Supreme Court Decision

Anti-injunction Act not applicable 9-0

Individual mandate 5-4
  – Violates Commerce Clause 5-4
  – Allowed under Congress’ Taxing Authority 5-4

Medicaid expansion 5-4
  – Unconstitutionally coercive 7-2
  – Remedy: no withholding existing Medicaid $ 5-4

Law of the land
ACA and Cardiology

Medicaid Expansion to 133% FPL optional

“Lies, damn lies and statistics”

– Will TX sacrifice billions when the “woodwork effect” will be marginal?
– Will Medicaid MD reimbursement decrease?
– Medicaid at Medicare levels

Prediction – less talk about “socialize medicine”, “Gov’t take over” or holding out for block grants after the election.
Impact on Cardiology

Quality and Value Based Purchasing (VBP)
- Quality Modifier 2015
- PQRS; extended bonus 4 yrs, added penalties

Public Reporting
- MD feedback; QRUR in 4 states
- Physician Compare (limited NCDR PCI and ICD measures)

Sunshine Act, CMMI, PCORI, IPAB
Quality Modifier Starts 2015*

- >25 MDs
  - Yes
  - No
    - 0%

- ppt in PQRS
  - Yes
  - No
    - -2.5%

- Elect ppt in VBM
  - Yes
  - No
    - 0%

Performance Resource use/risk adjustment

High quality, Low cost, High risk +3%

Average quality, Average cost, Average risk 0%

Low quality, High cost, Average risk -1%

* Based on 2013 data
“It’s the Rules not Reform!!!”

Payment = \[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Practice Expense RVU} \times \text{Practice Expense GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})\] \times (\text{Conversion Factor} \times \text{BNA})
MPPR – Multiple Procedure Payment Reduction

• Reduces the lesser Technical Charge(s) for multiple procedures by 25% (in PFS, not HOPPS or IPPS)
• E.g., Nuke/Stress -2%, ECG and ECHO -0.16%
• Risk: CMS applying similar cuts to Physician Charges in radiology; Picked up by payers; Bundling
• ACC actions with the CV societies:
• Comments - CMS really messed up codes
  – Possible year delay or refinement
• Legislative v. drawing attention
“1% here, 1% there it eventually adds up to real money”

- Penalties for nonppt in PQRS -1.5%
- MPPR, 2010 phase-in -3%
- Transition care -1%
- Sequestration -2%
- HOPPS mean v. geom mean -5% for some services
- SGR -28%
- PCI, EPS/Ablation: if CMS accepts RUC -17.5%
Threat of Automatic Cuts

The bipartisan committee charged with cutting the deficit must present at least $1.2 trillion in reductions by Nov. 23. If a plan fails to get approved by Congress by Jan. 15, $984 billion in automatic spending cuts will be triggered. This is how the automatic cuts would affect different spending categories from 2013 to 2021. Related Article »

**Defense**
- $492 billion in cuts
- 9% of $5.3 trillion spending cap
- Half the cuts are required to come from national security operations and military costs.

**Nondefense**
- **Discretionary**
  - $322 billion
  - 7% of $4.9 trillion spending cap
  - Includes health, education, drug enforcement, national parks and other agencies and programs.

- **Nonexempt Mandatory**
  - $47 billion
  - 4% of $726 billion estimated spending
  - Mostly agriculture programs.

**Medicare**
- $123 billion
- 2% of $6.1 trillion estimated spending
- Includes payments to Medicare providers and plans, limited to a 2 percent cut.

**Exempt Entitlements**
- No cuts
- $17 trillion estimated spending
- Social Security, Medicaid, veterans' benefits, federal retirement benefits, nutrition and other low-income programs.

What Direction Will Deficit Politics Take Healthcare Reform?

“We basically have two economic health care options: we can cut care; or we can improve care”

Berwick
ACC Reform Leadership

• Rational reimbursement and gain sharing

• Educate clinicians on their practice habits – “knowledge changes habits”
  • FOCUS
  • Registries - PCI, Pinnacle
  • Measurement, transparency, self study, LLP
  • Coordination with PCPs

• Emphasize clinical indications to drive testing
  Because we should; not because we can

ABIMF Choosing Wisely Campaign

• Improve cost effectiveness of CV care
Imaging is not the cause of rising Medicare costs

Source: CMS, OMB and RUC data
Summary

Change is inevitable
Uncertainty - SGR, politics - is more disruptive than change
ACA = politics; 2010 & 2013 PFS rules = impact
Cardiology disrupted by the 2010 PFS, adapted
ACC quality and education initiatives position cardiac care for the future no matter the setting or payment model