



Testimony

of

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on

How Evidenced Based Medicine will Impact African American
Physicians and the Communities they Serve

before the

Committee on Energy and Commerce
United States House of Representatives

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Introduction

On behalf of our physicians and the patients we serve, the National Medical Association (NMA) thanks you for the opportunity to testify before the committee today on the issue of "Medicare Physician Payments." We understand that the hearing will focus on Medicare payments and various proposals for Pay-for-Performance (P4P), or quality measurement.

The (NMA) promotes the collective interests of physicians and patients of African descent. We carry out this mission by serving as the collective voice of physicians of African descent and as a leading force for parity in medicine, elimination of health disparities, and promotion of optimal health.

The NMA is the largest and oldest national organization representing African American physicians and their patients in the United States. The NMA is a 501(c) (3) national professional and scientific organization representing the interests of more than 25,000 African American physicians and the patients they serve. NMA is committed to improving the quality of health among minorities and disadvantaged people through its membership, professional development, community health education, advocacy, research and partnerships with federal and private agencies.

As the nation's only organization devoted to the needs of African American physicians, health professionals and their patients, the NMA serves as the conscience of the medical profession in the ongoing fight to eliminate health disparities in the nation's health care delivery system.

The NMA has historically been an unwavering advocate for health policies that improve the quality and availability of health care of African Americans and other underserved populations. For instance, the National Medical Association was a key force behind such landmark reforms as Medicare and Medicaid. Today, the NMA continues to provide leadership in shaping the national health policy agenda through continued involvement in a variety of critical policy matters.

The Medicare Physician Payment Formula Should be Replaced

The NMA stands in league with the entire physician community or "House of Medicine" in calling for the replacement of the current Medicare physician payment formula. The formula, including the so called "sustainable growth rate," is an untenable mechanism that harms physicians and Medicare patients.

If Congress does not act before the end of 2006, physician payments will be slashed by more than 5% beginning in January 2007. We urge Congress to act quickly to redress this wrong, and ensure that the Medicare payment system is replaced with a fair and more effective system.

NMA's Views on Pay for Performance/Quality Measurement

The NMA embraces efforts designed to improve access to and quality of health care services. P4P is of significant interest to the NMA as its implementation will have far reaching effects in communities throughout this country. Successful efforts will ensure that P4P increases the quality of health care and decreases health disparities, instead of decreasing the quality of health care and increasing health disparities.

The NMA is committed to the highest quality care for all patients, and to the optimal delivery of such care under all circumstances. The NMA is focused on the reduction or elimination of all disparities in health care, especially those that are racial and ethnic in origin. As such, we remain committed to the integrity of America's health care safety net, of which Medicaid and Medicare are vital components.

We stand firm in our resolve that P4P initiatives should not have the unintended consequence of exacerbating racial or ethnic disparities in health care. We also offer our expertise and guidance to Congress and other decision-makers in developing proper programs that benefit, and not harm, those who are in the greatest danger, the underserved and uninsured.

Racial and Ethnic Disparities Are Real and Must Be Corrected, Not Exacerbated by P4P Legislation

Last week, the Institute of Medicine released a report entitled, "Rewarding Provider Performance: Aligning Incentives in Medicare (Pathways to Quality Health Care Series) (2007)." The NMA was pleased to see that the IOM report encouraged a systematic and phased-in approach to instituting quality measurement and specifically stated:

"However, pay for performance needs to be closely monitored because it could have unintended adverse consequences, such as decreased access to care, increased disparities in care, or impediments to innovation (emphasis added)."

Statistics about racial and ethnic disparities should guide Congress, the White House, the Centers for Medicare and Medicaid Services (CMS), the Institute of Medicine (IOM), and other policymakers in their decision-making on P4P.

We urge Congress to review the following statistics about racial and ethnic disparities as they craft P4P or any other quality measurement legislation. For example,

- Racial disparities in health status persist across the entire human lifespan. At the start of life: Black infant mortality is two and a half times higher than that of white babies. And at the end of life: White men outlive black men by 7 years; and white women outlive black women by a half-decade.

- Black Americans lead the nation in 12 of the top 15 leading causes of death, including heart disease, cancer, diabetes, and kidney disease.
- The uninsured have worse health and higher morbidity compared to the insured.
- The uninsured are also more likely to forego needed care and obtain inadequate care for even the most serious illnesses like diabetes, heart disease, hypertension, kidney disease, cancers, and AIDS.
- The uninsured are also less likely to receive preventive services such as screenings for breast, cervical, and colorectal cancer. When they do receive these services, they receive them less frequently than recommended.
- When minorities do have healthcare coverage, there are still deep disparities in healthcare delivery which results in worse health and higher morbidity for minority patients.
- Further, minority patients have poorer health status, higher levels of noncompliance, and greater distrust. Consequently, patient outcomes are significantly influenced by racial disparities in health status, compliance, and overall distrust.
- Well-documented practice patterns among minority physicians are exceptionally well-suited for improving minority care and reducing racial disparities in care.
- As minority doctors are more likely to serve at-risk populations and patients prefer and are more satisfied with racially-concordant physicians, P4P should NOT have the unintended effect of compromising care or access for minority patients by negatively altering provider service patterns (among both minority and non-minority physicians).

Excellence Centers To Eliminate Ethnic/Racial Disparities (EXCEED). AHRQ Publication No. 01-P021, May 2001. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/research/exceed.htm>;

Williams, DR. 2003. Racial/Ethnic Disparities in Health, www.macses.ucsf.edu/News/williams.pdf;

2004 U.S. Census

The U.S. Department of Health and Human Services, HRSA Health Disparities Collaboratives (HDC) <http://bphc.hrsa.gov/quality/Collaboratives.htm>.

NMA Experience and Policy on Pay for Performance/Quality Measurement

NMA Presidential Task Force on Pay for Performance

As an outgrowth of the NMA's March 2006 7th National Colloquium on African American Health entitled "Addressing Evidenced Based Medicine and P4P: Projected Impact on Physician Practices," the NMA convened a "Presidential Task Force on Pay for Performance." The Presidential Task Force took a serious and in-depth look at the various P4P proposals being advanced in Congress and through the Administration. Our physician task force members contributed their direct experience with P4P and various performance-based incentive programs in the states where they practice. Further, the NMA leadership recently launched a grassroots initiative to educate and inform our members about P4P and enlist their advice and guidance on the issue.

The NMA Presidential Task Force found that "responsible governance of P4P" requires the following:

- Quality of care measures must be clearly delineated from cost containment measures.
- All measures must be culturally relevant to the population served, with due consideration to and stratified measures associated with social economic status, self-reported race, ethnicity, co-morbidities, chronic conditions, high risk, and disease burdened populations.
- Quality measures, cost containment measures, and reimbursement formulas must be appropriate for the population served.
- Capacity-building support must be provided to small and disadvantaged health care providers to ensure infrastructure allows quality data gathering and reporting.
- Ample input from a diverse population of specialty and culturally representative physicians and patients should be used in the development, implementation, and evaluation of the effectiveness and impact of P4P measures, policies, procedures, regulations, and programs.
- Effectual physician and patient education on P4P measures, policies, procedures, regulations, and programs must be provided.

Following these recommendations will help the nation successfully achieve its goal of improved quality of care and efficiency in health care cost and systems without exacerbating health care disparities. Without these measures, increased health disparities and health care cost will result, accompanied by a decrease in access to quality care, physician viability, and community economics.

NMA Policy on Pay for Performance

The NMA has developed written policy on P4P that recognizes that the P4P framework developed and implemented by the Centers for Medicare and Medicaid Services (CMS) is very likely to set the pace for the rest of the nation, given that millions of providers serve the 100 million or so beneficiaries enrolled in Medicare and Medicaid.

Accordingly, any P4P frameworks should be constructed with great care, and with the following key considerations in mind:

- Most of the recent experience with P4P has been in large, multi-specialty practices. As many minority physicians practice in the solo or small practice setting, extrapolating results to all practice settings is misguided. More research and analysis of how P4P will impact small and solo practices is therefore warranted and necessary to protect against increased disparities.
- Implementation of health technology would be an important means to effectuate P4P efforts; however, the cost of health technology is often prohibitive for physicians practicing in small or solo practices. According to a recent Commonwealth Fund study, 'Information Technologies: When Will They Make It into Physicians' Black Bags?' -- "There remains a technological divide between physicians depending on their practice environment and mode of compensation. This is a major discrepancy that will need to be addressed since three quarters of U.S. physicians provide care in solo and small group practices.
- The scientific and clinical data that constitute the 'evidence base' by which performance is measured should be compiled across diverse populations. P4P frameworks should therefore focus on 'quality improvement', stratified by appropriate demographic group.
- Clinical data are more reliable predictors of quality improvement than are claims data and therefore P4P frameworks should therefore rely more heavily on clinical data.
- Patients will not necessarily comply with quality improvement protocols just because their health care provider does. In other words - an undesirable clinical outcome does not necessarily bespeak poor [or non-compliant] 'performance' by the provider.
- The design, implementation, and evaluation of P4P frameworks should include practicing physicians with expertise in working among populations that suffer the ill effects of ethnic and racial health disparities.
- P4P frameworks and the current Sustainable Growth Rate [SGR] framework cannot co-exist. SGR must be repealed if P4P is to have any chance of sustained success.

- P4P reporting requirements must be voluntary in this preliminary stage. Requiring cash-strapped providers to report on quality measures while they are still in their infancy further compounds the challenge of systematic data collection.
- Health Information Technology is vital to this process. There must be a national commitment to providing financial and technical assistance to America's healthcare providers, in order to facilitate their transition into the Information Age.

In addition, the NMA supports the American Medical Association's (AMA's) Minority Affairs Consortium Resolution 210, and AMA's Principles for Pay-for-Performance Programs. The resolution is consistent with our position on P4P and a strong statement of AMA's commitment to work with us to eliminate racial and ethnic disparities.

The NMA recognizes that P4P can lead to reduced disparities and improved physician viability, quality of care, and community economics. However, reliable and valid measures must be used; providers must be granted adequate resources to sufficiently develop their infrastructure; and effective 2-way channels of communication must be established allowing physicians and patients necessary input and education on P4P measures, policies, procedures, regulations, and programs.

Therefore, NMA recommends that quality improvement initiatives targeting minority populations must be voluntary, patient-focused, have realistic quality measurements, recognize minority physician practice patterns and care dynamics, reward physicians working with minority patient groups with greater reimbursement for time spent and patient education.

NMA Support for Measures to Address Disparities in P4P Legislation

The NMA was particularly pleased to see the introduction H.R. 5866, the "Medicare Physician Payment Reform and Quality Improvement Act of 2006" on July 24, 2006. The legislation, introduced by Congressman Burgess and co-sponsored by a number of members of this committee, would address three very important concerns directly related to racial and ethnic disparities.

The Burgess legislation would direct the Secretary of Health and Human Services, to:

- measure quality by "stratified groups and the review of the absolute level of quality provided by a physician or medical group;" and
- include "practicing physicians with expertise in eliminating racial and ethnic disparities in the design, implementation and evaluation of the program."

- Further, the legislation would direct the Secretary to develop quality measures with a consensus building organization that would include those who “serve a disproportionate number of minority patients.”

The legislation is an excellent first step in addressing racial disparities because it recognizes the importance of seeking the advice and guidance of physicians who practice in underserved areas where patients are often under or uninsured and suffer greater co-morbidities and have direct experience in working to eliminate racial disparities.

We applaud Congressman Burgess for recognizing the unique needs of minority physicians and those who serve minority populations. We hope that this committee and others who are working on P4P follow his wise and thoughtful lead.

We also hope to see legislation and/or regulations that adopt other principles that we have outlined in this testimony. We also thank Chairman Barton and Deal for their recent efforts to address the Medicare physician payment problem and hope that they too will incorporate Congressman Burgess’ language, and our other suggestions, into any pending legislation.

Thank you for the opportunity to share the NMA’s views with this honorable Committee. The NMA and our leadership look forward to working with you to ensure that any P4P/quality programs are reasoned approaches that seek to eliminate racial disparities.