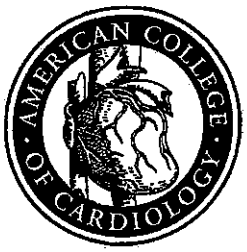

Statement for the Record

Presented to the

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
HEALTH SUBCOMMITTEE

Hearing on

IPAB: The Controversial Consequences for Medicare and Seniors

July 13, 2011

The American College of Cardiology (ACC) is pleased to submit a statement for the record for the Energy and Commerce Health Subcommittee hearing, **"IPAB: The Controversial Consequences for Medicare and Seniors."**

The ACC is a professional medical society and teaching institution made up of 40,000 cardiovascular professionals from around the world – including over 90 percent of practicing cardiologists in the United States and a growing number of registered nurses, clinical nurse specialists, nurse practitioners, physician assistants and clinical pharmacists.

The College is committed to working with Congress, the physician community, the Center for Medicare and Medicaid Services (CMS), 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.

The ACC strongly supports efforts to align financial incentives to inspire greater focus on providing care that is patient-centered, evidence-based and cost-effective. Early in the health reform debate, the College hoped the Independent Payment Advisory Board (IPAB) concept would offer an opportunity to break down the silos of parts A and B in Medicare and modernize the program by focusing on quality improvement. Unfortunately, the ACC believes that the IPAB as enacted in the Affordable Care Act (ACA) is a flawed way to control spending and will be harmful to patient care. Significant modifications to the current model are necessary.

Reforming the Flawed Medicare Physician Reimbursement Formula

First and foremost, Congress must act to permanently repeal the flawed sustainable growth rate (SGR) formula used to set Medicare physician payment rates prior to implementation of IPAB. Physicians are already subject to an expenditure target and other potential payment reductions as the result of the Medicare physician payment formula. The College believes it does not make sense to subject physicians to expenditure targets while at the same time exempting from IPAB's recommendations large segments of Medicare providers who are subject to no target at all. Until the SGR is replaced, the ACC cannot support implementation of IPAB.

Since the formula was established, Congress has repeatedly stepped in and stopped pending cuts but did not address the underlying problems with the formula. Each time Congress has passed a short-term intervention it has only created practice instability, deepened the payment cuts in future years, and increased the cost of permanently resolving the problem.

It is widely known that the current reimbursement formula is severely flawed. It does not accurately reflect the cost of providing care to Medicare beneficiaries, nor does it account for changes and improvements in technology, shifts in the site of service, and the changing demographics of the Medicare population.

Congress must act this year to stop the 29.5 percent Medicare physician payment cut scheduled for January 1, 2012. The ACC strongly urges Congress to repeal the SGR, provide stable payments for a period of several years to allow testing of different payment models, and then allow for a transition to new payment models.

Re-Aligning Incentives to Reward Quality Instead of Volume

The ACC believes IPAB must place more emphasis on payment reforms that improve quality and lower costs rather than price controls that could hurt access—and as history proves---won't work.

Through its national cardiovascular data registry, clinical guidelines, appropriate use criteria, and other quality initiatives, the ACC is committed to providing its members with tools to help ensure that the highest quality of care is provided to patients with cardiovascular disease, leading to better outcomes and more responsible use of limited health care resources.

With more than 2 million patient records, the ACC's PINNACLE Outpatient Registry is an example of a quality of care monitoring and feedback system. This ambulatory registry can be an invaluable resource in terms of identifying variations in care, reducing disparities, and measuring performance and providing opportunities for performance improvement at the practice level. The suite of other National Cardiovascular Data Registries (NCDR®) is also important for measuring outcomes at the hospital level, with more than 14 million patient records. Measuring cardiovascular quality across the care continuum will allow a thorough tracking of these new payment initiatives to ensure that quality is improved at the same time that spending is reduced.

Given the important role guidelines play in bridging the gaps between science and practice, the ACC is also committed to increasing adherence to guidelines and appropriate use criteria through the use of clinical decision support tools; development of educational tools and programs; and the creation of a network of hospitals and practices committed to quality improvement. In

addition, the ACC is piloting ways to increase primary and secondary prevention through the development of tools to monitor and encourage patient adherence to medications, as well as patient involvement and understanding of cardiovascular disease and impacts of lifestyle choices. As a part of building this understanding, ACC believes in engaging patients with shared decision making, providing individualized patient risk profiles and care support information.

Based on the College's experience, deficiencies in quality and efficiency are not generally the result of uneducated or recalcitrant physicians, but rather the result of misaligned incentives and inadequate feedback systems. The use of claims data instead of clinical data will go a long way to educate physicians about their quality of care and change their care patterns. Blunt cuts to reimbursement for services do not change behavior. The ACC strongly supports moving the current Medicare physician payment system away from a volume-based system and toward a value-driven system that aligns financial incentives with performance of evidence-based medicine and with improving care delivery systems.

The College strongly supports the testing of new models for delivering and reimbursing care through the CMS Innovation Center, private payers, and other initiatives, with priority placed on high cost, high impact conditions. Models are needed that work for a variety of settings, and must address the infrastructure challenges of private practice and rural areas.

While there are many clinical reasons to implement these changes, the financial impact will be substantial. The current system wastes substantial costs on inefficient or unnecessary care.

Table 1 represents just some of the potential savings:

Table 1. Projected Annual Savings by Avoiding Low Value Care and Inefficient Utilization Review

Current Practice	Savings
Inefficient Radiology Benefit Management Utilization Reviews in Private Health Plans	$271 - $869 million
1% reduction in stenting not meeting appropriate use	$44 million (10% reduction = $490 million)
1% reduction in ICD not meeting guidelines	$10 million (10% reduction = $100 million)

The experience gained by testing models should be seriously considered by IPAB.

Other Necessary IPAB Improvements

In addition to permanently replacing the SGR formula and placing more emphasis on quality improvement, the College urges Congress to work in a bipartisan manner to enact the following improvements to the IPAB framework and authority:

- IPAB must apply to all sectors of health care at the same time (segments of health care should not be carved out till later dates)
- Flexibility should be provided to help recruit high quality Board candidates
- Congress should retain the ability to achieve a different level of savings than proposed by the IPAB to adjust for new innovations that warrant spending growth
- Congress should maintain its ultimate accountability for the sustainability and stability of the Medicare program
- Recommendations should require an affirmative vote by Congress before they can be implemented

Conclusion

Thank you for the opportunity to share the College's views on the IPAB. ACC's CEO John C. (Jack) Lewin, M.D., and Senior VP for Advocacy James (Jim) Fasules, M.D., F.A.C.C., offer the ACC as a resource to you and your colleagues as you work to strengthen the Medicare program to ensure that Medicare beneficiaries have access to high quality care.

Summary

The American College of Cardiology (ACC) strongly supports efforts to align financial incentives to inspire greater focus on providing care that is patient-centered, evidence-based and cost-effective. Early in the health reform debate, the College hoped the Independent Payment Advisory Board (IPAB) concept would offer an opportunity to break down the silos of parts A and B in Medicare and modernize the program by focusing on quality improvement. Unfortunately, the ACC believes significant modifications are necessary to the IPAB as enacted in the Affordable Care Act (ACA).

First and foremost, Congress must act to permanently repeal the flawed sustainable growth rate (SGR) formula used to set Medicare physician payment rates prior to implementation of IPAB. Physicians are already subject to an expenditure target and other potential payment reductions as the result of the Medicare physician payment formula. The College believes it does not make sense to subject physicians to expenditure targets while at the same time exempting from IPAB's recommendations large segments of Medicare providers who are subject to no target at all. Until the SGR is replaced, the ACC cannot support implementation of IPAB.

In addition to permanently replacing the SGR formula, the College urges Congress to work in a bipartisan manner to enact the following improvements to the IPAB framework and authority:

- IPAB must apply to all health sectors at the same time (hospitals and other segments of health care should not be carved out)
- Flexibility should be provided to help recruit high quality Board candidates
- More emphasis should be placed on payment reforms that improve quality and lower costs rather than price controls that could hurt access
- Congress should retain the ability to achieve a different level of savings than proposed by the IPAB to adjust for new innovations that warrant spending growth
- Congress should maintain its ultimate accountability for the sustainability and stability of the Medicare program
- Recommendations should require an affirmative vote by Congress before they can be implemented