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

Testimony of the American College of Physicians

May 8, 2008

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

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

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

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

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

The Effects of Medicare Payment on Small Practices

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The numbers are startling:

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

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

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

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

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

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

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

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

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

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

Ending the Cycle of SGR Pay Cuts

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

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

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

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

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

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

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

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

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

Comprehensive Medicare Reform

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

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

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

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

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

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

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

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

technology to improve care, who are fully committed to ongoing quality improvement, and who have organized their practices to achieve the best possible outcomes.

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