

American College of Cardiology
Statement for the Record of the
Committee on Ways and Means Subcommittee on Health
Hearing on Medicare Payment Policies

March 1, 2006

The American College of Cardiology (ACC) appreciates the opportunity to provide a statement for the record of the subcommittee's hearing on the March 2006 Medicare Payment Advisory Commission's (MedPAC) report to Congress.

The ACC is a 33,000 member non-profit professional medical society and teaching institution whose purpose is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and formulation of health care policy.

The ACC commends the subcommittee for its work to address the problems with the current system of Medicare physician reimbursement. We are committed to working with Congress and the Administration to strengthen the Medicare program and to ensure that Medicare patients can benefit from the life-saving and life-enhancing care that cardiovascular specialists provide. As such, the ACC outlines its position below on many of the issues MedPAC addresses in its current or past reports, including the Medicare physician reimbursement formula, office-based medical imaging, valuing of physician services and pay-for-performance.

Medicare Physician Reimbursement Formula

The ACC thanks Congress for its action to stop the 4.4 percent cut in Medicare physician reimbursement scheduled for 2006 by enacting a one-year freeze in reimbursement levels through the Deficit Reduction Act of 2005 (DRA). However, we are concerned that physicians continue to face cuts in reimbursement totaling 25 percent over the next six years, including a 4.6 percent cut scheduled for January 1, 2007. The ACC is also concerned that Congress singled out office-based medical imaging for significant cuts in the DRA arbitrarily and without a public vetting process. The cumulative effect of these cuts, in addition to administrative changes being considered by the Centers for Medicare and Medicaid Services (CMS), will devastate some physician practices like never before, resulting in challenges for Medicare beneficiaries in accessing needed medical services.

We appreciate that MedPAC recommends an update of 2.8 percent in 2007 Medicare physician reimbursement in its report to Congress. The ACC urges Congress to act in 2006 to avert further scheduled physician reimbursement cuts and to correct underlying flaws in the Sustainable Growth Rate (SGR) reimbursement formula. This formula should be eliminated and replaced with a formula that more accurately reflects the cost of providing health care services to Medicare beneficiaries. Medicare physician payment rates that keep pace with the rising cost of practicing medicine are essential to physicians' efforts to improve the quality of care provided to Medicare beneficiaries, and in some cases, to provide care at all.

The ACC also commends the efforts of Congress to address quality improvement through pay-for-performance type programs. The ACC's position on pay-for-performance is described in detail below; however, it is important to note that physicians will be unable to develop the infrastructure required to support effective pay-for-performance systems if steep cuts in reimbursement are allowed to continue. The ACC is grateful for Chairman Johnson's attention to this concern, and we support her legislation, the "Medicare Value-

Based Purchasing for Physicians' Services Act of 2005" (H.R. 3617), which would replace the SGR formula and establish a value-based system for Medicare physician reimbursement. In addition, we are pleased that several of the health information technology (HIT) proposals before Congress would provide incentives, such as tax credits, to physician offices for implementing HIT systems. Such incentives will be critical in helping physician offices build the infrastructure necessary to participate in pay-for-performance systems, particularly for small physician practices.

Office-Based Medical Imaging

The ACC believes the increase in office-based medical imaging utilization needs to be studied to determine the extent to which the growth is appropriate and medically necessary. MedPAC, in its 2005 examination of imaging growth, could not determine if the growth in imaging utilization is inappropriate. The ACC recognizes the intense pressure to control Medicare spending; however, Congress should be cautious in singling out specific physician services (such as medical imaging) on the basis of growth alone to achieve cost savings through arbitrary cuts.

The ACC is disappointed that Congress enacted significant cuts to office-based medical imaging in the DRA, and we urge Congress to mitigate the cuts before they take effect on Jan. 1, 2007. Under the DRA, the technical component of office-based imaging services will be paid at the lesser of the Medicare Physician Fee Schedule (MPFS) or the Hospital Outpatient Prospective Payment System (HOPPS) rate. These cuts were included in the dead of night without open dialogue. In many cases, the HOPPS payment rate would not reflect the true costs of owning and operating imaging equipment in the physician office. Many physicians may no longer be able to afford to provide imaging in their office due to the cuts, which will drive Medicare beneficiaries to the hospital setting where they could have longer wait times, will lose the benefit of having imaging services performed by their treating physician, and in some cases, will be responsible for co-pays up to 40 percent of the hospital payment. Co-pays in the physician office setting are limited to 20 percent.

Quality initiatives for medical imaging developed by specialty societies, such as the development of appropriateness criteria, quality measures and certification standards, are growing and should continue. For instance, the ACC is working to foster collaboration among health plans, payers and cardiologists to improve the efficiency and equity of cardiovascular imaging. Last fall, the ACC and the American Society of Nuclear Cardiology (ASNC) released Appropriateness Criteria for Single-Photon Emission Computed Tomography Myocardial Perfusion Imaging (SPECT MPI) as a means of defining "when to do" a specific procedure in the context of scientific evidence, the health care environment, the patient's profile and a physician's judgment. The ACC currently is developing appropriateness criteria for CT, MR and echocardiography, all of which will be completed in 2006. It is important to note that the ACC is employing a collaborative and multi-disciplinary approach to the development of appropriateness criteria.

The ACC believes that such efforts help to ensure that Medicare and private payers spend its resources on the most effective, most appropriate care for beneficiaries. Neither arbitrary payment cuts, nor one-size-fits-all regulatory requirements can achieve this goal. Public policy initiatives should support efforts by individual medical societies to ensure appropriate utilization by qualified specialists, but should not encumber these efforts by overly burdensome regulations or duplicate them through the implementation of generic, non-specialty specific requirements.

Valuing Physician Services

Ensuring the accuracy of the work relative value units in the physician fee schedule and the fairness of the process for reviewing those values is a high priority. During the past year, MedPAC has devoted substantial attention to discussions about the role of the American Medical Association Specialty Society Relative Value Scale Update Committee (RUC) in helping the Centers for Medicare and Medicaid Services (CMS) review, maintain, and update Medicare's Resource Based Relative Value Scale (RBRVS). The ACC was a founding member of the RUC and has been an active participant in the RUC process since its inception. The ACC believes that the cooperation between the RUC and CMS is an outstanding example of a successful public-private partnership and we take MedPAC's recommendations for improving this process very seriously. We are, therefore, concerned with several aspects of MedPAC's report on valuing physician services.

The Commission's recommendations for improving the review process for the work relative values center on establishment of an expert panel to assist CMS and "augment" the RUC process. There is no question that lack of resources limits CMS's ability to identify services that warrant review and to provide the RUC with supporting data for that review. MedPAC has not, however, provided evidence that investing resources in an expert panel is the best way to improve the accuracy of physician reimbursement. The ACC urges that CMS be consulted regarding the need for and potential benefit of an expert panel before one is established. We also note that the RUC and the specialty societies are acutely aware of MedPAC's concerns about the RUC's ability and willingness to identify and review overvalued services. The RUC is now considering ways in which to strengthen its performance in this area.

The Commission has been concerned about the ability of the RUC to overcome what the report describes as specialty societies' financial stake in the outcome of the RUC's deliberations. Although it is certainly true that members of one specialty society may have a financial stake in having the RUC recommend high values for their codes, physician reimbursement still operates within a zero sum game. Therefore, the RUC process assures that one specialty society's representatives must also persuade other physicians who have a financial stake in keeping other specialty's values low. Competing interests result in the RUC providing a very rigorous review of all specialties' recommendations.

MedPAC has also been concerned that the RUC's composition does not provide adequate representation for primary care physicians. The RUC's primary function is to recommend

relative values for new procedures, most of which are performed by non-primary care specialties. It is essential that the RUC encompass the broad spectrum of medical practice to ensure that adequate expertise is available to review new procedures. The combination of viewpoints and broad range of experience RUC members bring to the process has been a key to the committee's ability to closely examine and evaluate the work of new technology.

Pay-for-Performance

Discussions regarding physician payment reform increasingly revolve around proposals that would transition the Medicare program to a performance-based reimbursement system. The ACC supports the concept of aligning financial incentives with the performance of evidence-based medicine to inspire greater focus on improving care delivery systems. In fact, the ACC has a long history in working with CMS on cardiovascular care performance measurement and quality improvement. Below are a few examples of our collaborations:

- The ACC and American Heart Association (AHA) issued their first clinical practice guideline on Implantation of Pacemakers in 1984, in part to respond to a CMS (then HFCA) request for expert opinion on patient indications for the device.
- In 1993, the ACC lent support to development by CMS of objective performance measures based on the ACC/AHA Guideline for the Early Management of Patients with Acute Myocardial Infarction. These measures tracked inpatient care first at the state level and then at the national level.
- The ACC, AHA and Physician Consortium collaborated in 2003 on coronary artery disease (CAD), Heart Failure and Hypertension measurement sets. CMS agreed to use many of the measures from these sets in the Doctors Office Quality demonstration project.
- The ACC, AHA, CMS and JCAHO collaborated on updating the ACE measure for acute myocardial infarction (AMI) and Heart Failure patients in 2004.
- Last spring, the ACC, AHA, CMS, JCAHO and AHRQ issued a practice advisory on the impact of the COMMIT trial on current beta blocker measures for AMI patients.
- In the fall, CMS announced mandatory use of NCDR ICD Registry for data collection for the devices.
- Finally, in 2006, the ACC, AHA, CMS, JCAHO and AHRQ issued an editorial on collaboration related to evolution of STEMI/NSTEMI measures.

The ACC's experience with performance measurement in cardiovascular care reinforces our belief that physician pay-for-performance systems should be designed to support and facilitate the quality improvement process and strengthen the patient-physician relationship, not just to report performance and outcomes or to control Medicare spending. The ACC, therefore, developed the following principles to guide the development of pay-for-performance programs. Physician pay-for-performance programs should:

1. Be built on evidence-based, well established and proven performance measures.
2. Provide adequate incentives for investments in structure, best practices and tools that can lead to improvement and high quality care.
3. Reward process, outcome, improvement and sustainability.
4. Assign attribution of credit for performance to physicians in ways that are credible and encourage collaboration.
5. Favor the use of clinical data over claims based data.
6. Set targets for performance through national consensus processes that address factors such as local resource constraints and socio-demographic differences.
7. Address appropriateness (i.e. what behaviors should be encouraged as well as discouraged).
8. Emphasize success and reward achievement, rather than be punitive.
9. Use an objective third party to audit performance measure data.
10. Establish transparent provider rating methods.
11. Not create perverse incentives, such as excluding sicker patients from a physician's panel.
12. Invest in outcomes and health services research.

Conclusion

As the subcommittee works this year to strengthen the Medicare program and improve the Medicare physician reimbursement system, the ACC is committed to working with you. Thank you for the opportunity to provide a statement for the record. Should you have any questions, please contact Camille Bonta at cbonta@acc.org or (301) 897-2620 or Jennifer Brunelle at jbrunell@acc.org or (301) 581-3477.