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Society Grassroots Efforts Pay Off: Senate Approves Additional \$7 Billion for Health Care Spending

On March 16, 2006 the Senate narrowly approved its version of the Fiscal Year 2007 Budget Resolution by a vote of 51-49. The measure approves spending caps for the upcoming fiscal year and provides a fiscal blueprint for congressional appropriators. During deliberations of the Budget Resolution, an amendment was offered by Senator Arlen Specter (R-PA) and Senator Tom Harkin (D-IA) to add an additional \$7 billion to the budget for federal health and education programs. The amendment passed by a vote of 73-27. Before being sent to the Senate floor the Senate Budget Committee added an additional \$3 billion increase over the President's request to the same programs.

On the Senate floor Senator Specter, Chairman of the Senate Appropriations Labor/HHS/Education Subcommittee, stated that the amendment would bring back funding levels for the Subcommittee to its Fiscal Year 2005 levels after seeing a reduction in 2006 and a proposed reduction in 2007. While not all the additional spending would be slated for the National Institutes of Health (NIH), the agency would be expected to receive a more generous appropriation than was proposed by the President. The President's budget proposed to freeze funding levels for NIH at 2006 levels for 2007.

The House has not yet drafted its version of the 2007 Budget Resolution but is expected to act in the coming weeks. If the House does not agree to add the additional \$7 billion in its version of the Budget Resolution, the two versions would have to be worked out in a conference committee between the House and the Senate.

In advance of the resolution the Society sent a member alert asking Society members to contact their Senators and urge them to support the Specter/Harkin amendment. In response to this alert, more than 1,400 messages to the Senate were generated by Society members helping push for the ultimate passage of the amendment.

Also included in the Senate version of the Fiscal Year 2007 Budget Resolution, passed on March 16, was a provision to stop the annual cut in Medicare reimbursements to physicians. The amendment, sponsored by Senator Kay Bailey Hutchison (R-TX), would create a deficit neutral "reserve fund to ensure that physicians will receive an appropriate reimbursement rate under Medicare instead of a scheduled cut which would threaten the adequate provision of care for seniors and disabled citizens."

It is unclear if the House will adopt the provision in its version of the Budget Resolution. The provision does not have standing as law, but does provide a benchmark to gauge Congress' attitudes towards fixing the flawed Medicare payment system.

More Details Emerge on AMA Deal with Congress Regarding P4P

More details have emerged regarding the December 16, 2005 "deal" struck between the AMA and congressional leaders. This agreement stated that physician groups will develop performance measures that will be used by the federal government to improve the quality and efficiency of health care and patient outcomes in Medicare. These performance measures will be used in "pay-for-performance" (P4P) initiatives, which attempt to link performance on standard measures of care to Medicare payments. The signed deal is as follows:

Joint House-Senate Working Agreement with the AMA

- In 2006, physician groups will work with the Centers for Medicare and Medicaid Services (CMS) to reach agreement on a starter set of evidence-based quality measures for a broad group of specialties for review by a consensus-building process.
- By the end of 2006, physician groups will have developed a total of approximately 140 physician performance measures covering 34 clinical areas.
- In 2006, physician groups will work with CMS to develop the most accurate and efficient method for physicians to report quality data to CMS.
- During 2006, physician groups will develop with CMS, the House Committee on Ways & Means, the House Committee on Energy & Commerce, and the Senate Committee on Finance to implement additional reforms to address payment and quality objectives.
- In 2007, physicians would report voluntarily to CMS on at least 3 to 5 quality measures per physician. Physicians that report measures should receive an additional quality update to offset administrative costs.
- By the end of 2007, physician groups will have developed performance measures to cover a majority of Medicare spending for physician services.

This deal was signed by: Duane Cady, M.D., AMA Board Chair; Sen. Chuck Grassley (R-IA), Senate Finance Committee Chairman; Rep. Bill Thomas (R-CA), House Ways & Means Committee Chairman; Rep. Nathan Deal (R-GA), House Energy and Commerce Health Subcommittee Chairman.

News of this pact was met with an overwhelmingly negative reaction from many physician specialty groups. In particular, groups were skeptical about the ambitious timetable and frustrated that the AMA signed an agreement on behalf of specialty society members without prior consultation. The AMA letter stated that the deal was made under pressure from the congressional leadership, and they were not given time to consult with the specialty societies and that physician groups must demonstrate a commitment to work with policy makers on p4p initiatives in exchange for a one-year fix that would avert the scheduled 4.4 percent cut in physician Medicare reimbursement for 2006. In a February 7 memo to state medical societies and national medical specialty associations, AMA CEO Michael Maves, M.D., writes that "[The White House and the committee chairman] were less inclined to

address payment cuts triggered by the sustainable growth rate (SGR) formula if there was insufficient progress on the quality front.”

The AMA also stated that it signed the deal on behalf of the Physician Consortium for Performance Improvement (Consortium), an AMA-convened group comprising more than 70 national medical specialty and state medical societies that works to develop evidence-based clinical performance measures and outcomes reporting tools for physicians. The Consortium has already developed 90 performance measures, with approximately 20 slated for development in 2006. The American College of Physicians (ACP), which has also been at the forefront of P4P discussions, did not express much concern over the deal. Richard Trachtman, Director of Congressional Affairs for ACP, stated that ACP does not “think [the agreement] is as big a deal as some of the specialties are making of it. It just commits AMA to work with physician groups to develop more measures and support voluntary reporting by as early as 2007.”

Further evidence of the AMA drive to be a leader in P4P discussions came when, ten days after the AMA signed the pact, CMS announced modifications to its newly implemented Physician Voluntary Reporting Program (PVRP). Originally, the quality initiative was based on a starter set of 32 quality reporting measures, but was downscaled to a starter set of 16 measures. Initial resistance from the medical community towards the PVRP was likely a driving force behind components of the AMA deal set forth by congressional leaders.

NIDDK Addresses Society’s Government Relations Committee

Dr. Judith Fradkin, Director of the Division of Diabetes, Endocrinology, and Metabolic Diseases at NIDDK, presented to the Society’s Government Relations Committee during its March 12 meeting. Dr. Fradkin outlined how the Institute will be adjusting to shrinking budgets and how they intend to engage new investigators.

Among the initiatives Dr. Fradkin mentioned was the Institute’s K99/ROO Pathway to Independence Award for new investigators. The Pathway to Independence Award will provide up to five years of support consisting of two phases. The initial phase will provide 1-2 years of mentored support for highly promising, postdoctoral research scientists. This phase will be followed by up to 3 years of independent support contingent on securing an independent research position. Award recipients will be expected to compete successfully for independent R01 support from the NIH during the career transition award period. Currently, 28 percent of R01 grants are distributed to new investigators. Dr. Fradkin indicated that the Institute plans to keep the same grant distribution percentage, but that the plan is to decrease allocations to non-competing grants by 2.3 percent.

The Director also made it clear that the Institute will not penalize those investigators who carry multiple grants, but that the Institute is actively seeking a balance between seasoned investigators and new investigators. In addition, Dr. Fradkin pointed out to the Committee that a special line item appropriation, which has been allocated to the Institute specifically for study in Type I diabetes, is scheduled to sunset in 2009. For Fiscal Year 2007 this Type I special appropriation is scheduled to receive \$150 million.

Dr. Fradkin also mentioned that Dr. Griff Rogers will be acting director of the Institute following Dr. Allen Spiegel’s announcement in February that he would be leaving his

position as Institute Director. Dr. Fradkin asked that The Endocrine Society work closely with the NIH to identify potential candidates for a new Director.

Society Submits Comments to U.S. NRC

On September 2, 2005 the Nuclear Regulatory Commission (NRC) received a citizen petition regarding iodine I-131 treatment. The petitioner requested that the NRC amend the regulation that governs the use of byproduct material and the release of individuals who have been treated with radio pharmaceuticals. The request asked that the rule be altered to not allow patients to be released from radioactive isolation with more than the equivalent of 30 millicuries (mCi) of radioactive iodine I-131 in their bodies.

The Endocrine Society joined several other medical societies in submitting comments opposing the rule change. In the Society's comments, it was argued that the current regulation provides the most effective and efficient care for patients being treated for life threatening thyroid diseases. The Society stated that there is no compelling evidence to support the modification of the current Patient Release Rule (10 CFR 35.75). In fact, available data published in the *Journal of the American Medical Association*, suggests that radiation exposure to household members of patients who received outpatient I-131 treatment ranged from ~75 to ~150 mCi of I-131 was low. The comments further suggested that any change in current policy should be developed using evidence-based data and carefully performed studies, not anecdotal evidence, to prevent unintended negative consequences for both patients and the nation's health care system.

The Society's comments can be viewed at <http://www.endo-society.org/publicpolicy/legislative/index.cfm>.

MedPAC Calls for Independent Panel to Advise RUC

The Medicare Payment Advisory Commission (MedPAC), an independent federal body established in 1997 to advise the U.S. Congress on issues affecting the Medicare program, released a new March 2006 report. MedPAC is charged with reviewing Medicare payment policies and recommending updates and improvements to Congress each March. In this latest report, MedPAC states that CMS should convene an independent panel, funded by Congress, to improve CMS's ability to identify potential overvalued services, as well as review work relative value unit (RVU) recommendations made by the AMA Specialty Society Relative Value Scale Update Committee (RUC).

The RUC is a multi-specialty committee formed by the AMA that works to make relative value recommendations for new and revised CPT codes as well as annually update RVUs to reflect changes in medical practice. The RUC works in conjunction with the Current Procedural Terminology (CPT) Editorial Panel in a process where specialty societies can present recommendations for codes. The RUC comprises representatives from medical specialty societies, including The Endocrine Society. MedPAC argues in its report that periodic review and accurate valuation of RVUs is essential because the resources needed to perform a service may change over time, and that the RUC does not effectively identify services that may be overvalued. The Committee also recommends establishing a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC. Furthermore, the Secretary of Health and Human Services should initiate

review for services that may have experienced substantial changes in factors that may indicate changes in physician work and identify new services likely to experience reductions in value.

The MedPAC report also recommends that Congress grant physicians a positive update in payments for physician services in 2007. Currently, a flaw in the sustainable growth rate (SGR) formula has resulted in negative payment updates from 2007 through 2011. The report comments that these scheduled fee cuts could threaten beneficiary access to physician services; particularly those offered by primary care physicians. It also encourages Congress to examine alternatives to the flawed SGR payment formula.

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