Statement of

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On behalf of

The Alliance of Specialty of Medicine

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“Medicare Physician Payments: 2007 and Beyond”

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Mr. Chairman and members of the subcommittee, thank you for holding this hearing on the Medicare physician payment issue. I appreciate the opportunity to present the perspective of medical specialists on legislative proposals pending before the committee, as well as to provide recommendations for modifying the Medicare physician payment formula to ensure continued beneficiary access to timely, quality healthcare. I also thank the committee for its leadership in preventing reimbursement cuts since 2003 and for your continued bipartisan support through proposals to fix the current payment system.

I am Dirk Elston, Director of the Department of Dermatology at Geisinger Medical Center in Danville, Pennsylvania. I co-chair the American Medical Association's (AMA) Physician Consortium's Skin Cancer Work Group. I am a member of the American Academy of Dermatology Association (AADA). I am here today representing the Alliance of Specialty Medicine – a coalition of 11 medical societies, representing nearly 200,000 specialty physicians.

The Un-Sustainable Growth Rate

As we are well aware, sharp cuts in Medicare physician payments will take effect on January 1, 2007 unless Congress takes action this year to avert this reduction, and keep the program strong for seniors and disabled patients and the physicians who care for them. At the heart of the 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 National Product (GDP) instead of the costs of furnishing medical care to Medicare patients and running a medical practice;
- Costs for Medicare Part B covered drugs are in the payment formula although drugs are separate and distinct from 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 the SGR formula is not fixed, physicians will receive negative updates of approximately five percent each year from 2007 until 2015.[1] These reductions may prompt a number of physicians to reconsider their participation in the Medicare program, to limit services to Medicare beneficiaries, or to restrict the number of new Medicare patients they are able to accommodate in their practice.

As advocates for patients and their specialty physicians, the Alliance of Specialty Medicine is very concerned that failure to correct the flaws in the Medicare physician payment system will put the healthcare of seniors and disabled patients in the Medicare program at risk. No physician wants to turn away patients or limit health care to our nation's elderly and disabled patients, but decreasing reimbursement will negatively impact the ability to provide these

[1] 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance. April 2006. Pgs. 135-136. http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2006.pdf

services. Therefore, for the sake of our patients, the Alliance urges Congress make the prevention of the scheduled 5.1 percent reimbursement cut in 2007, the first order of legislation business when lawmakers return to work in November.

Pay-For-Reporting/Pay-For-Performance

As Congress seeks methods to incorporate quality incentives into the Medicare physician payment system, the Alliance believes that several crucial principles must be kept in mind to ensure the final result preserves patients' access to specialty care and promotes the stability and security of the Medicare program. If a quality-based payment system is eventually adopted, it should not be implemented in a budget-neutral manner that would penalize some physicians and thereby provide a disincentive for further measurement development. And, physicians must not be penalized for any volume increases resulting from compliance with performance measures as some measures may involve additional office visits or procedures that would only exacerbate the volume calculation in the current SGR formula. Indeed, for these reasons, the Alliance believes that the SGR and pay-for-performance reimbursement systems are incompatible.

A quality incentive system should be phased in over several years. Phasing in should begin with adequate pilot testing and a "pay-for-reporting" period. Any pay-for-performance program should be voluntary and based on evidence-based

guidelines of care developed by physicians and physician specialty societies. Quality and safety process and outcome measures used in the Medicare system must have widespread acceptance in the physician community prior to adoption by Medicare.

Over a very short period of time the specialty physician community has come a long way towards the incorporation of quality reporting and performance measures based on these principles. During the past year, every Alliance organization has become a member of the Physician Consortium for Performance Improvement (Physician Consortium) of the AMA. In addition, each Alliance organization has a committee within its individual organizational structure focused on Pay-for-Performance (P4P) or Quality Improvement. Each organization also has mobilized quickly to develop new guidelines of care if they did not exist or work with existing evidence-based clinical guidelines to draft quality measures. However, there are challenges in creating standard quality measures for the diverse medical specialists and sub-specialists that we represent.

Measure Development Process

The Alliance of Specialty Medicine's member organizations have worked diligently to prepare physicians for quality improvement. As members of the AMA Physician Consortium, we understand the current measure development, validation, and implementation processes to include specific steps. In summary,

a medical specialty organization proposes quality measures, based on practice guidelines, and the measures are developed and approved by the AMA Physician Consortium. The AMA Physician Consortium process involves private sector insurance companies, state medical societies, organizations geared to ensure quality patient care, methodologists, multiple medical specialty societies, and others to make sure the quality measures are properly vetted. After a public comment period, the AMA Physician Consortium-approved measures are then submitted to a multi-stakeholder group for endorsement. Those endorsed measures are then sent to another multi-stakeholder group that selects a uniform, consistent set of endorsed measures that are warranted for implementation by public and private payers.

It can take up to two years or more for quality measures to go from the initial AMA Physician Consortium submission to implementation. This timeline does not take into account the medical society's own timeline for discussing, developing, testing, and approving the original practice guideline that is the evidence-based foundation for the quality measure. In addition, most of the Alliance member organizations have not been able to participate in Centers for Medicare and Medicaid Services (CMS)'s 16-measure Physician Voluntary Reporting Program (PVRP) because the PVRP measures are not applicable to our specialty physicians. Thus, most Alliance member physicians lack the experience with measurement reporting.

While the measure development process should be fully understood and applied across all organized medicine, as well as scrupulously followed, the process has been vulnerable to misunderstanding. For example, we are aware of an effort by CMS to circumvent the consensus-driven measure development process by requesting that measures go through a multi-stakeholder implementing body before approval by the AMA Physician Consortium. Changing the process midstream will jeopardize physicians' acceptance of the established quality measurement development process currently in place. Furthermore, shifts in the process could lead to the promulgation of measures that do not result in genuine quality gains for patients and physician practices – an outcome that would defeat the purpose of our work to date on measurement development.

Therefore, we urge Congress to ensure that the AMA Physician Consortium remains the proponent for the measure development process. The AMA Physician Consortium has established credibility and plays a critical role in the consensus building process. This process, in which physicians have placed their trust, should not be circumvented. Defining the development process and the AMA Physician Consortium's role in that process is a necessary step before implementing a Medicare Pay-for-Reporting or Pay-for Performance initiative.

Legislative Proposals

As mentioned earlier, the Alliance is greatly appreciative of the work of this committee on the Medicare physician payment issue. We would particularly like

to thank Committee Chairman Barton and Subcommittee Chairman Deal for soliciting input from the physician community. Chairman Barton's proposal is a step in the right direction for averting the payment crisis over the next three years. We are also grateful for the efforts of Ranking Member Dingell and Congressman Burgess – a physician himself who has interacted with the Medicare program firsthand as a provider.

Chairman Barton's Draft Legislation

Chairman Barton's draft legislation providing a three-year, positive .5 percent update that does not impose penalties on physicians who do not (or cannot) report quality measures is greatly appreciated by the Alliance of Specialty Medicine. The legislation is consistent with our principles on P4P as it does not contain punitive elements and allows a full year (in 2007) to ramp up to quality reporting in 2008, with a bonus for reporting. In its favor, the positive updates in the Barton proposal would be changes in law and regulation, effectively beginning to dig us out of the SGR payment hole. Thus, the updates will not serve to deepen the scheduled SGR payment cuts in the out years.

Furthermore, the Alliance appreciates the menu of reporting options in the Barton proposal; physicians can report from either the CMS PVRP or from 3-5 structural measures to be determined by the physician community. This is important since, as we have previously stated, because most Alliance member organizations are unable to participate in the PVRP at this time. As members of the AMA

Physician Consortium, the Alliance organizations have been engaged in the process of measurement development for the past year. It will take some time for our organizations to work through the process and we greatly appreciate ramp-up period in 2007.

The Alliance would appreciate clarification on how provisions in the Barton proposal that provide for contracts with Medicare quality improvement organizations (QIO) or state medical societies for reporting on utilization would be implemented. Additionally, we are concerned that reporting quality measures will require a good deal of physician practice resources. This may be an increased burden to physician practices in staff time, education, and additional personnel at a time when Medicare physician reimbursement has not kept pace with the cost of furnishing services to beneficiaries. Incentive must be adequate to cover the cost of these resources.

Lastly, removing limitations on balance billing would boost physician payment, while making the Medicare program more competitive. Balance billing, when means-tested as stipulated in the Barton proposal, adds coverage options for beneficiaries, allowing them to compare physician fees and make their decisions accordingly.

H.R. 5916, the "Patients' Access to Physicians Act of 2006"

Ranking Member Dingell's legislation outlines a positive physician update reflecting physicians' costs under a Medicare Economic Index (MEI) based payment system for 2007 and 2008, and would produce a much more equitable payment schedule in the short term than is currently in place. Furthermore, the temporary relief provided under the legislation offers lawmakers the necessary time to develop an alternative to the SGR payment formula.

H.R. 5866, the "Medicare Physician Payment Reform and Quality Improvement Act of 2006"

As a fellow physician, Congressman Burgess is personally aware that the current SGR payment system inequitably ties updates in Medicare physician payments to fluctuations in the Gross Domestic Product (GDP) and not the costs of health care inputs. Congressman Burgess's legislation replaces the SGR formula with the MEI minus 1 percent. Cognizance of physicians' costs under an MEI-based payment system would produce a much more equitable payment schedule.

The Alliance also appreciates the legislative language that any voluntary system of quality measurements that may be established must produce relevant, accurate, and useful data in a manner not unduly burdensome to physicians. H.R. 5866 recognizes that measurement development should take place in conjunction with medical specialty organizations and we strongly agree. It is equally important that new funding be allocated as part of a quality-based Medicare payment system. Attempting to launch such a system under the

current constraints of budget neutrality could have the adverse consequence of discouraging quality measurement development and utilization. Further, like the Barton proposal, Dr. Burgess's legislation also contains a provision for balanced-billing, and we applaud this.

Conclusion

The Alliance of Specialty Medicine recognizes the challenges that lawmakers face in creating an equitable Medicare physician payment system that includes quality improvement, and which will lead to genuinely improved quality for Medicare beneficiaries. We applaud the leadership of Chairman Barton, Ranking Member Dingell, Dr. Burgess, and other Republicans and Democrats on this committee for addressing the serious, perennial crisis with declining Medicare physician payments. We sincerely thank you for your willingness to work cooperatively with the physician community. The Alliance is ready to work with the committee to ensure that the Medicare physician payment system is sustainable for the long-term for patients and their specialty physicians, and would ask that this issue be the first order of business when Congress returns from the elections. At this time, I would be happy to answer questions from the subcommittee members. Thank you.