

Statement to the

Energy and Commerce Committee  
Subcommittee on Health  
United States House of Representatives

“Medicare Physician Payment: How to Build a Payment System That Provides  
Quality, Efficient Care for Medicare Beneficiaries”

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On Behalf of the American Osteopathic Association

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## **Executive Summary**

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. For these reasons, the AOA is supportive of programs aimed at improving the quality of care provided and believe that we have a responsibility to help the Committee and Congress craft such a program. However, we do not, and will not, support programs whose sole goal is to reduce or curb spending on physician services. The goal must be improved health care for beneficiaries, which in the short-term likely will result in increased, not decreased, spending.

The AOA recognized early on the need for quality improvement and the national trend toward quality improvement programs. In response, we took 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 the quality of care in clinical practices in osteopathic residency programs. The goal of the CAP is to improve patient outcomes by providing valid and reliable assessments of current clinical practices and process sharing of best practices in care delivery. The CAP provides evidence-based measurement sets on eight clinical conditions including diabetes, coronary artery disease, hypertension, women's health screening, asthma, COPD, childhood immunizations, and low back pain. Data elements collected by the residency training programs include both demographic and clinical information. CAP has been widely acknowledged as a tool to improve quality in ambulatory care and is beginning to provide data on quality improvement.

In December 2005, the CAP became available for physician offices and offers initial measurement sets on diabetes, coronary artery disease, and women's health screening. The "CAP for Physicians" will measure current clinical practices in the physician office and compare 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.

The AOA is convinced that the current Medicare payment methodology cannot support the implementation of a quality-reporting or pay-for-performance program. The SGR methodology is broken and, in our opinion, beyond repair. This Committee, the Medicare Payment Advisory Commission, and every physician organization recommends eliminating the formula and replacing it with a payment system that more accurately reflects the costs of providing care to beneficiaries. Steps must be taken to eliminate the year-to-year uncertainty that has plagued the Medicare physician payment formula for the past five years. To this end, **every physician participating in the Medicare program should receive a positive 2.8 percent update in 2007.** This will ensure that participation in the program remains robust. Additionally, this provides time for Congress to develop, adopt, and implement a new payment methodology.

We recognize that Congress faces financial obstacles to accomplishing this goal. However, the costs of not reforming the system may be greater. Physicians cannot afford to have continued reductions in reimbursements. Ultimately, they either will stop participating in the Medicare program or limit the number of beneficiaries they accept into their practices. Either of these scenarios results in decreased access for our growing Medicare population.

Additionally, we believe it is time for Congress to consider changes in the Medicare funding formulas that allow for spending adjustments based upon the financial health of the entire Medicare program. As Congress and CMS establish new quality improvement programs, it is imperative for Medicare to reflect fairly the increased role of physicians and outpatient services as cost savers 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 Part D. These savings should be credited to physicians through a program between Parts A, B, and D.

As quality reporting and pay-for-performance programs become more prevalent, fundamental issues must be addressed. Some of our top concerns are:

- Quality and pay-for-performance programs must be developed and implemented in a manner that aims to improve the quality of care provided by all physicians. New formulas must provide financial incentives to those who meet standards and/or demonstrate improvements in the quality of care provided. The system should not punish some physicians to reward others.
- The use of claims data as the sole basis for performance measurement is a concern. Claims data does not reflect severity of illness, practice-mix, and patient non-compliance. These issues and others are important factors that must be considered. Sole reliance on claims data may not indicate accurately the quality of services being provided. We believe that clinical data is a much more accurate indicator of quality care.
- The financial and regulatory burden quality and pay-for-performance programs will have upon physician practices, especially those in rural communities, must be minimized. Physicians, and medicine in general, have one of the highest paperwork burdens anywhere. We want to ensure that new programs do not add to physicians' already excessive regulatory burden.
- Quality and pay-for-performance programs should have some degree of flexibility. The practice of medicine continuously evolves. Today's physicians have knowledge, resources, and technology that didn't exist a decade ago. This rapid discovery of new medical knowledge and technology will transform the "standards of care" over time. It is imperative that the quality reporting and pay-for-performance system have the infrastructure to be modified as advances are made.

Mr. Chairman, my name is Paul Martin. I am a family physician from Dayton, Ohio and currently serve as the Chief Executive Officer and President of the Providence Medical Group, a 41-member independent physician owned and governed multi-specialty physician group in the greater Dayton metropolitan area. I am honored to be here today on behalf of the American Osteopathic Association (AOA) and the nation's 56,000 osteopathic physicians practicing in all specialties and subspecialties of medicine.

The AOA and our members wish to express our appreciation to you and the Committee for your continued efforts to improve the nation's health care system, especially your ongoing efforts to reform the Medicare physician payment formula and improve the quality of care provided by physicians. These are goals that we share. I want to acknowledge and thank Rep. Michael Burgess for introducing the Medicare Physician Payment Reform and Quality Improvement Act of 2006. This legislation is consistent with many AOA policies related to Medicare physician payment, quality reporting, and Medicare financing. We appreciate his efforts to introduce new policy concepts that would eliminate the use of the sustainable growth rate methodology and move physicians toward a more equitable system based upon actual practice cost and reflective of increased quality in care provided. Mr. Chairman, we also applaud your leadership and your willingness to work with Dr. Burgess and other Members of the Committee to advance achievable solutions to this ongoing policy issue.

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 other aspects of the Medicare program. Over the past decade, this relationship has become 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.

### **Quality Improvement and Pay for Performance**

Today's health care consumers—including Medicare beneficiaries—demand 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 their millions of patients. Through those 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 early on the need for quality improvement and the national trend toward quality improvement programs. In response, we took 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 web-based Clinical Assessment Program (CAP). When the CAP was initially introduced six years ago, it measured the quality of care in clinical practice in osteopathic residency programs. The goal of the CAP is to improve patient outcomes by providing valid and reliable assessments of current clinical practices and process sharing of best practices in care delivery.

The CAP provides evidence-based measurement sets on eight clinical conditions including diabetes, coronary artery disease, hypertension, women's health screening, asthma, COPD, childhood immunizations, and low back pain. Data elements collected by the residency training programs include both demographic and clinical information. CAP has been widely acknowledged as a tool to improve quality in ambulatory care and is beginning to provide data on quality improvement. For example, the percent of diabetics having foot exams performed routinely increased 24% in programs re-measuring as of June 2006. Likewise, in outcome of care measures, the LDL cholesterol levels and diabetic HgbA1c have decreased.

The CAP is able to collect data from multiple clinical programs and provide information regarding performance back to participating residency 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 December 2005, the CAP became available for physician offices offering initial measurement sets on diabetes, coronary artery disease, and women's health screening. The "CAP for Physicians" measures current clinical practices in the physician office and compares the physician's outcome 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 the national debate on the issues of quality reporting and pay-for-performance began, the AOA established a set of principles to guide our efforts on these important issues. These principles represent "achievable goals" that assist in the development of quality improvement systems while recognizing and rewarding the skill and cost benefits of physician services.

First, the AOA believes that the current Medicare physician payment formula, especially the sustainable growth rate (SGR), is seriously flawed and should be replaced. Additionally, we are convinced that the current Medicare payment methodology cannot support the implementation of a quality-reporting or pay-for-performance program.

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 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.

To support this goal, the AOA adopted the following principles:

1. Quality reporting and/or pay-for-performance systems whose primary goal is to improve the health care and health outcomes of the Medicare population must be established. 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.
2. 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.
3. Physicians are 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.
4. The exclusive use of claims-based data in quality evaluation is not recommended. Instead, the AOA supports the direct aggregation of clinical data by physicians. Physicians or their designated entity would report this data to the Centers for Medicare and Medicaid Services (CMS) or other payers.
5. Programs must be established that allow physicians to be compensated for providing chronic care management services. Furthermore, the AOA does not support the ability of outside vendors, independent of physicians, to provide such services.

### **Resource Utilization and Physician Profiling**

Over the past few years, Congress, MedPAC and other health policy bodies have placed greater emphasis on controlling the use of “resources” by physicians and other health care providers. The AOA supports, in concept, a systemic evaluation of resource use that measures overuse, misuse, and under use of services within the Medicare program.

Additionally, we do not oppose programs that confidentially share with physicians their resource use as compared to other physicians in similar practice settings. However, any effort to evaluate resource use in the Medicare program must not be motivated only by financial objectives. Instead, the AOA believes that physician utilization programs must be aimed at improving the quality of care provided to our patients. In measuring the performance of physicians the singular use of utilization measures without evaluation of clinical process and outcomes can lead to adverse impact on care delivery. Tracking methods to determine the unintended consequences of reduced utilization on patient safety should be incorporated in any utilization reports developed.

If the intent of the program is to improve the quality of care, then the validity, reliability, sensitivity, and specificity of information intended for private or public reporting must be very high. Comparative utilization information cannot be attained through administrative or claims-based data alone without adequate granulation for risk adjustment.

In an effort to support the establishment of quality improvement programs that stand to benefit the quality of care provided to patients, the AOA adopted the following ten principles that guide our policy on comparative utilization or physician profiling programs:

1. Comparative utilization or physician profiling should be used only to show conformity with evidence-based guidelines.
2. Comparative utilization or physician profiling data should be disclosed only to the physician involved. If comparative utilization or physician profiling data is made public, assurances

must be in place that promise rigorous evaluation of the measures to be used and that only measures deemed sensitive and specific to the care being delivered are used.

3. Physicians should be compared to other physicians with similar practice-mix in the same geographical area. Special consideration must be given to osteopathic physicians whose practices mainly focus on the delivery of osteopathic manipulative treatment (OMT). These physicians should be compared with other osteopathic physicians that provide osteopathic manipulative treatment.
4. Utilization measures within the reports should be clearly defined and developed with broad input to avoid adverse consequences. Where possible, utilization measures should be evidenced-based and thoroughly examined by the relevant physician specialty or professional societies.
5. Efforts to encourage efficient use of resources should not interfere with the delivery of appropriate, evidence-based, patient-centered health care. Furthermore, the program should not impact adversely the physician-patient relationship or unduly intrude upon a physician's medical judgment. Additionally, consideration must be given to the potential overuse of resources as a result of the litigious nature of the health care delivery system.
6. Practicing physicians must be involved in the development of utilization measures and the reporting process. Clear channels of input and feedback for physicians must be established throughout the process regarding the impact and potential flaws within the utilization measures and program.
7. All methodologies, including those used to determine case identification and measure definitions, should be transparent and readily available to physicians.
8. Use of appropriate case selection and exclusion criteria for process measures and appropriate risk adjustment for patient case-mix and inclusion of adjustment for patient compliance/wishes in outcome measures, need to be included in any physician specific

reports. To ensure statistically significant inferences, only physicians with an appropriate volume of cases should be evaluated. These factors influence clinical or financial outcomes.

9. The utilization measure constructs should be evaluated on a timely basis to reflect validity, reliability and impact on patient care. In addition, all measures should be reviewed in light of evolving evidence to maintain the clinical relevance of all measures.
10. Osteopathic physicians must be represented on any committee, commission, or advisory panel, duly charged with developing measures or standards to be used in this program.

### **Medicare Payments to Physician**

Reform of the Medicare physician payment formula, specifically, the repeal of the sustainable growth rate (SGR) formula, is one of the AOA's top priorities. 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, rational, and predictable payment formula that reflects physician cost of providing care.

In 2002, physician payments were cut by 5.4 percent. Thanks to the leadership of this Committee, Congress acted to avert payment cuts in 2003, 2004, 2005, and 2006 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 a freeze at 2005 levels for 2006.

The AOA and our members are appreciative of actions taken over the past four years to avert additional cuts. However, even with these increases physician payments have fallen further behind medical practice costs. Practice costs increases from 2002 through 2006 were about two times the amount of payment increases.

According to the 2006 Medicare Trustees Report, physicians are projected to experience a reimbursement cut of 4.6 percent in 2007 with additional cuts predicted in years 2007 through 2015. Without Congressional intervention, physicians will face a 34 percent reduction in

Medicare reimbursements over the next eight years. During this same period, physicians will continue to face increases in their practice costs. If the 2007 cut is realized, Medicare physician payment rates will fall 20 percent below the governments measure of inflation in medical practice costs over the past six years. 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.

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. And, it 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.

It is important to recognize that, in 2007, substantial changes to other components of the Medicare payment formula will shift billions of dollars which will lead to cuts of up to 10 to 12 percent for certain physician services. It is imperative that Congress acts to stabilize the update to the conversion factor in order to bring stability to this volatile system and dampen the impact of payment cuts caused by unrelated policy changes. The non-SGR related changes to physician payment in 2007 include:

#### Geographic Practice Cost Index (GPCI)

The Medicare Prescription Drug, Modernization and Improvement Act (MMA) (P.L. 108-173) included a three-year floor of 1.0 on all work GPCI adjustments. This provision is set to expire on December 31, 2006. Nationwide, 58 of the 89 physician payment areas have benefited from this provision. If this provision is not extended many physicians, especially those in rural areas, will experience additional cuts. The AOA supports the "Medicare Rural Health Providers Payment Extension Act." (H.R. 5118)

introduced by Rep. Greg Walden. We urge the Committee to include the provisions of H.R. 5118 in any legislative package considered this year.

#### Five-Year Review

Every five years, CMS is required by law to review all work relative value units (RVU) and make needed adjustments. These adjustments must be made in a budget neutral manner. Changes related to the third five-year review will be implemented on January 1, 2007.

In total, more than \$4 billion will be shifted to evaluation and management (E&M) codes, which will be increased by upwards of 35 percent in some instances. The AOA is very supportive of the changes in values for E&M codes. We believe E&M codes have been undervalued historically. The proposed changes are fair and should be implemented.

We do recognize that increases in E&M codes will require decreases in other codes. CMS has proposed a 10 percent decrease in the work RVU's of other codes in the physician fee schedule or an additional five percent cut to the conversion factor as a means of achieving budget neutrality.

#### Practice Expense

CMS also has announced significant changes to the formulas used to determine the practice expense RVU. These changes also are budget neutral and will shift approximately \$4 billion. Again, these increases will require cuts in other areas of the physician fee schedule.

This dramatic shift in the allocation of funding will have a significant impact on many physicians across the country. The AOA is concerned about the impact a reduction in the SGR, along with cuts resulting in the reallocation of funding required by other policy changes, might have upon physicians. While the total impact of the changes will vary by specialty, geographic location, and practice composition; it is clear that physicians specializing in certain specialties may see significant cuts prior to any adjustments to the conversion factor are made as a result of the SGR

formula. For these reasons we call upon Congress to ensure that all physicians participating in the Medicare program receive a positive payment update in 2007.

In its 2006 March Report to Congress, MedPAC stated that payments for physicians in 2007 should be increased 2.8 percent. We strongly support this recommendation. Additionally, since 2001, MedPAC has recommended that the flawed SGR formula be replaced. Again, the AOA strongly supports MedPAC's recommendation.

Steps must be taken to eliminate the year-to-year uncertainty that has plagued the Medicare physician payment formula for the past five years. **To this end, every physician participating in the Medicare program should receive a positive 2.8 percent update in 2007** as recommended by MedPAC. This will ensure that participation in the program remains robust. Additionally, this provides time for Congress to develop, adopt, and implement a new payment methodology.

#### **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. As a result, the Balanced Budget Act of 1997 (BBA 97) (Public Law 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 have resulted. The AOA would like to highlight 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.

*Utilization of Physician Services*—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 move away from acute based care to a more ambulatory based delivery system. This trend 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, the Centers for Medicare and Medicaid Services (CMS) have failed to account for the numerous 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.

*Physician Administered Drugs*—The other 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, you and the Committee have encouraged the Administration to remove the cost of physician-administered drugs from the formula. The AOA encourages the Committee 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.

Gross Domestic Product—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. Again, we appreciate your leadership and insistence that that provision be included in the final legislation.

However, 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.

#### **A New Payment Methodology for Physicians**

Several bills aimed at providing both short and long-term solutions to the Medicare physician payment issue have been introduced during the 109<sup>th</sup> Congress. The AOA supports many of these bills and appreciates the continued efforts of Members of Congress to find achievable solutions to these ongoing policy issues.

The AOA has worked with the American College of Surgeons to develop a new payment methodology that would provide positive annual updates to physicians based upon increases in practice costs, while being conducive to quality improvement and pay-for-performance programs.

The AOA proposes a new payment system that would replace the universal volume target of the current sustainable growth rate (SGR) with a new system, known as the service category growth rate (SCGR), that recognizes the unique nature of different physician services by setting targets for six distinct service categories of physician services. The service categories, which are based on the Berenson-Eggers type-of-service definitions already used by CMS, are: evaluation and management (E&M) services; major procedures (includes those with 10 or 90 day global service periods) and related anesthesia services; minor procedures and all other services, including

anesthesia services not paid under physician fee schedule; imaging services and diagnostic tests; diagnostic laboratory tests; and physician-administered Part B drugs, biologicals, and radiopharmaceuticals.

The SCGR target would be based on the current SGR factors (trends in physician spending, beneficiary enrollment, law and regulations), except that GDP would be eliminated from the formula and be replaced with a statutorily set percentage point growth allowance for each service category. To accommodate already anticipated growth in chronic and preventive services, we estimate that E&M services would require a growth allowance about twice as large as the other service categories (between 4-5 percent for E&M as opposed to 2-3 percent for other services). Like the SGR, spending calculations under the SCGR system would be cumulative. However, the Secretary would be allowed to make adjustments to any of the targets as needed to reflect the impact of major technological changes.

Like the current SGR system, the annual update for a service category would be the Medicare medical economic index (MEI) plus the adjustment factor. But, in no case could the final update vary from the MEI by more or less than 3 percentage points; nor could the update in any year be less than zero. The formula allows for up to one percentage point of the conversion factor for any service category to be set aside for pay-for-performance incentive payments.

Like the SGR, the SCGR would retain a mechanism for restraining growth in spending for physician services. It recognizes the wide range of services that physicians provide to their patients. Unlike the current universal target in the SGR, which penalizes those services with low volume growth at the expense of high volume growth services, the SCGR would provide greater accountability within the Medicare physician payment system by basing reimbursement calculations on targets that are based on a comparison of like services and providing a mechanism to examine those services with high rates of growth while reimbursement for low growth services would not be forced to subsidize these higher growth services. By recognizing the unique nature of different physician services, the SCGR enables Medicare to more easily study the volume growth in different physician services and determine whether or not volume growth is appropriate.

Additionally, the AOA believes the SCGR provides a sound framework for starting a basic value-based purchasing system. Given the diversity of physician services provided to patients, it is difficult to find a set of common performance measures applicable to all physicians. However, development of common performance measures is much easier when comparing similar services.

### **Beneficiary Access to Care**

The continued use of the flawed and unstable sustainable growth rate methodology will 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 its members what actions they or their practice would take if the projected cuts in Medicare physician payments were implemented. The results are concerning. 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. According to a 2005 survey conducted by MedPAC, 25 percent of Medicare beneficiaries reported that they had some problem finding a primary care physician. MedPAC 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.”*

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.

### **Health Information Technology**

A viable interoperable health information system is key to the implementation and success of quality improvement and performance-based payment methodologies. For these reasons, we support the “Health Information Technology Promotion Act” (H.R. 4157). An interoperable health information system will improve the quality and efficiency of health care.

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.” While we continue to advocate for financial assistance for these physicians, we appreciate inclusion of provisions in

H.R. 4157 that provide safe harbors allowing hospitals and other health care entities to provide health information hardware, software, and training to physicians. This would, in our opinion, facilitate rapid development of health information systems in many communities.

I appreciate the opportunity to testify before the Energy and Commerce Committee Subcommittee on Health. Again, I applaud your continued efforts to assist physicians and their patients. The AOA and our members stand ready to work with you to develop a payment methodology that secures patient access, improves the quality of care provided, and appropriately reimburses physicians for their services. Additionally, we stand ready to assist in the development of new programs that improve quality, streamline the practice of medicine, and make the delivery of health care more efficient and affordable.

**Paul A. Martin, D.O.**

Paul A. Martin, D.O., a board certified family physician from Dayton, Ohio, is a recognized leader within the medical profession in Ohio and across the nation. He currently serves as the Chief Executive Officer and President of the Providence Medical Group, a 41-member independent physician owned and governed multi-specialty physician group in the greater Dayton metropolitan area. Dr. Martin oversees the operations of one of the largest multi-physician organizations in southwest Ohio serving urban, suburban, and rural demographic areas. He is deeply knowledgeable about health care financing, including the Medicare and Medicaid programs. He also possesses a strong understanding of the health care delivery system as a whole.

Dr. Martin received his undergraduate degree, Cum Laude, in Biology from the University of Dayton in 1970 and a Masters in Microbiology from the University of Dayton in 1972. He earned his medical degree, Cum Laude, from the Chicago College of Osteopathic Medicine in 1977. He completed his post-graduate training at Grandview/Southview Medical Center in Dayton. Dr. Martin obtained his board certification in family medicine in 1986 from the American Osteopathic Board of Family Physicians and was recertified in 2004. Additionally, he became a Fellow in the American College of Osteopathic Family Physicians in 1997.

Dr. Martin has served in numerous leadership positions throughout his career. He currently serves as a Governor on the American College of Osteopathic Family Physicians Board of Trustees. He is a Past-President of the Ohio Osteopathic Association and the Ohio Chapter of the American College of Osteopathic Family Physicians. He is a former Chief-of-Staff and Chairman of the Physician-Hospital Steering Committee at Grandview/Southview Medical Center in Dayton. Additionally, he is a past member of the Board of Governors for the Chicago College of Osteopathic Medicine, the Board of Trustees for Midwestern University in Chicago, IL, and the Board of Trustees at Grandview/Southview Medical Center in Dayton.

Dr. Martin remains closely tied to academic medicine. He serves as a Clinical Professor at the Ohio University College of Osteopathic Medicine and is a member of the Adjunct Faculty at the University of Dayton.