



AMERICAN OSTEOPATHIC ASSOCIATION

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**Statement
of the
American Osteopathic Association
to the
Practicing Physicians Advisory Council**

August 28, 2006

The American Osteopathic Association (AOA) appreciates the opportunity to provide a statement to the Practicing Physicians Advisory Council regarding Medicare physician payment issues.

The AOA represents the nation's 59,000 osteopathic physicians (DOs). The AOA serves as the primary certifying body for DOs, and is the accrediting agency for all osteopathic medical colleges and health care facilities. The AOA's mission is to advance the philosophy and practice of osteopathic medicine by promoting excellence in education, research, and the delivery of quality, cost-effective healthcare within a distinct, unified profession.

Doctors of osteopathic medicine (DOs) are fully licensed, fully trained physicians practicing in all specialties of medicine. They are entitled to the same rights and privileges (prescribing, hospital, surgical) as allopathic physicians (MDs). DOs comprise a separate, yet equal branch of American medical care. Approximately 65% of all osteopathic physicians practice in primary care areas such as pediatrics, family practice, obstetrics/gynecology, and internal medicine.

Physician Payment: Sustainable Growth Rate

Since its inception in 1965, a central tenet of the Medicare program is the physician-patient relationship. Medicare beneficiaries rely upon physicians for access to all aspects of the Medicare program. However, this relationship has become compromised by dramatic reductions in reimbursements, increased regulatory burdens, and escalating practice costs.

The AOA is concerned about the projected 5.1% decrease in the Medicare payment update for 2007. According to the Centers for Medicare and Medicaid Services (CMS), "spending on physician services and other Part B services has been growing at a much faster rate than target spending. Expenditures for physicians' services in 2005 increased 10 percent over 2004, even faster than had been previously projected, mainly due to an increase in the number and complexity of services furnished to Medicare beneficiaries." CMS cited more frequent and intensive office visits, and rapid growth in the use of imaging techniques, laboratory tests and physician-administer drugs.

However, CMS failed to account accurately for the numerous policy changes and coverage decisions in the Sustainable Growth Rate spending targets. With more preventive services being offered through Medicare and an expected growth in the number of national coverage decisions, utilization is certain to increase. The Congressional Budget Office (CBO) cited 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.

Physicians are the only Medicare providers subject to a payment formula that penalizes them with lower payments when utilization exceeds the SGR spending target. The SGR formula must be eliminated and replaced with a payment system that more accurately reflects the costs of providing care to beneficiaries. Overall, physicians face reductions of more than 35% in their Medicare reimbursements over the next eight years. Since other health care programs and private insurers link their payments to Medicare rates, cuts in other systems will compound the impact of the projected Medicare cuts.

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 Council, 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 there are 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 an integrated program between Parts A, B, and D.

Proposed Payment Formula

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.

For the long term, the AOA supports 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). The SCGR 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).

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. 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.

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. 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.

Five-year review

The AOA applauds CMS' decision to accept the RUC recommendations for Evaluation & Management (E&M) services' work RVUs and for incorporating the full increase for these codes into the global surgical periods for each CPT code with a global period of 010 and 090

days. We agree with the RUC's conclusion that the previous methodology utilized by CMS to determine work RVUs for E&M services was flawed and the proposed values more accurately reflect work performed relative to other services within the Medicare Fee Schedule (MFS).

The work of E&M services has changed significantly over the past several years. Physicians are expected to be more proactive in diagnosing and treating illnesses and disease prevention. This is evidenced by screening services that have been added to the Medicare program in recent years. We commend CMS for recognizing the need to increase the work RVUs to address the increased intensity and complexity of E&M services. The AOA urges CMS to finalize the proposed values for E&M services in the final rule.

Budget Neutrality

CMS proposes to make budget-neutrality adjustments to address the financial impact of the proposed changes in the five-year review by reducing all work RVUs by 10 percent as opposed to adjusting the conversion factor (CF) to preserve statutory budget neutrality.

The AOA disagrees with this approach and requests that CMS review the problems encountered with the previous policy during the years 1993-1998 that utilized adjustments in work RVU's as the method to preserve budget neutrality. This policy ultimately was rejected by CMS in 1999.

The AOA is concerned that adjusting only the work RVU's will result in undervaluing these services relative to the remaining MFS. We believe that budget neutrality adjustments should not alter these existing relationships. In addition, adjusting the Medicare conversion factor is preferable because it will prevent confusion and misinterpretation by other payers who utilize the MFS to determine physician payments.

The AOA believes that adjustment to the conversion factor appropriately recognizes that budget neutrality is a fiscal issue, not an issue of relativity, and will maintain the integrity of the entire MFS. Therefore, the AOA supports adjustment of the conversion factor as the appropriate method to adjust for budget neutrality and requests that CMS reconsider its present position.

Practice Expense (PE) Update

The AOA supports the proposed change in methodology to the practice expense formula as outlined in the proposed rule. We agree that the 'bottom-up' method will more accurately reflect the relative resources required for each service; is understandable so that specialties can better predict the impacts of changes in the PE data; will stabilize PE RVUs and reduce the large fluctuations in the payment for given procedures from year to year that can occur with the present methodology; and utilize the direct inputs established by the Practice Expense Review Committee (PERC) during the PE RVU refinement process.

The AOA is concerned with the quality of the practice expense inputs currently utilized by CMS. We support and will participate in the multi-specialty survey that will be completed in the next two years. It is anticipated that this data will be available for the 2009 Medicare Physician Fee Schedule. The AOA does not support the incorporation of recently submitted specialty-specific practice expense data until the multi-specialty survey is complete and all specialties have an opportunity to provide similar updated inputs.

We support CMS' proposal to transition the changes in the PE methodology over a four-year period. We agree with CMS that "when combined with the estimated negative update for 2007 and the proposed changes to the work RVUs, the shifts in some of the PE RVUs resulting from the immediate implementation of our proposals could potentially cause some disruption in medical practices."

Quality

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 patients.

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.

The AOA's Clinical Assessment Program (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 residency programs re-measuring data. 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.

Pay for Performance: Physician Resource Use/Cost measurement

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 shifted 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.

We generally support programs aimed at improving the quality of care provided and believe that we have a responsibility to help CMS 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.

Any effort to evaluate resource use in the Medicare program must not be motivated only by financial objectives. The AOA believes that physician utilization programs must be aimed at improving the quality of care provided to our patients. The AOA has 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.

E-Prescribing/Health Information Technology

A viable interoperable health information system is key to the implementation and success of quality improvement and performance-based payment methodologies. 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. 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.”

Conclusion

Reductions in reimbursement, increased regulatory and administrative burdens, escalating practice costs and third-party influences all have had a de-humanizing effect on the practice of medicine. As we move forward with reforms to Medicare and our health care system overall, we must proceed with caution, so that the measures we take actually improve the quality of patient care and do not exacerbate the problems that already exist.