# Adapting cardiology practice to recent and future health care legislation

David May MD, PhD FACC

# Disclosure

– Chairman, ACC Board of Governors
– Served on a number of ACC committees (pro bono)
  - Payment reform work group
  - Advocacy Steering Committee
  - Lifelong Learning Oversight committee
  - Executive committee
  - Board of Trustees
– Managing partner of my private practice group

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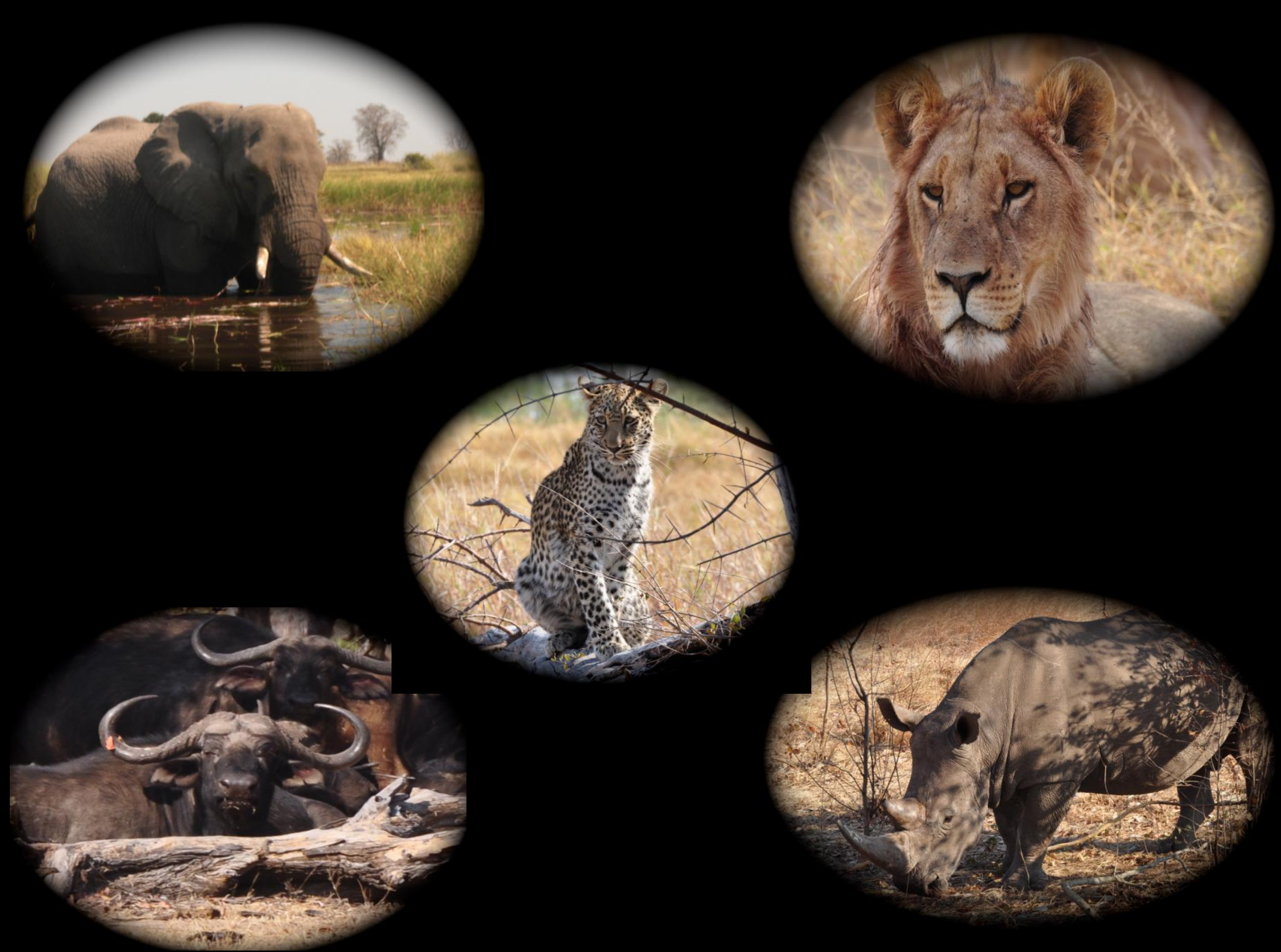
"Those who do not remember the past are condemned to repeat it"

George Santayana



# Medicare and Medicaid

The elephant in the room

# Medicare and Medicaid

- Enacted in 1965 via Title XVIII and XIX of the Social Security Act
- 19 million covered lives added July 1 1966
- 1977 HCFA formed to administer
- 1983 DRG system implemented
- 1988 RBRVS system developed, adopted in 1992 (The PFS was born!)

# Medicare and Medicaid

- 1996 Welfare Reform Act / HIPPA
  - required HHS to issue privacy regulations if Congress failed to enact substantive privacy legislation.
- 1997 Balanced Budget Act of 1997 (SGR)
- 2000 Hospital Outpatient Prospective Payment (HOPPS) implemented
- 2003 Medicare Prescription Drug Improvement and Modernization Act

# A closer look at Medicare/ Medicaid

# Medicare and Medicaid

- 1983 DRG's implemented…to reduce cost
  - Developed by Fetter and Thompson at Yale
  - 467 "groupers" with 467 being "ungroupable"
  - Hospitals immediately respond by
    - Reducing length of stay
    - Gaming the system by upcoding
    - Adding in comorbid conditions
  - Led directly to "observation status"

# Medicare and Medicaid

- 1988 RBRVS
  - Hsiao (Harvard) developed w CMS support
  - Implemented in 1992
  - Has no methodology to account for down time, supervisory time in academic medical center or "on call" time.
  - Felt to have led to physician "churning" to increase production
  - Led to the physician fee schedule released by CMS in July for comment and Nov final rule

# Medicare and Medicaid

## Impact of the RVU Fee Schedule on Medicare Reimbursement of Physicians, by Specialty From 1991–1997[10]

| *Specialty* | *Total Impact on Medicare Payment* |
|---|---|
| Cardiothoracic surgery | - 9.3% |
| Cardiology | - 15% |
| Urology | + 12.2% |
| Family practice | + 36.0% |
| Orthopedic surgery | - 1.7% |
| Ophthalmology | - 18.4% |
| Dermatology | + 9.0% |
| General surgery | + .1% |
| Gastroenterology | -14.4% |
| Internal medicine | + 16.5% |

Ingelhart NEJM 340(4), 1999

# Medicare and Medicaid

- 2000 HOPPS payment system
  - Authorized by 1833(t) of the Social Security Act
  - Pays hospitals for outpatient services such as imaging (at a rate 3-4 times higher than in a physician office under the PFS)
  - Not subject to CMS PFS rulings
  - Has made it very attractive to employ physicians to gain the “testing” under HOPPS

# Medicare and Medicaid

**PFS % of HOPPS for four services**

140%
120%
100%
80%
60%
40%
20%
0%

2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012

EKG
Stress Test
Rest Echo
Cath

# Sustainable Growth Rate formula

"The SGRrrrrrrrrrr"

# Sustainable Growth Rate

- Created in 1997 to control growth of Part B
- Ties increase in expenditure to GDP growth
- Included drugs and testing in the formula
- In 2002, 5.4 % reduction imposed
  - The turmoil was enormous
  - Congress blinked

# Sustainable Growth Rate

| Year | Scheduled Rate | Congressional Action |
| --- | --- | --- |
| 2002 | -5.4% cut | None |
| 2003 | -4.4% cut | 1.6% increase |
| 2004 | -4.5% cut | 1.5% increase |
| 2005 | -3.3% cut | 1.5% increase |
| 2006 | -4.4% cut | Freeze at 2005 level |
| 2007 | -5% cut | Freeze at 2005 level |
| 2008 | -10.1% cut | 0.5% increase |
| 2009 | -15% cut | 1.1% increase |
| 2010 | -21% cut | |

# Sustainable Growth Rate

- Now, to correct it requires about a 135 billion dollar "hickey"
  - "pay for" such as war savings, HOPPS savings or some other saving
  - Add it to the national debt
- Source of the "doc fix", that annual ritual of "kicking the can down the road"
- Really a political club today
- Recent legislative interest in eliminating it (it's "on sale")

# “Meaningful Use”

EHR, HITECH and the digital strategy

# Meaningful Use

- American Recovery and Reinvestment Act
  - The "stimulus bill"
  - Feb 19, 2009
  - Included Health Information Technology for Economic and Clinical Health Act (HITECH)
    - Formed office of national coordinator
    - Provides funds for "meaningful use" of EHR

# Meaningful Use

- "The HITECH Act program focuses on attaining meaningful use of EHRs as a pathway toward improved health system performance. The attainment of meaningful use depends, in turn, on adoption of EHRs and the development of secure and private pathways for exchanging health information. Adoption and exchange will be supported by a variety of HITECH Act initiatives."
- *-- David Blumenthal, MD, National Coordinator*

# Meaningful Use

- ~ 350 EHR vendors before HITECH
- Now just over 600
- Ambulatory EMR/EHR software spending
  - $633.5 million in 2009
  - $1.4 billion in 2015
  - CAGR for ambulatory EMR spending between 2009 and 2015 is expected to be 14.2%

http://www.emrandhipaa.com/emr-and-hipaa/2012/04/11/over-600-ehr-vendors/

# Meaningful Use

- Inpatient EMR/EHR
  - $1.3 billion in 2009
  - expected to grow to $2.4 billion in 2015
  - CAGR for inpatient EMR/EHR spending between 2009 and 2015 is expected to be 10%.
- Spurred the exploration of HIE
  - Projected to be $16 b “cottage industry”

http://www.informationweek.com/healthcare/electronic-medical-records/ehr-spending-to-hit-38-billion-in-2015/229000480

# Meaningful Use

**Healthcare IT Spending To Reach $40 Billion**

**The U.S market for healthcare IT hardware, software, and services is expected to grow 24% annually for several years, driven in part by mandatory use of EHRs.**

Projected total Health IT expenditure through 2014

http://www.informationweek.com/healthcare/electronic-medical-records/healthcare-it-spending-to-reach-40-billi/229500682

# Meaningful Use

**Meaningful use creates consulting boom**

September 07, 2012 | Bernie Monegain, Editor

Well, at least we've stimulated the economy!

http://www.healthcareitnews.com/news/meaningful-use-creates-consulting-boom

# “The Rule”

January, 2010

# "The Rule"

- The usual CMS PFS released for comment July, 2009
  - Draconian cuts to nuclear and echo
  - No CMS director at the time
  - (there were a lot of comments, most not publishable!)
  - ACC, MedAxiom & others go into action as cardiology is severely damaged by imaging cuts, rolled out as a "new code".

# “The Rule”

- Initial ACC response to “educate” members and congress
- About October, 2009 came the realization that the cuts were not “in error”
- Strategically, house of medicine was divided, our response relegated to “all about the money” which it was.

# "The Rule"

- Echo fee reduction 24%
- SPECT 35-56% depending on how you billed
- Within 6 months, there was a huge surge in "integration"

# “The Rule”

Currently….

- 64% of cardiologists are “integrated”
- 40% of practices are “integrated”
- No indication it is slowing
- 68% of “integrated” doctors say they are better or the same. (What happened to the 32%?)

# “The Rule”

- At present….
  - There is roughly a 40% increase in expenditure in integrated markets
  - The first wave of integrated contracts are starting to be re-negotiated
  - The congress has recognized that there are other ways to cut the PFS without changing the conversion factor
    - IOASE
    - Change the utilization rate assumption

# Patient Protection and Affordable Care Act

"The mother of all tax legislation"

# PPACA

- 907 pages in consolidated print
- Exhaustive in scope and jargon
- Still under attack from a number of angles
- It is the law of the land
  - Signed March 23, 2010
  - SCOTUS ruling June 28, 2012

# PPACA

- Establishes the ACO concept, VBP, re-admission penalty
- Requires all to buy insurance or pay a tax (~30 mil added to rolls)
- Establishes that states must have health insurance exchanges by 2014 for small employers (<100)
- Large employers in 2016 may use exchange

# PPACA

- does not have “death panels”
- does establish a huge number of commissions and committees such as the IPAB
- does give incredible authority to CMS and HHS in the form of regulatory determination

# In summary…

Federal involvement in healthcare financing and expenditure has, in the last 50 years, been extensive, pervasive, in fact the dominant force, shaping the practice of medicine in the US

# And so what does all this mean for cardiovascular practices in the near future?

# Likely/possible

- Medicare
  - IOASE will likely be trimmed/eliminated
  - PFS used to reshape payment
  - SGR likely still political football
  - HOPPS payment cuts in next years
- MU ~implementation of MU-2
- PPACA
  - VBP
  - Expansion of re-admission penalty
  - DSH payment reductions out of phase w Medicaid expansion

# And so what to do….?

- Define your practice model
- Private practice
  - Work toward debt free
  - Focus on E and M, limit exposure to imaging cuts
  - Examine/invest in IT that is flexible & learn to use it
  - Explore virtual relationships
  - Demonstrate your quality/conservative care
  - Examine/understand the potential effect of various payment models on your practice

# And so what to do…?

- Integrated practice
  - Honestly evaluate your integration- horizontal/vertical/employed by system/employed by hospital
  - Understand your hospital partner and their threats…generally they have more at risk and the culture is very different.
  - Anticipate HOPPS cuts/lost revenue due to re-admission penalties/VBP misses & the impact
  - Be prepared for workforce modification if severe cuts occur.

# And so what to do…?

- Academic practice
  - Expect, explore, understand the impact of GME cuts
  - These will be in addition to your University Hosp cuts
    - Imaging cuts
    - VBP issues
    - Readmission fee reductions
    - DSH reductions
  - Examine your potential to lead ACO models of care, particularly in specialty arena
  - Pay particular attention to sequestration cuts to research funding & its impact on the institution

# Discussion?