conversion factor that determines the payment amount per service.

The conversion factor is determined annually by adjusting the previous year's conversion factor by the change in the MEI to account for the cost of inputs for physician services and adjusting this product on the basis of the relationship between the cumulative SGR target and Medicare physician spending. The conversion factor update is greater than the MEI when physician spending has been below the targets and is less than the MEI when the physician spending has been higher.

Does that make sense to you? Do you understand it? And if you do, can you decipher it? But truly, the serious question is whether there a real life application of this to what the physician faces today in their practice?

Mr.BURGESS. You want the theory or the application?

ChairmanGONZÁLEZ. I think application. The practical—you know, theory is good, but the practice is what counts.

Mr.BURGESS. From a perspective of a practicing physician, this formula is fantasy. It is fiction. It is made up.

ChairmanGONZÁLEZ. Is your mike on?

Mr.BURGESS. From the standpoint of the practicing physician, the formula is fantasy, it is fiction, it is made up. We don't understand why how in reality the GDP in this country for the short time that I have been in Congress has actually done pretty well. Heaven help the doctors of the world if we had a couple quarters that we were in recession because it would have hurt worse. From the perspective of someone who spent now the last 5 years as sort of an amateur health policy person, yeah, I spent some time studying the formula and studying the various relationships.

Some things make sense, some things don't. But you got down to it at the end of your discussion about the allocation based upon the conversion factor. And where we really get hurt is with what is called the conversion factor of the prior year times the conversion factor update. The update is then one plus the MEI over a hundred times one plus the UAF. The UAF is the bad actor here. The update adjustment factor makes actual expenditures and target expenditures equal, which I believe you alluded to in the first couple sentences of what you addressed. That is not based on reality. And Medicare has never, ever paid enough to equal what the commercial insurance will pay. They just never have.

And I think—I can't speak to it, because I wasn't here, but I think the philosophy was that if a doctor takes Medicare we will pay them just enough so that they go broke slowly, and they are able to continue in their business for a number of years and provide care for our patients. But the reality is if you construct a practice that is primarily Medicare, even in the heady days of the late 1980s and early 1990s, you were still hard put upon to make that practice go, because nothing in what the economists who figure this stuff and figure out the numbers for relative work values, it is always figured on the cost of delivering care, and it never figures in an amount for what do you pay the physician at the end of the day? There is never an amount in there for the doctor actually

making a salary. So even back in the old days, it was never a formula that was based on reality.

And unfortunately over time, because of the influence of the what we call the update adjustment factor, we compound the problem over time such that this year we face a 10.1 percent cut if we legislatively don't do something. So we will do something. I will predict that we will do something. That something will be we spend $40 billion to prevent that 10 percent cut. But now what happens when I say the cost of repealing the SGR, the CBO scores it at $260 billion over 10 years time, since we added $40 billion to the price tag, the $40 billion doesn't come off the top of the SGR, it is added to the end of the out year.

So the next 10-year moving budgetary window the cost is that much more. And again, as I said in my opening statement, I suspect it will be over $300 billion. And it becomes a hill too far. No one want to take it on. I am not supposed to say this, but in my mind the money has already been spent. You have already paid these fine doctors for the business that they conducted on your behalf.

So the money has already been spent. We just haven't accounted for it on the books. So we just play this little shell game. And year over year, we kind of hold this money off the books because we are going to recoup it from the doctors by and by putting into play the SGR formula. But the reality is the money is not sitting there in the Federal Treasury waiting to go to the doctors. It went to the doctors. They provided the care. They paid their overhead. That money has been spent and is gone.

That is why I would like for us to take the type of long-term strategy that gets us past this point. Because eventually we will be in a hole so deep that we just simply can't do anything about it and we are locked in forever. These guys won't continue to practice. Younger guys will look at it and say, you know, and ladies, will look at it and say that I don't know that it is worth it going into medicine anymore. And we will irreparably harm the profession. And is that bad? I submit that it is, because we are on the cusp of a time when medicine is going to deliver in ways I didn't think possible when I started medical school. We are on the cusp of a transformational change in medicine the likes of which we have never seen.

The era of personalized medicine, the value of cracking the genetic code and the work that has been done on the human genome. Look what happened last Monday Francis Collins got the Medal of Freedom by the President. That was a significant event. And the reason he got that medal was because of his work on breaking the genetic code and because of the promise that genetic medicine is going to play in the future, very personalized medicine. A year ago, when we were having our NIH reauthorization hearing, the doctor from Johns Hopkins, and right now I am blocking out his name, talked about the fact they have decoded the genetic sequence for the 20 genes involved in colon cancer. What a powerful tool to puts in the hands of researchers. We are probably just a few steps away from actually stopping that disease.

ChairmanGONZALEZ. I have exceeded my 5 minutes, and I do need Lynn to—and I know that you are looking to the future, and

I appreciate that. And the question is, you know, the Federal Government has basically invested in health care with the Medicare Act of 1965. And we have to figure out how we are going to deal with it. But I appreciate your response. And at this time I would recognize my colleague, the ranking member, Mr. Westmoreland.

Mr.WESTMORELAND. Thank you, Mr. Chairman. And Congressman Burgess, I know that you talk about the fix, and the Band-Aids that have continually been put on. And I believe there are several bills that have been introduced that do a fix to the SGR, where yours does away with it in some gradual steps. Do you think that there is any way it can be fixed for a short-term, or do you see the only real solution to this as just doing away with the SGR completely?

Mr.BURGESS. Well, I think I said that in my testimony. The ultimate solution is stop the cuts, repeal the SGR. And how we get to that point is really the rest of the argument. I have proposed a fix that is postponed. I did that because simply trying to repeal the SGR in one fell swoop didn't seem to gain a lot of traction. What does gain a lot of traction, and in fact, the doctors and their groups do a good job of educating members of Congress that we have got to do something.

So we get to the end of the year and we play it out every year, just really predictable, sometime between Thanksgiving and New Year's Eve, we will have something delivered to us. I cannot believe going into an election year we are going to allow this to be an unresolved issue. No one wants that. This will be our last—you know, obviously 2008 is the election year, but this is our last chance to do something to protect the physician community in this country before the November '08 elections, because anything that is done next year will obviously be done after election day. So this is our chance to show some resolve to our physician community, to our health care community. And I hope we take that up and do it.

I am not saying we have got the perfect answer. But I think the problem has gotten so large that while it is still fixable it is going to take an approach where you divide it up and you get some now and you get some later. And quite honestly, that was the discomfiture. I know the American Medical Association, the American Academy of Family Practice, the American Association of Physicians had some difficulty with the concept that they were going to go back to their members and say, hey, we are supporting a plan that repeals the SGR, but it doesn't do it for a couple years. That is pretty untenable. You can imagine walking into the House of Delegates at the AMA and having to give that sort of report. That is why I tried to build in some protections for the doctors for the next 2 years. There is the mid-term strategy that we have to employ, because if we drive everyone out of medicine in the next 2 years, it doesn't matter that we have repealed the SGR.

Mr.WESTMORELAND. Well, Congressman, let me ask you this. The SGR, when it was put in place, it was kind of destined to fail anyway, was it not, because it was not indexed for inflation? And anybody that doesn't believe that your cost is going to go up, you know, is not being very realistic. So was the SGR put in as—I hate to say this—but kind of some of the smoke and mirrors we have seen in this Congress as a payfor for the Medicare?

Mr.BURGESS. I don't know. I can't speak to it because I wasn't here. Obviously, I was on the receiving end, and it was a way to control growth. And the other term for controlling growth is a way to ration care. And we would ration it in the treatment room. That way people sitting on the Committee didn't have to ration the care, the people who administer over at CMS didn't have to ration the care, it would be the doctors who would ration the care because after all, in our American healthcare system—

Mr.WESTMORELAND. Did the AMA not see this coming?

Mr.BURGESS. I don't think they have ever endorsed the SGR, not that I recall during my tenure with the AMA. But the reality was in the early years, right after the Balanced Budget Act was passed, and I don't want to put it all on the Balanced Budget Act because I don't remember the three letter acronyms, but there were precursors to the SGR that were essentially the same philosophical trajectory. And this is not a problem that is owned by one party or another. It is a problem that is owned by Congress in general.

Mr.WESTMORELAND. I wasn't here either, but it seems to me like this was some kind of gimmick pay for that has had some unintended consequences when it comes to the health care for the people in this country.

Mr.BURGESS. If I may, it was a reaction to the reality that paying on a fee-for-service basis in Medicare, even though it was vastly less than what other fee-for-service payment models were, it was still Medicare was growing faster than anyone ever thought possible. And I mean we know that from looking at our history books. The number, who would have believed that we would be spending over $300 billion a year on Medicare.

Mr.WESTMORELAND. I understand. But rather than cutting doctors' pay, you know, we have expanded so many of the services and really broadened those people that can get the service. To me that was, you know, not very well thought out.

Mr.BURGESS. It is a disconnect. And I have heard people suggest that maybe congressional pay ought to be run through the SGR formula, and then maybe that would improve our resolve for getting it done.

Mr.WESTMORELAND. Thank you.

ChairmanGONZÁLEZ. I will make sure I tell the other members of Congress, Michael, what you are proposing.

Mr.BURGESS. Take two of those and call me in the morning.

ChairmanGONZÁLEZ. Thank you very much, Dr. Burgess, for your testimony.

Mr.BURGESS. Thank you.

ChairmanGONZÁLEZ. We are going to set up for the next panel. And as we are sitting up I am going to remind the witnesses that they have 5 minutes. And I know that Dr. Burgess went over his 5 minutes, but that was some sort of a professional courtesy, I guess. And again, though, and the reason is I want to get your testimony in before we have the next round of votes and get a couple of questions in. And I would be very curious, and I am sure that Congressman Westmoreland may be curious as to how you view Dr. Burgess's testimony and his suggested solution.

The other thing that I want to explain to the witnesses is that you are before the Small Business Committee of the U.S. House of

Representatives. And you may wonder, you know, how do we play a role? Because we think of you, of course, as practitioners out there as small businesses. And so that our policies impact your ability to conduct business. But you are the last standing profession in the United States also. But you are still a business. The Chairwoman Nydia Velázquez meets every week with the Chairs—and please, if the witnesses will take their places at this time—Nydia Velázquez meets with the Chairs of all other committees once a week, and they have a discussion of shared concerns. That is why your appearance today is very important, because she will be discussing what transpires here today with the chairs of the Committees on Ways and Means and Energy and Commerce. And we all have a shared jurisdiction.

So we will get our voice heard. And we are hoping that through us your voices will be heard. What I am going to do is introduce the witnesses as they testify. So it is my pleasure to welcome Dr. Brad Fedderly. Dr. Fedderly serves on the board of directors of the American Academy of Family Physicians, AAFP. AAFP is the national association representing family doctors, and one of the Nation's largest medical organizations, with more than 94,000 members throughout the United States. Dr. Fedderly practices with the Wheaton Franciscan Medical Group, a full service primary care large group practice in South Milwaukee, Wisconsin. He earned his medical degree from the University of Wisconsin, and completed his residency at the University of Massachusetts family practice residency in Worcester.

STATEMENT OF BRAD FEDDERLY, ON BEHALF OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

ChairmanGONZÁLEZ. At this time I welcome the testimony of Dr. Fedderly. You may proceed, sir.

Dr.FEDDERLY. Chairman González, Representative Westmoreland, and members of the Subcommittee, I am Dr. Brad Fedderly, as you just heard, a member of the board of directors of the AAFP. I am pleased to provide testimony on behalf of nearly 94,000 members who provide medical care for 50 million of your constituents. The Academy commends the Subcommittee for your consistent efforts to ease the burdens of small businesses in this country. Family physicians share the Subcommittee's concerns that the current payment system is inaccurate and outdated. Therefore, AAFP supports the restructuring of Medicare payments to reward care coordination and quality and to prevent expensive and duplicative tests and procedures. About 25 percent of all office visits in the United States are to family physicians, nearly half of whom work in small and medium-sized practices of five physicians or less, small business practices that operate with tight financial margins. Medicare beneficiaries comprise about a quarter of the typical family medicine practice. Therefore, an accurate and more contemporary Medicare physician payment method is key. AAFP appreciates past Congressional action that avoided a 5 percent payment reduction in the Medicare fee schedule for 2007. Nevertheless, reimbursement rates for physician services are lower today than they

were in 2001. Moreover, if Congress does not act in the next 7 weeks, reimbursement for family physicians will decline 10.1 percent in 2008, and 5 percent more in 2009.

In fact, scheduled cuts of nearly 40 percent over the next 9 years will render the operation of small business medical practices unsustainable. From the outset, the Medicare program has based physician payment on a fee-for-service system. This system rewards individual providers for ordering more tests and performing more procedures. This system does not pay physicians to coordinate the patient's care generally, and has resulted in an expensive, fragmented Medicare program.

AAFP recommends that Medicare incorporate a fee for physicians who coordinate the care of Medicare patients. This should be a blended model that combines fee-for-service with a monthly care coordination payment. Such compensation will go to the physician practice chosen by the patient. And any physician practice prepared to provide care coordination should be eligible to serve as a patient's personal medical home. Patients who select a personal medical home should be rewarded with reduced copays and reduced deductibles. This model has already been proven effective. North Carolina has employed the Medical Home model in its Medicaid program, and saved taxpayers more than $231 million in fiscal years 2005 and 2006.

Effective care coordination requires affordable health information technology in the form of an electronic health record in the physician's office. Using HIT also reduces errors and allows for ongoing care assessment and quality improvement in the practice setting, two additional goals of the recent Institute of Medicine reports. But cost continues to be a significant barrier.

AAFP joins the Institute of Medicine in encouraging Federal funding for physicians to install HIT systems, which according to HHS, will save billions. Funding must be directed to the systems that will provide the best return on investment. We, therefore, encourage Congress to consider funding in the form of grants or low interest loans for those small group and solo medical practices committed to integrating health information technology in their practice. In closing, AAFP urges Congress to modernize Medicare by embracing the patient-centered Medical Home model as an integral part of the program and to reform the payment system in the following three ways.

First, enact a 2-year positive update to the payment rate and use the time to develop a replacement for the dysfunctional SGR formula. This new formula must consider and reflect the change in the costs for small business medical practices to provide care.

Second, adopt the patient-centered medical home and give beneficiaries incentives to use this model with reduced copays and deductibles. The physician designated by the patient as the medical home shall receive a monthly payment for the non-face-to-face services associated with care coordination.

And third, provide health information technology grants and low interest loans to solo and small group medical practices that provide a patient-centered medical home to Medicare beneficiaries. AAFP commends the Subcommittee for its commitment to identify a more accurate and contemporary Medicare payment methodology

for physician services, one that recognizes and fosters the important small business model used by thousands of family doctors across America. Thank you for the opportunity to speak today, and I look forward to your questions.

ChairmanGONZÁLEZ. Thank you very much, Dr. Fedderly.

[The prepared statement of Dr. Fedderly may be found in the Appendix on page 40.]

ChairmanGONZÁLEZ. The next witness is Dr. Jeffrey P. Harris. Dr. Harris is the president-elect and former chair of the Board of Governors of the American College of Physicians' American Society of Internal Medicine. The ACP is the Nation's largest medical specialty society. Its membership comprises more than 115,000 internal medicine physicians and medical students. Dr. Harris has practiced internal medicine and nephrology in Winchester, Virginia, since 1977. He is a clinical associate professor at the University Virginia School of Medicine. Thank you very much, Dr. Harris, and you may proceed,

STATEMENT OF JEFFREY HARRIS, M.D., FACP, PRESIDENT-ELECT, AMERICAN COLLEGE OF PHYSICIANS

Dr.HARRIS. Good morning, Mr. Chairman, and members of the Committee. As you have heard, I am Jeff Harris, president-elect of the American College of Physicians. I have been a general internist for 3 decades. As clinical associate professor of medicine at the University of Virginia School of Medicine, I have been involved a bit in community-based teaching for third year medical students. The College is the largest medical subspecialty society in the United States, representing 124,000 internal medicine physicians and student members. Among our members involved with direct patient care after training, approximately 20 percent are in solo practice, and approximately 50 percent are in practices with five or fewer physicians. Until recently, I have practiced in a town in Virginia with a population, as you heard, of about 50,000.

My practice focused on the delivery of primary care and nephrology. We routinely saw overhead expenses which exceeded 60 percent. As a community small business, we discovered firsthand the financial struggles of an uncertain and low Medicare reimbursement and the effect it had on our practice. We greatly appreciate Subcommittee Chairman González for his focus of the attention on the impact of the Medicare's flawed physician reimbursement formula and the effect it has on small and solo practitioners.

These are the practices that are the least able to absorb the uncertainty of annual payment decreases and the below inflationary adjustments Congress has grown accustomed to making. The College offers three points for the Committee to consider. Number one, the College believes that the Medicare payment policies are fundamentally dysfunctional and do not serve the interests of Medicare patients. These policies have an especially negative impact on solo and small practices.

In particular, Medicare payment policies discourage primary care physicians from organizing care processes to achieve optimal results for patients. Research shows that health care, managed and

coordinated by a patient's personal physician, using a system of care centered on the patient's needs can achieve better outcomes for patients and potentially lower the cost by reducing complications and hospitalizations. The American College of Physicians, joined by the American Academy of Family Physicians, the American Osteopathic Physicians, and other physician groups have adopted the concept of care delivery called the patient-centered medical home.

The second point we would make is that the dysfunctional Medicare payment policies have resulted in a dwindling workforce of primary care physicians at a time when the aging population is growing and more Americans are living with chronic diseases. As a community-based teacher for the University of Virginia, I have had the pleasure of teaching third-year medical students in our office setting. These youngsters are uniformly excited about the unique challenges and the opportunities of being a patient's primary care physician. But when it comes to choosing a career path, very few see a future in primary care.

Now medical students are acutely aware that Medicare and other payers undervalue primary care and overvalue subspecialty medicine. With the national average student debt of $150,000, by the time they graduate from medical school, students feel that they have no choice but to go into more specialized fields and practices that are better remunerated. The precipitous decline in young people entering the fields of primary care is occurring at the same time we are witnessing the fact that only 35 percent of the nation's internists, 35 percent of them are over the age of 50, with increasing numbers retiring from practice early due to frustration with practice difficulties like the SGR. Coincident with this declining number of internists, our country has an aging population, with a growing incidence of chronic disease, who will need more primary care physicians to take care of them.

As you know, within 10 years, 150 million Americans will have one or more chronic diseases. And the population over the age of 85 between the years 2000 and 2010 will increase by 50 percent. Our final point is that Congress must take immediate steps to avert the 10.1 percent reduction and work towards eliminating the SGR. It is essential that Congress act this year to avert more SGR cuts. But we urge Congress not to simply enact another temporary fix without moving in a direction of replacing the underlying formula. The so-called Sustainable Growth Rate is simply not sustainable. The College recognizes and appreciates that with the support of this Subcommittee the House passed legislation under the CHAMP Act to reverse this 10.1 percent cut in Medicare payments scheduled to take place January the 1st, and proposed to replace it with a .5 percent increase in 2008 and 2009.

Unfortunately, the future of the legislation remains uncertain. We request the House to work with your Senate colleagues to ensure that the following elements of the CHAMP Act are enacted into law and that these steps will lead to a total repeal of SGR, guarantee at least 2 years of positive updates, pay for the updates in a way that doesn't make the problem worse in the future, and implement expanded pilots of the medical home to facility physician-guided care coordination. In conclusion, the College commends

Chairman González and the members of this Committee for holding this important hearing to shine a spotlight on how the SGR is impacting solo and small physician practices. Medicare patients deserve the best possible medical care, but they also deserve a physician payment system that will help physicians deliver the best possible care. Thank you, and I look forward to answering your questions.

[The prepared statement of Dr. Harris may be found in the Appendix on page 49.]

ChairmanGONZÁLEZ. Thank you very much, Dr. Harris. At this time, for the purpose of the introduction of the next witness, the chair is going to recognize my colleague, Congresswoman Mary Fallin.

Ms.FALLIN. Thank you, Mr. Chairman. And it is a great pleasure to be here today to hear this important testimony. And let me just say thank you to all of our panelists who are providing good information for us to consider on this legislation. I had the opportunity this week to have what is called a tele-town hall meeting in my office and to be able to visit with constituents back in my district. And I was surprised to find that a large portion of my constituents in my district were complaining about the lack of access to doctors because of the Medicare reimbursement rate, and how they were having a hard time finding anyone to take care of them. Now you might expect that to happen in the rural areas, which I do have a couple rural counties in my district, but I was actually talking to constituents in the metropolitan area of Oklahoma City.

So this is a very important topic I know not only for physicians and doctors and hospitals, but also for access to care and quality care for our constituents back in our district. And today I am very pleased to welcome one of our fellow Oklahomans, Dr. Melinda Allen. And she and I had the opportunity to visit earlier this morning about some of the things that she finds in her practices. She is a doctor in internal medicine, and she is also chief of staff of the Ponca City Hospital Medical Center, which has 140 beds in northern Oklahoma. She also serves as the medical director of the Ponca City Nursing Home, and so she coordinates and manages care for over 70 residents of the elderly. She also serves as a Qualified Veterans Physician, contracting with the Veterans Administration. So I think she has well-rounded experience not only with folks out in our community, but our seniors and our veterans. So Doctor, we appreciate you coming today, and I am looking forward to hearing your testimony. Welcome.

STATEMENT OF MELINDA ROTHER ALLEN, D.O. ON BEHALF OF THE AMERICAN OSTEOPATHIC ASSOCIATION

Dr.ALLEN. Thank you, Congresswoman. I think my testimony today will reflect the feelings of Dr. Harris and Dr. Fedderly. Mr. Chairman, Ranking Member Westmoreland and members of the Subcommittee, my name is Melinda Allen. I am an osteopathic internal medicine physician in solo private practice in Ponca City, Oklahoma. I am honored to be here today on behalf of the American Osteopathic Association and the Nation's 61,000 osteopathic

physicians practicing in all specialties and subspecialties of medicine. The AOA and our members appreciate the efforts of this Committee to raise awareness regarding the devastating impact current Medicare reimbursement policies are having upon beneficiary access to care and on physician practices, especially those like mine.

Nowhere do Medicare beneficiaries experience access issues more severely than in rural communities. These communities are often medically underserved, as Congresswoman Fallin had said, and are home to seniors who will enter my practice with multiple conditions due to lack of care. Sadly, many seniors in these areas find the physicians serving in these communities have no room in their practices for new Medicare patients. Upon graduation from medical school, there were multiple opportunities presented to me. Although taking a position with a hospital or in a private practice in a larger city would have allowed much more financial stability, I was determined to return to my roots in rural Oklahoma. A partner and I opened Internal Medicine Associates in Ponca City in June of 2002. We purchased a small building and renovated it for use as a medical practice. But despite our best efforts, my partner could not support his family, manage his medical school debt, and sustain his portion of the practice. Just 18 months after opening our practice, he filed for bankruptcy and left Ponca City, leaving me with a practice and a staff to support. In my first year of practice, Medicare physician payments were cut 5.4 percent. While Congressional actions over the past 5 years to avert additional cuts are greatly appreciated, I operate today at approximately the same level of compensation I received when I opened my practice over 5 years ago. Unlike any other small business, I am forced to comply with regulations that limit my ability to recover overhead through fees. This is an impossible way to sustain any business. As a result, in 2006, I reluctantly curtailed my participation in the Medicare program. But since that time I estimate that I turn away about six to eight Medicare beneficiaries every day that call my office looking for new physicians. However I do accept new Medicare payments through attrition, my patients are getting older, through hospital admissions, and nursing home admissions. I see approximately 5,000 patients, 25 percent of whom are enrolled in Medicare. However, Medicare beneficiary visits total over 40 percent of my daily routine. And I estimate that approximately 60 percent of my time is spent caring for these 25 percent Medicare patients that I have. This not only includes the individual visit for which I am compensated, but also many hours of follow-up and coordination, time for which physicians are not compensated.

I am a small business owner. I own my own building and I employ a staff of six, one of whom really provides services specifically to my Medicare patients. I provide my employees with annual cost of living increases. My office is open for an estimated 235 days per year. This allows for a week of vacation, a week of continuing education, and 10 holidays. And if you notice, there are no sick days. I never get sick. We are not allowed to get sick. Generally, I average 22 to 25 patients per day during a 60-hour work week. My estimated practice costs in 2007 will be approximately $265,000. As evidenced by the chart in my written statement on page five and six, I have a flow chart of costs. If the scheduled Medicare pay-

ments cuts are realized, sustaining my practice, which is comprised of only 25 Medicare and 75 percent private insurance will be impossible. By 2015, I will be operating at a $65,000 annual loss. If I chose to see only Medicare patients over the next 5 years, I would lose $122,000 annually. These numbers indicate the real impact that the Medicare physician payment cuts have on a small business owner. The modest increases in annual operational costs do not include major maintenance or repairs, hiring new staff, investing in health information technology, or any other challenges facing a solo practitioner. Without any real adjustment to the system, many physicians like myself that are called to serve in these rural communities will be unable to do so, compounding existing health disparities, and leading to a true access crisis for my patients. Any future Medicare physician payment formula should provide annual positive updates that reflect increases in practice costs for all physicians participating in the program. Additionally, those of us choosing to participate in pay-for-reporting programs, implement health information technology systems, or provide patient-centered care coordination services should receive bonus payments above the annual payment updates for their participation and investment. I would like to express my gratitude to the Committee for focusing its attention on this often overlooked segment of our nation's small business community. I implore you to take the appropriate steps to ensure that I can continue to serve my patients, and I look forward to answering any questions. Thank you.

[The prepared statement of Dr. Allen may be found in the Appendix on page 58.]

ChairmanGONZÁLEZ. Thank you very much, Dr. Allen. Our next witness is Dr. Kenneth L. Noller. Dr. Noller is testifying here today on behalf the Alliance of Specialty Medicine as well as the American College of Obstetricians and Gynecologists. He is currently the president of the ACOG, which has over 49,000 members, with its members representing over 90 percent of the United States' board-certified OB-GYNs. The Alliance of Specialty Medicine is a coalition of 11 national medical specialty societies, representing more than 200,000 physicians. Dr. Noller is chair of the OB-GYN department, and a professor in the Department of Family and Community Medicine at Tufts University in Boston, and the gynecologist and chief at Tufts New England Medical Center. Welcome Dr. Noller, and you may start your testimony.

STATEMENT OF KENNETH NOLLER, M.D., PRESIDENT, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr.NOLLER. Thank you. Mr. Chairman and members of the Subcommittee, thank you for holding this hearing on the effect on solo and small practitioners of the 10.1 percent Medicare physician payment cut. It is important and appropriate that this Subcommittee consider the impact of the cut on these small businesses. ACOG and the Alliance appreciate the leadership of the House Ways and Means, and the Energy and Commerce Committees in addressing the physician payment cut in the CHAMP Act. We strongly support a 2-year reprieve from payment cuts, and look forward to a perma-

nent solution to this crippling problem. We urge Senate action to end the uncertainty facing small medical practices. These practices remain the backbone of the U.S. health care system, but financial and regulatory burdens are making it hard for these practices to stay open. For example, OB-GYNs in solo practice fell from 34 percent in 1991 to 23 percent today. Often this means that a small community lost its local doctor. Patients must now travel farther to see an OB-GYN, or they may receive no medical care at all. If Congress does not enact a long-term solution soon, physicians serving Medicare patients will see cuts year after year, eventually totaling 40 percent. No small business can remain solvent with such drastic reductions in its revenues, while at the same time office rent, salary increases, medical supplies, medical liability insurance costs all increase. Medicare cut payments in 2002, increased them less than inflation in 2003, 4 and 5, and froze payments in 2006 and 7. Is it any wonder that more and more physicians will no longer see Medicare patients? Under today's flawed formula that determines Medicare physician payments, the payments are tied to gross domestic product instead of the cost of providing medical care.

Physicians are penalized for skyrocketing increases in the costs of in-office prescription drugs, and physicians are required to offer services that are beyond their control. These include such things as new benefits authorized by legislation, increased regulation, new technology, and growing patient demand. The bottom line is that Medicare cuts cause patient access problems and hurt patients throughout the health care system.

Here are four examples: Elderly patients in fee-for-service Medicaid are the first to lose their doctors as physicians are forced to restrict the number of new beneficiaries they can see. Secondly, TRICARE, the health care system for our military families, uses the Medicare fee schedule, thus diminishing access for these families. Thirdly, many private insurers follow Medicare's lead, cutting or freezing physician payments. And lastly, as Medicare and private insurance payments decline, practices often have to make the hard choice to stop caring for patients of their lowest payer, Medicaid, creating access problems for those patients.

Community clinics serving low-income patients have difficulty recruiting physicians, and have to cut back on care. These cuts will be felt by rural areas first. The loss of even one small practice in a rural area means that patients must travel further for routine care, and further still if they need specialty care. And recruiting physicians to rural areas has become very difficult, if not impossible. It is simply too risky for a young physician with 150 or $200,000 in debt to open a practice in these areas. Falling and unpredictable payment rates also make it very difficult for small practices to buy expensive new technology such as HIT, even though such systems can probably improve patient safety.

Dr.NOLLER. A few of us entered medicine to become businessmen, we entered medicine to care for our patients, but no matter your business sense, it is clear the payment cuts of 10 percent in 2008 and a total of 40 percent over the next decade will make it impossible for the private practice of medicine to survive.

As advocates for patients and physicians, ACOG and the Alliance of Specialty Medicine applaud the House for acting to prevent these cuts. We call on the Senate to do the same and very much appreciate your leadership in continuing to highlight this critically important issue. I thank you.

ChairmanGONZÁLEZ. Thank you very much, Doctor.

[The prepared statement of Dr. Noller may be found in the Appendix on page 74.]

ChairmanGONZÁLEZ. I am going to recognize the Ranking Member Mr. Westmoreland for the purpose of introducing the next witness.

Mr.WESTMORELAND. Thank you, Mr. Chairman.

Before I introduce Dr. Whitlow, I want to recognize Tom Spatonik from Georgia also who made the trip up here.

Mr. Chairman, it is my pleasure to introduce my constituent, Dr. John Whitlow, who serves as president of the Georgia Optometric Association. Dr. Whitlow also practices at the West Georgia Vision Center, which he and his wife, Dr. Donna Whitlow, founded in 1993, a true small business, mom-and-pop operation. An active member of his professional association, Dr. Whitlow has held several leadership positions with the Georgia Optometric Association.

In the legislative arena he has worked to promote insurance for quality, and in 2001 received the GOA Legislative Service Award for his efforts. Dr. Whitlow has been a member of the Troup County Chamber of Commerce for 14 years. He has been an effective member of the LaGrange community.

I thank Dr. Whitlow for his willingness to share his thoughts and look forward, as I am sure we all do, in hearing his testimony.

STATEMENT OF JOHN WHITLOW, ON BEHALF OF THE AMERICAN OPTOMETRIC ASSOCIATION

Dr.WHITLOW. Thank you. Good afternoon. Thank you, Ranking Member Westmoreland for those kind words.

As he said, my name is John Whitlow, president of the Georgia Optometric Association and a doctor of optometry from LaGrange, Georgia.

It is an honor to represent the American Optometric Association and its 34,000 doctors this afternoon. We appreciate the opportunity to provide the House Small Business Subcommittee on Regulations, Healthcare and Trade with our views and recommendations concerning the current state of Medicare payments to physicians, especially doctors of optometry and other health care providers.

As a small business owner of a private optometric practice, and, again, as Ranking Member Westmoreland alluded to, truly a small business, most days I am the doctor there; a lot of days I am the office manager; then there are days where I am the plumber; then there are days that I am the electrician; and then there are days that I am even the dish washer. So it is a truly small, small practice.

But it is my pleasure to testify before you today regarding the disheartening effect that Medicare reimbursement is having on efficient and high-quality health care, including the delivery of eye

and vision care that I provide to over 1,200 Medicare patients that I see personally.

The SGR formula currently used to determine Medicare payments is producing dire results for all health care providers, especially those in the small and rural communities. As the primary eye care providers in over 6,500 communities across this Nation, my colleagues and I are very well aware of the many obstacles that health care providers face as they strive to provide care to an ever-increasing number of Medicare patients. Access to quality care is increasingly at risk because of the strains on the current system that threaten the ability of providers to deliver needed care.

We are often the only eye care providers available in the rural communities and underserved areas and, like other providers, are struggling to serve America's children, America's seniors, and America's underserved while keeping pace with the standard of care 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.

The impact of Medicare physician payment cuts affects the entire health care community, including the non-MD/DO community. PARCA, a coalition of organizations representing the interest of millions of patients and clinicians, applauds the efforts put forth by Members of Congress and the congressional staff as they work to address Medicare payment reform. PARCA supports congressional efforts to bring forward legislation that will provide multiyear positive updates to bring stability to the Medicare payment system.

The American Optometric Association in concert with other health care provider organizations asserts that the SGR payment formula has produced disastrous results for both doctors and the patients. None of the factors in the SGR take into account Medicare spending due to technological advances or where utilization has increased because of new Medicare coverage policies and expanding preventive services.

The AOA gratefully acknowledges the recent efforts by Congress to provide some temporary fixes; however, a permanent solution must be found and is needed to resolve a full-blown meltdown of the Medicare system that looms on the horizon. The AOA urges the Subcommittee and Congress to work with the CMS to avert future cuts by enacting a system that produces rational health care provider payments and accurately reflects increases in practice costs. The SGR should be repealed and replaced with a payment update system that reflects these increases in practice costs.

Congress must at the very least first establish some sort of transition, some sort of pathway to allow us to have the complete elimination of the SGR; and second, to stabilize payments in the short term for a minimum of 2 years by providing positive baseline updates to all health care providers consistent with the Medicare Payment Advisory Commission's recommendation. A scheduled cut of 10 percent in 2008 should be replaced with an increase of 1.7.

As a small business owner of a private practice, I, along with the AOA, appreciate the opportunity to provide our views to the Subcommittee on these critical matters. We look forward to working with the Small Business Committee and Congress to pass imme-

diate legislation that preserves access, averts the next 2 years of payment cuts, and provides a positive update that reflects optometric practice costs. Thank you.

ChairmanGONZÁLEZ. Dr. Whitlow, thank you very much.

[The prepared statement of Dr. Whitlow may be found in the Appendix on page 79.]

ChairmanGONZÁLEZ. It is the Chair's intention to get at least one round of questions. The Members will be restricted to 5 minutes. Taking into account the Ranking Member's schedule this afternoon, because I am afraid we will go and vote, he may not be able to make it back or stay very long if we do, I am going to defer to the Ranking Member in allowing him to pose his questions at this time.

Mr.WESTMORELAND. Thank you, Mr. Chairman.

Dr. Harris, you mentioned the CHAMP Act and 5 percent increase in the reimbursement. That was just a temporary fix, though, correct? That did not deal with the real problem of the SGR.

Dr.HARRIS. No. The CHAMP Act, as you know, is a new proposal. What we would much prefer is for the CHAMP Act to avert the cut and impose these positive updates, but even then that it is only for 2 years, and we are back to where we started.

Mr.WESTMORELAND. It would be better in the long run to go ahead and let us get this thing worked out, and suffer whatever we are going to suffer now and fix it. It is like Dr. Burgess said, it will only continue to get more and more expensive the further down the road we get.

Dr.HARRIS. It is. And it is hard to exaggerate the magnitude of the effect of this. It is devastating to small practices.

If I just interject, I am absolutely persuaded that SGR was a major factor in something which I experienced last July. Our practice, 40 years old, imploded. It is over with. We had started—I was a nephrologist/internist with another internist, and we practiced for about three decades. Along the way we added another nephrologist, who eventually, a very bright guy, after about 18 years returned to teaching at Chapel Hill. We went on to add other young internists who were comfortable, but we began encountering these pressures where it was so difficult with a 60 percent overhead.

We brought specialists, consultants in on two occasions who told us exactly the same thing: Our overhead was the best we could do. And our choices were simply leave the hospital earlier in the morning after rounds to get there, stay in the office longer, and make evening rounds later, or see more patients per unit time. And we did that as fast as we could, but it still didn't spare us.

We finally added a young woman, a very bright young woman, from the University of Virginia who joined us. But most medical school classes now are 50 percent women and, like most young people, would like to also start their families. So this young woman knew that, and she knew it would mean working part time. But if you think it is difficult to practice under these circumstances full time, it is terribly difficult part time, and so we lost her. Virginia offered her a part-time job at an outpatient community.

We have since then had a terrible time attracting new young internists now because they can go and become hospitalists, inpatient physicians. It pays 16 percent more. All of this effect makes it terribly difficult at a time when the Nation needs more primary care physicians. And the SGR bears a tremendous responsibility for this current situation.

Mr.WESTMORELAND. Dr. Whitlow, following up on that, in your written testimony you indicate that access to care may be jeopardized by the current Medicare payments, that they don't meet the practice costs. Can you elaborate on that access problem we are going to inherit, and how far down the road do you see this getting to a critical stage if it is not already there?

Dr.WHITLOW. Well, in any private practice, especially when you start looking at being basically a primary care frontline physician, looking at new technology that is coming out, looking at when you have that technology, a lot of times needing to ask staff people to help you with that technology, looking on further down the road with electronic health records that is also looming there, all of these things start adding up into costs that somehow has to be absorbed into the practice. And with that comes your decision whether you can accept payment. When I say accept payment, as far as with an insurance company, and, of course, talking about Medicare, whether Medicare is paying us enough to accept that.

But taking that even a step further, being on the front line, I may have a patient that I see because I am accepting the insurance, but I may need to refer that patient to a secondary or even a tertiary care doctor, and it is getting more difficult to find a doctor to refer the patient to.

One of the examples that keeps running through my mind right at this moment, what is happening with Medicaid right now in the State of Georgia is basically, I think, a precursor to what I see that is happening with Medicare now. They have just constantly cut fees and produced more red tape for doctors to not only accept the patient, but then even filing the claims, more and more red tape so it gets more cumbersome.

To make it short, these doctors are dropping out of the Medicare system. So I may have a patient that needs care, and it is getting extremely difficult to find the doctor to refer that patient to, and especially somebody that is fairly local, without a patient driving 50, 60, 70 miles to have to do that, because, again, when you start talking about Medicare, we are speaking mostly about the elderly patients of our Nation.

Mr.WESTMORELAND. Yes, sir.

Let me just ask, if I could, a quick question. I know Dr. Allen mentioned that she has limited her Medicare patients. In your practices, do you limit your Medicare patients, and if you do, what percentage would that be?

Dr.FEDDERLY. I currently do not limit my Medicare patients in my practice.

Dr.HARRIS. Since beginning this role with American College, I have slowed down appreciably in the last year, but my former partners, I believe they do limit it. I don't know the percentage.

Dr.NOLLER. We do not limit it at this time.

Dr.WHITLOW. Not yet.

Mr.WESTMORELAND. Okay. Thank you very much.

ChairmanGONZÁLEZ. You noticed that the bells have gone, and we have another vote. We are within 5 minutes, but what I would like to do, because I am not real sure about other Members' schedules—m definitely coming back, so I will again ask for your patience and indulgence because I have some questions.

Congresswoman Fallin, if you would like to pose your question, just if you have something that you feel we need to put out there? Even if we can't take the complete response, I want to give you that opportunity.

Ms.FALLIN. Thank you, Mr. Chairman.

As I mentioned, I had the opportunity to visit with Dr. Allen beforehand, and one of the things I was concerned about that she expressed to me was the time with the rules, the regulations, the systems, the expenses that doctors have to buy to try to manage their practice, and their access to care, and their quality of care for their patients. But she told me that she receives about 60 phone calls by noon a day from various patients trying to just talk about an illness, or schedule an appointment, or calling in about a prescription, just the amount of time.

We were talking about how if that was an attorney, that if she talked to them for 5 minutes, she would be paying probably 150 or $200 an hour. But the doctors don't get paid for their phone call time.

We talk about access to care and being able to see lower-paid patients. It is hard for the doctors, it seems, to be able to make the income that they need to make while they are investing in the intellectual properties that they need to have for their practices. So we were visiting about a nationwide system to where they could share information about their patients and their records.

So I guess my comments are I hope we can continue to work on this issue and see what we can do to help create better access to care.

Dr.ALLEN. And as a comment, we have been looking at adding electronic medical records to systems to our office. There are 400 systems out there. How do I know that the one that I pick will be the one that is chosen several years down?

ChairmanGONZÁLEZ. Dr. Allen, we will be able to enlighten you on that, because we do have something. We will stand in recess so I make sure I don't have my colleagues missing votes, and I shall return. If they can make it back, they will be back, and we may be joined by other Members, but we definitely will resume. We stand in recess.

[Recess.]

ChairmanGONZÁLEZ. Thank you very much. We will reconvene the hearing. Obviously I want to get more than 5 minutes, so I appreciate it very much.

First of all, I need to express the regrets of Congressman Westmoreland. He has to be at another hearing. The hearing that he will be attending deals with the drought, and I think, Dr. Whitlow, you know exactly the circumstances there and why he is needed at that hearing.

I am going to start off with general observations. As Republicans, Democrats, we all try to come up with some answer to this. The

bottom line will always be how we pay for it, and there will be a disagreement on how we pay for things. But I think everyone acknowledges a few things; maybe we can all agree on something. It will cost more in all probability, but if we do it right, we can save money down the road and make up for some of that cost, and I am going to touch on that. But it is interesting if we could agree on some things.

I am going to request this, and I say this to all my doctors and to all the specialists in the group, and I see some of the representatives out there, is for the medical profession to try to get on the same page on the overall approach. Dr. Burgess's approach, obviously you wouldn't really have a replacement of the SGR for a period of 2 years. Well, believe it or not, I heard from a lot of doctors and a couple of associations that it was not sufficient or adequate. They wanted an immediate fix. So we need to make a determination, one, do we bridge or transition into it? Some of you have already indicated we probably should, and maybe have 2 years as we go into it with some predictability so that you know you will be reimbursed, and it keeps up with inflation and so on.

The next thing I think we should all agree on is if we index reimbursement rates, they have to reflect the increased cost of providing the service, which SGR is pretty blind to. That is fundamental, so that is one thing.

What we replace it with is probably more difficult, but I think we are getting into some areas where maybe we can reach greater agreement on this, too, and that is managing disease. I know that it has been approached, and I want to make sure that I get the exact description of it, and that is how you have a center of care or a health care home, more or less, which is very important, and which will be accommodated, and then we get into the next issue of health information technology.

I will ask Dr. Fedderly and Dr. Harris, when you describe this to me, it sounds like managing disease, making sure you keep track of the patient and so on. So there's a lot of prevention. And if I had my notes a little more clearly, I could tell you exactly how each of you described it, but I think both of you may have used a centered or home, to that effect. Is that akin to what Secretary Leavitt has been talking about in the way of pay for performance? And how does it fit in to what has been proposed, this pay for performance?

I will start with Dr. Fedderly.

Dr.FEDDERLY. Thank you.

It is part of that. Pay for performance is part of the patient-centered medical home, and the idea is that if the care is more efficient and better provided, and if people are kept healthier, then that is a better performance marker, so there is compensation in the form of better performance and for better quality of care provided to our patients.

The patient-centered medical home idea is that a patient will have a central location or one place, first call shopping, if you will, to know where to go to deal with particular issues. So it is not only a preventive health care mechanism, but if a person feels ill, she or he knows where to go to obtain their medical care. And if the

physicians in their medical home can't provide that care, then they certainly know where that care will be best obtained.

ChairmanGONZÁLEZ. Dr. Harris?

Dr.HARRIS. I think the key phrase is patient—

ChairmanGONZÁLEZ. I am sorry, go ahead.

Dr.HARRIS. The key phrase is ″patient-centered.″ When you ask patients what they want, they obviously want access to a physician. Two, they would like someone who knows them well and longitudinally over a period of years, if not decades. And they want to be able to access them easily, perhaps by phone or e-mail in addition to office visits. This patient-centered medical home is built around that.

The notion is that the physician also accepts responsibility for helping patients navigate a very complex health care system, whether it is getting them to a subspecialist or helping them communicate between what happens in and out of hospitals or to and from nursing homes. It is all united by a health information technology so there is a smooth connection, and everyone knows what is going on in that patient's medical life, and it is done appropriately, but all while treating preventive care, acute and chronic care and end-of-life care.

We believe that there are a number of payment mechanisms that will make it happen, one of which is pay for performance. The college believes that paying for quality, tracking quality is a healthy thing to do, beginning with pay for reporting, but ultimately with pay for performance.

We believe that there are three other pieces, though, that go with pay for performance. One is a fee for helping overcome this enormous cost of the health information technology, about 30- to $50,000 per doctor. Two is a fee for coordinating the care, when you are managing all the people that it is going to take to make this work successfully. And lastly is the traditional fee-for-service system.

ChairmanGONZÁLEZ. Doctor, to all of you in a minute I am going to ask you the question in your practice—and some of you may have responded already, but I want to take a roll on it—if you utilized health information technology. And I know electronic health records, on the Hill we call it HIT, and there are proposals out there. Obviously Dr. Gingrey and I have introduced a piece of legislation that would assist the physicians, and it will be the small practices by way of the tax treatment, of course, but that will not be enough, so we go into grants, but that would be limited. So we go into loans, which obviously would be subsidized, which would be of some assistance, but also has a Medicare payment aspect to it where you are rewarded, in essence, for it. So we will see where that goes. We are attempting to do that.

My concern is, of course, it may be easier for larger entities to do this, such as the HMOs and so on. I am just real concerned about the small business application, and not to leave you out of that equation, because I think in the future it would put you at a real disadvantage.

I will just go down the road and just ask do you utilize health information technology, electronic health records? Dr. Fedderly.

Dr.FEDDERLY. Yes, we use electronic technology. And your comments are right on target in terms of the need for small businesses to be able to afford this, because it is fairly certain that large businesses can afford it and can have the staff and infrastructure to keep it up and running, but it is the small businesses that are going to have the greatest deal of difficulty handling this. So that would be a very good key to your suggestion.

ChairmanGONZÁLEZ. Dr. Harris, do you utilize it?

Dr.HARRIS. As I mentioned before, in the last year I have been involved with a college almost full time, but, yes, the individuals with whom I—they are subsequently involved in other practices, but they are all converting to an electronic medical record. It is terribly expensive and a steep learning curve.

ChairmanGONZÁLEZ. Dr. Allen.

Dr.ALLEN. Yes, I am familiar with them at the hospital. I use the CPR system that the Veterans Administration gives, but I do not have a system in place in my office for my patients, and the reason is simply because there are 400 systems out there. How do I know that the one that I pick won't be the DOS that is now outdated 5 years from now? How do I know that the system I pick will coordinate with my pharmacies and my hospital?

It doesn't do any good for each one of us to have a different system that doesn't talk to each other. We definitely need some forward movement on this, especially from Congress, at helping us select a system, helping a system come to the forefront so that when we make that investment, that investment is sound and will be with us 10 or 20 years from now, and then my patients will also benefit from one system. Again, it doesn't help if the cardiologist across town does not coordinate with my system, or my pharmacy doesn't, or my hospital doesn't.

ChairmanGONZÁLEZ. There is some good news. I believe it is good news.

Dr. Noller.

Dr.NOLLER. Yes. Our biggest concern is the same as Dr. Allen, is that the system that we have now are going to be not the one that is chosen nationally, not the one that is going to interface with others. In the city of Boston, there must be 100 different systems, and when a patient moves from one doctor's office to another, that electronic record won't fit in that computer. So even if she takes the disk with her, it doesn't work in the other system. So coordination is a big one.

ChairmanGONZÁLEZ. And Dr. Whitlow.

Dr.WHITLOW. We are presently looking at it. We do not use it now for some of the reasons that have been mentioned as far as waiting to see what is coming on the horizon as far as which one could we choose. The other has been the cost issue.

The other issue is going back to the learning curve that Dr. Harris referred to. A lot of the practitioners that are on my level are saying that they have to decrease the number of patients that they are seeing per day in order to get the records entered properly; either that, or you are going to have to hire more staff. It is not only the start-up cost, but getting the whole process going.

ChairmanGONZÁLEZ. The news is, of course, as we try to introduce a system where we assist you—and that is going to be the

carrot, of course, because there will probably be a penalty if you don't down the road. I really believe that is going to happen. So I think the medical profession needs to be prepared. We owe you a responsibility, Dr. Allen and others, to make sure whatever you utilize will obviously not be outmoded or outdated and so on.

So there will be conditions. There will be criteria. We have someone at HHS who is putting it all together, but definitely there will be a certification process, and so that we do have interoperability and so on. We will not leave you hanging out there with old systems, because it is going to cost the Federal Government money then.

We are hoping that by assisting you, how does this all play in? Well, you know, we get back to the SGR, and it will be part of whatever we replace it with is going to have, in my opinion, HIT components. So we need to be ready for that, and with good reason. You need to survive in the modern world and the competition that awaits anybody who doesn't make that particular transition.

The other thing that I wish the medical profession would just get out there and somehow help Congress with the news that we have to find streams of revenue to finance some of this.

Dr. Harris, I think you probably mentioned the CHAMP Act more than anybody else, but, you know, we were paying for that out of the House with a decreasing payment to the Medicare Advantage. We just met a firestorm, decrease in payments on some imaging from the radiologists. And, of course, just tax on cigarettes, we are still running into problems with that. And that is all we are doing now is a reduced package financed by cigarette tax. But we have the administration that now is coming up and saying that is a tax increase, and we will not approve a tax increase. We could have a veto of the SCHIP bill, which no longer has the 10 percent reduction fix or any of that.

But you really do have to let your Member of Congress know that you understand that it will not be free, and we have to pay for it somehow. All the choices are bad, but some are worse than others. And so the cigarette tax seemed like the least doing harm to the greatest number of American citizens and taxpayers. Of course, Medicare Advantage didn't appreciate it much, but I think there was some room for improvement on the payment that we made to them to deliver their particular service.

The last question I will leave you with before we adjourn and conclude the hearing, we hear that doctors are taking fewer Medicare patients, some are not, but we have conflicting news or reports. On one hand, I know I have constituents who are saying they are making those 30 phone calls, trying to find someone to take them. That is the reality. And yet we have studies that show that accessibility by Medicare beneficiaries to physicians is not really being impacted, and that there is still sufficient, maybe even an increasing number of physicians available to Medicare recipients. So we are getting kind of cross messages. I am not sure. Maybe it depends where you live. If it is a metropolitan area or a rural area, it may be that takes care of some of the figures. But if you all have any opinions as to why we are getting conflicting messages on the availability of physicians.

The last observation I have is, Dr. Allen, you pointed out something so important. You did reduce your patient load of Medicare beneficiaries. You still accepted those that come through your church or other referrals, but they still represented more than 40 percent of your practice, of your time that you spend, and that should be an easy conclusion to reach because it is an older population. But I don't think we really think of that. We may say, this is your percentage of Medicare patients, but it is an inordinate amount of time and service that you are providing them. So I thank you very much for bringing it up.

The last question, though, is the conflicting messages that we are getting. Is there any explanation, in your opinion, whether we really are suffering a decrease in the number of doctors treating the Medicare patients? And we will just go in order.

Dr.FEDDERLY. The reason you are getting a conflicting message is because it is by virtue of what we do as physicians. We have trouble saying no, and we—oftentimes by the time you are forced, like Dr. Allen is forced, to restrict her Medicare patient load, you are often far beyond the desperate measure.

I think that the best description is that especially as primary care physicians, we feel like we are hamsters on the wheel, and we are making the wheel go faster and faster and faster to try to accommodate everybody. Where this system will break down is in the quality of care that is provided, so that if I see 25 patients in a day, but in turn I am accepting more Medicare patients, then I am going to try to squeeze in 30, 32, 34 and think about how the individual Medicare beneficiaries then are going to get less of my face, less of my time, less of my ability to coordinate the multiple issues they have.

Now, if I have more of my practice in healthy young people that don't require a lot of care and a lot of coordination, sometimes you can make that happen. But as the baby boomer population is aging and hitting Medicare age, there are more and more of them out there, and there is fewer and fewer doctors, yet there's not that many doctors who are willing to say no. We are just doing our best to try to make the wheel spin.

ChairmanGONZÁLEZ. I always say you are the last standing profession in the United States.

I am going to apologize to the remaining witness. That question is out there for your response. Julie Hart, to my left, is my medical issues individual, if you could provide her with that information as to the conflict. I think it is very important; quantity versus quality is so important. At this time, and again with my apologies, I cannot miss this vote.

I ask unanimous consent that the members of the Committee have 5 legislative days to enter statements and supporting materials into the record, and, without objection, it is so ordered.

ChairmanGONZÁLEZ. This hearing at this time is adjourned. Thank you very much.

[Whereupon, at 1:40 p.m., the Subcommittee was adjourned.]

STATEMENT
of the
Honorable Charles Gonzalez, Chair
Subcommittee on Regulation, Health Care and Trade of the
House Committee on Small Business
Hearing on the
"Medicare's Reimbursement Cuts: The Potential Impact on Solo and Small Group Practitioners and the Businesses they Run""

I now call this hearing to order on "Medicare's Reimbursement Cuts: The Potential Impact on Solo and Small Group Practitioners and the Businesses they Run. "

The practice of medicine is changing. With the rise in managed care, increased insurance consolidation, and growing paperwork, small health care providers face many challenges. Complicating matters is that the physician graduate of today faces a much different business environment than in the past.

Today's hearing will address one of the next great challenges that could affect the small medical practice. In 2008, Medicare is scheduled to cut physician payment rates by 10 percent. These reductions will continue annually, and it is predicted that the total cuts will be about 40 percent by 2016. That could have a devastating impact on the operation of small medical practices.

The potential impact of these cuts must be considered in light of the fact that these medical practices function like any other small business and face low profit margins. Physicians are responsible for expenses like rent, payroll, employee health insurance and malpractice insurance. Beyond the Medicare cuts, these general business costs are expected to increase 20 percent in the next nine years.

Some may find the link between medicine and money objectionable, but the truth is that the current business model for the practice of medicine is not sustainable. At a time when more and more baby boomers are approaching the age of 65, some physicians have simply stopped accepting Medicare patients. Already, some practices lose money every time a Medicare patient is seen.

The problem of access to care will only grow if the Medicare cuts are not stopped. Some seniors are already faced with calling 20 to 30 providers in the desperate hope that someone will accept Medicare.

According to a recent survey by the American Medical Association, 60 percent reported that they would have to limit the number of new Medicare patients they treat due to next year's cut. Half would reduce their staff. Fourteen percent would "completely get out of patient care." That means these cuts in physician payments will affect everyone not just Medicare patients.

It is unlikely that the primary care shortage will improve in the near future, as Medicare reimbursement rates continue to be a primary driver of physician salary. Medical students, already burdened with an average debt in excess of $100,000, are clearly gravitating towards specialties.

According to **Center for Studying Health System Change**, incomes of primary care physicians fared amongst the worst in keeping pace with inflation between 1995 and 2003, while medical specialists fared the best. The report concludes that with "the diverging income trends between these specialties and primary care, the result is likely to be an imbalance in the physician workforce and perhaps a future shortage of primary care physicians."

The facts are clear. Medicare reimbursement cuts are a barrier to the successful operation of solo and small group practice. For many small practices, Medicare is the single most important source of revenue and is often used to extend or supplement charitable care to the uninsured and underinsured. Cutting Medicare's low reimbursement rates would result in many practitioners denying or limiting access to charitable care.

Medicare is an important component in America's health care system. It provides source revenue for physicians to invest in capital projects like Health IT, computers, and expand to offer necessary tests like mammography services, and other preventative screenings. It also enables small practices, particularly in rural and underserved communities, to extend the scope of their charitable services. Without it many of our nation's most vulnerable populations would receive no care.

The question is how we can reform the system to keep the small medical practice viable. There must be careful consideration to how those rates are developed and their impact on small practices. The panel before us today knows firsthand these challenges. Unfortunately, they may be put in a situation where they must deny access to care in order to keep their business running.

I would now yield to Ranking Member Westmoreland for an opening statement.

Opening Statement of
Ranking Member Lynn A. Westmoreland
Committee on Small Business
Subcommittee on Regulation, Healthcare, and Trade

"Medicare Physician Fee Schedule's Sustainable Growth Rate (SGR)"

Thursday, November 8, 2007

Thank you, Mr. Chairman, for holding this hearing today. I would also like to thank all of the witnesses for their participation. I am sure that today's testimony will prove to be very helpful.

Medicare's Physician Payment program is an issue of great concern, not only in my district, but all over the country. Mr. Chairman, I know that you and I agree that the Sustainable Growth Rate (SGR) specifically, is a system that needs to be examined carefully.

With an issue as complex as this, I think it is important to lay out the facts. We know that the SGR system was designed to respond to concerns that the fee schedule would not adequately control overall increases in physicians' services. Also, we know that the SGR is a formulated target for cumulative spending.

Unfortunately, we also know that in the past few years, expenditures have been significantly above the formula's target, causing cuts to physician payments. Congress has attempted to treat symptoms, by placing legislative Band-Aids on the problem and overriding the reductions. However, we have yet to fully treat the illness, and I believe that our work here today is a step towards that goal.

It is important that we have an honest and frank discussion about the situation that we now face. There is a growing, and in my opinion, real concern that physicians may be unable to absorb continued payment cuts. I know that the fallout of such a scenario is something that we all want to avoid.

I welcome this distinguished panel, and thank you all for your willingness to testify.

Statement of The Honorable Jason Altmire
House Committee on Small Business Hearing
"Medicare Reimbursement Cuts: The Potential Impact
on Solo and Small Group Medical Practices"
November 8, 2007

Thank you, Chairman Gonzalez, for calling today's hearing to discuss Medicare reimbursement cuts and the potential impact they will have on solo and small group medical practices. Small medical practices face their fair share of challenges, from insurance provider consolidation to cuts in physician payment rates. The 10 percent physician payment cut scheduled to occur in 2008 will only complicate matters for our nation's small medical practices that already see low profits. If these scheduled cuts go into effect, I worry about the future availability of health care services. These cuts will force small medical practices to accept fewer Medicare patients, reduce the size of their staff and potentially face the tough choice of closing their doors for good.

One of the primary concerns I have with these scheduled cuts is the impact they will have on TRICARE, a comprehensive system of health care benefits for retired military over the age of 65. While TRICARE has proven to be successful, the scheduled cuts have prompted some small practices to stop accepting TRICARE patients. As our veteran population increases, this is not the time to cut the men and women that have honorably served our country out of the health care system.

No one can dispute the important role Medicare plays in servicing the needs of our vulnerable populations, including our nation's veterans. We must takes steps to ensure that the necessary reforms are made to the Medicare system without negatively impacting the operations of small medical practices.

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

# # #

November 8, 2007

Congressman Bruce Braley Opening Statement
House Small Business Subcommittee on Regulations, Health Care and Trade

Hearing on "Medicare Reimbursement Cuts: The Potential Impact on Solo and Small Group Medical Practices"

Thank you Chairman Gonzalez, and thank you for holding this hearing. Cuts to Medicare reimbursements are a very serious issue, and I am glad you are holding this hearing to examine the impact of those cuts on small group practitioners.

I am committed to fighting the proposed 10% cut to physician reimbursements and working to replace the Sustainable Growth Rate (SGR) formula. This proposed cut is one more piece of evidence that the SGR formula is seriously flawed.

The amount of current Medicare physician payments are essentially the same as they were in 2001, despite inflation and significant increases in the cost of practicing medicine. Over the next eight years, these payments are slated to be cut about 40 percent while practice costs increase nearly 20 percent. Of all of these long-term problems, the most immediate problem is the estimated 10 percent cut to physician payments in 2008. Physicians in Iowa and across the nation are asking Congress prevent the cut and update payments in 2008 for physician services. These same physicians have long called for replacing this broken payment formula with one that is actually based on practice costs.

I have asked the leadership of this body to address the proposed 10 percent cut, and I have been glad to see a certain amount of progress in the House. In August, I supported H.R. 3162, the *Children's Health and Medicare Protection (CHAMP) Act of 2007,* which passed the House by a vote of 225 to 204. The CHAMP Act, in addition to expanding health care for low-income children, would have eliminated the proposed 10 percent cut to Medicare reimbursements in 2008, and instead provide a 0.5 percent increase in 2008 and 2009 for physician payment rates. This measure also 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 fix to the 10 percent cut was lost along the way, as the Senate was obliged to make compromises with the White House. As we all know, the fix to the 10 percent cut, and the expansion of children's health care in the CHAMP Act, both remain unresolved.

The hugely negative impact of this proposed cut to physician reimbursement rates is only compounded when it comes to Iowa doctors. This is because Iowa is already short-changed in the reimbursement formula, due to another flawed piece of the puzzle: the Geographic Practice Cost Indexes, or GPCIs. These antiquated figures ensure that some parts of the country receive drastically lower Medicare reimbursement rates than other parts, and have led to a tremendous shortage of doctors in certain parts of the country.

In an attempt to achieve some leveling of the geographic inequity of physician reimbursement, the Medicare Modernization Act of 2003 (MMA) established a temporary floor of 1.00 to the Work GPCI, which helps level the playing field for physicians in Iowa and other rural states. Set to expire December 31, 2006, the Tax Relief & Healthcare Act of 2006 extended this floor to year-end 2007. So here we are again: another temporary fix to the flawed Medicare reimbursement formula that is about to expire. Again, the CHAMP Act included a 2-year extension of the Work GPCI floor, but, as I mentioned, a White House veto threat caused this fix to be moved off the table. The end-of-this-year expiration of the Work GPCI floor looms heavily for Iowa doctors, compounded with the end-of-this-year 10 percent cut. Despite the well-documented efficiency 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 an effort to create a long-term 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 to help retain our doctors, recruit new doctors, and improve patient access to quality healthcare. It would do so by instituting 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 resulted in a companion bill in the Senate. It is supported by the state medical associations in 25 states, including the Iowa Medical Society. The will of the people is clear on this issue – 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, Mr. Chairman, for considering this important issue, and thank you to the witnesses for coming in today.

Congressman Michael C. Burgess, M.D.
Subcommittee on Regulation, Health Care and Trade Hearing
"Medicare's Reimbursement Cuts: The Potential Impact on Solo and Small Group Practitioners and the Businesses they Run"
November 8, 2007

First, let me thank Chairman Gonzalez and Ranking Member Westmoreland for extending an invitation for me to be here today and talk about this important issue. This is a critical issue and I am happy that this subcommittee has taken the time to highlight it so that we as decision-makers can gain a greater understanding of this serious issue that faces medicine.

For most of us that have spent some time around here, addressing Medicare physician payment has become somewhat of an annual rite. Congress usually acts, but the problem typically gets worse. In fact, this issue was one of the factors that led me to run for the House in 2002. Not satisfied with some of the solutions proposed in the past, during the 109th Congress I introduced H.R. 5866. This bill represented a long-term solution to declining Medicare physician payment and would have stabilized the Medicare physician workforce for now and in the future. Unfortunately, it would have been extremely expensive. But that is one thing I have learned after working on this issue over the last few years and a fact that is unavoidable—any long-term solution will be expensive and it is becoming a fact as well that any short-term solution will be expensive, and maybe impossibly so.

In December 2006, I and my staff began to reframe the problem that the Sustainable Growth Rate imposes on physicians participating in Medicare

and determine how we can move from a solution that is largely transactional in nature to one that is transformational and one that prioritizes value in the doctor-patient relationship. After numerous informal conversations with organized medicine, and I appreciate the cooperation of staff from the American Medical Association, American College of Surgeons, and the American Osteopathic Association, I developed a set of principles that would inform legislation that I would eventually introduce. I believe that these principles are transformational in nature and will help this House avoid solutions that are merely transactional. They are as follows:

1. The Sustainable Growth Rate has proven to be insufficient to meet the cost of physicians or even a methodology that the political class deems sufficient—SGR must be eliminated.
2. Medicare reimbursement must fairly compensate physicians to provide services under the Medicare program.
3. Any new Medicare payment system must be able to adjust for growth in services, but also be agile enough to determine what constitutes appropriate growth in service volume and when growth results in better patient outcomes.
4. Any future cost containment device must be de-linked to trends in the economy that are external to medicine.
5. Quality reporting should encompass a variety of options for physicians with standards on information that can be gathered and how to aggregate the data.
6. Quality reporting systems that are more outcomes focused should be weighted for patient compliance and the Secretary should monitor whether

quality reporting systems exacerbate health care disparities or close gaps in care.

7. Implementation of HIT should be rewarded by Medicare as it will help diminish inefficiencies in the system.

Based upon that set of principles I introduced H.R. 2585. In brief, this bill will eliminate the SGR in 2 years. It would rely on the Medicare Economic Index, a much fairer and market based methodology, to calculate Medicare reimbursement to physicians. It would provide payment incentives for the adoption of Health Information Technology and quality reporting. H.R. 2585 would improve transparency in Medicare billing so physicians can truly understand what their Medicare spending is each year, and gives beneficiaries similar information.

Now, just a little bit less than 2 years ago, Alan Greenspan, as one of his last trips around the Capitol, came and talked to a group of members one morning. And a question was posed to him: What do you think about Medicare? Are we ever going to be able to pay for the unfunded liability of Medicare in the future? And he stopped and thought for a moment and said, "Yes, I think when the time comes Congress will make the hard choices, make the hard decisions, and, indeed, we will be able to salvage and pay for the Medicare system." And he paused for a moment and then went on to say, "But what concerns me more is, will there be anyone there to deliver the services when you require them?"

Finding a solution to the SGR problem is a key component to creating the right incentives to grow the physician workforce. It is a key factor to encouraging mature physicians to keep their practice doors open.

You can't deliver value to the doctor-patient interaction if you don't have a doctor there to interact with the patient. The current Medicare system of pricing is one that is not based on any sort of reality. And over the next 10 years time, the budgetary projection is for physician payment rates for Medicare patients to be reduced on the order of 30-38 percent. That's untenable. No doctor can continue to practice; they can't even plan for their practice. They can't plan for hiring; they can't plan for the purchase of new equipment all of the time they're laboring under that type of restriction. We need to reform the system now, or preside over its demise.

I am happy to take questions from Members and again I thank the chairman and the ranking member for their indulgence.

STATEMENT of the American Academy of Family Physicians

Submitted

Before The

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

Concerning

Medicare Reimbursement Cuts: The Potential Impact on Solo and Small Group Medical Practices

Presented By

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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 your invitation to participate in this hearing. The Academy commends the committee for your persistent and successful efforts to ease the burdens of small businesses in this country.

A large percentage of family physicians work in small and medium sized practices of four physicians or fewer. Our practices are typical of small businesses that operate with very tight financial margins. As family physicians, nearly half of our patients are Medicare beneficiaries, on Medicaid, 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, our 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 reward quality 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 beneficiaries can coordinate their 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 Academy, therefore, is committed to involvement in the design of a new payment system that meets the needs of patients and physicians.

While the AAFP appreciates the Committee's action that avoided a 5-percent payment reduction in the Medicare Physician Fee Schedule for this year, the fact that current Medicare reimbursement rates for physician services is less than it was in 2001 underscores the urgency of correcting this problem for this all-important health program for our nation's seniors.

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, at best, discouraging. In the current environment, physicians know that, without Congressional action now, they face Medicare payment cuts of 10-percent and subsequent annual cuts in the range of 5-8 percent for the foreseeable future (nearly 40 percent over the next nine years) while their practice costs continue to increase. Clearly, the Sustainable Growth Rate (SGR) formula belies its name and simply is not sustainable.

Primary Care Physicians in the U.S.
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 those in other developed countries, Americans spend the highest amount per capita on healthcare but have 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. Two 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, we waste resources and forego significant quality improvement to the system of health care.

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. 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.

To correct these inverted incentives, the American Academy of Family Physicians recommends that beginning in 2008, 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 "personal 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, have been working with the National Committee on Quality Assurance (NCQA) to develop a certification program for those physician practices that want to be recognized as a "patient-centered medical home." We would recommend that once this process is completed, the Congress might want to consider requiring third party certification by NCQA or another non-profit third party before a patient can designate a practice as his or her medical home. By requiring this certification, the federal government can be assured that the physician practice will have met rigorous standards of 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, headed 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 us to work smarter, raise the quality of health care for the patient while at the same time making it cheaper for the purchaser.

The model has been the subject of discussions between the primary care physician organizations and IBM in Austin, Texas, 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.

Payment of the care management fee for the medical home would reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management, 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.*

Another IOM report released in autumn of 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 reward care that is patient-centered and efficient and reward providers who improve performance as well as those who achieve high performance.
- Providers should be offered (adequate) incentives to report performance measures.
- Because electronic health information technology will increase the probability of a successful pay-for-performance program, the Secretary should explore ways to assist providers in implementing electronic data collection and reporting to strengthen the use of consistent performance measures.

Aligning the incentives requires collecting and reporting data through the use of meaningful quality measures. AAFP supports collecting and reporting quality measures and has demonstrated leadership in the physician community in the development of

such measures. It is the Academy'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 we do not change the Medicare payment system, 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.

The AAFP advocates for a new Medicare physician payment system that embraces the following:

- Adoption of the Medical Home model which would provide a per month care management fee for physicians whom beneficiaries designate as their Patient-centered Medical Home;
- Continued use of the resource-based relative value scale (RBRVS) using a conversion factor(s) updated annually by the Medicare Economic Index (MEI). and providing no geographic adjustment in Medicare allowances except as it relates to identified shortage areas.

Information Technology in the Family Medicine Office Setting
An effective 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 (IHA) 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.

In an HHS-supported EHR Pilot Project conducted by the AAFP, we learned that practices with a well-defined implementation plan and analysis of workflow and processes had greater success in implementing an EHR. CHiT used this information to develop a practice assessment tool on its Web site, allowing physicians to assess their readiness for EHRs.

In any discussion of increasing utilization of an EHR system, there are a number of barriers, and cost is a top concern for family physicians. The AAFP has worked aggressively with the vendor community through our Partners for Patients Program to lower the prices of appropriate information technology. The AAFP's Executive Vice President serves on the American Health Information Community (AHIC), which is working to increase confidence in these systems by developing recommendations on interoperability. The AAFP sponsored the development of the Continuity of Care Record (CCR) standard, now successfully balloted through the American Society for Testing and Materials (ASTM). We 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. In preparation for greater adoption of EHR systems, every family medicine residency will implement EHRs by the end of this year.

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 & Human Services, billions of dollars will be saved each year with the wide-spread adoption of HIT systems. While the federal government has already made a financial commitment to this technology, the funding, unfortunately, is not directed to the systems that will truly have the most impact and where ultimately all health care is practiced - at the individual patient level. We encourage you to include funding in the form of grants, low interest loans or tax credits for those physicians committed to integrating an HIT system in their practice.

Conclusion
It is time to modernize Medicare by recognizing the importance of, and 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-member, per-month stipend in addition to payment under the fee schedule for services delivered.

- When appropriate, phase in value-based purchasing by starting with 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.

The Academy 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.

Statement For the Record
of the
Hearing of the
House Small Business Committee
Subcommittee on Regulation, Health Care and Trade
On
"Medicare's Reimbursement Cuts: The Potential Impact on Solo and Small Group Practitioners and the Businesses They Run."

Testimony of the American College of Physicians

November 8, 2007

Thank you, Subcommittee Chairman Gonzalez and Ranking Member Westmoreland:

I am Jeffrey P. Harris, MD, FACP. I am the President-elect of the American College of Physicians, a general internist for three decades, and Clinical Associate Professor of Medicine at the University of Virginia School of Medicine. Until very recently, I practiced in a small, rural town in Virginia with a population of 50,000 people. The office which I practiced focused on the delivery of primary care and nephrology and routinely saw overhead expenses exceed 60 percent. As a community small business, we discovered first-hand the financial struggles that the reimbursement played on our practice.

The College is the largest medical specialty society in the United States, representing 124,000 internal medicine physicians and medical students. Of our members involved in direct patient care after training, approximately 20 percent are in solo practices and approximately 50 percent are in practices of 5 or fewer physicians. 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 lead to scheduled annual cuts for six consecutive years. On January 1, 2008, physicians face a 10.1 percent decrease in reimbursement unless Congress intervenes.

Many private insurance plans tie their fee schedule payments to those set under Medicare. Due to this significant influence, the College believes that we have an abiding professional commitment to making sure that our patients get the best care possible by advocating for payment policies that meet the needs of our elderly and disabled patients that are covered by Medicare and ensure access to care.

Instead of encouraging high quality and efficient care *centered on patients' needs*, however, existing Medicare payment policies have contributed to a *fragmented, high volume, over-specialized and inefficient model of health care delivery that fails to produce consistently good quality* outcomes for patients.

We greatly appreciate Subcommittee Chairman Charles Gonzalez and Ranking Member Lynn Westmoreland for focusing attention on the impact Medicare's flawed physician reimbursement formula impacts solo and small group practitioners. These are the practices that are the least able to absorb the uncertainty of annual payment decreases and the below inflationary adjustments Congress has grown accustomed to making.

Medicare Payment Policies are Dysfunctional
The College believes that Medicare payment policies are fundamentally dysfunctional because they do not serve the interests of Medicare patients or the taxpayers that support the program:

1. Medicare payment policies discourage internists and other primary and principal care physicians from organizing care processes to achieve optimal results for patients.

Research shows that health care that is *managed and coordinated by a patient's personal physician*, using systems of care centered on patients' needs, 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 an internist who is trained in and practices in general internal medicine or geriatrics or a family physician.

Unfortunately, Medicare payment policies discourage primary and principal care physicians from organizing their practices to provide effective diagnosis, treatment and education of patients with chronic diseases:

- 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 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.

2. Medicare payment policies are contributing to an imminent collapse of primary care medicine in the United States.

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

My medical students are acutely aware that Medicare and other payers undervalue primary care and overvalue specialty medicine. With a national average student debt of $150,000 and rising, by the time they graduate from medical school, medical students feel that they have no choice but to go into more specialized fields of practice that are better remunerated.

The numbers are startling:

- In 2004, only 20 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;

- A 2004 survey of board-certified internists found that after ten years of practice, 21 percent of general internists were no longer working in primary care compared to 5 percent for medical subspecialties working in their subspecialty.

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. Within 10 years, 150 million Americans will have one or more chronic diseases and the population aged 85 and over will increase 50 percent from 2000 to 2010.

3. The sustainable growth rate (SGR) formula 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:

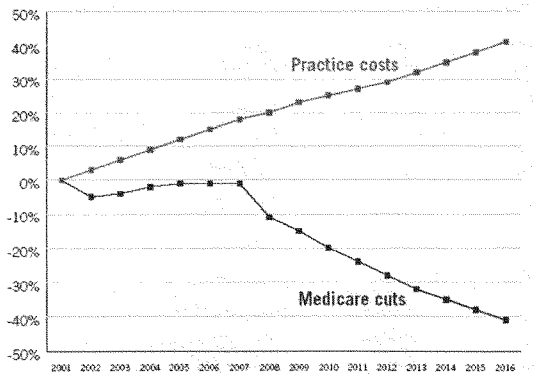
- Does not control volume or create incentives for physicians to manage care more effectively;

- 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 into 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 of their control;
- Is particularly detrimental to primary care physicians in solo and small group practices, because they are already paid less than other specialties and have such low practice margins that they cannot absorb additional payment cuts.

The College recognizes and appreciates that with the support of this Subcommittee, 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, 2008 and replace it with an annual 0.5 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.

Still, the legislation would not provide for an inflation update in 2008, which would make the seventh consecutive year that Medicare payments have declined relative to increases in the average costs physicians incur in providing services to Medicare patients. The chart below, courtesy of the American Medical Association, illustrates how Medicare payment has not kept up with actual practice costs and will continue to accelerate this trend unless Congress acts:



Sources: Physician cost data is from the MEI, a consumer price index of practice cost growth, maintained by the Centers for Medicare & Medicaid Services. Medicare physician payment updates are from the 2007 Medicare Trustees report.

Creating a Framework for a Better Payment and Delivery System
It is essential that Congress act this year to avert more SGR cuts, but we urge Congress not to simply enact another temporary fix without moving in a direction of replacing the underlying formula. *The so-called sustainable growth rate is simply not sustainable.* We strongly urge this Subcommittee to work with the authorizing committees in the House and the Senate to report legislation that puts Medicare on a pathway to completely eliminate the SGR.

1. Congress should set a specified timeframe for eliminating the SGR.

The College recognizes that the cost of eliminating the SGR will be very expensive, but the cost of keeping it—as measured by reduced access and quality—is much higher. Instead of enacting another temporary reprieve from the cuts without eliminating the SGR, the College believes that it would be preferable to set a "date certain" when the formula will be repealed, such as those Medicare provisions originally-contained in the CHAMP Act. Such a framework will allow for a transition period during which Congress and CMS could implement permanent payment reforms that can improve access and reduce costs, thereby reducing the perceived need for formula-driven volume controls like the SGR.

2. If there is a transition period before the SGR is repealed, Congress should mandate positive updates for all physicians in each year of the transition. The positive updates should reflect increases in the costs of providing services as measured by the Medicare Economic Index (MEI).

The College specifically recommends that any legislation that creates a pathway and timetable for repeal of the SGR should specify in statute the minimum annual percentage updates (floor) during the transition period. Establishing the minimum updates by statute will provide assurance to physicians and patients that payments will be fair and predictable during the transition.

3. Congress should authorize and direct Medicare to institute changes in payment policies to support patient-centered, physician-guided care management based on the patient-centered medical home model of care.

ACP, the American Academy of Family Physicians, and the American Osteopathic Physicians, have endorsed proposals for improving care of patients through a patient-centered practice model called the "personal medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006). Similarly the American Academy of Pediatrics has proposed a medical home for children and adolescents with special needs. The organizations, representing nearly 400,000 physicians, adopted a joint statement of principles that describes the key attributes of a patient-centered medical home:

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; 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 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.

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

- It should reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management;
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources;

- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access, such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology;
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits);
- It should recognize case mix differences in the patient population being treated within the practice;
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting;
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Such payments could be organized around a "global fee" for care management services that encompass the key attributes of the patient-centered medical home.

4. Congress should direct Medicare to provide higher payments to physicians who acquire and use health information technology (HIT) to support quality measurement and improvement and authorize separate payments for e-mail and telephonic consultations that can reduce the need for face-to-face visits.

The College has endorsed H.R. 1952, the bipartisan "National Health Information Incentive Act" of 2007. We commend Subcommittee Chairman Gonzalez for introducing this important legislation to support the widespread adoption of HIT. Among other incentives for physician adoption of HIT, the legislation would direct Medicare to include an "add on" to office visit payments when such visits are supported by approved health information technology, conditioned on physician participation in designated programs to measure and report quality. The bill targets the "add on" to physicians in solo, small and rural practices, because the cost of acquiring HIT are insurmountable barriers for many of those practices.

Last week, the Administration embraced this new policy initiative by the announcement of a five-year demonstration project that will encourage small to medium-sized physician practices to adopt electronic health records (EHRs). Conducted by the Centers for Medicare & Medicaid Services (CMS), the demonstration would be open to participation

by up to 1,200 physician practices beginning in the spring. Over a five-year period, the program will provide financial incentives to physician groups using certified EHRs to meet certain clinical quality measures. A bonus will be provided each year based on a physician group's score on a standardized survey that assesses the specific EHR functions a group employs to support the delivery of care.

Conclusion

The College commends Subcommittee Chairman Gonzalez and the members of the House Subcommittee on Regulation, Health Care and Trade of the Small Business Committee 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 10.1 percent cut in Medicare physician reimbursement but also move toward enacting new Medicare payment policies that will improve quality and lower costs by aligning incentives with the needs of patients. This transition should:

- lead to repeal of the SGR by a specified date;
- guarantee at least two years of positive updates so that all physicians receive predictable and fair payments during any transition period;
- pay for the positive updates in a way that does not make the longer-term problem worse;
- allow time for Congress to review alternative approaches to addressing inappropriate volume increases during such a transition;
- increase reimbursement for care provided by primary and principal care physicians;
- implement an expanded pilot test of the patient-centered advanced medical home and other reimbursement changes to facilitate physician-guided care coordination;
- implement incentive-based payments for health information technology to support quality measurement and improvement;

I began my testimony by discussing why Medicare's payment policies are dysfunctional: because they are not aligned with patients' needs.

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. Or it can 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*.

The framework proposed by the College and outlined under the CHAMP Act 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 with chronic diseases will benefit from 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 advances in health information technology to improve care, who are fully committed to ongoing quality improvement and measurement, and who have organized their practices to achieve the best possible outcomes.

Medicare patients deserve the best possible medical care. They also deserve a physician payment system that will help physicians deliver the best care possible. The College looks forward to working with members of the Subcommittee and those on authorizing committees on legislation to reform physician payment that will help us achieve a vision of reform that is centered on patient's needs.

Statement to the

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

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

Presented by: Melinda Allen, D.O.
Internal Medicine—Ponca City, Oklahoma
On Behalf of the American Osteopathic Association

November 8, 2007

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICARE PHYSICIAN PAYMENTS: 2008 AND BEYOND

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

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

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

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

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

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

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

ANALYSIS OF CURRENT MEDICARE PHYSICIAN PAYMENT POLICIES

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

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

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

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

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

Problems with the Sustainable Growth Rate (SGR) Formula

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

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

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

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

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

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

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

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

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

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

IMPACT OF CURRENT MEDICARE POLICIES ON BENEFICIARY ACCESS TO CARE

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

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

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

HEALTH INFORMATION TECHNOLOGY

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

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

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

PATIENT CENTERED MEDICAL HOME

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

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

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

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

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

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

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

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

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

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

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

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

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

QUALITY IMPROVEMENT AND PAY FOR PERFORMANCE

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

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

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

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

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

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

- The American Osteopathic Association (AOA) supports the establishment of quality reporting and/or pay-for-performance systems whose primary goal is to improve the health care and health outcomes of the Medicare population. The AOA believes that such programs should **not** be budget neutral. Appropriate additional resources should support implementation and reward physicians who participate in the programs and demonstrate improvements. The AOA recommends that additional funding be made available through the establishment of bonus-payments.

- The AOA believes that to the extent possible, participation in quality reporting and pay-for-performance programs should be voluntary and phased-in. The AOA acknowledges that failure to participate may decrease eligibility for bonus or incentive-based reimbursements, but feels strongly that physicians must be afforded the opportunity to not participate.

- The AOA recommends that physicians be central to the establishment and development of quality standards. A single set of standards applicable to all physicians is not advisable. Instead, standards should be developed on a specialty-by-specialty basis, applying the appropriate risk adjustments and taking into account patient compliance. Additionally, quality standards should not be established or unnecessarily influenced by public agencies or private special interest groups who could gain by the adoption of certain standards. However, the AOA does support the ability of appropriate outside groups with acknowledged expertise to endorse developed standards that may be used.

- The Federal government must adopt standards prior to the implementation of any new health information system. Such standards must ensure interoperability between public and private systems and protect against exclusion of certain systems. Interoperability must apply to all providers in the health care delivery system, including physicians, hospitals, nursing homes, pharmacies, public health systems, and any other entities providing health care or health care related services. These standards should be established and in place prior to any compliance requirements.

- The AOA encourages the Federal government to reform existing Stark laws, allowing physicians to collaborate with hospitals and other physicians in the pursuit of electronic health records systems. This will promote widespread adoption, ease the financial burden on

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

- The AOA supports the establishment of programs to assist all physicians in purchasing health information technology (HIT). These programs may include grants, tax-based incentives, and bonus payments through the Medicare physician payment formula as a way to promote adoption of HIT in physician practices. While small groups and solo practice physicians should be assisted, programs should not expressly exclude large groups from participation.

- The AOA supports the establishment of programs that allow physicians to be compensated for providing chronic care management services. Furthermore, the AOA does not support the ability of outside vendors to provide such services.

- The AOA does not support the exclusive use of claims-based data in quality evaluation. Instead, we support the direct aggregation of clinical data by physicians, such as the data collected through the CAP. Physicians or their designated entity would report this data to the Centers for Medicare and Medicaid Services (CMS) or other payers. Claims data are used to look at a provider's total cost for delivering care to a group of individuals or costs associated with various episodes of care. Based on that information, private insurers commonly place doctors into tiers. Patients are then "steered" to those doctors identified with lower resource use. We believe these practices are misleading to patients and do nothing to enhance consumer awareness of health care services. In fact, using claims data may put patients at risk by steering them to physicians and institutions that do not merit a high ranking.

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

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

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

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

SUMMARY

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

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

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

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

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

Statement of

Kenneth L. Noller, MD, MS, FACOG
President, American College of Obstetricians and Gynecologists
(ACOG)

On behalf of
The Alliance of Specialty Medicine
and
The American College of Obstetricians and Gynecologists

Before the
House Committee on Small Business
Subcommittee on Regulations, Healthcare and Trade
U.S. House of Representatives

Hearing on
"Medicare Reimbursement Cuts: The Potential Impact on Solo and Small Group Medical Practices"

November 8, 2007

Mr. Chairman and Members of the Subcommittee, thank you for holding this hearing on the impending Medicare physician payment cut and its effect on solo and small practitioners. This 10.1% cut, and the threat of future reductions, hits small practices first and hardest, and so it is important and appropriate that this Subcommittee consider the impact of Medicare on these small businesses.

I am Dr. Kenneth L. Noller, President of the American College of Obstetricians and Gynecologists (ACOG), a national organization representing 51,000 ob-gyns and partners in women's heath, including more than 90% of all board-certified ob-gyns in the U.S. I chair the ob-gyn department and am a professor in the department of family and community medicine at Tufts University in Boston, and I am the gynecologist-in-chief at Tufts-New England Medical Center. I am here today on behalf of ACOG and the Alliance of Specialty Medicine – a coalition of 11 medical specialties representing nearly 200,000 specialty physicians.

The Alliance appreciates the leadership of the House Ways and Means and Energy and Commerce Committees and their Health Subcommittees, under the direction of Chairmen Rangel, Dingell, Stark and Pallone in addressing the impending physician payment cut in the CHAMP Act. Under their leadership, and with the support of members of this Committee, the House passed legislation that would eliminate this cut and instead give physicians payment increases for the next two years. And most importantly, the legislation was fully funded.

The Alliance strongly supports a two-year reprieve from cuts and progress toward a permanent solution to this crippling problem. This week, more than 7,500 postcards from ob-gyns across the country are being delivered to Capitol Hill asking the U.S. Senate to follow the House's lead to enact a fully-offset two-year fix. We urge immediate action from the Senate and a swift resolution that will take away the uncertainty facing small practices as they plan for the upcoming years.

The Un-Sustainable Growth Rate

As we are well aware, Medicare physician payments will be cut by 10.1% on January 1, 2008, unless Congress takes action to stop this cut and keep fee-for-service Medicare strong for seniors and disabled patients and the physicians who care for them. At the heart of this problem is the Sustainable Growth Rate (SGR) formula, which calculates annual updates in Medicare payments for Part B physician services. Under this flawed formula:

- Payments are tied to fluctuations in the Gross Domestic Product (GDP) instead of to the actual costs of running a medical practice and of providing medical care to Medicare patients;

- Costs for physician-administered drugs are included in the calculation, although drugs are separate and distinct from physician services and their lopsided growth lowers the SGR target for actual physician services; and
- Physicians are penalized for increases in the volume of services they provide that are beyond their control – such as new benefits authorized by legislation, regulations, coverage decisions, new technology, growing patient demand for services, and the growing number of beneficiaries.

If Congress does not enact a long-term solution soon, physicians serving Medicare patients will see cuts year after year. As this testimony shows, the effect of Medicare cuts will be felt far beyond the Medicare population, affecting military families, patients covered by private insurance, and low-income patients as well.

While we very much appreciate Congressional intervention that has prevented similar cuts over the last several years, these short-term fixes and delays in implementing a permanent change have sent the cost of a permanent fix skyrocketing.

The Importance of Small Practices in American Medicine

Small medical practices have long been the backbone of our health care system. About half of dermatology practices are run by solo practitioners and about 75% have three or fewer physicians. In cataract and refractive surgery, 80% of practices have five or fewer physicians. But in some specialties, including ob-gyn, financial and regulatory burdens are forcing consolidation and are making small and solo practices more difficult to operate. For instance, one-third of ob-gyns were in solo practice in 1991. Today, only 23% are solo practitioners. While consolidation may make good business sense, it might also result in a small community losing its local doctor or patients traveling additional miles to reach a specialist.

One central cause of this is economic pressure and the need to achieve economies of scale and 'efficiencies' in our practices. The costs of practicing medicine grow every year. We face increases in our office rent, staff salaries, medical supplies and equipment, and historic increases in our medical liability insurance costs. While costs have seen sharp increases, Medicare physician payments were cut in 2002. In 2003, 2004, and 2005, minimal increases were below the cost of inflation, and, since then, fees have been frozen again and large cuts loom. These payment realities and threats of future cuts make it a very uncertain time for solo and small practices.

Effect on Patients

Our primary concern has to be the effect of the Medicare payment cut on patients. Many physicians will be forced to reconsider their participation in the Medicare program or restrict the number of new Medicare beneficiaries they are able to

accommodate in their practices. For patients, this might mean finding a new doctor or waiting longer for an appointment. Practices or specialties with a large Medicare base may need to find other ways to trim office costs through staff cuts, benefit reductions or other means. Cuts will have similar impact on TRICARE, the health care system for our military families, which uses the Medicare fee schedule. For medical practices near major military installations, these cuts will cause great hardship and military families will have greater difficulty finding care. Following Medicare's lead, many private insurers will also cut or freeze physician payments.

As Medicare and private insurance payments decline, practices often have to make the hard choice to stop caring for the patients of their lowest payor – usually Medicaid – creating an access crisis for those patients. Community care clinics have difficulty recruiting physician volunteers. Hours physicians once spent volunteering are used to make up for Medicare payment losses in their own practices in the face of ever-increasing practice costs.

As economics force a reduction in the number of small practices, rural patients must travel farther for routine care, and further still if they need specialty care. Recruiting a new physician to take over a small practice when a doctor retires is increasingly difficult. Entering even a well-established small practice, with escalating practice and liability costs and declining payments, is just too risky for a young physician starting a family and saddled with $200,000 of student debt.

Innovation Stalled

Electronic medical records can help us make needed improvements in patient safety, reduce the occurrence of medical errors, and may result in savings to the health care system, as we reduce unnecessary tests. But payment cuts and uncertainty seriously stall the acquisition of health information technology.

The system-wide benefits of electronic medical records don't necessarily translate into cost savings for physician offices. As Dr. Margaret Kelly testified to this Subcommittee in March, start-up costs are commonly upwards of $50,000 per physician. Because interoperability standards are still in their infancy, this investment is something of a gamble. The technology changes rapidly and systems often do not communicate well with each other. Many physicians are fearful that this year's investment will be outdated or obsolete in a few short years.

Some people mistakenly believe that physicians will easily recoup their investment because the new technology will make them more efficient and able to see more patients. The irony is that health IT makes many offices significantly less efficient for months or even years after upgrading to EMR. It can take up to two years to handle

their previous patient load. And even when efficiencies are realized, it doesn't necessarily translate into more patients or more revenue.

For many ob-gyns, the goal is not to see more patients, but to better care for the patients we already have. Many pressures over the last decade have compressed the office visit into a few short minutes. We want to use technology to make those minutes more meaningful, not to strip additional minutes off an already too-short office visit.

With falling and unpredictable Medicare and private insurance payment rates, and with no specific incentives for the investment in electronic record systems, it is that much more difficult for doctors to make the plunge into health IT.

Very few people go into medicine in order to become 'businessmen.' We enter medicine to deliver health care to patients. But despite our lack of business acumen, we know that payments plummeting 10% in 2008, and by 40% over the next decade, seriously restrict our ability to hire and keep good administrative and clinical staff, to recruit a new physician into our practice, to purchase better medical equipment, to computerize our practices, and to keep delivering high quality care. These cuts will make it difficult to keep some practices open altogether.

As advocates for patients and their physicians, the Alliance of Specialty Medicine applauds the House for acting to prevent these cuts and to help us continue providing the best care for our patients. We call on the Senate to do the same and appreciate your leadership in continuing to highlight this critically important issue.

Statement

of the

American Optometric Association

to the

Committee on Small Business

Subcommittee on Regulations, Healthcare and Trade

United States House of Representatives

Re: The Medicare Sustainable Growth Rate (SGR) Payment Formula

Presented by: John B. Whitlow, OD

November 8, 2007

Statement of the
American Optometric Association
to the

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

Re: The Medicare Sustainable Growth Rate (SGR) Payment Formula
Presented by: John B. Whitlow, OD
November 8, 2007

The American Optometric Association (AOA), representing over 34,000 doctors of optometry, appreciates the opportunity to provide the House Small Business, Subcommittee on Regulations, Healthcare and Trade, with our views and recommendations concerning the current state of Medicare payments to physicians, specifically doctors of optometry, and other health care providers. It is our position that the Sustainable Growth Rate (SGR) formula currently used for Medicare payment is producing dire results for all health care professionals, especially for small and rural health care provider practices/businesses. This is having a chilling affect on the efficient and effective delivery of health care in America, including the delivery of eye and vision care for America's seniors.

The AOA commends you, Chairman Gonzalez, Ranking Member Westmoreland, and Members of the Subcommittee, for the leadership and vision you have shown in recognizing the fundamental need to address the hopelessly flawed Medicare-SGR payment formula. It is time to find an equitable and long-lasting replacement for this payment formula in order to ensure the health of the Medicare program, both for the short-term and long-term, particularly in light of the program preparing to usher in an unprecedented number of new enrollees as baby boomers reach eligibility age. Moreover, a long-lasting solution must be found to ensure that health care remains accessible to America's seniors, especially in small towns and rural communities, because these cuts have a disproportionate effect on small and rural health care providers/businesses and their patients.

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 Medicare patients and to the American people—access to 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 nation.

As the frontline providers of eye and vision care in over 6,500 communities across the nation, doctors of optometry are well aware of the many obstacles health care providers face 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. 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. Our members feel these strains on a daily basis and would like to work with Congress to find a more equitable solution.

Doctors of optometry are often the only eye care providers available in rural communities and underserved areas and, like other rural health care 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. That is the inherent evil in any flawed payment formula. Medicare beneficiaries are experiencing difficulties accessing health care services because providers have limited the number or are no longer accepting new Medicare patients.

The impact of Medicare payment cuts affects the entire health care community, including optometrists, podiatrists, chiropractors, audiologists, nurse anesthetists, nurse practitioners, occupational therapists, physical therapists, psychologists, speech language pathologists, and social workers. PARCA, a coalition of organizations representing the interests of millions of patients and non-MD/DO health care providers, is committed to quality, cost-effective care, and ensuring patients have options in the delivery of such care. PARCA applauds the efforts put forth by Members of Congress and congressional staff as they work to address Medicare payment reform. PARCA supports congressional efforts to bring forward legislation that will provide multi-year positive updates to bring stability to the Medicare payment system.

The Search to Find a Solution to the Medicare Payment Formula

Since the Medicare program was created in 1965, several methods have been used to determine how much doctors are reimbursed for covered services. Initially, the program compensated doctors on the basis of their charges and allowed health care providers to bill for the full charge of their services. In 1975, Congress then determined that the annual increase in fees could not exceed the increase in the Medicare Economic Index or MEI – a conservative government index of practice cost inflation. In 1992, the system was replaced by a fee schedule that was updated annually by a combination of the MEI and an adjustment factor known as the Volume Performance Standard (VPS), which was based on historical trends in volume. However, this payment formula soon led to highly variable changes in payment rates, and Congress again searched for a payment formula solution.

In 1997, the *Balanced Budget Act* created the Sustainable Growth Rate (SGR) payment formula as a target rate of growth in Medicare spending for health care services. It aimed to control spending for services provided under Part B of Medicare, and aimed to do so by setting an overall target amount of spending for certain types of goods and services under Part B. The key factors in setting the SGR are Gross Domestic Product (GDP) growth, changes in law and regulation, and Medicare enrollment and price changes. However, if expenditures exceed the SGR targets, then annual payment updates are less than annual increases in practice cost inflation.

The SGR-Induced Medicare Meltdown on the Horizon

AOA, in concert with other health care provider organizations, asserts that the SGR payment formula has produced disastrous results for both doctors and patients. It has kept the average 2007 Medicare payment rates about the same as they were in 2001; it continually sets the target too low because the utilization of health care services tends to grow more rapidly than the GDP. Therefore, Medicare payments do not cover current practice costs, preventing doctors from making needed investments in staff and health information technology to support quality improvement. In addition, the flawed payment formula punishes health care providers for participating in initiatives that encourage greater use of preventive care in order to reduce hospitalizations. None of the factors in the SGR take into account Medicare spending due to technological advances, or track shifts from care being provided in hospitals to being provided in doctors' offices, or track any other such practice trends. Payment policy must also take into consideration where utilization has increased because of new Medicare coverage policies and expanding preventive services. Omitting these costs from the SGR targets increases the likelihood of pay cuts. The SGR formula has led to a budget baseline that is widely viewed as unrealistic and has driven policymakers to enact short-term interventions that have increased the duration of the cuts and the cost of a long-term, permanent solution.

The Congressional Budget Office (CBO) recently forecast that Medicare payment rates would be reduced by 10 percent in 2008, under current law, and a 2006 Medicare Trustees report predicts cumulative reductions in Medicare payment rates of nearly 40 percent by the year 2015. Health care providers cannot absorb these additional draconian Medicare cuts and continue to fulfill the promise that America has made to Medicare beneficiaries. Medicare payments already lag far behind the cost of caring for seniors. Furthermore, these cuts come at a time when the baby-boomers are ready to enter the Medicare program. In 2010, Medicare enrollment has been projected to rise to 43 million beneficiaries, and will grow to 49 million in 2015.

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 resolve a full-blown meltdown of the Medicare system that looms on the horizon.

The AOA urges the Subcommittee 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.

The Way Forward

After five 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, and we acknowledge that the health care professional community must do their part to help make Medicare more efficient. The AOA joins its physician colleagues in laying out a transitional path to reform, and outlines a number of steps that Congress could take to support and encourage optometry's efforts to ensure that Medicare beneficiaries receive the most appropriate care in the most appropriate setting at a value for the taxpayer.

The AOA firmly believes that successful efforts to encourage judicious use of care are best fostered through positive incentives that inspire physicians, including 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.

Recommendations on Eliminating SGR and Developing a Sustainable Payment Formula

1. The SGR should be repealed and replaced with a payment update system that reflects increases in physicians' and other health providers practice costs. Given that an immediate repeal poses budgetary challenges, Congress should:

   - Establish by law a transition, pathway, and "date certain" to complete elimination of the SGR.

   - Provide positive physician and other health care provider updates set by statute for each year until repeal takes effect.

   - Stabilize payments for a minimum of two years by providing positive baseline updates to all physicians and other health care providers.

   - Urge the Administration to exercise its authority to remove physician-administered drugs from the SGR and make other refinements in the formula to help reduce the cost of Congressional action.

2. Congress should support initiatives by the AOA and other health care provider organizations to bridge gaps in care and assure the appropriateness of services provided to Medicare beneficiaries.

3. To make Medicare sustainable in the future, Congress should identify and begin to enact additional reforms that will be necessary to create incentives for judicious use of services and to adequately fund the program.

The AOA appreciates the opportunity to provide our views to the Subcommittee on these critical matters. We look 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.

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