Statement of

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On behalf of the

American College of Cardiology

Presented to the

HOUSE SMALL BUSINESS COMMITTEE

SUBCOMMITTEE ON INVESTIGATIONS, OVERSIGHT AND REGULATIONS

Health Care Realignment and Regulation: The Demise of Small and Solo Practices?

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Chairman Coffman and members of the Subcommittee, I am Jerry Kennett, Chairman of the American College of Cardiology (ACC) Advocacy Steering Committee. I am a cardiologist with Missouri Cardiovascular Specialists - a seventeen person cardiology and cardiovascular surgery practice in Columbia, Missouri. I also serve in the role of Chief Medical Officer for Boone Hospital Center, a large community hospital in the BJC Healthcare System.

The ACC is a 40,000-member nonprofit medical society serving the needs of both providers and patients in this country and internationally. The College has been a leader in producing guidelines of care, professional and patient education, and operating national registries for assessing process measures and outcomes of cardiovascular procedures and everyday outpatient care.

A little more than a year ago, our group was an independent practice but now we are integrated with Boone Hospital in what is termed a purchased service agreement. According to a 2011 Lewin Group report on the economic impact of office based physician practices, these small businesses, such as mine, account for 4 million jobs across the United States with $833 billion in wages and benefits. These small businesses generate $63 billion in state and local tax revenue.

My group was one of those typical office based practices but due to a variety of factors, some of which are discussed (below), chose to become integrated with our hospital. We had grown to over 100 employees. We occupy over 15,000 square feet in an office building attached to our hospital. Our practice included a cardiac diagnostic center where patients had easy access to echocardiograms, stress tests and even an outpatient cardiac catheterization laboratory.

Physician practices are different from almost any other small businesses. The payment for services performed is not controlled by free market dynamics but instead payment is tightly regulated by Medicare and Medicaid and private payers who essentially follow the lead of the government with the recipient of the services or patient often having very little personal cost.

The ACC estimates that 60-70 percent of our current physician members have integrated with hospitals. Why has this happened? There are a variety of factors that have contributed to this evolution. The prominent reasons relate to Medicare physician payment not keeping up with actual practice costs (See Appendix A), direct cuts in Medicare physician reimbursement (See Appendix B), and increased administrative and regulatory burdens. All these add up to tremendous uncertainty among physicians as to what the future holds and so many physician practices see hospital integration as their only choice.

Congress Must Act To Permanently Repeal the SGR

Every year since 2002, physician practices have been threatened with significant cuts in Medicare reimbursement. In March 2012, Congress stepped in to prevent a 27 percent payment

cut effective until January 2013, marking the 14th time Congress has had to intervene with a short term patch in the last 10 years. Congress must act again before the end of the year for the 15th time to avoid a nearly 30 percent cut. This process is a vicious cycle that creates uncertainty for physicians and their practices and threatens access to seniors.

An online survey conducted by the American Medical Association (AMA) in May 2010 received feedback from over 9,000 Medicare physicians about the impact of short-term delays on Medicare physician payment and found the following:

- Physicians looked into opting out of Medicare and treating patients through the private contracting option (60%)
- Delayed payments for supplies, rent and/or other expenses (39%)
- Took out a loan or line of credit in order to continue paying bills (17%)
- Held up paychecks or laid off/furloughed staff (17%)
- Cancelled or postponed scheduled services to Medicare patients (14%)
- Temporarily closed practice to new appointments with Medicare patients (13%)

This is no way to conduct a small business. Our practice just like many others has to consider these options when cash flow is interrupted. How would Members of Congress feel if you didn't know what next month's check would be?

Another major turning point occurred in the 2010 Medicare Physician Fee Schedule in which payment to cardiology practices for some in-office procedures such as echocardiograms, and stress tests were reduced by up to 35 percent. The same test performed at the hospital and interpreted by the same physician was reimbursed to the hospital by as much as three times greater. How many small businesses could survive a 35 percent cut in payment for the exact same service? Our practice, like many others, decided we could not continue to run our diagnostic center without losing large amounts of money and decided our best option was to integrate with the hospital.

The College urges Congress to avert the nearly 30 percent scheduled Medicare reimbursement cuts, repeal the sustainable growth rate (SGR) and provide stable payments for several years to allow the development of new delivery and payment models. Medicare's future uncertainty stifles physician practices from making real investments aimed at improving coordination and reducing the current fragmentation of care and reducing waste. It also hinders badly needed economic activity and growth in our communities. Congress needs to take decisive action to end this continuous cycle that harms physician practices, our patients, and our economy.

Congress Must Act to Limit and Reduce Regulatory and Administrative Burdens to Practices

There are a significant number of regulatory and administrative burdens that contribute to the uncertainty for physician practices and hinder their ability to grow. Here are a few examples:

Audits

While physician claims for services are generally subject to contractor medical review, greater scrutiny in recent years has increased costs and uncertainty. Physician claims must comply with National Correct Coding Initiative (NCCI) Edits, Medically Unlikely Edits (MUEs), Comprehensive Error Rate Testing (CERT), and Recovery Audit Contractors (RACs). Other initiatives such as prepayment review demonstrations for certain cardiovascular and orthopedic DRGs have been delayed, but continue to create uncertainty for providers. Each of these programs has different rules and regulations. Physicians struggle at first to determine the program to which they are being subjected, and then attempt to quickly resolve any issues to minimize the impact on the practice's ability to provide high-quality patient care.

ICD-10

The Centers for Medicare and Medicaid Services (CMS) has announced the implementation of ICD-10, a diagnostic coding system, to replace ICD-9. Moving to ICD-10 is expected to impact all physicians due to the increased number, complexity and specificity of codes. ICD-9 has 14,315 codes to choose from for a diagnosis, ICD-10 will have more than 87,000. This transition will require significant planning, training, software/system upgrades/replacements, as well as other necessary investments which can cost, for example, a small three physician practice a total of over $83,000 to implement. These figures are higher than CMS originally estimated and place a heavy financial burden on physician practices.

Multiple Medicare Penalties

Starting in 2011, Medicare began to penalize physicians for not meeting the requirements of certain incentive programs. In the coming years, physicians will be penalized for not prescribing electronically, not participating in the meaningful use of an electronic medical record, and not submitting quality data through the Physician Quality Reporting System (PQRS). In addition, beginning in 2015 a value-based purchasing modifier, as yet not specified, has the potential to further penalize physicians. Because CMS will base its assessment of a physician's performance as much as two years in advance of the actual penalty, physician practices must account for the possibility of even further decreased payments in long-term planning.

Cost and challenges of implementing EHR and achieving meaningful use

ACC strongly supports the establishment of a nationwide health information technology infrastructure as a critical step in improving the quality of healthcare. The costs and challenges of implementing an electronic health record and taking the steps necessary to qualify for the incentives offered through the electronic health record (EHR) incentive program authorized by Congress under the American Recovery and Reinvestment Act (ARRA), however, can be overwhelming for small and medium sized physician practices. ACC members – even those who were early adopters of EHRs-- have reported significant challenges in meeting the requirements for just the first stage of the meaningful use incentive program.

Small practices can have difficulty making the initial outlays required to implement an EHR. A recent study of EHR implementation in a network of primary care practices estimated direct costs through the first year at $46,000 per physician, with anticipated annual maintenance costs of $17,000 per physician in subsequent years. [1] In addition, practices must re-engineer workflow for both physicians and staff to accommodate the additional time needed for electronic documentation. Practices in the early stages of implementation typically experience significant lost revenue due to reduced productivity. The payments offered under the EHR Incentive Program for those who quality can offset some of these costs, but the challenges of making the upfront investment, retraining staff and physicians, and marshaling the necessary expertise can be too much for an independent practice to manage on its own.

The Future of Medicare Physician Payment

Finally, physicians have significant anxiety regarding the future of Medicare payment reform. New payment systems that are being implemented such as accountable care organizations (ACOs) and bundled payments often require specialized staffing just to administer them. Future payment models may be even more complex. Physicians are afraid of being left out or being unable to participate in these new payment systems, further contributing to uncertainty.

Conclusion

The financial pressures associated with declining reimbursements and rising operational costs on private cardiology practices have resulted in rapid migration of practices to hospital affiliation. Continued cuts in Medicare reimbursement, combined with increasing overhead costs, increased

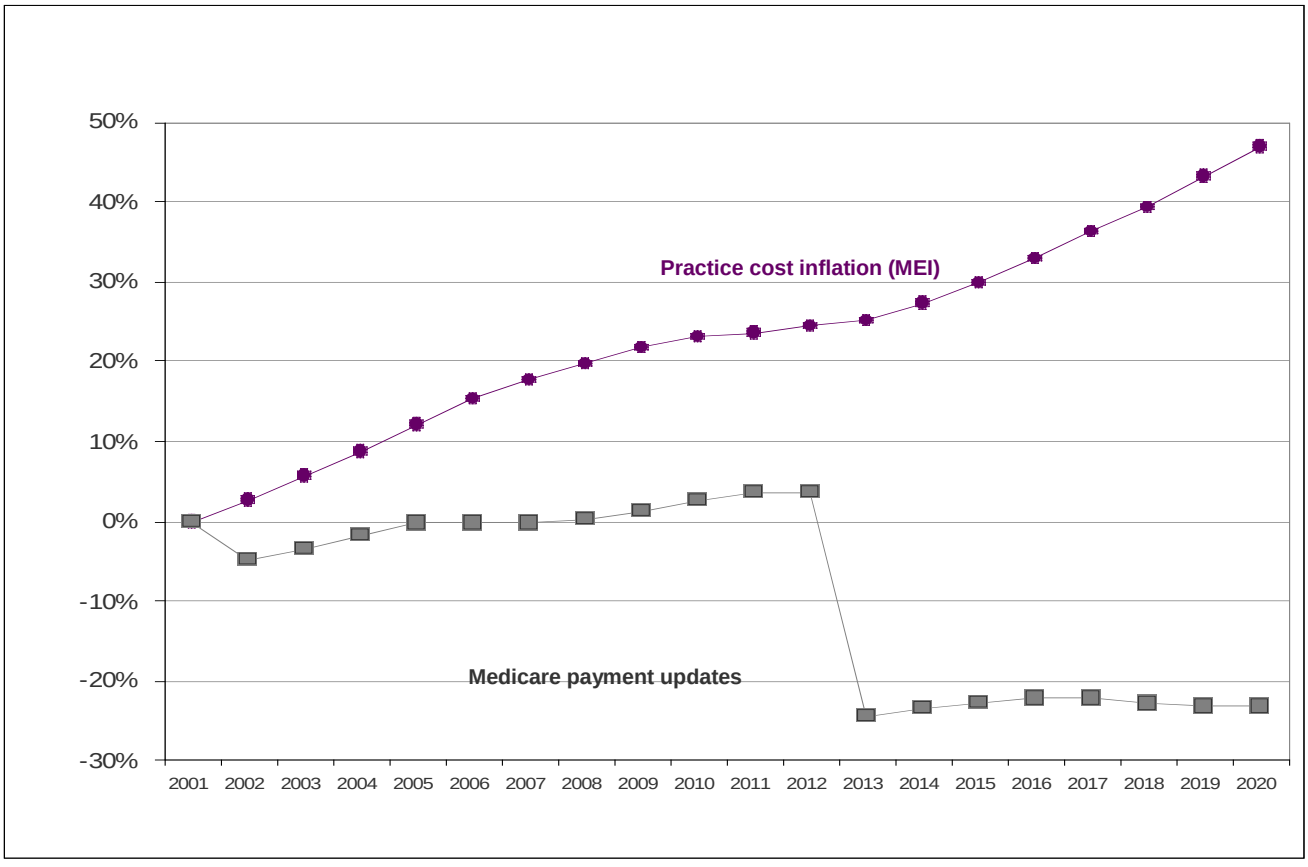
[1] Fleming, et al. The financial and nonfinancial sots of implementing electronic records in primary care practices. *Health Affairs*, 30, no. 3 (2011): 481-489.

regulation, unfunded mandates and an uncertain, cloudy future are making it difficult for practices to remain viable.

We believe that a well-functioning Medicare payment system provides opportunities for physicians to practice both independently or as employees of a hospital. Increased payment should come from increased quality and demonstrated appropriate utilization and physicians should be appropriately paid for the increasing expectations associated with the practice of medicine.

Thank you for the opportunity to share my views with the Committee.

Appendix A



Source: 2011 Medicare Trustees Report for all years except 2013, which is derived from CMS letter to Medicare Payment Advisory Commission of March 6, 2012. Prepared by American Medical Association, Economic and Health Policy Research, April 2012.

Appendix B

Timeline of Payment Reductions Impacting Cardiology

January 2007

- Imaging cuts included in the Deficit Reduction Act of 2006 implemented – capped payment for advanced imaging services paid under the Physician Fee Schedule (PFS) at the lower of the PFS rate or the Hospital Outpatient PPS (HOPPS) rate
- CMS implemented Relative Value Unit (RVU) Cuts (4 year phase-in)

January 2010

- CMS implemented first year of Physician Practice Information Survey (PPIS) cuts. Survey data resulted in significant reduction in practice expense per hour rates over 4 year phase-in
- CMS increased equipment utilization rate assumption to 90% from 50% for expensive imaging equipment. Increase set to be phased-in over 4 years

January 2011

- Patient Protection and Affordable Care Act (PPACA) set equipment utilization rate assumption at 75 percent (up from an effective rate of 62.5 percent due to 4 year phase-in of 90 percent assumption)
- Bundled payments for procedures performed together more than 75 percent of the time

July 2012

- CMS proposes 25 percent reduction of the technical component when one cardiovascular diagnostic service is provided by the same physician practice at the same session

January 2013

- Physicians who do not e-prescribe are subject to a 1.5 percent Medicare penalty

January 2015

- Physicians who elect not to participate in PQRS or are found unsuccessful during the 2013 program year, will receive a 1.5% payment penalty in 2015, and 2% thereafter.
- Value-Based Payment Modifier program will begin in 2015 to adjust some physician or group Medicare payments based on 2013 quality and cost measurement data