

**Legislative Conference
ACC 9/07
Washington, DC;
Impact to Puerto Rico**

**Jose R. Rivera Del Rio, MD,
F.A.C.P., F.A.C.C.
President and Governor PRACC**

MESSAGE

- Physicians have a personal and professional responsibility to provide quality, patient-centered care, **but!** they are limited in what they can do as a result of Medicare physician payment cuts and pressure to reduce costs.

TOPICS

- Medicare Physician Payment
- Medical Imaging
- Health Information Technology
- Transparency and Public Reporting

Medicare Physician Payment

- The Center for Medicare and Medicaid Services (CMS) uses the sustainable growth rate formula (SGR) to calculate annual physician payment services
- This formula is considered inappropriate and incorrectly reduces the physician payment services
- For **January 1, 2008 a 10%** cut is expected!

Medicare Physician Payment

- The expected cut for the year **2016 is of 40%!**
- The Medicare Physician Reporting Initiative (PQRI), which gives incentive payment of 1.5% for physician who voluntarily report a series of quality measures to CMS, will **no longer give** incentive payments in 2008

Medicare Physician Payment

- If the scheduled cuts due to the flawed SGR occur and are coupled with proposed changes outlined in the 2008 Medicare physician fee schedule proposed rule, cardiology faces a **10% payment cut in 2008**

Medicare Physician Payment

- The Children Health and Medicare Protection Act in August 2007 (CHAMP Act) which combines a reauthorization of the State Children Health Insurance Program (SCHIP) states an apparent benefit by stopping the 10% payment cut in 2008 and 5% in 2009
- It replaces the SGR with 6 separate expenditure targets as an interim step to a new payment formula

Medicare Physician Payment

- In spite of the attractiveness of these Acts the legislation contains numerous troubling provisions for the cardiology community
 - The separate expenditure targets (Primary care, Other E & M services, Imaging, Major procedures, Minor procedures and Anesthesia) which **exceed its target** will be cut

Medicare Physician Payment

- The conversion factor which at present is limited to 7% maximum, after 2010 **could increase to 14%**
- It gives the secretary the authority, without going through the RUC (Relative Value Scale Update Committee), to **arbitrarily reduce the work component** for services with excess of volume growth (defined as 10% or more)

Medicare Physician Payment

- Requires the Secretary to implement by July 2008 a **confidential feedback system** on how their private practice compares to other physicians
- **Does not** include PQRI
- Requires CMS to increase its assumption in amount of time imaging equipments is in use from 50 % to 75% for purposes of determining practice expense RVU's. The higher utilization rate will lead to lower estimates of the cost of using imaging equipment **and thus result in lower payments**

Medicare Physician Payment

- The **decisions were not built** on a foundation of advancing the quality and appropriateness of care provided to Medicare beneficiaries
- **Congress didn't helped with tools** which will assist physicians in being good stewards of limited health care resources. (Data registry, electronic health records, confidential comparative feedback programs, appropriateness criteria, and clinical guidelines)

Clinical elements for meaningful comparative feedback

- Physician should receive federal funding to implement EHR
- The EHR will allow evaluation of the physician performance in accordance to his adherence to guidelines and performance measures
- Use of clinical data is integral. While the information obtained from Medicare claims is valuable, utilization data alone is insufficient for effective feed back programs
- **Feedback must be on patterns of care and not use of individual services**

Clinical elements for meaningful comparative feedback

- **Standards use must be widely accepted**
- **Comparative data must be adjusted to patient characteristics**
- **Physician must be compared with similar peers**
- **Data must be fed back for physician practice changes**

Office-based clinical imaging

- In December 2005 the Deficit Reduction Act (**DRA**) was developed and implemented in January 2007.
- It requires that the payment for the technical component of an imaging service be at either the hospital outpatient prospective payment system (HOPPS) or the physician fee schedule amount, **whichever is lower**
- The **net loss** resulting from DRA is **150 million dollars in 2007**
- **Mostly attributed (50%) to SPECT MPI** although any study was affected

Office-based clinical imaging

- The CHAMP Act, as explained before in Medicare Physician Payment, **also affect negatively** the reimbursement
- It does so when the imaging separate expenditure target because of the growth will exceed the expenditure target
- The Act establishes also **accreditation process** but as written **is not in accordance** with the ACC recommendations
- Also the amount in time imaging equipment is in use will impose more cuts. The higher utilization rate will lead to lower estimates of the cost of using imaging equipment, thus lower payments

Office-based clinical imaging

- The Color Flow Doppler Echocardiography component (CPT 93325) will be eliminated with no adjustment
- Contiguous body parts imaging studies will receive a 50% cut
- Interest rate: The maximum rate of interest for capital purchase will be of 11%. At present is at 11%!

Office-based clinical imaging

- **Medical Imaging=Good patient Care**
 - Growth in medical imaging is driven by good patient care
 - In-office imaging provides patients with prompt, convenient and reliable results
 - In-office imaging allows quicker diagnosis and treatment with minimized patient anxiety

Office-based clinical imaging

■ ACC

- Recognizes the benefit of in-office imaging
- Has taken proactive approach to ensuring quality and reasonable medical imaging through the development of appropriateness criteria
- Accreditation or certification is accepted to improve quality
- The ACC has published appropriate criteria and guidelines which can help in

Health Information Technology

- President Bush called for Health Information Technology (HIT) in 2004
- For 2015 most Americans **most** have it
- The ACC supports this endeavor
- Only 15% of practices uses EHR
- In view the cost of implementations **for small offices is prohibitive** the government should assist in its implementation by tax credits, grants or loans

Transparency and public reporting

- **The public release of Medicare claims in a physician identifiable format are insufficient for quality improvement**

The impact of CMS changes in Puerto Rico

The impact of CMS changes in Puerto Rico

- All the changes stated before will impact Puerto Rico
- Puerto Rico will have a 20-30% magnified cut effect as its reimbursement status is already lower
- Puerto Rico has similar reimbursement as some rural areas in mainland USA (California, Texas, Georgia to mention a few)

The impact of CMS changes in Puerto Rico

- The past social reality has changed in the last 30 years but not the reimbursement
- San Juan, Puerto Rico is the 10th most inhabited state capital of the USA
- The cost of living in Puerto Rico is also significantly higher than in other states
- The “rules” are the same as in mainland:
 - Certification for medical practice
 - Quality assurance
 - CMS evaluation policies

The impact of CMS changes in Puerto Rico

- **In view of the stated information the urgency to optimize Puerto Rico reimbursement status should be a priority for Congress before the impact of the imminent Medicare changes**